CREATING CONFIDENTIALITY:

PHYSICIAN-PATIENT PRIVILEGE AND MEDICAL CONFIDENTIALITY

IN THE UNITED STATES, 1776-1975

by

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DISSERTATION ABSTRACT

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Creating Confidentiality: Physician-Patient Privilege and Medical Confidentiality in the United States, 1776-1975

This dissertation examines the rise of physician-patient privilege in the United States. Owing to the Duchess of Kingston's 1776 trial for bigamy, the privilege is not recognized in many common law jurisdictions, including federal courtrooms. Beginning in New York in 1828, however, physician-patient privilege was gradually incorporated into the statutory codes of numerous states. At present, most American courtrooms observe some form of the privilege. Drawing upon medical and legal sources, especially professional journals, this dissertation places physician-patient privilege in its historical context, analyzing the ways in which developments within the medical and legal professions have shaped the evolution of the privilege. Understanding this history is essential in order to explain the history of privilege as policy—that is how physician-patient privilege became a widely accepted legal doctrine in the United States, why the privilege remains such an unevenly applied rule in American courts, and how law protects medical confidentiality today. But it is also sheds light on the intersections of two of America's most powerful professions—medicine and the law—and carries implications to the broader history of professionalization.

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CHAPTER I: INTRODUCTION

Medical confidentiality mandates that doctors work to protect their patients' secrets. But what happens when physicians are called upon to testify in a court of law? Upon questioning in the courtroom, are physicians ethically—or legally—justified in revealing their patients' secrets? In the United States, the laws governing medical testimony in the courtroom are myriad and contradictory. In some courtrooms, doctors are forbidden from disclosing their patients' secrets. In others, doctors risk being held in contempt of court if they withhold any information. New York's statutory code protects almost all communications between doctor and patient. Massachusetts, on the other hand, requires physicians to submit to any and all questions. In California, physicians must reveal their patients' secrets in criminal trials, but cannot in civil trials. At present, federal law is ambiguous on the subject.[1]

These contradictions are a product of the unusual origins and uneven evolution of physician-patient privilege.[2] This dissertation traces the history of physician-patient privilege

[1] On the law of Evidence today, see Kenneth C. Broun, *McCormick on Evidence* 7th edition (Eagan, MN: Thompson West, 2013). In criminal cases, federal courts operate under the *Federal Rules of Evidence* which were adopted in 1975 and do not include physician-patient privilege. In civil cases, federal courts operate according to the laws of the state in which the suit is adjudicated—physician-patient privilege is observed in those states that have privilege statutes and not observed in those states that do not have statutes. Federal Rules of Evidence, H.R. Rep. No 93-650, 93rd Congress, 1st Session 28 (1973), rule 501.

[2] To date, the most thorough treatment of this history has occurred in legal treatises, where legal scholars have traced the evolution of various privilege statutes over the course of the nineteenth and twentieth centuries. Among these sources, my dissertation draws heavily upon John Henry Wigmore, *A Treatise on the System of Evidence in Trials at Common Law Including the Statutes and Judicial Decisions of All Jurisdictions of the United States* vol. 4 (1st ed., Boston, 1905); Clinton DeWitt, *Privileged Communications Between Physician and Patient* (Springfield, Ill.: Charles C. Thomas, 1958); and Edward J. Imwinkelried, *The New Wigmore: Evidentiary Privileges* (3rd ed., New York: Wolters Kluwer, 2016). The best historical analysis of physician-patient privilege is Andreas-Holger Maehle, *Contesting Medical Confidentiality: Origins of the Debate in the United States, Britain, and Germany* (Chicago and London: University of Chicago Press, 2016). Angus Ferguson, *Should a Doctor Tell? The Evolution of Medical Confidentiality in Britain* (Farnham: Ashgate, 2013) offers an overview of similar developments in the United Kingdom. Legal examinations such as Daniel Shuman, "The Origins of Physician-Patient Privilege and the Professional Secret," *Southwestern Law Journal* 39:2 (June 1985), 661-688 offer useful information on the

in the United States over the course of the nineteenth and twentieth centuries. It explains how our current laws regulating medical testimony in the courtroom were cobbled together in response to a variety of disparate medical and legal developments—many predating the modern notions of privacy and patients' rights often associated with the privilege today.[3] This is a story shaped by long mis-remembered court cases, sweeping movements to reshape American law, and attempts to professionalize the medical and legal professions.[4]

This study is also an examination of two of America's most powerful professions.[5] By analyzing the debates surrounding physician-patient privilege, my dissertation illuminates some of the means that lawyers and doctors have utilized to set their professions apart from other occupations. Nearly all forms of privileged communications have been justified on utilitarian grounds. If not for the protection afforded by privileged communications, the

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evolution of legal arguments for and against physician-patient privilege in America, but do not analyze the social context in which these statutes arose or their effects on the medical profession.

[3] Legal scholars Samuel Warren and Louis Brandeis first proposed a "right to privacy" in 1890, long after medical confidentiality laws had been enacted in many states. Over the course of the twentieth century, the Supreme Court gradually came to see privacy as a constitutionally protected right, ruling in 1965 that "zones of privacy" were guaranteed by the Bill of Rights. By this point, nearly all of the laws on physician-patient privilege were already in effect. Samuel Warren and Louis Brandeis, "The Right to Privacy," *Harvard Law Review* 4:5 (Dec., 1890), 193-220; Griswold v. Connecticut, US 479, 484 (1965); Leigh Ann Wheeler, *How Sex Became A Civil Liberty* (Oxford and New York: Oxford University Press, 2013); Amitai Etzioni, *The Limits of Privacy* (New York: Basic Books, 1999); Sarah Igo, *The Known Citizen: A History of Privacy in Modern America* (Cambridge, MA: Harvard University Press, 2018); and Deborah Nelson, *Pursuing Privacy in Cold War America* (New York: Columbia University Press, 2002).

[4] On the professionalization of medicine, this study draws most heavily upon Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a Vast Industry* (New York: Basic Books, 1982); and William Rothstein, *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: Johns Hopkins University Press, 1972). On professionalization in general, see Bruce A. Kimball, *The "True Professional Ideal" in America: A History* (Lanham, MD: Rowman & Littlefield, 1995); Nathan O. Hatch ed., *The Professions and American History* (Notre Dame, IN: University of Notre Dame Press, 1988); Samuel Haber, *The Quest for Authority and Honor in the American Professions* (Chicago: University of Chicago Press, 1991); and Thomas Haskell ed., *The Authority of Experts: Studies in History and Theory* (Bloomington: Indiana University Press, 1984).

[5] Kimball defines a profession as "a dignified occupation espousing an ethic of service organized into an association and practicing functional science." Kimball, *The "True Professional Ideal" in America*, 16. See also John F. Dillon, "The True Professional Ideal," *American Law Review* 28 (1894), 671.

argument goes, individuals would be reticent to disclose all relevant information to their physician or attorney. This, in turn, might hinder the physician's ability to prescribe and treat his or her patient, and could lead to injury or death. Likewise, an attorney, without full knowledge of all relevant facts would be unable to provide useful advocacy for his or her client. Because of this, the logic follows, it is imperative to protect these relationships through evidentiary privilege. Implied in this protection, is the idea that the privileged relationship—whether physician-patient, attorney-client, or any of a number of other relationships that have been, at one point or another, granted the status of privilege—is deemed more essential than the fact-finding mission of the courts.[6]

This makes privilege a powerful tool for those trying to prove the social value of their respective professions. Yet the medical and legal positions on physician-patient privilege were never fixed. Since the early nineteenth century, distinct groups of medical and legal scholars have embraced and rejected physician-patient privilege at different times in accordance with their larger agendas. At times, doctors viewed physician-patient privilege as a powerful indicator of professional status and the logical extension of medical ethics into the courtroom.[7] At other points, however, many physicians came to view the privilege—and its restriction on their ability to exercise discretion in disclosing medical information—as a challenge to their professional autonomy. Similarly, legal scholars have, at times, embraced

[6] On the justification of privileges, see Imwinkelried, *The New Wigmore: Evidentiary Privileges* 3rd ed.

[7] For discussion of these topics, this relies upon Robert Baker, *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (Oxford: University Press, 2013); Robert Baker, Arthur Caplan, Linda Emanuel, and Stephen Latham, *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society* (Baltimore: The Johns Hopkins University Press, 1999); Albert R. Jonsen, *A Short History of Medical Ethics* (Oxford and New York: Oxford University Press, 2008); and Donald E. Konold, *A History of American Medical Ethics, 1847-1912* (Madison: The State Historical Society of Wisconsin, 1962).

physician-patient privilege as a tool to make the judicial process more legible, while, at others, disregarded it as an unwanted impediment to the judicial process.[8]

Many scholars have asserted that the physician-patient privilege was first invoked during the Duchess of Kingston's trial for bigamy in 1776. Because of the lasting influence of this case, Chapter 2, "Privilege and Professional Honour in the Duchess of Kingston's Trial for Bigamy," examines that trial in detail. Only by focusing on its specific circumstances can this powerful—yet misinterpreted—precedent be understood for what it really was: an appeal to the traditions of "professional honour" associated with the aristocracy, rather than an attempt to secure a special status for any and all medical testimony.

The unique circumstances and timing of the case, however, allowed the judge's ruling to be transformed into a lasting legal precedent that seemed to address modern notions of medical confidentiality. The trial took place in the midst of larger transformation of courtroom proceedings in which the advent of adversarial criminal trials, with separate attorneys representing both prosecution and defense, demanded the formation of standardized rules of evidence. Lord Mansfield, whose ruling has been cited since the trial itself as a rejection of physician-patient privilege, was at the head of this movement; his decisions on numerous other evidential issues had already formed crucial precedents that helped modernize English law. Consequently, as the notions of gentlemanly honor subsided and the influence of the medical profession increased, British legal scholars increasingly looked to the Duchess's trial as a legal precedent, ascribing that well-remembered and well-

[8] On the evolution of the legal profession in the United States, see Kermit L. Hall, *The Magic Mirror: Law in American History* (New York and Oxford: Oxford University Press, 1989); and Lawrence M. Friedman, *A History of American Law* (New York: Touchstone, 1973).

documented case with modern notions of medical confidentiality and medical ethics that it would not have had at the time.

In the United States, the Mansfield precedent was broken in 1828, when physician-patient privilege was clearly and unambiguously incorporated into the New York legal code. Chapter 3, "Codification and the Origins of Physician-Patient Privilege," weighs three different explanations for the origins of this law: 1) that medical societies successfully lobbied for the privilege; 2) that the privilege was the product a medico-legal expert consulted in revisions of the state's medical code; and 3) that the law was the product of efforts to codify and streamline all aspects of New York's legal code. Chapter 3 argues that the third explanation is the most compelling and suggest that physician-patient privilege first arose as a byproduct of legal codification itself.

The decision of New York's codifiers to incorporate physician-patient privilege into their new legal code had cascading implications. By 1875, nineteen states or territories had followed suit by enacting similar statutes, many of which copied verbatim from the original New York law. Chapter 3 also examines these early laws, linking the rapid spread of physician-patient privilege to codification movements elsewhere throughout the nation in the mid-nineteenth century. This emphasis on codification might help explain why no one—whether doctors, lawyers, or the general public—made much of physician-patient privilege at the time, even as all these laws were being adopted. This is because privilege was merely a tiny piece of a much larger and more controversial legal development.

A close examination of nineteenth century legal texts reveals that privilege was seldom invoked in the courtroom. Until the late 1870s, only a few cases—all adjudicated in New York—appear in any of these sources. Chapter 4, "Early Privilege Cases," focusses on these trials and highlights the lingering uncertainties that plagued privilege cases throughout

much of the nineteenth century. In these cases, the courts often contradicted one another as doctors, lawyers, and judges were all unsure as to how privilege was to be interpreted in the courtroom. Chapter 4 also examines the use of privilege in criminal abortion proceedings, where attempted applications of physician-patient privilege were not only more frequent than they were in any other type of case, but especially problematic.

The next two chapters address the evolution of American medical ethics, showing that physicians increasingly took confidentiality seriously over the course of the 19th century. Chapter 5, "Confidentiality and Medical Ethics in the Nineteenth Century," examines the rise of codified medical ethics and medical police that led doctors to embrace, and increasingly advocate, the spread of physician-patient privilege. The earliest legislation on physician-patient privilege came at point in time when the medical profession was especially weak and did not have the means to lobby or push for major legal changes—this was a period when the few medical licensing laws on the books were being stripped away and so-called "regular"—or mainstream, MD-educated—physicians were forced to compete on the open marketplace with homoeopaths, botanists, eclectics, and other types of healers.

Distressed regular physicians sought ways to elevate their own status both within the fractured medical profession and in the eyes of the public. To this end, regular physicians formed numerous medical societies—and eventually in the 1840s, the American Medical Association (AMA). In these societies, they created codes of ethics designed to distinguish regular physicians from irregulars and members vigorously policed these codes. In doing so, physicians came to embrace medical confidentiality and especially physician-patient privilege. The AMA *Code of Ethics*, adopted in 1847, celebrated the fact that privilege was observed in some states. By the final decades of the nineteenth century, physicians were actively lobbying for the further spread of such laws in states where they did not exist.

Consequently, during the second half of the nineteenth century, doctors emerged as the foremost proponents of physician-patient privilege. Beginning in the 1880s, doctors openly campaigned to secure physician-patient privilege in numerous states, using medical societies and professional journals as instruments to rally support for proposed legislation. At the same time, however, the consensus that underpinned codified medical ethics gave way. Increasingly disillusioned with the ways in which medical policing was being conducted, many physicians rebelled against the American Medical Association's *Code of Ethics* and hence against the statutory protection of medical confidentiality. Chapter 6, "Professionalization and Privilege," examines the conflicted advocacy of doctors on both sides of this debate.

Beginning in the 1870s, medico-legal developments produced a sudden spike in the number of cases where physician-patient privilege was invoked by one side or the other, thus raising the stakes for all sides in debates over how to deal with the issue. Chapter 7, "Privilege in the Turn of the Century Courtroom," examines these cases and traces the ways in which they shaped the policy of physician-patient privilege. The rapid transformation brought new institutions and new types of litigation to which the privilege could not be easily applied. In particular, a dramatic rise in insurance, accident, and will cases proved especially difficult to adjudicate where the physician-patient privilege could be applied forcefully. As a result, legal critics began to challenge the spread of physician-patient privilege, arguing that it served as an unnecessary and untenable impediment to justice.

Chapter 8, "Criticism and Reform in the Twentieth Century," examines legal and medical responses to the proliferation of physician-patient privilege in the early twentieth century. By 1900, dissent within the medical profession had reached a boiling point. Doctors came to see physician-patient privilege and codified medical ethics as an unwelcome limitation on their professional autonomy. The AMA revised its *Code of Ethics* twice in first

two decades of the twentieth century, each time reducing its proscriptive powers. With the problematic applications of privilege in personal life insurance cases, injury litigation, and contested will disputes readily apparent, legal scholars mounted an all-out offensive against physician-patient privilege.

The combination of these two developments—ethical conflicts within the medical profession and opposition from the legal profession—profoundly shaped the policy of physician-patient privilege in the twentieth century. In the face of criticism from both the medical and legal professions, the proliferation of physician-patient privilege abruptly came to an end. Since 1900, few jurisdictions have adopted physician-patient privilege. Instead many jurisdictions reversed course, amending their laws to limit the applications of the privilege. Finally, over the course of the twentieth century, legal reformers drafted a series of revised legal codes intended to simplify American evidence law. Many of the architects of these legal reforms were staunch critics of physician-patient privilege. Accordingly, the new *Federal Rules of Evidence* that were adopted in 1975 featured no mention of physician-patient privilege. Because of this, physician-patient privilege is not currently recognized in federal courtrooms.

Over the course of the past two centuries, contradictory impulses—including the advocacy of numerous physicians and medical societies on one hand and the criticism of prominent doctors and legal scholars on the other—have prevented any formation of consensus on physician-patient privilege. This uncertainty surrounding medical confidentiality laws is a byproduct of the long and fractured history of physician-patient privilege in America. Understanding this history is essential in order to explain how physician-patient privilege became a widely accepted legal doctrine in the United States, why the privilege remains such an unevenly applied rule in American courts, and how law

protects medical confidentiality today. Understanding how we got to this point might also help future policy makers decide how to handle many of the same or related issues going forward.

CHAPTER II: PRIVILEGE AND PROFESSIONAL HOUNOUR IN THE DUCHESS OF KINGSTON'S TRIAL FOR BIGAMY

> Caesar Hawkins: I do not know how far any thing, that has come before me in a confidential trust in my profession should be disclosed, consistent with my professional honor.
>
> Lord Mansfield: …If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as an indiscretion whatever.
>
> Testimony from the Duchess of Kingston's Trial for Bigamy, 1776

Most legal sources maintain that physician-patient privilege was first invoked in 1776 during the Duchess of Kingston's trial for bigamy. When asked to reveal the intimate details of a longtime client before her peers in the House of Lords, the Duchess's surgeon, Caesar Hawkins, bravely took a stand for the "honour of [his] profession." Hawkins argued that medical men were entrusted with great secrets and to betray these secrets under any circumstances would damage the welfare of their patients and the honor of their profession. But the presiding judge, Lord Mansfield, was unsympathetic, stating, "If a surgeon was voluntarily to reveal these secrets, to be sure he would be guilty of a breach of honour, and of great indiscretion; but, to give that information in a court of justice, which by the law of the land he is bound to do, will never be imputed to him as any indiscretion whatsoever."[1]

Documented in court cases and evidence manuals ever since, this brief aside by Lord Mansfield has long been cited as a foundational legal precedent that denies doctors any inherent claim to privileged communications. In 1792, Mansfield's protégé Francis Buller

[1] *The Trial of Elizabeth Duchess Dowager of Kingston for Bigamy, before the Right Honourable the House of Peers, in Westminster-Hall, in Full Parliament, on Monday the 15th, Tuesday the 16th, Friday the 19th, Saturday the 20th, and Monday the 22d of April 1776; on the Last of Which Days the Said Elizabeth Duchess Dowager of Kingston Was Found Guilty. Published by Order of the House of Peers.* (London, 1776), 119-120.

became the first to invoke this ruling in the courtroom when he "lamented" that physicians could be compelled to testify. In the process, Buller unwittingly helped to secure the precedent established by his late mentor.[2] Ten years later, Leonard MacNally quoted Mansfield's conversation with Hawkins in his influential text, *The Rules of Evidence on Pleas of the Crown*.[3] Numerous judges and legal scholars followed Buller and MacNally over the course of the nineteenth century and, in doing so, they transformed Mansfield's ruling into a lasting legal precedent.[4] Because of this precedent, physician-patient privilege is still not recognized under British common law nor in American Federal courts.

Yet these sources have often overlooked the peculiar circumstances surrounding the Duchess's trial. A close examination of the trial reveals that Hawkins's attempt to invoke "professional honor" was not an appeal to widely practiced or universally recognized medical standards, but rather a suggestion that his standing at the top of the medical profession granted him privileges that would have been denied to other practitioners. In order to build a career as a wealthy and successful surgeon, Hawkins sought to distinguish himself from other, more humble practitioners. He relied upon his relationships with aristocratic clients to gain social status and adopted the values and styles of the fashionable elite. Hawkins took great care to comport himself according to the norms of gentlemanly honor—an unwritten and extralegal code that regulated aristocratic life.[5] When called into

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[2] Wilson v. Rastall, 99 T.E.R. 1866 (1792).

[3] Leonard MacNally, *The Rules of Evidence on Pleas of the Crown* (London: J Butterworth, 1802), 247-248.

[4] Rex v. Gibbons, 1 Car. & P. 97 (1823); Broad v. Pitt 3 C. & P. 518 (1828); Thomas Peake, *A Compendium on the Law of Evidence* (Philadelphia, 1812), 183; Samuel March Phillips, *A Treatise on the Law of Evidence: First American Ed., from the Second London Ed.* (New York, 1816), 104; Thomas Starkie, *A Practical Treatise on the Law of Evidence and Digest of Proofs in Civil and Criminal Proceedings* vol. 2 (Philadelphia, 1834), 230.

[5] Donna T Andrew, "The Code of Honour and Its Critics: The Opposition to Dueling in England, 1700-1850," *Social History* 5:3 (1980), 409-434; Donna Andrew, *Aristocratic Vice: The Attack on Dueling, Suicide, Adultery, and Gambling in Eighteenth Century England* (Newhaven: Yale University Press, 2013); V.G. Kiernan, *The Duel in European History: Honour and the Reign of Aristocracy* (Oxford: Oxford University Press, 1988).

court to reveal the intimate details of one of these clients, Hawkins demurred, arguing that he, as an aristocratic gentleman, could not reveal secrets entrusted to him. Thus his appeal to "professional honor" was an attempt to secure the privileges of elite social status and to protect his personal relationship with the Duchess. It was not a claim that medical ethics mandated confidentiality in the courtroom.[6]

The trial itself marked the climax of a decades-long marital drama that had long transfixed the British public with illicit affairs, secret marriages, slander, and accusations of bribery. For five days, the seat of Britain's government was converted into a theater-in-the-round. More than four thousand spectators, including King George III, crowded into London's Westminster Hall to witness the Duchess of Kingston's trial. Aristocrats watched the proceedings from private boxes with their attendants. Others crammed into improvised bleachers that had been erected in the hall. Those who could not afford the steep price of tickets, followed the proceedings in the local papers, where the latest news from Westminster Hall often displaced reports of mounting tensions in America.

The defendant—now going by her new and disputed title, the Duchess of Kingston—had been born Elizabeth Chudleigh in 1720.[7] Her father, the lieutenant-governor

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[6] Several historians and legal scholars have recently reexamined this case: Danuta Mendelson, "The Duchess of Kingston's Case, the Ruling of Lord Mansfield and Duty of Medical Confidentiality in Court," *International Journal of Law and Psychiatry* 35 (2012), 480-489; Angus Ferguson, "The Lasting Legacy of a Bigamous Duchess: The Benchmark Precedent for Medical Confidentiality," *Social History of Medicine* 19 (2006), 37-53; Angus Ferguson, *Should a Doctor Tell?: The Evolution of Medical Confidentiality in Britain* (Farnham, Surrey: Ashgate, 2013).

[7] There been numerous biographies of the Duchess of Kingston, many focusing on the most lurid details of her life in aristocratic society. Recent scholarship has reexamined the Duchess of Kingston and her trial as a means of analyzing gender relations in Georgian England. In detailing the life and trial of the Duchess of Kingston, this chapter draws upon the following accounts: Elizabeth Mavor, *The Virgin Mistress: The Life of the Duchess of Kingston* (London: Chatto and Windus, 1964); T.A.B. Corley, "Chudleigh, Elizabeth," *Oxford Dictionary of National Biography* (Oxford and New York: Oxford University Press, 2004); Gillian Russell, *Women, Sociability and Theatre in Georgian London* (Cambridge and New York: Cambridge University Press, 2007); Betty Rizzo, *Companions Without Vows: Relationships Among Eighteenth-Century British Women* (Athens and London: University of Georgia Press, 1994); and Matthew Kinservik, *"The Production of a Female Pen": Anna Larpent's Account of the Duchess of Kingston's Bigamy Trial of 1776* (Lewis Walpole Library: Yale University, 2004).

of Chelsea Hospital, died in 1726 after squandering the family fortune speculating on foreign investments. Following her father's death, Chudleigh, along with her mother and brother, left London for the family's small Devonshire estate, where they lived in "genteel but straitened circumstances."[8] Chudleigh's introduction to aristocratic society came at the age of twenty-three, when, with the support of a wealthy benefactor, she managed to secure a position as a maid of honor to Augusta, Princess of Wales. The position allowed Chudleigh to move in the highest circles of English society, but it also provided her with a much-needed £200 salary.

In court, Chudleigh's charm and beauty won her numerous suitors. She was said to be enamored of the Duke of Hamilton but elected to marry Augustus John Hervey, a naval lieutenant and the second son of a wealthy aristocratic family. The couple had only known each other for a few weeks when they were hastily wed in small parish church. The ceremony was conducted in secret so that Chudleigh could maintain her appointment as maid of honor to the Princess of Wales. The sole witnesses were three members of the bride's family along with a servant, Anne Braddock, who would later provide damning testimony in in the Duchess's trial.[9]

By all accounts, this marriage was brief and loveless. Shortly after their nuptials, Hervey was shipped off to sea while Chudleigh resumed her life at court. Though the couple

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[8] Rizzo, *Companions Without Vows*, 63.

[9] Such marriages were not uncommon at the time. According to Kinservik, English society had a long history of secret marriages and "retained vestiges of medieval marriage practices well into the eighteenth century." In the eighteenth century, secret weddings were especially popular among social elites who wished to remain out of the public eye. This "situation made regulation and verification of marriages exceedingly difficult for the Church of England and the Civil Authorities." The legal reforms of Lord Hardwicke's Marriage Act of 1753 were intended to make this sort of ceremony illegal and to avoid the type of marital drama that would follow Chudleigh's secret wedding. Kinservik, *"The Production of a Female Pen"*, 3-6; Lawrence Stone, *Road to Divorce: England, 1630*-1987 (Oxford: Oxford University Press, 1990), Ch. 2.

seldom saw one another, Chudleigh gave birth to a child in 1747. By the time their son died the following year, it was clear that both Chudleigh and Hervey wanted out of the marriage. Divorce was out of the question, however, as it would have required the couple to acknowledge their illicit union and to provide evidence that Chudleigh had committed adultery. Instead, the couple opted for an informal separation, and each publicly denied that the union ever took place.

At first, this arrangement caused few problems—Chudleigh began an affair with Evelyn Pierrepont, an extravagantly wealthy man and the Duke of Kingston-Upon-Hull while Hervey spent much of the next decade at sea. In the late 1750s, however, Augustus Hervey's brother George fell ill. This left the once-impoverished Augustus Hervey next in line to the family fortune and the Countship of Bristol. And so, in February 1759, Chudleigh seized the chance to secure an aristocratic title for herself and sought out the parish priest who had officiated her wedding fifteen years earlier. In an incredible stroke of luck, "she found him on his deathbed and, with the advice of a pliant lawyer, persuaded the dying vicar to forge a parish register to record her marriage to Hervey." Chudleigh's scheme backfired, however, when the ailing George Hervey recovered. Not only did she fail to secure fortune or title, but "she never destroyed the register, a careless error she would rue in 1776."[10]

Though now official, their marriage remained a secret for another decade until Hervey, wishing to remarry, pressed for a divorce. With her private affairs thrust into the public eye, Chudleigh sued Hervey for falsely claiming marriage. Hervey, likely due to a £16,000 bribe from his former spouse, mounted little defense and the court ruled that the marriage had never taken place. With the legal issues seemingly put to rest, Chudleigh was

[10] Kinservik, *"The Production of a Female Pen"*, 10.

now free to remarry. In March 1769, "in a hasty and quiet ceremony in the duke's dressing room," Chudleigh married Evelyn Pierrepont, the Duke of Kingston. With this union, Chudleigh "had now achieved her ambition of becoming a peeress: she was both a duchess and one of the richest women in Europe."[11]

When Pierrepont died in 1773, he left his estate to his widow, the new Duchess of Kingston. The Duke's nephew Evelyn Meadows, who had long assumed that he would inherit the Duke's land and titles, was incensed and immediately began investigating Chudliegh's marital status. Meadows managed to find several servants who had worked for Chudleigh over the years, including Anne Craddock, who had attended her first wedding. Meadows was also able to track down "the widow of Mr. Amis, the parson who married [Chudleigh] to Augustus Hervey… With her help, Meadows learned of the phony registry that Amis made and was able obtain it." Meadows brought this evidence to the Grand Jury of Middlesex County, which indicted the Duchess for bigamy in December 1744.[12]

The ensuing trial, set to take place in 1775, quickly captivated the British press. In an attempt to capitalize on the trial's publicity, Samuel Foote, a popular comedian and playwright, authored *A Trip to Calais*, a satire that cast the Duchess as Kitty Crocodile, an allusion to Chudleigh's "gift for tears," or, alternately, Lady Betty Bigamy.[13] Though never published, the play caused a controversy when Foote and the Duchess each published letters in several London newspapers. Over the course of several months they exchanged insults. While Foote often feigned ignorance at the source of the Duchess's anger, Chudleigh

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[11] Ibid., 12-13.

[12] Ibid., 13.

[13] Phyllis T. Dircks, "Foote, Samuel (*bap.* 1721, *d.* 1777)," *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004); and Russell, *Women, Sociability and Theatre in Georgian London*, 158.

offered scathing critiques of Foote's honor and manhood, calling him a "subservient vassal" and stating that she would not "prostitute the term manhood by applying it to Mr. Foote."[14] Printed throughout the summer of 1775, the exchange heightened anticipation for the Duchess's upcoming trial. Her antics outraged many who saw her insults as poor conduct for a woman of her status. Others, believing Foote's play to be an indecent attempt to sully the reputation of a peer, wrote to the London papers in support of the Duchess.[15]

After several postponements on behalf of the Duchess's failing health, the trial began in April 1776. At her own request, the Duchess was tried as a Peer by the House of Lords, which meant that her jury would be comprised of fellow aristocrats and that she would be afforded unique privileges denied to those of a lower social standing.[16] Most importantly, the Duchess, who had never convicted of any crime could plead the benefit of peerage—aristocrats convicted of any crime (other than treason or murder) were not be punished for their first offense. This was good insurance for the Duchess as it was common knowledge that she had been married twice: first to the naval lieutenant Augustus John Hervey and then to Evelyn Pierrepont, the Duke of Kingston. It was also a clever legal tactic, as, no matter how the court ruled, the Duchess would retain her status as peer. If the court ruled that she had never been married to Hervey, she would rightfully be the Duchess of Kingston. If, as was likely, the court found that the Duchess had been married to Hervey, her marriage to the Duke of Kingston would be annulled. Instead, the Duchess would become the Countess

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[14] Elizabeth Chudleigh, "Note to the Public," *Public Ledger* (London, England), 15 Aug. 1775.

[15] "For the Morning Post: To the Duchess of Kingston," *Morning Post and Daily Advertiser* (London, England), 19 Aug. 1775; Russell, *Women, Sociability, and Theatre in Georgian London*, 158-163.

[16] A vestige of an earlier legal system, peerage trials were exceedingly rare by the late eighteenth century. In fact, after the Duchess of Kingston's 1776 trial, only three such cases would ever come before the House of Lords. These were the 1841 trial of James Brudenell, Earl of Cardigan for dueling; the 1901 trial of Frank Russell, Earl of Russell for bigamy; and the 1935 trial of Edward Russell, Baron de Clifford for manslaughter.

of Bristol as Hervey had become the Earl of Bristol in 1775. Either title—Duchess or Countess—would enable the Duchess to claim the privilege of peerage and avoid punishment.[17]

Although the outcome of the trial was never in doubt, the proceedings took on different meanings to various elements of British society. The public, whose opinion of the Duchess of Kingston had been shaped by decades of gossip and rumors, saw the trial as an indictment of the excesses of the aristocracy. To many, the Duchess of Kingston was most famous for her appearance at the Jubilee Ball in 1749, where she showed up half-naked in the costume of Iphigenia, Agamemnon's daughter in Greek mythology, and pronounced herself, "ready for sacrifice." In doing so, she caught the eye of King George II and earned herself a nickname— "Iphigenia"—that would stick for the rest of her life.[18] The presiding lords, who intended the trial as a means to showcase the dangers of clandestine marriage, bigamy, and adultery, were keen to play up the Duchess's numerous provocations. Many of the aristocrats in attendance, including two of the Duchess's prosecutors, were embroiled in their own scandals. To these aristocrats, the Duchess of Kingston made an ideal "scapegoat for [their own] sexual indiscretions."[19] By putting the Duchess of Kingston's honor on trial, they hoped "that her sacrifice would wash away their sins."[20]

The first two days of the trial were dedicated to matters of legal procedure, as attorneys for both sides argued whether the Duchess's marital status—previously settled in

[17] Kinservik, *"The Production of a Female Pen"*, 6.

[18] Ibid.

[19] For her part, the Duchess was willing to play into this role, arriving at court in a long black gown and the black headdress of the martyred Mary Queen of Scotts.

[20] Kinservik, *"The Production of a Female Pen"*, 16.

an ecclesiastical trial—fell under the jurisdiction of the House of Lords. After deciding they would hear the case, the Lords began hearing testimony from witnesses. Over the next two days, the court learned that the Duchess had previously been married to John Hervey and that the earlier ruling of the ecclesiastical court had been found in error. On the fifth day of the trial, after arguments had concluded, the Lords arose one by one. Each placed his right hand upon his chest, delivering the verdict: "guilty, upon my honor." Only the Duke of Newcastle, who had formerly enjoyed a brief affair with the Duchess, deviated, stating "guilty erroneously, but not intentionally."[21] Though the court's ruling stripped Chudleigh of her title as the Duchess of Kingston, recognition of her marriage to Hervey, who was now the Count of Bristol, allowed her to plead the privilege of peerage and avoid the typical punishment for bigamy, burning of the hand. Following the conclusion of the trial, the Duchess fled England for Calais. Though she retained most of her fortune, the Duchess spent much of the remainder of her life in self-imposed exile.

Lost amidst the spectacle and controversy of the trial, another battle over honor—one that would have profound effects on the history of medicine and the law—went largely unnoticed. In the midst of the trial's fourth day, Caesar Hawkins, a prominent surgeon and witness, was asked if he knew of any marriage between Chudleigh and Hervey. Not wanting to harm the Duchess's defense, he responded, "I do not know how far any thing, that has come before me in a confidential trust in my profession should be disclosed, consistent with my professional honor."[22] Hawkins's query to the presiding lords has been interpreted as the first invocation of physician-patient privilege in the history of English common law.

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[21] *The Trial of Elizabeth Duchess Dowager of Kingston*, 154–156.

[22] Ibid., 119.

Accordingly, Lord Mansfield's response—that Hawkins must answer all questions asked of him—has long been invoked by legal scholars as proof that medical practitioners cannot claim privileged communications.[23] A close examination of Hawkins's career and personal relationships, however, reveals that the surgeon never intended to claim medical confidentiality or argue on behalf of the medical profession.

Caesar Hawkins, the Duchess's surgeon and confidant was one of the most successful medical practitioners of his time. Born into a family of surgeons, he had learned the practice under the tutelage of his father. As a young surgeon, Hawkins cultivated a network of powerful clients and used their patronage to propel him to the top of his profession. He managed to convert his personal relationships into prestigious and lucrative appointments, most notably, surgeon to the Prince of Wales and sergeant-surgeon to King George II. He also maintained a prominent and lucrative practice at St. George's Hospital in London. These positions allowed Hawkins to amass considerable wealth and social standing; in 1778, he was made a Baronet for his services to the crown. At the time of the trial, Hawkins had reached the apex of a long and distinguished career.[24]

Hawkins's successes came in spite of a gradual weakening of the status of the medical profession. Throughout the seventeenth century, the Royal College of Physicians, an elite cadre of medical practitioners, dominated medicine in London while apothecaries and surgeon-barbers formed the lower ranks of the medical profession. The hierarchical

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[23] See, for example Wilson v. Rastall (1792); Sherman v. Sherman, 1 Root 486 (1973); Falmouth v. Moss, 11 Price 455 (1822); Rex v. Gibbons (1823); Broad v. Pitt (1828); Wigmore, *On Evidence* 1st ed., 3347-3348; and Shuman, "The Origins of Physician-Patient Privilege and the Professional Secret," 671-676.

[24] Susan C. Lawrence, *Charitable Knowledge Hospital Pupils and Practitioners in Eighteenth-Century London* (Cambridge; New York: Cambridge University Press, 1996); J.F. Payne, "Hawkins, Sir Caesar, first baronet (1711-1786)," *Oxford Dictionary of National Biography*.

structure of the medical profession was thrown into disarray in 1704, when William Rose, an apothecary, went to court and successfully challenged physicians' attempts to regulate and control the profession. The court's ruling confirmed the status of apothecaries and surgeons, while also opening the medical marketplace to outside influence; clergy, folk healers, and domestic medicine all offered formidable challenges to traditional medicine. At the same time, the availability of medical texts and the relative simplicity of many treatments meant that little knowledge or expertise separated professionals from informed laypersons.[25]

For many practitioners, greater competition weakened their professional status and undermined the potential for collective action. The Rose Trial crippled the Royal College—a longstanding barrier that differentiated esteemed medical professionals from folk healers and other, more humble practitioners—leaving individual practitioners to fend for themselves. At the same time, a growing market for medical services and increased competition made doctors desperate to enhance their own name. Some used advertisements, catchy jingles, and slogans. Others turned to more dubious methods and hired actors to call for their services at opportune moments. Even more troubling, many practitioners garnered reputations for debauchery and sexual exploitation, further cementing the profession's poor reputation. Pamphlets and cartoons mocked the inefficacy of physicians with quips like, "While the doctors consult, the patient dies."[26] Widespread criticism of physicians' morality and competency meant that, in 1776, arguments on behalf of honor of the medical profession would have garnered little sympathy.

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[25] Toby Gelfand, "The History of the Medical Profession," in *Companion Encyclopedia of the History of Medicine vol. 2* (London: Routledge, 1993) edited by W.F. Bynum and Ray Porter, 1124-1136; and Roy Porter, *Bodies Politic: Disease, Death, and Doctors in Britain, 1650-1900* (Ithaca, N.Y.: Cornell University Press, 2001), 139.

[26] Roy Porter, *Bodies Politic*, 142.

Nevertheless, a small group of practitioners flourished in the eighteenth century. William Hunter, a prominent physician, managed to pull in more than £10,000 per year, a salary equal to the income of a peer. Several other physicians made even more. In many cases, success depended upon practitioners' ability to successfully cultivate networks of aristocratic patrons and to garner the respect of clients as social companions rather than patients. Richard Warren, the physician to the Prince of Wales, employed this strategy to great effect, as a contemporary observer noted:

> [Warren] added various literary and scientific attainments, which were most advantageously displayed by a talent for conversation that was at once elegant, easy and natural. Of all men in the world, he had the greatest flexibility of temper, instantaneously accommodating himself to the tone of feeling of the young the old, the gay and the sorrowful… no one ever had recourse to his advice as a physician, who did not remain desirous of gaining his friendship and enjoying his society as a companion.[27]

Dressed in powdered wigs, satin coats, buckled shoes, and tricorn hats, wealthy physicians adopted the styles and mannerisms of the aristocracy. They bought vast estates, medals, paintings, manuscripts, and other expensive signals of social status. Likewise, they filled their gold canes with perfume to mask the odors of their profession. In seeking to incorporate themselves into aristocratic society, these physicians sought to dissociate themselves from the rest of the medical profession.[28]

Accordingly, Caesar Hawkins's position atop the medical profession stemmed from his ability to adopt the manners and styles of aristocratic society. His interactions with the Duchess of Kingston demonstrate the ways in which doctor-patient

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[27] William Macmichael and M.D. Rare Book Collection of Rush University Medical Center at the University of Chicago Stanton A. Friedberg, *The Gold-Headed Cane,* (New York: P. B. Hoeber, 1915), 106. Quoted in Porter, *Bodies Politic.*

[28] Rosemary O'Day, *The Professions in Early Modern England, 1450-1800: Servants of the Commonwealth* (Harlow, England; New York: Longman, 2000), 243–247.

relationships could be recast as friendships that conferred status and privilege on the surgeon. Hawkins first met the Duchess around the time of her brief marriage to Augustus Hervey. The surgeon attended to Chudleigh professionally and was present when she gave birth to her child. What was initially a professional relationship, however, quickly became a personal one in which the surgeon often served as confidant and messenger to both the Duchess and her former husband. Before the Duchess's ecclesiastical trial, for example, Hervey entrusted Hawkins to pass messages between the two parties because he "thought [news of his desire for a divorce] would be less shocking to be carried by and received from, a person [the Duchess of Kingston] knew, than from any stranger."[29] Likewise, the avenues of communication between the Duchess and Hawkins often fell outside the normal confines of a physician-patient relationship. Chudleigh visited Hawkins's home and passed messages to his wife. The breakdown of firm barriers between physician and patient was also evident in Hawkins's testimony at the Duchess's trial. Though Hawkins's testimony confirmed some medical information, including the birth of a child, much of his testimony addressed the contents of private or 'loose' conversations.[30]

Similarly, Caesar Hawkins's views toward medical confidentiality embodied contradictions within the developing medical profession. In the late eighteenth century, medical practitioners were not always committed to maintaining patients' secrets. In professional disputes between practitioners, physicians and surgeons frequently revealed

[29] *The Trial of Elizabeth Duchess Dowager of Kingston*, 121.

[30] Ibid., 122–125.

patients' names and medical problems to the public.[31] Just four years before Caesar Hawkins invoked "professional honor" in the Duchess's trial, for example, he engaged in a public debate with Samuel Lee, a well-known surgeon and former colleague of Hawkins at St. George's Hospital.[32] In a letter published in the *Morning Chronicle and London Advertiser*, Hawkins, along with several other notable London surgeons, admonished Lee for improperly treating his patients' ruptures. In the process, they unashamedly revealed both patients' names and medical conditions.[33] Four years later, Hawkins testified that he had no written records of the Duchess's brief marriage and the birth of her son. He stated that he had long been in the habit of destroying documents that could reveal personal details of patients.[34] The disparate treatment of patients in these two cases illustrates that Hawkins and other medical practitioners viewed confidentiality as a part of their personal relationships with specific clients. Certainly, not all patients' secrets were worthy of protection. The cultivation of a network of elite clients, such as the Duchess of Kingston, however, required discretion and propriety on behalf of the practitioner.

Thus, by asking to be absolved from testifying, Hawkins departed from the norms of his profession. In the eighteenth century, physicians frequently testified in civil and criminal proceedings without objection.[35] Before the trial, for example, several physicians were called

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[31] Robert Baker, *Before Bioethics: A History of American Medical Ethics form the Colonial Period to the Bioethics Revolution* (Oxford: Oxford University Press, 2013), 53-56.

[32] John Ranby and Caesar Hawkins, *The True Account of All the Transactions Before the Right Honourable Lords, and Others the Commissioners for the Affairs of Chelsea Hospital; as Far as Relates to the Admission and Dismission of Samuel Lee, Surgeon. To Which Is Prefixed, A Short Account of the Nature of a Rupture. By John Ranby and Caesar Hawkins, Serjeant-Surgeons to His Majesty* (London, 1754).

[33] Benjamin Hoadly, Messenger Monsey, Caesar Hawkins, T. Hawkins, and William Hunter, "To Mr. Lee, Surgeon, in Arundel-Street and surgeon of that Thing called the Rupture Hospital, near the Asylum, Westminster-Bridge," *Morning Chronicle and London Advertiser*, February 16, 1773.

[34] *The Trial of Elizabeth Duchess Dowager of Kingston*, 120.

[35] Shuman, "The Origins of Physician-Patient Privilege and the Professional Secret," 672-673.

in front of the House of Lords to answer questions about the Duchess's failing health. Their testimony relayed information acquired through the practice of their profession; "[The Duchess's] mental facilities have been injured," they stated, "She is at present afflicted with an alienation of mind."[36] At the time, this revelation of the Duchess's intimate medical details in front of the Duchess's peers (and to the public by way of the London papers) was uncontroversial. Unlike Hawkins, none of the physicians apparently viewed their indiscretion as a slight upon their professional honor.

Because the testimony of physicians and surgeons was frequent and uncontroversial, Hawkins surely knew that claims to privilege on the basis of his profession would have been met with little sympathy. Thus, Hawkins's attempts to secure privileged communications, a powerful indicator of status that had never been granted to a medical practitioner, suggest both the importance of his personal relationship to the Duchess and a strong assertion of his own social standing. The patronage and friendship of important clients, such as the Duchess and King George III, placed Hawkins amongst England's social elite and served as the source of his professional honor. Called into the courtroom to reveal the intimate secrets of one of these invaluable clients, Hawkins likely felt as though his precarious standing among the aristocracy was under attack. While Hawkins could not claim privilege as a medical practitioner, he hoped that his status as an aristocrat might offer him the privileges of gentlemanly honor. Accordingly, Hawkins's claims to professional honor were not based upon the idea that physicians were obligated to protect the intimate secrets of their patients. Instead, Hawkins argued that the standing of his patients gave him specific privileges that would have been denied to many other practitioners.

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[36] "Debates in the House of Lords: The Duchess of Kingston's Trial," *Middlesex Journal and Evening Advertiser* (London, England), Dec. 12, 1775 - December 14, 1775; Issue 1048.

In this way, Hawkins's appeal to "professional honor" mirrored other claims to confidentiality that arose during the trial. Immediately after Hawkins, the prosecution called Sophia Fettiplace, a former friend of the Duchess, to the bar. Fettiplace asked to be excused from answering questions that might tarnish her relationship with the Duchess, stating, "Unless your Lordships require it of me as a witness of justice, I should wish to be excused." Like Hawkins, Fettiplace was of a lower social standing than the presiding lords. The Lord High Steward refused Fettiplace's request, requiring her to answer all questions.[37]

Next, the prosecution called Lord Barrington. Again, the witness was a close friend of the Duchess and wished to be excused from divulging information revealed to him through private, personal conversations. Barrington argued, "If anything has been confided to my honor, or confidentially told to me, I do hold… that as a Man of Honor, as a Man regardful of the Laws of Society, I cannot reveal it."[38] Though this appeal, with its references to personal honor, mirrored those made by Hawkins and Fettiplace, it was met with greater sympathy from the presiding lords. "I think that it would be improper in the noble lord to betray any conversations," the Duke of Richmond responded, "I submit to your Lordships, that every matter of fact, not of conversation, which can be requested, the noble Lord is bound to disclose."[39]

Against Mansfield's suggestion, the lords decided to adjourn to discuss the matter. After a lengthy discussion of courtroom proprieties and evidentiary procedure, the lords returned to the courtroom, again compelling another witness to answer all questions asked

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[37] *The Trial of Elizabeth Duchess Dowager of Kingston*, 126.

[38] Ibid., 127.

[39] Ibid.

of him.[40] Though Barrington's arguments did not convince the lords to relieve him of his duties to testify in court, he seemingly managed to convince both sets of attorneys. Neither was willing to press Barrington to disclose information learned in confidence, and he was allowed to leave the courtroom after answering several harmless questions.[41] In each of these three cases—Hawkins, Fettiplace, and Barrington—the witness desired to withhold information from the court that might incriminate the Duchess on the grounds that revealing the Duchess's secrets would constitute a violation of their honor.

Honor, in eighteenth-century Britain's hierarchical society, referred to the social recognition afforded to one's social standing or rank. To lexicographer Samuel Johnson, the word was synonymous with "dignity, high rank," or "title."[42] Men and women of a certain rank or status were expected to abide by a set of norms that comprised the 'code of honour'—an informal set of rules that regulated aristocratic life.[43] William Paley, a prominent priest and philosopher described this code of honor as:

> a system of rules constructed by people of fashion and calculated to facilitate their intercourse with one another and for no other purpose. Consequently nothing is advertised to by the law of honor, but what tends to incommode this intercourse.[44]

Historian Donna Andrew has argued that codes of honor were widely accepted both within and outside genteel society. Even if the public did not abide by the same laws as the aristocracy, English society maintained that aristocrats needed to follow a set of norms that

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[40] Ibid., 128–129.

[41] Ibid., 129–130.

[42] Samuel Johnson, *A Dictionary of the English Language: In Which the Words Are Deduced from Their Originals, and Illustrated in Their Different Significations by Examples from the Best Writers. To Which Are Prefixed, A History of the Language, and An English Grammar, A.M. In Two Volumes.*, 3rd ed., vol. 1 (London, 1765), 1011.

[43] Andrew, "The Code of Honor and Its Critics," 413.

[44] William Paley, *The Principles of Moral and Political Economy,* 2 vols. (1790), 1, 7. Quoted in Andrew, "The Code of Honor and its Critics," 413.

could and often did conflict with the rule of law.[45] In duels, for example, notions of honor led combatants to maim and sometimes kill one another in defiance of the law. Though illegal, these transgressions were rarely prosecuted.[46] Likewise, in the courtroom, the assertion that individuals were bound to the norms and standards of honor marked a challenge to legal conventions. By invoking honor, Hawkins, Fettiplace, and Barrington all argued that their status within the English aristocracy precluded them from submitting to questioning that might prove harmful to the reputation of their peers.

The strength of these claims varied, however, and the court's response to witnesses marked an evaluation of each witness's respective social standing. While Lord Mansfield clearly believed that honor had no place in the courtroom—he pushed to deny all three witnesses' claims to privileged communications—his fellow Lords seemed to disagree, allowing Barrington to leave the courtroom without tarnishing his honor. Of a lower social standing, attorneys from both sides were especially reluctant to challenge Barrington's honor, indicating that Barrington's title commanded deference from his inferiors. Hawkins and Fettiplace, however, occupied more tenuous positions. Neither held an aristocratic title. Though they moved among the most prestigious men and women in English society, both would have been perceived as outsiders. Within the context of a trial in the House of Lords, it is hardly surprising that their claims to honor—a privilege of fashionable elites—were rejected.

[45] Andrew, "The Code of Honour and Its Critics," 413.

[46] Ibid.; Andrew, *Aristocratic Vice*; Kiernan, *The Duel in European History*.

In the midst of the trial's fifth and final day, William Berkley, Augustus Hervey's attorney, was called to testify. Like Hawkins, Fettiplace, and Barrington before him, Berkley asked to be absolved from testifying:

> My Lords, what knowledge I had of this business arose from my being attorney to Lord Bristol, and I must leave it to your Lordships, whether I ought to be examined as for Lord Bristol consistent with Honour to myself and the duty I owe to him.[47]

While Berkley, like other witnesses, framed his request around notions of honor, his appeal differed in an important way from earlier requests by alluding to an established legal precedent that applied specifically to attorneys. Dating back to the late sixteenth century, attorney-client privilege had been an accepted custom in English courtrooms. Berkley was thus drawing upon centuries of legal practice maintaining that attorneys could not be required to testify against the interests of their clients.[48] Instead of suggesting that he should be relieved of his legal obligations based upon his adherence to a personal code of honor, Berkley merely asked if the law would allow him to testify. In response, Mr. Wallace, attorney for the defense, replied that he called Berkley to the bar only to testify to a brief conversation with another key witness and did not intend to discuss his relationship with Hervey.[49] After hearing claims from both the witness and attorney, Mansfield responded,

> the protection of attorneys is as what is revealed to them by their client, in order to take their advice or instruction with regard to their defense… [yet] this is no secret

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[47] *The Trial of Elizabeth Duchess Dowager of Kingston*, 146.

[48] A history of attorney-client privilege can be found in Wigmore, *On Evidence* 1st ed., 3194-3256; and T.C. Dawson Jr., "The Attorney-Client Privilege," *University of Richmond Law Review* 19 (1984), 560-599. Some recent scholarship contests that attorney-client privilege was not widely recognized until much later. According to these histories, while privilege was sometimes accepted in earlier trials, it was not until the 1833 case, Greenough v. Gaskill that privilege was widely recognized under common law. See: Imwinkelried, *The New Wigmore: Evidentiary Privileges*, 163; and Geoffrey C. Hazard Jr., "An Historical Perspective on the Attorney-Client Privilege." *University of Pennsylvania Law School Scholarship Repository* Paper 1068 (1978). Nevertheless, as this conversation exchange between Berkley and Wigmore attests, communications with lawyers generally received at least some protections by 1776.

[49] *The Trial of Elizabeth Duchess Dowager of Kingston*, 146.

> of the client, but is a collateral fact…and it has been often determined, that as to fact, an attorney or counsel has no privilege to withhold evidence.[50]

Here Mansfield's rhetoric differed markedly from his responses to earlier requests for privileged communications. Instead of immediately dismissing the claim, he acknowledged the privilege but maintained that it did not apply in this instance. Berkley was only allowed to answer questions regarding his conversations with Anne Craddock, another witness, and did not reveal confidential information entrusted in him by his client, Augustus Hervey.[51]

Modern legal scholars might suspect that the first mention of physician-patient privilege would resemble this exchange between Mansfield and Berkley, the attorney—a careful and measured evaluation of legal principles, seeking to define the limits of established privileges. Yet the differences are telling. The appeal of Hawkins, the physician, did not draw upon the established expectations of his profession. Instead, Hawkins had based his claims on the tradition of gentlemanly honor and aristocratic privilege.

And yet, a close examination of the trial transcripts reveals some of the reasons contemporary legal scholars began to see the case as a binding legal precedent that denied physician-patient privilege. Though Hawkins sought to be absolved from revealing the Duchess's marital status, a fact he learned through private conversation and that was already public record, his invocation of "professional honor" used language that could easily be adapted to cover modern notions of medical confidentiality. Likewise, Mansfield's response— "if a surgeon was to voluntarily reveal these secrets, to be sure he would be guilty of a breach of honor, and of great indiscretion; but to give that information in a court of justice, which by the law of land he is bound to do, will never be imputed to him as any

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[50] Ibid.

[51] Ibid., 146–147.

indiscretion whatsoever"[52]—emphasized a conflict between Hawkins's legal and professional duties. Though neither Mansfield nor Hawkins would have distinguished between Hawkins's practice as a surgeon and his personal relationship to the Duchess (the two would likely have been seen as one and the same), Hawkins also testified to facts revealed through the course of his professional duties. At one point, he was asked by the prosecuting attorney, "did you ever attend to the [Duchess's] child in the course of your profession?" Hawkins responded affirmatively, confirming the birth of a child through the Duchess's marriage to Augustus Hervey.[53] Removed from the historical context of the courtroom, the initial exchange between Hawkins and Mansfield, with references to "professional honor" and the conflicting obligations of surgeons, would seem to address medical practitioners' duties of confidentiality. Likewise, the admission of evidence learned through the service of a surgeon's profession without objection would have supported this reading of the exchange.

Over the next several decades, this interpretation of Mansfield's ruling gradually became the accepted legal precedent on physician-patient privilege. The unique nature of the Duchess's trial and Lord Mansfield's commanding figure provide clues as to why this ruling has been readily accepted into the legal canon. By the late eighteenth century, precedent had become the predominant source of law for Mansfield and other royal court judges.[54] Administering law based upon precedent required finding relevant cases and evaluating the accuracy of documentation. Well-versed in legal history and aware of some of the major transformations taking place in contemporary law, Mansfield often used his position on the

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[52] Ibid., 120.

[53] Ibid., 121.

[54] James Oldham and William Murray Mansfield, *The Mansfield Manuscripts and the Growth of English Law in the Eighteenth Century* (Chapel Hill: University of North Carolina Press, 1992), vol. 1, 201.

King's Bench to render high profile verdicts and rulings on procedural issues, knowing that these rulings would often become the standard procedure in future trials. As a legal scholar, Mansfield was deeply committed to modernizing the common law; to establishing rules that would increase its predictability; and to ensuring that these rules and precedents were applied evenly across myriad jurisdictions.[55]

Mansfield's remarks in pre-trial proceedings reveal that he viewed the Duchess's trial as a means of setting legal precedent that would have lasting impact. While pre-trial discussions focused primarily upon the location of the trial and whether the House of Lords had the appropriate authority to try the Duchess, Mansfield and the other presiding lords were acutely aware of the unique circumstances surrounding the trial. The rarity of trying peers in the House of Lords along with the spectacle surrounding the affair meant that every ruling in the trial—whether the appropriate jurisdiction of ecclesiastical courts, the location of the trial, or the admissibility of evidence—would be subject to public scrutiny and could potentially form the basis for precedent.[56] The lords were not the only people interested in the trial for its potential to set legal precedent. In the months before the trial, a number of legal scholars published letters in the London papers arguing that the prosecution of the Duchess was illegal and represented a dangerous challenge to the authority and autonomy of Britain's ecclesiastical courts, which had already ruled on the Duchess's marital status.[57] Others worried that the trial might challenge the legality of divorces in England.[58]

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[55] Ibid., 1:197.

[56] "Debates in the House of Lords: The Duchess of Kingston's Trial" *Middlesex Journal and Evening Advertiser* Dec. 12, 1775 - December 14, 1775; and "Debates in the House of Lords: The Duchess of Kingston's Trial," *Middlesex Journal and Evening Advertiser*, Dec. 14, 1775 - December 16, 1775.

[57] "For the Morning Post: Kingston Cause," *Morning Post and Daily Advertiser* (London, England), 2 Jan. 1776.

[58] "To the Printer of the Gazetteer: Kingston Cause," *Gazetteer* (London, England), 7 Mar. 1776.

Well-preserved cases, such as the Duchess's trial, have often served as important sources of legal precedent. Because of the unique nature of the trial, few cases from the eighteenth century remain as well preserved in historical records. As a prominent and controversial figure in English society, the Duchess of Kingston's trial prompted numerous publications such as *Gentleman's Magazine* and *The Lady's Magazine* to publish abridged versions of the trial transcript. Often, these periodicals emphasized the drama and spectacle of the trial, making note of the fashion of the Duchess and other British aristocrats.[59] Popular periodicals, however, were not the only publications that published trial transcripts. The House of Lords also published a 178-page account of the proceedings in 1776. Unlike the abridged versions in popular periodicals, this transcript was likely intended for an audience of legal scholars and contained detailed accounts of the court's proceedings.[60] Francis Hargrave incorporated the House of Lords' transcript into his five-volume collection of state trials. In addition to a collection of notable trials, Hargrave included a lengthy appendix that linked established evidentiary procedures to specific cases. In the appendix, Hargrave quoted Mansfield's comments to Hawkins as precedent to show that surgeons had no legal claim to confidentiality and could be compelled to testify in court.[61] Reprinted several times throughout the late-eighteenth century, Hargrave's collection demonstrates that legal scholars almost immediately began to use the Duchess's trial as an important source for legal precedent.

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[59] "Classified Ads," *General Evening Post* (London, England), Apr. 30, 1776 – May 2, 1776; Issue 6608; and Gillian Russell, *Women Sociability and Theatre in Georgian London* (Cambridge: Cambridge University Press, 2007), 168-174.

[60] *The Trial of Elizabeth Duchess Dowager of Kingston.*

[61] Francis Hargrave, *A Complete Collection of State-Trial and Proceedings for High-Treason and Other Crimes and Misdemeanors* Vol. 11 (London, 1776), 504.

This process fits neatly into the larger history of the radical transformation of legal procedure that took place during the eighteenth century. During this period, the advent of adversarial criminal trials with attorneys representing both prosecution and defense led to the formalization of rules for the admissibility of evidence.[62] Legal treatises on evidence provided legal scholars with a formalized set of rules for courtroom proceedings. By 1800, early evidence manuals like Leonard MacNally's *The Rules of Evidence on Pleas of the Crown* routinely cited Mansfield's ruling in the Duchess's trial as evidence that medical practitioners had no claims to confidentiality in the courtroom.[63] Frequently mentioned in legal treatises, the legal implications of this brief conversation were greatly amplified over the next few decades. In his 1793 treatise, *A Digest of the Law of Actions and Trials at Nisi Prius* Isaac Espinasse stated,

> And this privilege of not being compellable to divulge secrets professionally disclosed to them, is confined to attorneys and counsel only, and does not extend to persons of other professions: For where on the trial of the Duchess of Kingston, Sir Caesar Hawkins the surgeon was called to speak to some matters wherein he had been employed by the Duchess, and objected to speak to them, he was ordered by the court, they holding that he had no such privilege.[64]

Here Espinasse espoused the broadest possible interpretation of the precedent—the unsuccessful attempt of a surgeon to secure privileged communications meant that, apart from lawyers, no professionals could claim privilege. These examples indicate that by the beginning of the nineteenth century, Mansfield's brief response to Caesar Hawkins had been

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[62] J. M Beattie, "Scales of Justice: Defense Counsel and the English Criminal Trial in the Eighteenth and Nineteenth Centuries," *Law and History Review* 9:2 (1991), 221–267; J. H Langbein, "Historical Foundations of the Law of Evidence: A View from the Ryder Sources," *Columbia Law Review* 96:5 (1996), 1168–1202; and Barbara Shapiro, *A Culture of Fact: England, 1550-1720* (Ithaca, NY: Cornell University Press, 2000).

[63] MacNally, *The Rules of Evidence on Pleas of the Crown*, *247*-248.

[64] Isaac Espinasse, *A Digest of the Law of Actions and Trials at Nisi Prius. The Second Edition, Corrected, with Considerable Additions from Printed and Manuscript Cases, and Three New Chapters on the Law of Corporations and Evidence. By Isaac Espinasse, of Grays Inn, Esq. Barrister at Law*, vol. 2 (London, 1793), 719.

transformed from a discussion of a specific practitioner's social standing into a binding precedent that limited privileged communications to lawyers alone.

At the same time, many of the issues that had been central to the original conversation gradually disappeared from view. By referring to Hawkins with the honorable title, "Sir," these legal scholars downplayed the notions of gentlemanly honor that had been central to the brief exchange between Mansfield and Hawkins. In the courtroom, Caesar Hawkins—not yet a Baronet—was viewed as a surgeon, meaning Hawkins occupied a much less honorable position than the lords who filled the courtroom. In the historical records of the trial, however, Hawkins's knighthood would likely have placed his honor beyond reproach. This subtle change in the historical record of the trial allowed the conversation to be given new meanings. Without codes of honor as a powerful subtext, the conversation could easily be recast as an attempt by Hawkins to gain new privileges for an entire profession. Under this interpretation, Hawkins was not denied privilege because of his social standing, but because the medical profession could not successfully articulate its need for privileged communications.

In 1776, neither Mansfield nor Hawkins could have predicted that their brief conversation would have such a lasting impact. Over time, their words have been removed from their historical context and ascribed with new meanings; the notions of gentlemanly honor that were central to the case of have been replaced with more modern notions of medical ethics. This ability to be recast around contemporary debates has helped ensure the trial's historical legacy. Some legal scholars have recently begun to reexamine the use of the Duchess's trial as legal precedent, arguing that its use in modern law is based upon a misinterpretation of Hawkins and Mansfield's arguments during the trial.[65] While these

[65] Mendelson, "The Duchess of Kingston's Case," 480-489.

scholars' assertion that neither was speaking to medical confidentiality in the modern sense is correct, the common law precedent established by this brief aside was a product of the unique historical circumstances surrounding the Duchess's trial. In Britain, this legal precedent has long proven a difficult obstacle to overcome, and there remains no formalized physician-patient privilege.[66] In the United States, legal interpretations of the Duchess's trial have relegated battles over medical confidentiality to the state level, where many states have enacted statutes to codify physician-patient privilege. Even today, the Duchess of Kingston's case continues to shape the contested boundaries between medicine and the law

[66] On this evolution in Britain, see Ferguson, *Should a Doctor Tell?*. For a comparative approach on the law of privilege in Britain, the United States, and Germany see Maehle, *Contesting Medical Confidentiality*, 7-35.

CHAPTER III: CODIFICATION AND THE ORIGINS OF PHYSICIAN-PATIENT PRIVILEGE

> No person duly authorized to practice physic or surgery, shall be allowed to disclose any information which he may have acquired in attending to any patient, in a professional character, and which information was necessary to enable him to prescribe as a physician, or do any act for him, as a surgeon.
>
> *Revised Statutes of New* York, 1828

Through the first two decades of the nineteenth century, no common law jurisdiction recognized physician-patient privilege. Like their British counterparts, American courts followed the precedent established in the Duchess of Kingston's trial with regard to physician-patient privilege. Mansfield's ruling was widely regarded as "an enduring precedent."[1] The Connecticut Supreme Court, for example, twice ruled that privileged communications were granted to attorneys and attorneys alone.[2] But in 1828, as part of a sweeping revision of the state's legal code, the New York legislature enacted a statute that barred doctors and surgeons from revealing their patients' secrets in court. With this addition to the state's laws, New York became the first jurisdiction to extend medical confidentiality into the courtroom—thereby initiating a spread of privilege statutes that would continue throughout the rest of the nineteenth century. By 1905, thirty different states or territories had followed New York's example and incorporated similar statutes into their own newly revised legal codes.[3]

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[1] The Mansfield precedent was cited in series of British decisions: Wilson v. Rastall, 99 T.E.R. 1886 (1792); Rex v. Gibbons, 1 Car. & P. 97 (1823); and Broad v. Pitt, 3 C. & P. 518 (1828). For a historical analysis of these decisions, see Ferguson, *Should a Doctor Tell?*, 24; and Maele, *Contesting Medical Confidentiality*, 8-11.

[2] Mills v. Griswold 1 Root 383 (1792); and Sherman v. Sherman, 1 Root 383 (1793).

[3] Wigmore, *On Evidence* 1st ed., vol. 4, 3348-3349.

Somewhat surprisingly, however, the spread of privilege statutes went largely unnoticed in the medical journals and medical textbooks of the day—unnoticed even in treatises on medical jurisprudence. Likewise, legal scholars took little note of these new laws, and, until the latter half of the nineteenth century, physician-patient privilege was, in fact, seldom exercised in the courtroom. If privilege remained an arcane and seemingly inconsequential legal doctrine even after New York and other states recognized it, why, then, did New York adopt physician-patient privilege in the first place? And why did state after state follow New York's lead, adopting similar statutes throughout the mid-nineteenth century?

Until 1828, medical witnesses in the United States were, in theory, governed by the precedent established in the Duchess of Kingston's trial for bigamy. The matter was seldom considered in American courtrooms, however, and the few instances in which medical confidentiality was invoked in the courtroom demonstrated that American courts were often unable to reach a consensus on the issue. In *Sherman v. Sherman*, a 1793 divorce case, a doctor was forced to testify despite his objection that "all he could testify came to his knowledge in confidence." Legal scholars have cited this case as proof that the precedent established in the Duchess of Kingston's trial "would probably have been acknowledged as a common law principle in every American court."[4] Other sources suggest, however, that some courts were willing to grant physicians privileged communications. The Medical Society of the State of New York's *System of Ethics* claimed that, in 1800, the Pennsylvania courts barred the disclosure of medical secrets in the courtroom on the grounds that these communications

[4] Sherman v. Sherman; and Wigmore, *On Evidence* 1st ed., vol. 4, 3348.

were analogous to privileged communications between priest and penitent.[5] And yet none of these references appeared in nineteenth-century evidence manuals or became lasting precedents.[6]

Instead, American legal scholars continued to look to England, where only a few judicial decisions addressed the topic of physician-patient privilege. *Wilson v. Rastall*, the first and most frequently cited of these British decisions, was adjudicated in 1792. A bribery suit brought before the King's Bench, the case featured no medical testimony. Yet in the court's decision, Justice Buller, a protégé of Lord Mansfield, delivered a brief aside that reiterated the precedent established by his late mentor:

> There are cases to which it is much to be lamented that the law of privilege is not extended; those in which medical persons are obliged to disclose the information which they acquire by attending in their professional characters. This point was very much considered in the Duchess of Kingston's case, where Sir C. Hawkins, who had attended the Duchess as a medical person made the objection himself, but was overruled, and compelled to give evidence against the prisoner.[7]

Part of a lengthy monologue on attorney-client privilege, these few lines were the first to invoke Mansfield's ruling in a court of law, showing that, within a few decades of the Duchess's trial, the historical meaning of the brief exchange between Mansfield and Hawkins had drastically changed. The conversation was no longer about gentlemanly honor. Instead, Buller's speech articulated what has become the modern reading of the trial—that Mansfield denied Hawkins's claims of physician-patient privilege, establishing a precedent for all

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[5] The society failed to mention the name of the case, merely stating that "secrecy was vindicated to a physician (by a superior court of Philadelphia, 1800) refusing the disclosure of his professional acts, against a plaintiff suing for Divorce on the plea of adultery." Medical Society of the State of New York, *System of Ethics* (Albany: 1823), 21-22.

[6] See, for example, Samuel March Phillips, *A Treatise on the Law of Evidence: First American Ed.* (New York, 1816), 104.

[7] *Term Reports in the Court of King's Bench: from Michaelmas Term 31st George III. 1790 to Trinity Term, 32nd George III. 1792. Both Inclusive* (London, 1799), 760.

common law jurisdictions. In Buller's brief description of the trial, the exchange between Hawkins and Mansfield was stripped of its historical context and imbued with new values. What was originally a minor aside in a very controversial case suddenly became "much considered" and was preserved one of the trial's lasting legacies. Ironically, Buller's lament that privileged communications ought to be extended to medical practitioners helped secure this new reading of the Duchess's trial, reaffirming the notion that issues of privileged communications had been central to the Duchess's case. Buller's remarks were then cited, along with Mansfield's ruling, in *Rex v. Gibbons* and *Broad v. Pitt*.[8]

Nineteenth-century legal scholars typically cited these cases as a source of binding legal precedent that limited privileged communications to lawyers and lawyers alone.[9] In 1804, Thomas Peake's *A Compendium on the Law of Evidence* cited Mansfield to argue that "[the] rule of professional secrecy extends only to the case of facts stated to a legal practitioner, for the purpose of enabling him to conduct a cause; and therefore… the statement… of a patient to his physician [is] not within the protection of the law." [10] Similarly, Samuel March Phillips' *A Treatise on the Laws of Evidence* cited both Mansfield and Buller to show that "privilege extends to the three enumerated cases of council, solicitor, and attorney, but it is confined to those

[8] Wilson v. Rastall; Rex v. Gibbons; Broad v. Pitt; and Ferguson, *Should a Doctor Tell?*, 24.

[9] There was some debate as to whether priests and other religious figures would have been barred from testifying at trial. Despite the arguments of several judges, however, "the almost unanimous expression of judicial opinion (including at least two decisive rulings) [denied] the existence of a privilege [protecting communications between priest and penitent]." Wigmore, *On Evidence* 1st ed., vol. 4, 3362-3363.

[10] Thomas Peake, *A Compendium on the Law of Evidence* (London, 1804), 175.

cases alone."[11] In this way, evidence manuals lifted brief asides from justices Mansfield and Buller and transformed them into enduring legal precedents.[12]

In the decades following the American Revolution, New York, like the rest of the union, struggled with questions of how to adapt British common law to the realities of the new republic. Some questions challenged the fundamental principles of American society—how would property relationships designed to function within a feudal, mercantilist society need to be reworked to function in an increasingly democratic and capitalist nation?[13] Others were more practical. New York's constitution specified that all British statute law as well as all relevant common law decisions would remain in effect. The state's constitution carved out an exception, however, for all laws and decisions deemed "repugnant to the constitution." These were to be "abrogated and rejected." Which laws and decisions were to be enforced and which were to be tossed out remained largely unanswered into the early nineteenth century.[14]

These enduring questions were further complicated by the New York's rapid growth. Between 1800 and 1820, the state's population tripled. New York City emerged as the nation's preeminent commercial center after the Erie Canal opened in 1825. The canal also facilitated rapid growth in the state's interior. In boomtowns like Rochester and Buffalo and throughout the surrounding countryside, an emergent middle class seized opportunities to

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[11] Phillips, *A Treatise on the Law of Evidence*, 104.

[12] Ferguson, *Should a Doctor Tell?*, 24.

[13] Roscoe Pound, *The Formative Era in American Law* (Boston: 1938); Morton Horwitz, *The Transformation of American Law, 1780-1860* (Cambridge, MA: Harvard University Press, 1977); Christopher Tomlins, *Law, Labor, and Ideology in the Early American Republic* (Cambridge: Cambridge University Press, 1993); and William E. Nelson, *The Americanization of the Common Law: The Impact of Legal Change on Massachusetts Society, 1760-1830* (Athens and London: University of Georgia Press, 1994).

[14] *The Constitution of New York,* Article XXXV (1777).

improve their social and economic status. Populated by new immigrants and Yankee migrants from New England, the region became known as the "burned-over-district" for the numerous religious revivals that swept over it. This combination of religious zeal and economic prosperity made the region fertile ground for various reform movements. Some looked outwards, advocating sweeping changes—the abolition of slavery, women's suffrage— in the hopes of producing a more just society. Others isolated themselves from the outside world, striving for "perfection" within the enclosed confines of utopian communities.[15]

Likewise, the New York legislature worked at a furious pace to regulate the state's booming economy—in one legislative term, for example, the state passed some three-hundred forty-three new laws. One cumulative effect of all of this legislation, however, was to create a sprawling, often-contradictory body of laws. By the 1820s, the New York statutes were catalogued in nineteen different, privately published volumes, some of which approached one thousand pages. At the same time, an additional thirty volumes recorded relevant common law decisions and another seven volumes on chancery law were in circulation.[16] For lawyers and legislators faced with sorting through this morass of obscure

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[15] Daniel Walker Howe, *What Hath God Wrought: The Transformation of America, 1815-1848* (Oxford and New York: Oxford University Press, 2007), 117-120, 170-176, and 216-217. The social transformations, as well as the numerous reform movements and religious revivals that emerged out of New York during this period have long been the subject of historical debate. On these social transformations and the various reform movements that emerged in New York in the 1820s, see: Sean Wilentz, *Chants Democratic: New York City and the Rise of the American Working Class* (Oxford: Oxford University Press, 2004); Mary Ryan, *Cradle of the Middle Class: the Family in Oneida County, New York, 1789-1860* (Cambridge: Cambridge University Press, 1981); Paul Johnson, *A Shopkeeper's Millennium: Society and Revivals in Rochester New York, 1815-1837* (New York: Hill & Wang, 1978); Thomas Bender, ed., *The Antislavery Debate: Capitalism and Abolitionism as a Problem in Historical Interpretation* (Berkley: University of California Press, 1992); and Nathan O. Hatch, *The Democratization of American Christianity* (New Haven, CT: Yale University Press, 1991).

[16] Charles Cook, *The American Codification Movement: A Study of Antebellum Legal Reform* (Westport, CT: Greenwood Press, 1981), 132.

and often-contradictory laws, it could be difficult to determine which statutes and which rulings applied to specific cases.

In order to bring clarity to the New York law, the state legislature commissioned three separate revisions of the state code.[17] Each round of revisions only added more uncertainty, however, and in 1821 the New York legislature called a convention to completely rewrite the state constitution. Gathering in Albany, delegates to the convention trimmed away sections of the state's code that were outdated or, in some cases, "repugnant" to the principles of American democracy. Still, the vague language of New York's new constitution did little to resolve the complications surrounding the state's law.[18] And so, in 1824, the state legislature commissioned a three-man committee to "alter the phraseology" of the state's legal codes and increase the legibility of the state's statutory law.[19] The legislature asked attorneys Benjamin Butler and Erasmus Root, as well as the prominent legal scholar James Kent, to examine the state's laws. Root and Butler accepted, but Kent declined. In his place, the legislature appointed John Duer, one of New York's foremost private attorneys.[20]

While the state legislature commissioned multiple revisions of New York's statutory code, a small cadre of lawyers began to call for more drastic reforms. To these reformers, the problems facing New York were emblematic of larger, structural problems with the common law system. Inspired by the British legal philosopher Jeremy Bentham as well as the

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[17] Ibid., 155. These revisions occurred in 1789, 1801, and 1813. New York's colonial government also revised its laws in 1752, 1762, and 1774.

[18] Ibid., 132-135.

[19] *New York State Constitution of 1821*, Article 6, Section XIII; Mohr, *Doctors and the Law*, 78.

[20] James C. Mohr, *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* (Oxford and New York: Oxford University Press, 1993), 79.

French Code Napoleon, these reformers believed that codification, the process of collecting and restructuring the law into singular legal code, offered a means to eschew the mysteries of a common law system based on tradition and precedent in favor of a simpler, more accessible legal code.[21] Codifiers argued that the common law was too complicated for a fledgling democracy as, in many cases, Americans did not have the knowledge necessary to represent their interests in court. Moreover, the common law, with its reliance on arcane precedents and traditions, added numerous unnecessary steps to the judicial process, making the legal system both slow and expensive. The only solution to these problems, codifiers argued, was to replace the entire common law system with a new set of codes and statutes.[22]

Codification also offered the promise of Americanizing a legal system still tied to traditions and legal precedents established in Great Britain. To William Sampson—a New York attorney, an Irish-Catholic refugee, and one of the most vocal advocates of codification—the common law was a "pagan idol" imposed by British tyrants. Americans, Sampson argued, "should have… laws suited to [their] condition and high destinies." With codified laws, the United Sates would "no longer [be] forced into the degrading paths of Norman subtleties, nor [be forced] to copy from the models of Saxon barbarity, but taught

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[21] Cook, *The American Codification Movement*, 69-79, 102. The term "codification" was coined by Bentham. According to Cook, "the French codification achievement… was the greatest source of tangible inspiration for the codifiers." While many codifiers were quick to acknowledge Napoleon's autocratic tendencies, "when they spoke of Napoleon as a law reformer, they spoke with unrepressed admiration;" to these codifiers, Napoleon was "a modern Justinian" (73-74). The code was transported to the United States in bits and pieces. The French penal code was translated and published in the *American Review* in 1811. The *United States Law Journal* also published the French Penal code along with sections of the French civil code on bankruptcy in 1823. John Rodman published a translation of the French commercial code in New York in 1811.

[22] Discussion of the codification movement in this section draws upon: Cook, *The American Codification Movement*; Kermit Hall, *The Magic Mirror: Law in American History* 2nd ed. (New York: Oxford University Press, 2009), 139-140; Lawrence Friedman, *A History of American Law* 3rd ed. (New York: Simon and Schuster, 2005), 391-411; Charles McCurdy, *The Anti-Rent Era In New York Law and Politics, 1839-1865* (Chapel Hill, NC: University of North Carolina Press, 2006); Michael Grossberg and Christopher Tomlins eds., *The Cambridge History of Law in America Vol. II: The Long Nineteenth Century (1789-1920)* (Cambridge and New York: Cambridge University Press, 2008), 95-99.

to resolve every argument into principles of natural reason, universal justice, and present convenience."[23] In this way, codification tapped into a growing democratic sentiment in the 1820s, offering a utopian overhaul of the American legal system. Through codification, Sampson and others argued, the law would "advance with a free and unimpeded step towards perfection... [It would] be separated from the rubbish and decay of time and stripped of the parasitical growths that darken and disfigure it."[24] If the proclamations of the most ardent reformers are to be believed, codification was, as one legal scholar put it, nothing short of "a democratic movement for access to justice—for reforming the legal system so that laypersons could not only understand, but operate the machinery of law."[25]

These reformers found powerful allies within the New York government. Governor DeWitt Clinton quickly emerged outspoken advocate of codification. In 1825, he successfully lobbied to expand the ongoing revisions of the New York legal code. Clinton empowered the revisory committee to consolidate laws relating to the same subject, to expunge expired or outdated legislation from the state code, and to suggest new laws to the

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[23] William Sampson, "Showing the Origin, Progress, Antiquities, Curiosities, and the Nature of the Common Law," *Anniversary Discourse Before the Historical Society of New York* (Dec. 6, 1823) quoted in Norman W. Spaulding, "The Luxury of the Law: The Codification Movement and the Right to Counsel," *Fordham Law Review* 73:3 (2004), pp. 983-996, at 986.

[24] Ibid.

[25] Spaulding, "The Luxury of the Law," 985. This view was first championed by Charles Warren in *A History of the American Bar* (Boston, 1911), 508-532. Warren's thesis found numerous champions throughout the twentieth century, including Roscoe Pound who argued that this period represented a "formative era of American Law." Other scholars, such as Robert Gordon have more recently challenged this thesis, however, arguing that codification often failed to achieve the lofty goals set by Sampson and other reformers. Gordon highlights the fact that, while codifiers made up a vocal subset of the bar in New York and elsewhere, there remained a larger contingent of moderate and conservative lawyers who were either indifferent to or outright opposed to codification. To Gordon, the American legal profession, "a notoriously conservative profession" steeped in common law tradition, was never going to fully adopt codification in the early nineteenth century. Robert W. Gordon, "The American Codification Movement," *Vanderbilt Law Review* 36 (1983), pp. 431-458, quote at p. 433. Others have shifted the focus on the codification movement toward later developments, most notably the advocacy of New York attorney David Dudley Field. See, for example, Friedman, *A History of American Law*, 391-411; or Kellen Funk, "Equity Without Chancery: The Fusion of Law and Equity in the Field Code of Civil Procedure, New York 1846-76," *The Journal of Legal History* 36:2 (2015), 152-191.

state legislature. By entrusting the committee with these unprecedented powers, Governor Clinton sought nothing short of a complete overhaul of New York's legal system—Clinton boldly asserted to the assembled legislature that he hoped to create "[a new] complete code founded on the salutary principles of the common law, adopted to the interests of commerce and the useful arts, the state of society and the nature of our government, and embracing those improvements which are enjoined by enlightened experience." Governor Clinton hoped codification would "free [state] laws from uncertainty, elevate a liberal and honorable [legal] profession, and utterly destroy judicial legislation, which is fundamentally at war with the genius of republican government."[26]

Not everyone on the committee shared Governor Clinton's lofty ambitions. Uncomfortable with the new powers entrusted to the committee, Erasmus Root resigned. His replacement, Supreme Court reporter Henry Wheaton served for a year before he too resigned. To fill the seat opened by these resignations, the state legislature turned to John C. Spencer, a promising young New York lawyer who had previously served in both congress and the state legislature. A longtime friend of Dewitt Clinton, Spencer shared the governor's unwavering belief in codification. Spencer's views on the subject were likely shaped in part by his father, Ambrose Spencer, who had long served as a judge in a New York Supreme Court and was "well known for his efforts to construct what might be called an American common law on the basis of state court rulings." Throughout his legal career, Ambrose Spencer "often overrode English precedents in favor of what seemed to him to be commonsensical decisions appropriate to the circumstances of the new republic."[27]

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[26] Charles Z., Lincoln, ed. *Message from the Governors, Comprising Executive Communications to the Legislature*… 11 vols. (Albany, 1909), II:90, quoted in Cook, *The American Codification Movement*, 138.

[27] Mohr, *Doctors and the Law*, 80.

A tireless worker, John Spencer quickly took control of the committee where he put his political connections to use, drafting numerous laws and working tirelessly to secure their passage through the state legislature.[28] Seizing this unique opportunity, the revisers used the "liberal application" of their powers to completely rewrite the New York Statutory Code. The committee compiled all of the states' disparate statutes into a single volume, which was, in turn, split into five categories: the first dealt with issues of "internal administration and civil polity of the state;" the second contained "substantive laws relating to property domestic relations and private rights;" the third covered "the state's judicial machinery and civil procedure;" the fourth outlined the New York's criminal law statutes; and the fifth included "all public laws of a local and miscellaneous character." These statutes were delivered "in simple and concise declaratory statements" and each category was presented individually to the state legislature.[29] The new *Revised Statutes* made numerous substantive changes to New York's laws, reforming the state's electoral process, making early abortion illegal, and radically reshaping the state's property and inheritance laws. In general, New York's legal profession greeted this project with enthusiasm. While the legislature balked at a few specific provisions, the majority of the Revised Statutes were accepted with little controversy.[30] In the category pertaining to criminal law, the revisers included a new statute:

> No person duly authorized to practice physic or surgery, shall be allowed to disclose any information [in court] which he may have acquired in attending to any patient, in a professional character, and which information was necessary to enable him to prescribe as a physician, or do any act for him, as a surgeon.[31]

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[28] Ibid., 79; Cook, *The American Codification Movement*, 140-150.

[29] Cook, *The American Codification Movement*, 133.

[30] Ibid., 142-143. The organization of the *Revised Statutes* was based on the organization of Blackstone's *Commentaries.*

[31] *Revised Statutes of the State of New York* (Albany, 1828), 409.

The law was met with little objection from the state legislature, which quickly enacted the statute.

Without a transcript of the debate on the legislature floor, it is difficult to ascertain whether the lawmakers understood the historical significance of this specific statute.[32] Historians and legal scholars have advanced several theories to account for this unprecedented legislation. Some hypothesized that the revisers were influenced by British legal scholarship; others suggested that prominent New York physicians managed to successfully push for adoption of the statute.[33] Yet, as one historian writes, "the exact circumstances of the introduction of this statute are not known."[34] Any attempt to uncover these circumstances must begin with an examination of the revisers' published notes.

The revisers were well aware that their new law regarding physician-patient privilege challenged accepted legal precedents. As with all of their potentially controversial provisions, the committee kept careful notes, justifying their actions in case of potential opposition within the legislature. In their notes, the revisers provided the legislature with a lengthy argument in favor of the new statute. They began by citing *Wilson v. Rastall*, stating, "[Justice]

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[32] Mohr, *Doctors and the Law*, 79; Cook, *The American Codification Movement*, 140-150. Unfortunately, most legislative records from the New York were destroyed in a 1911 fire.

[33] Clinton DeWitt, *Privileged Communications Between Physician and Patient* (Springfield, Ill.: Charles C. Thomas, 1958), 15. DeWitt would go on to hypothesize, "admittedly the revisers were influenced to some extent by the comment of Mr. Justice Buller in *Wilson v. Rastall*. It seems likely, too that a compelling, if not paramount consideration was the desire to give the medical profession the same protection which the legal profession enjoyed." In *Contesting Medical Confidentiality,* the most thorough historical examination of the debate surrounding medical confidentiality in the United States, Andreas-Holger Maehle echoed DeWitt, stating, "the exact circumstances of the introduction of this statute are not known… Justice Buller's statement in the case of *Wilson v. Rastall* and a wish to grant the medical profession the same privilege as the legal profession in keeping communications with clients confidential seem to have been relevant." Maehle added a second hypothesis stating, "the position of the Medical Society of the State of New York probably played a role here" (11-12). Likewise, Wigmore had little to say on the origins of the New York statute, merely stating, that "in New York in 1828 came a statutory innovation, establishing a privilege." Wigmore, *A Treatise on Evidence* 1st ed., v. 4, 3347-3348.

[34] Maehle, *Contesting Medical Confidentiality*, 11-12.

Buller (to whom no one will attribute a disposition to relax the rules of evidence) said it was 'much to be lamented' that [medical communications were] not privileged." The statute was modeled upon attorney-client privilege and passed alongside a companion statute that also privileged to communications between priest and penitent. Yet the revisers saw the need to privilege medical communications as more pressing than the need to privilege communications between attorney and client:

> The ground on which communications to counsel are privileged, is the supposed necessity of the full knowledge of the facts, to advise correctly, and to prepare for the proper defense or prosecution of a suit. But surely the necessity of consulting a medical adviser, when life itself may be in jeopardy, is still stronger. And unless such consultations are privileged, men will be incidentally punished by being obliged to suffer the consequences of injuries without relief from the medical art, and without conviction of any offence.

Moreover, the revisers feared that physicians, if torn between conflicting obligations, would choose to protect their patients in any event, disobeying the courts in the process:

> Besides, in such cases, during the struggle between legal duty on the one hand, and professional honor on the other, the latter, aided by a strong sense of the injustice and inhumanity of the rule, will, in most cases, furnish a temptation to the perversion or concealment of truth, too strong for human resistance.

Given the support of prominent legal scholars and physicians' desire to protect their patients, the revisers urged the state legislature to adopt the privilege immediately. The revisers concluded, "In every view that can be taken of the policy, justice or humanity of the rule, as it exists, its relaxation seems highly expedient." They also suggested that the proposed law was "so guarded that it can not be abused by applying it to cases not intended to be privileged."[35]

Still, the Reviser's Notes do not completely illuminate the reasons a few New York lawyers suddenly felt the need to entrust doctors with unprecedented legal privileges. One

[35] *Commissioners on Revision of the Statutes of New York* (Albany, 1836), III, 737.

possibility is that a small group of influential New York physicians managed to convince the revisers to enact a statutory guarantee of physician-patient privilege. Five years before the New York State Legislature enacted the United States' first medical confidentiality law, the Medical Society of the State of New York (MSSNY) had openly called for physician-patient privilege in its *System of Ethics*. Comparing physicians to Catholic priests, the *System of Ethics* suggested that physicians were obliged to maintain patient confidences even in a court of law. Written by several prominent physicians, this document may very well have informed the committee's decision to enact physician-patient privilege.[36]

Moreover, the revisers sought the council of the MSSNY's president, Theodoric Romeyn Beck, for guidance on the revised code's application to medical policy. Beck, an Albany physician, was already recognized as the nation's foremost scholar of medical jurisprudence, and as one of Albany's most prominent citizens, he was also well acquainted with the members of the revising committee, especially John C. Spencer. Beck and Spencer had both attended Union College, graduating one year apart. Each was a close friend of Governor Clinton. Historian James Mohr has demonstrated that Beck worked closely with the revisers—none of whom were experts on medical issues—to revise New York's medical laws.[37] Though much of the communication between Beck and the revisers was likely conducted in private, excerpts from Beck's personal correspondence reveal the extent to which Beck was involved in the process of revision:

Albany, Sept. 11, 1828

I have prepared various Sections against medical malpractice according to your

[36] Medical Society of the State of New York, *System of Ethics* (New York, 1823); Baker, *Before Bioethics*, 112-123. This document would prove influential in the history of American medical ethics and will be discussed in Chapter 5.

[37] Mohr, *Doctors and the Law*, 78-83.

> Suggestions, particularly the improper use of instruments, capital operations in surgery, selling poisons &c. which when examined by Mr. Butler I will have edited and sent to you. In the mean while I want you to prepare the public and particularly the Legislature, by communications in the different newspapers, by extracts from approved writers on such subjects, and by such other means as occur to you, for a favorable examination and discussion upon our provisions. I have neither the time nor ability to do it.
>
> Yours very respectfully,
> J. C. Spencer

To Mohr, this "letter makes clear the fact that Beck was given a reasonably free hand to try to insinuate into the proposed legal code any medically related provisions he wanted."[38] At the same time, Spencer entrusted his friend and colleague to curry the favor of state legislators, suggesting that Beck was actively involved in nearly every phase of the process. Furthermore, the law itself as well as the justification presented in the Revisers' Notes expounded upon many of the themes present throughout Beck's work. And Mohr makes a compelling argument that Beck was responsible for another new section of the code, a section that criminalized the performance of early term abortions. But was he also responsible for inserting the statute guaranteeing physician-patient privilege into the revised code?

A closer examination of Beck's publications provides no evidence physician-patient privilege, unlike early abortion, was an issue that concerned him. The initial 1823 edition of *Elements of Medical Jurisprudence*, Beck's seminal work, featured little discussion of the duties facing medical witnesses. In 1828, Beck addressed the Medical Society of the State of New York on the subject of medical testimony in the courtroom, but again did not mention

[38] Ibid., 81. A small collection of Beck's correspondence is preserved at the New York Public Library. While this letter is all that remains linking Beck to the revision process, it is safe to assume, given the responsibilities given to Beck here, that Beck played an active role in the process.

privileged communications.[39] Thus, while Beck might have been involved, he never publicly advocated in favor of physician-patient privilege before the law was passed. Moreover, in later editions of *Elements of Medical Jurisprudence*, Beck did mention the precedent established in the Duchess of Kingston's trial, but failed to mention New York's medical confidentiality law.[40]

Beck's silence on the subject of medical privilege makes it impossible to argue that the first law extending medical confidentiality into the courtroom was the work of the medical profession. This was not a simple oversight on Beck's part, but rather, paradigmatic of the field of medical jurisprudence as a whole. No surviving student notebooks on medical jurisprudence from the early nineteenth century "contained instruction about how information being conveyed to the students was supposed to be presented in actual courts of law."[41] Likewise, Beck's silence also rules out the possibility that the MSSNY successfully lobbied for the inclusion of physician-patient privilege in the *Revised Statutes*. If the society was responsible for this legislation, then surely Beck, as the MSSNY's president and foremost expert on medico-legal issues, would have known about the new law.

Instead, the *Revisers' Notes* suggest that the New York statue was prompted by nineteenth-century legal scholarship. The language in the revisers' notes echoed the language of earlier court cases and legal manuals rather than medical texts. The revisers specifically referred to physicians' "professional honor"—language lifted from the Duchess of Kingston's trial for bigamy. Likewise, the reviser's cited Justice Buller's aside in *Wilson v.*

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[39] Theodric Romeyn Beck, *Elements of Medical Jurisprudence* (Albany, 1823); Theodric Romeyn Beck, "Annual Address Delivered before the Medical Society of the State of New York, February 6, 1828," *Transactions of the Medical Society of the State of New York* (Albany, 1828).

[40] Theodric Romeyn Beck and John B. Beck, *Elements of Medical Jurisprudence* 5th ed., vol. 2 (Albany, 1835), 661.

[41] Mohr, *Doctors and the Law*, 94.

Rastall and the legal scholar Samuel March Phillips. They did not cite any physicians or medical experts. Likewise, the revisers justified their changes to the New York code, by comparing physician-patient privilege to attorney-client privilege, not priest-penitent privilege as the MSSNY had done. Moreover, while much of the legislation proposed by Beck was placed in the medical section of the code, New York's privilege statute was included in the state's evidentiary code, a topic on which neither Beck nor the MSSNY were likely to have been consulted.

Furthermore, the revisers would have had their own reasons to take issue with the common law position on physician-patient privilege. To the proponents of codification, judicial decisions like Lord Mansfield's ruling on physician-patient privilege were symptoms of two of the major problems plaguing the judicial system. First, as unelected officials, judges were afforded too much power to interpret and enforce the laws. Second, the common law, which depended upon the interpretation of legal precedent, was virtually incomprehensible to laymen. Replacing this arcane legal doctrine with a precise and proscriptive law would have solved each of these dilemmas. In their efforts to compress New York law into one coherent volume, the revisers often replaced the language of early statues with text pulled from "judicial exposition" and "professional criticism" where they believed it made the law more coherent.[42] Given the reasoning offered in the *Reviser's Notes*, it is likely that the revisers, influenced by the frequent recording of Justice Buller's lamentation in *Wilson v. Rastall* in nineteenth-century evidence manuals, simply believed physician-patient privilege to be an uncontroversial and commonsensical correction of a trivial legal matter.[43]

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[42] Cook, *The American Codification Movement*, 148.

[43] In this respect, American codifiers differed markedly from their intellectual forebears in Britain. Bentham was vehemently opposed to evidentiary privileges. For Bentham and his influence on the law of privilege see Imwinkelried, *The New Wigmore: Evidentiary Privileges*, 176-191. Beyond the *Revisers' Notes* the codifiers left behind

Whatever the motivations of the New York revisers, their statute quickly influenced other states to follow suit.[44] Missouri passed a law guaranteeing physician-patient privilege in 1835. Mississippi enacted a statute the following year.[45] By 1840, both Arkansas and Wisconsin had enacted statutes. Significantly, each of these states—like New York—passed their statutes guaranteeing physician-patient privilege as part of larger processes of codification, often using New York as an example.

For the most part, these laws echoed the language of New York's statutory provision. In Missouri, the legal code stated that no physician "shall be required or allowed to disclose" patients' confidences. Though the states' revisers added the word required to the statute, this minor alteration did little to change the effect or intent of the law.[46] Mississippi

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little writing on the subject of physician-patient privilege. However, William Sampson successfully made the case for a priest-penitent privilege in court before then-New-York-City-Mayor DeWitt Clinton in 1813. William Sampson, *The Catholic Question in America: Whether a Roman Catholic Clergyman be in any case compellable to disclose the secrets Aurieular Confession* (New York, 1813).

[44] Again, Maehle, Clinton, and Wigmore have provided the most thorough accounts of this phenomena, but each author focused more on the differences in form and language between the various statutes adopted over the course of the nineteenth century than on the underlying causes for the rapid spread of these laws. Maehle, *Contesting Medical Confidentiality,* 11-15; Clinton, *Privileged Communications Between Physician and Patient*, 15-18; and Wigmore, *A Treatise on Evidence* 1st ed., v. 4, 3349-3350. Perhaps the most compelling explanation of these early laws can be found in Frederick Stimson's paper, "Privileged Communications to Physicians," read before the Massachusetts Medical Society in 1903. In this paper, Stimson recast the debate as a contest between statutory and common law. To Stimson, states that embraced codification and statutory law were more likely to adopt physician-patient privilege. States that remained tied to the common law system, by contrast, were unlikely to adopt physician-patient privilege. Frederick J. Stimson, "Privileged Communications to Physicians," *Communications of the Massachusetts Medical Society* 19:1 (1904), 607-614.

[45] The Mississippi Statute offers an excellent example of the challenges in tracing the origins and transformation of some of these early statutes. The law appears in the state's *Revised Statutes of the State of Mississippi* (Jackson, 1836), 1052. Yet the law does not appear in any of the states' later revisions and was never mentioned in later publications on the history of physician-patient privilege. See, for example, *Revised Code of the Statute Laws of the State of Mississippi* (Jackson, MI: 1857); Wigmore, *On Evidence* 1st e., 3348-3349; or the list of statutes compiled in the 1882 case, Gartside v. The Connecticut Mutual Life Insurance Company, 76 Mo. 446 (1882). Mississippi would again adopt physician-patient privilege in the twentieth century.

[46] *The Revised Statutes of the State of Missouri, Revised and Digested by the Eighth General Assembly…With the Constitutions of Missouri and the United States* (St. Louis, 1835), 623.

adopted the New York statute word-for-word. Other states made minor alterations. Moreover, the revisers of later codes often had connections to New York's legal establishment. The revised codes of both Michigan and, later, Arizona, for example, were both written by William Thompson Howell, an attorney who had practiced in New York.[47]

Elsewhere physician-patient privilege was proposed, but not enacted. In the 1830s, the Massachusetts State Legislature debated a privilege statute identical to New York's 1828 law as part of a larger codification movement. When attempts to codify Massachusetts law stalled, however, the proposed privilege statute was scrapped and quickly forgotten.[48]

Table 1: Physician-Patient Privilege (through 1850)

State/Territory	Date Enacted
New York	1828
Missouri	1835
Mississippi	1836
Arkansas	1838
Wisconsin	1839
Michigan	1846

Only Wisconsin and Arkansas made changes that affected the potential applications of the privilege in court. Each of these states replaced the New York statutory prohibition on disclosing patients' secrets with a weaker provision that merely prevented doctors from being compelled to reveal their patients' secrets. For example, the Wisconsin statute read:

> No Person duly authorized to practice physic or surgery, **shall be compelled** to disclose any information which he may have acquired in attending any patient in a professional capacity and which information was necessary to enable him to prescribe for such patient as a physician or do any act for him as a surgeon.[49]

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[47] Alfred Lucking, "Privileged Communications to Physicians," *Physician and Surgeon: A Professional Medical Journal* 20 (Detroit and Ann Arbor: 1898), 493-496; John S. Goff, "William T. Howell and the Howell Code of Arizona," *The American Journal of Legal History* 11:3 (July 1967), 221-233.

[48] "Massachusetts Legislature," *Gloucester Telegraph* (October 14, 1835).

[49] *The Revised Statutes of the State of Wisconsin… to which are Prefixed the Declaration of Independence and the Constitutions of the United States and the State of Wisconsin* (Southport, WI: 1849), 526.

Legal scholars have attributed this change in language to the authors' desire to limit the power of the privilege.[50] In time, doctors would come to embrace these statutes as their language left decisions about the admissibility of medical secrets open to the interpretation of physicians. The Wisconsin statute would later serve as model as physicians lobbied for new privilege laws in the late nineteenth century.[51]

In the 1840s, further legal developments in New York facilitated the spread of physician-patient privilege. The state adopted a new constitution in 1846. One of provisions of this new constitution called for the "appointment of three commissioners to revise, reform, simplify and abridge the rules and practice, pleadings, form and proceedings of the courts of record of this state."[52] Like earlier codification movements, the newly appointed revising committee sparked controversy in the state's legal establishment. Horrified by the expansive powers entrusted in the committee, several commissioners resigned before completing their task. When the dust had settled, David Dudley Field, a young New York attorney who would quickly rise to prominence as America's foremost proponent of codification, headed the committee.[53]

Like Spencer two decades earlier, Field was committed to simplifying and improving New York's legal system. He took issue with the lack of uniformity in the ways cases were brought and pleaded before the state's courts, arguing that the state's myriad common law precedents should be replaced with a uniform and easily accessible code of procedure. In

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[50] John B. Sanbourn, "Physician's Privilege in Wisconsin" *Wisconsin Law Review* 1 (1922), 141-146.

[51] See, for example, Horatio Wood's proposal for Pennsylvania statute "Editorial: Professional Secrets and the Law," *Philadelphia Medical Times and Register* (February 26, 1881), 337.

[52] *Laws of the State of New York* (1848), c. 379. Quoted in Friedman, *A History of American Law*, 293.

[53] Friedman, *A History of American Law*, 293-298.

1848, Field and his colleagues presented the New York State Legislature with a revised Code of Civil Procedure. Modeled upon the French civil code, Field's Code of Civil Procedure took issue with the complexity and confusions of the common law as well as the jargon and Latin that underpinned nineteenth-century legal procedure. He posited, for example, that the new Code of Civil Procedure should replace "habeas corpus" with a "writ of deliverance from prison." Even more than the revisions of the 1820s, the Field code, as one legal historian wrote, was "a colossal affront to the common-law tradition."[54] While the state legislature rejected some of Field's most radical proposals, the bulk of Field's Code was accepted into law in 1848.[55]

Field's Code did not change New York's medical confidentiality law. The 1848 revisions did, however, spark a new wave of codification that brought similar statutes to still more jurisdictions, especially in the western United States. Compared to the older eastern states, the American west featured a young, progressive bar, greater exposure to civil law, and less rigidly established common law traditions—characteristics that made these states especially receptive to codification. California adopted Field's Code in 1851, adopting physician-patient privilege in the process. Other western states followed California's lead with identical statutes. In the following decades, Iowa, Minnesota, Indiana, Ohio, Washington Territory, Nebraska, Wisconsin, and Kansas all adopted the code. By the turn of the century the Dakotas, Idaho, Arizona, Montana, Wyoming, North Carolina, South

[54] Ibid., 293.

[55] Ibid., 293-298.

Carolina, Utah, Colorado, Oklahoma, and New Mexico had all adopted Field's Code of Civil Procedure.[56]

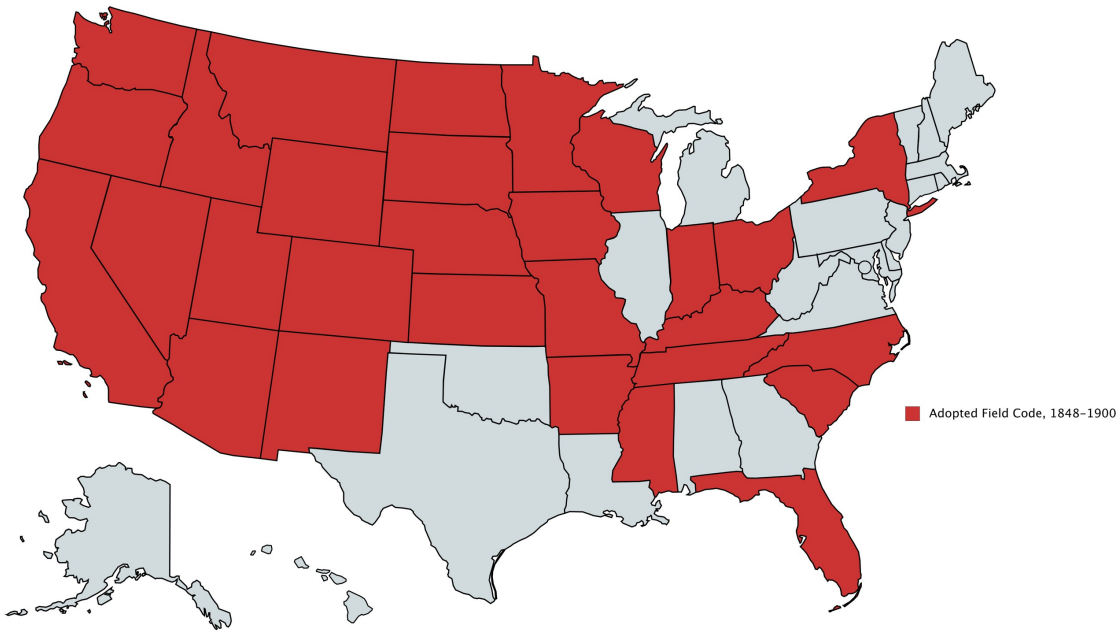
Some of these jurisdictions, like Missouri and Wisconsin had already adopted physician-patient privilege. In those states, the existing statutes were incorporated into the new Code of Civil Procedure. In many more jurisdictions, however, physician-patient privilege was adopted as part of Field's Code. Among others, California, Kansas, and Indiana adopted physician-patient privilege in this manner. At the same time, however, numerous states rejected the Field's controversial code altogether. Much of the eastern seaboard remained what one legal scholar termed, "common law states." Rejecting codification, these "older states, particularly of English origin, [stuck] to the common law, and never attempt[ed] to define it, rarely even to improve it by statute." These states remained bound to the precedent established in the Duchess of Kingston's trial for bigamy.[57]

The middle of the nineteenth century brought more legislation on physician-patient privilege than any time before or since. Between 1828 and 1870, seventeen states or territories enacted statutory guarantees of medical confidentiality. While all of these statutes have been amended and changed numerous times since the nineteenth century, these early statutes form the basis for modern physician-patient privilege. With the exception of Mississippi, none of these statutes was ever repealed. Instead, the effects of these early

[56] Ibid.; Mildred Coe and Lewis W. Morse, "Chronology of the Development of the David Dudley Field Code," *Cornell Law Review* 27:2 (February 1942), 238-245. For more on the similarities and differences between various codification movements, see Kellen Funk's online project, kellenfunk.org, which features the most comprehensive list of these various codification projects as well as the figures responsible for each respective codification movement.

[57] Friedman, *A History of American Law*, 293-298; Stimson, "Privileged Communications to Physicians," 608.

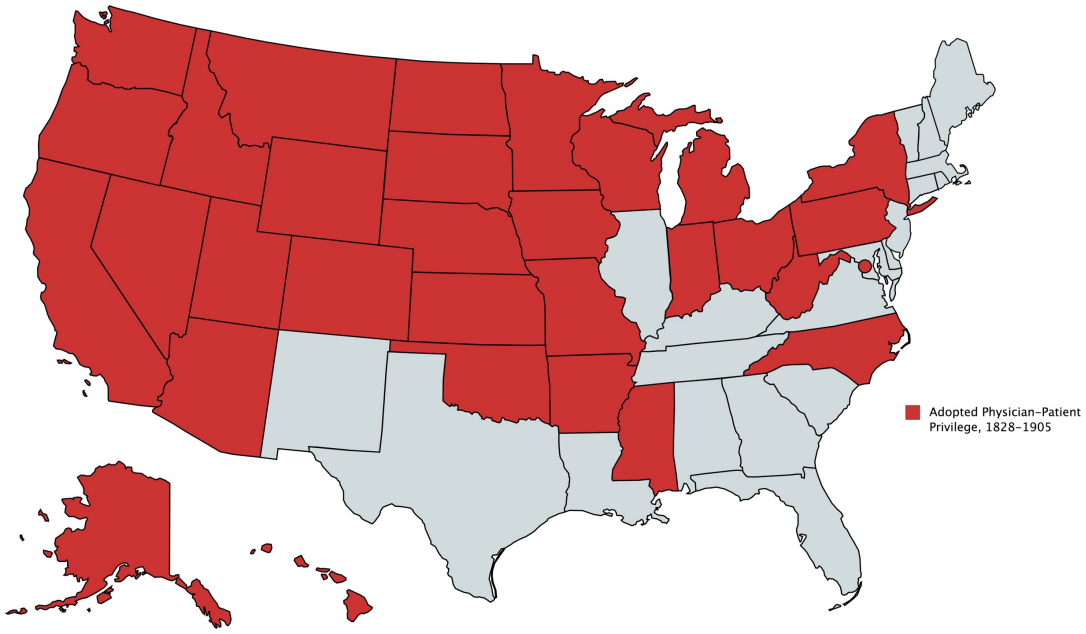
Figure 1: Field Code of Civil Procedure



statutes continue to shape the intersections between medicine and the law today. By and large, privilege is observed where it was adopted in the nineteenth century and is not observed in the few Southern and New England states that did not adopt it. Moreover, by adopting privilege via statute, these laws had the effect of cementing the absence of privilege in federal courts which remain to the present time still tied to the common law precedent.

A thorough review of these early statutes reveals that physician-patient privilege first emerged as an inadvertent byproduct of numerous codification movements. Though there were small variations between individual statutes, by and large, all of these laws shared a common language that had been inherited from earlier legal scholarship. More importantly, each statute was enacted as part of a larger scheme of codification. Physician-patient privilege appeared in jurisdictions where codification was most popular and remained absent

Figure 2: Privilege in the Nineteenth Century



where codification failed to take hold. By the latter half of the century, the dividing line that would characterize later debates over physician-patient privilege had been set. Western States, most of which embraced Field's Code of Civil Procedure, almost all guaranteed medical confidentiality in the courtroom. Eastern States, on the other hand, remained reluctant to enact physician-patient privilege.

And yet, many of these developments went unnoticed in their time. Throughout much of this period, both doctors and lawyers viewed the privilege as a legal issue and, as such, it was often overshadowed by other legal developments. For legal scholars, codification carried so many pressing implications that physician-patient privilege seemed trivial by comparison. At the same time, doctors—seldom trained in how to carry themselves in the courtroom—often failed to notice slight changes in states' evidentiary codes. Nevertheless, medical developments gradually led a small cadre of physicians to

embrace physician-patient privilege. In time, these doctors would recast the privilege not as a legal issue but rather as an issue of medical professionalization and, in doing so, they would bring physician-patient privilege into the public eye.

CHAPTER IV: EARLY PRIVILEGE CASES

> A medical attendant is ordinarily without privilege even as to the communications confidentially made to him by his patient. In the United States, however, statutes, in several jurisdictions, have been passed conferring this immunity, which statutes virtually prohibit physicians from disclosing information the derive professionally from their relations to their patient.
>
> Francis Wharton, *A Commentary on the Law of Evidence in Civil Issues*, 1877

When Jane Elizabeth Johnson filed for divorce on Saturday June 16th, 1832, she expected the proceedings to move quickly even though, at the time, New York's divorce laws were among the most rigid in the nation. Adultery was the only grounds upon which the courts would dissolve a marriage and, in some cases, even that was not enough. Shown any signs of condonation—if the aggrieved spouse had briefly forgiven or merely failed to leave their unfaithful partner— the courts were unlikely to grant a divorce.[1] Still, the case against her husband, Enos, was strong.

The couple had married seven years earlier. Shortly after their nuptials, Jane, a native of England, emigrated with her new husband to New York City, where Enos' father ran a thriving grocery business. Despite the family's affluence, Jane found life in New York lonely and difficult. Enos proved to be a terrible companion, berating and insulting his wife at every turn. When Jane fell ill, he was nowhere to be found. A regular at some of New York's

[1] On the law regarding divorce, see: Lawrence M. Friedman, "Rights of Passage: Divorce Law in Historical Perspective," *Oregon Law Review* 63 (1984), 649-670; Henrik Hartog, *Man and Wife in America: A History* (Cambridge, MA: Harvard University Press, 2000); Norma Basch, *In the Eyes of the Law: Women, Marriage, and Property in Nineteenth-Century New York* (Ithaca: Cornell University Press, 1982); and Nancy F. Cott, *Public Vows: A History of Marriage and the Nation* (Cambridge, MA and London: Harvard University Press, 2000), esp. 47-55. According to the presiding judge in Jane Johnson's case, "A voluntary cohabitation of a wife with her husband with full knowledge of an act of adultery committed by him, is legal evidence of condonation or a forgiveness of the offence, and bars suit for divorce." Johnson v. Johnson, 14 Wend. 637 (1835).

seedier establishments, Enos was frequently unfaithful. He twice contracted venereal disease as a result of his affairs.[2]

In 1832, in front of the New York Chancery Court, Jane's lawyers laid out the case against Enos.[3] They called numerous witnesses who recounted the "opprobrious epithets and insulting language" he directed toward his wife. Another witness placed Enos in the third-tier seats of a local theater—a known hub for prostitution. Enos' physician testified that Enos had come to him seeking treatment for venereal disease and "that [Enos] Johnson acknowledged to him [that] he had contracted the disease in adulterous intercourse." Finally, Jane took the stand. She corroborated the testimony of each witness and stated that she and Enos "had not lived together as man and wife" for two years. Unsurprisingly, the court ruled in Jane's favor, dissolving her marriage to Enos and enabling her to return to family and friends in Manchester.[4]

Jane's victory was fleeting, however, as Enos immediately appealed the Court's decision. A second trial was booked for 1834. Again, the case came before the New York Chancery Court. This time, Enos' attorneys took aim at the evidence presented in the first trial. They argued that, based on New York's 1828 law barring medical testimony from the courtroom, the testimony of Enos' physician should never have been accepted as evidence. Furthermore, Enos' attorneys, while admitting to some infidelities on the part of their client,

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[2] John Littell, *Family Records or Genealogies of the First Settlers of the Passaic Valley (And Vicinity) above Chatham* (1852), 192; England, Cheshire, Marriage Bonds and Allegations, 1606-1900, database, *FamilySearch* (https://familysearch.org/ark:/61903/1:1:F1SN-F5Y : 8 December 2014), Enos Ward Johnson, 09 Aug 1825; citing, Cheshire Record Office, Chester; FHL microfilm.

[3] The New York Court of Chancery was the state's top court of equity and one of the preeminent courts in the Early Republic. The Court of Chancery was abolished in 1846 and its jurisdiction was passed to the New York Supreme Court.

[4] Johnson v. Johnson, 1 Edw.Ch. 439 (1832); Johnson v. Johnson, 4 Paige 460 (1834); and Johnson v. Johnson, 14 Wend. 637 (1835).

pointed out that Jane had briefly continued living with Enos after these affairs took place. Thus, they argued, Jane's actions constituted a condonation of Enos' various sins and, therefore, no divorce should be granted. While the same court had ruled in Jane's favor two years earlier, the Chancery Court, now ignoring the testimony of Enos' physician, sided with Enos, rejecting Jane's petition for a divorce. Jane and her lawyers then appealed to the New York Court for the Correction of Errors, the highest court in the state.[5] And so, the following year, the New York courts were asked again to weigh the implications of the state's law privileging communications between physician and patient.[6]

Throughout this process, it became apparent that few people had any idea how to interpret this new statute. In the first trial, when Enos' physician, Dr. Smith, was asked whether his patient suffered from venereal disease, he had initially declined to answer. Court records show, however, that either the presiding judge or Jane's lawyers told Dr. Smith that he must divulge this information. Neither Enos' lawyers nor Dr. Smith objected, and the physician then testified that Enos had come to him to receive treatment for venereal disease and that he had contracted this disease as the result of his numerous infidelities. Enos' council first invoked privileged communications in the appeals process. This had been enough to sway the presiding judges—the same justices who had earlier compelled Dr. Smith to testify—that this evidence should be thrown out.[7]

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[5] The Court for the Correction of Errors was the appeals court for both the New York Chancery Court and the Court for the Correction of Errors. Proceedings were held in front of the New York Senate. State Senators served as justices along with wither members of the State Supreme Court or the New York Chancellor, depending on the jurisdiction from which the appeal was made. Like the New York Court of Chancery, the Court for the Correction of Errors was abolished in 1846.

[6] Johnson v. Johnson, 1 Edw.Ch. 439 (1832); Johnson v. Johnson, 4 Paige 460 (1834); and Johnson v. Johnson, 14 Wend. 637 (1835).

[7] Ibid.

Since the outcome of the case hung so clearly on Dr. Smith's testimony, the court devoted much of the proceedings to a discussion of the various implications of New York's privilege statute. The most pressing question was whether the privilege belonged to the "witness" (Dr. Smith) or to the "party" (Enos). To answer this query, the presiding justices compared physician-patient to privilege attorney-client privilege. Ultimately, based on established governing the use of attorney-client privilege, they ruled that "privilege is undoubtedly that of the party and not of the witness." Because of this, the justices reasoned, physician-patient privilege was not applicable in this situation. In the first trial Dr. Smith resisted questioning that might reveal embarrassing and incriminating information about his client. According to the New York Courts, he had no right to do so, as only Enos and his lawyers could invoke the privilege. Because Enos' lawyers did not object to this line of questioning, Dr. Smith's testimony was accepted on the court record. With this evidence, the courts finally ruled in Jane's favor. Three and a half years after she first petitioned for divorce, she was finally rid of Enos.[8]

Johnson v. Johnson was the first case to test New York's privilege statute, and it marked the beginning of a decades-long process through which the courts came to define physician-patient privilege. When the New York legislature adopted physician-patient privilege in 1828, it gave little instruction as to how this new statute was to be interpreted. The law itself was comprised of a single sentence and the vague language of the statute left many important questions to be decided by the courts: What did "duly authorized" mean? Who could be considered a physician or a surgeon? In an era when licenses were not required to practice medicine, were unlicensed practitioners covered by the privilege? What about dentists,

[8] Johnson v. Johnson, 14 Wend. 637 (1835).

nurses, or chiropractors? What communications were to be considered of "a professional character" or "necessary"? Who could invoke the privilege? Was the privilege absolute? Or could it be waived? Did the privilege continue to protect the deceased?[9]

With little instruction from the legislature, each of these questions would have to be decided by the courts. In this respect, New York was hardly exceptional. Statutes adopted in other jurisdictions—many of them based on the New York law—were similarly vague. Over the course of the nineteenth century, state courts would rule on each of these issues, establishing a series of precedents that would make the privilege into a formidable protection of patients' confidences. This process was incredibly slow, however, as physician-patient privilege was seldom invoked in the courtroom. Until the mid-1870s, only a few privilege cases were brought before the New York courts. In each, the proceedings were characterized by lingering uncertainty as few people—whether doctors, lawyers, or judges—had any idea how the state's new statute regulating medical testimony was to be implemented in the courtroom.

Hewit v. Prime, the second privilege case to appear before the New York courts was first adjudicated in 1835. Hewitt, the plaintiff in the suit, alleged that his neighbor, Prime, had seduced and impregnated his underage daughter. Hewit's daughter was called before the Essex circuit court to testify, recounting how "she was persuaded by the defendant to swear the child upon some person other than himself, on this promising that if she would do so, he would marry her, and that she accordingly made oath before a justice… that the child with which she was pregnant was begotten by

[9] The law read: "No person duly authorized to practice physic or surgery, shall be allowed to disclose any information which he may have acquired in attending to any patient, in a professional character, and which information was necessary to enable him to prescribe as a physician, or do any act for him, as a surgeon." *Revised Statutes of the State of New York*, 409.

Benjamin Flanagan, a fictitious person." Due to a technicality, however—Hewit's daughter's testimony was improperly taken by the court—this testimony carried little weight in the courtroom.[10]

And so, the trial's verdict hinged upon the testimony of a second witness. A practicing physician testified that that Prime had "repeatedly applied to him for drugs to produce an abortion, and upon one of those occasions told him that the female gotten with child was the plaintiff's daughter." The defendant's counsel "objected to the physician's testifying to any thing that was said by the defendant when applying for medical advice, whether such advice was for himself or another; but the objection was overruled." With this information taken into the record, the court ruled in Hewit's favor, finding Prime guilty of seduction. Prime appealed to the New York Supreme Court, arguing that this information had been taken in error. Like the Essex circuit judge, however, the Supreme Court justices were unsympathetic, stating:

> The witness, (the physician,) I think, was not privileged. It is very doubtful whether the communication made to him by the defendant can be considered as consulting him professionally, within the meaning of the statute; and it is certain that the information given was not essential to enable him to prescribe for the patient if the daughter of the plaintiff should be considered a patient in respect to the transaction.

With this, the New York Supreme Court upheld Prime's conviction. While little is known of individual actors is the cases, the trial was preserved in numerous evidence manuals where it was frequently cited to show that that physician-patient privilege did not protect patients seeking abortions nor did it protect physicians who provided these services in violation of state law.[11]

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[10] Hewit v. Prime, 21 Wend. 79 (1839).

[11] Ibid. The case appeared in numerous nineteenth-century legal treatises. See, for example, Francis Wharton, *A Commentary on the Law of Evidence in Civil Issues* vol.1 (Philadelphia, 1877), 582.

At the time, the very idea of criminal abortion remained a relative novelty. Anti-abortion laws evolved rapidly over the course of the nineteenth century and, in many ways, mirrored the evolution of physician-patient privilege. At the beginning of the nineteenth century, the legal status of abortion was governed by common law precedent, which recognized fetal life at quickening— "the first perception of fetal movement by the pregnant woman herself." This "generally occurred near the midpoint of gestation, late in the fourth or early in the fifth month… Before quickening, actions that had the effect of terminating what turned out to have been an early pregnancy were not considered criminal under the common law in effect in England and the United States in 1800." "After quickening, the expulsion and destruction of a fetus without due cause was considered a crime, because the fetus itself had manifested some semblance of a separate existence: the ability to move. The crime was quantitively different from the destruction of a human being, however, and punished less harshly."[12]

Between 1821 and 1841, numerous states enacted statutes that "made certain kinds of abortions explicit statute offenses rather than leaving the common law to deal with them."[13] In the same 1828 code revisions that first introduced physician-patient privilege, for example, the New York Legislature also added two statutes that effectively criminalized abortion after quickening. These laws were intended primarily as a means of protecting women from what was then a dangerous medical procedure. Under the New York Criminal

[12] Mohr, *Abortion in America*, 3-4.

[13] Ibid., 20.

Code, anyone who performed an abortion—but not the woman herself—could be held criminally liable and charged with second-degree manslaughter.[14]

These early laws were markedly different from later anti-abortion laws. In the mid-nineteenth century, numerous technological advances—including the invention of the stethoscope, which allowed the detection of the fetal heartbeat, as well as microscopic studies that revealed important stages in embryonic development—led many to question the use of quickening as a basis for determining fetal life. From the 1850s onwards, regular physicians, led by the Boston gynecologist and obstetrician Horatio Storer, campaigned to outlaw all abortions from the point of conception onward. These doctors were motivated in part growing moral sentiment that increasingly equated late-term abortion with infanticide. At the same time, however, "the regular physicians' crusade for stricter abortion laws opened up the possibility for them to regain authority in questions of social policy—something they had lost with the repeal of medical licensing laws earlier in the century."[15] To this end, the anti-abortion campaign was wildly successful. "Between 1860 and 1880… at least 40 anti-abortion statutes of various kinds were placed upon state and territorial lawbooks… [including] over 30 in the years from 1866 through 1877 alone."[16]

As abortion laws became stricter over the course of the nineteenth century, the need for medical evidence in abortion trials increasingly came into conflict with physicians' ethical

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[14] Ibid., 26-32.

[15] Maehle, *Contesting Medical Confidentiality*, 66. See also, Mohr, *Abortion in America*, 147-225. On the repeal of medical licensing laws see Owen Whooley, *Knowledge in the Time of Cholera: The Struggle over American Medicine in the Nineteenth Century* (Chicago: University of Chicago Press, 2013), 59-72; Starr, *The Social Transformation of American Medicine*, 58-59; Rothstein, *American Physicians in the Nineteenth Century*, 63-84; James C. Mohr, *Licensed to Practice: The Supreme Court Defines the American Medical Profession* (Baltimore: The Johns Hopkins University Press, 2013), 9-21.

[16] Mohr, *Abortion in America*, 200. On abortion policy, see also Leslie Reagan, *When Abortion Was a Crime: Women, Medicine, and Law in the United States* (Berkeley: University of California Press, 1997); Baker, *Before Bioethics*, 169-173.

duty to maintain confidentiality as well as the growing number of privilege statutes in effect throughout the United States. In time, the courts came to reexamine the precedent established in *Hewit v. Prime*. In the 1886 trial of an alleged abortionist, the New York courts ruled the testimony of the accused physician inadmissible because this evidence "tended to convict [his patient] too of crime or to cast discredit and disgrace upon her," contradicting the precedent established in *Hewit v. Prime*.[17]

These issues came to the fore again three years later in 1889 when a New York man was charged with manslaughter. The accused, a married man, had been having an affair and, when his lover became pregnant, he assisted her in procuring an abortion. In the procedure, the woman "introduced a catheter with a wire in her womb, and after she had introduced it far enough to hurt her, [the man] blew in it." When the woman fainted, the man called upon a local physician who rushed to the scene but was unable to save her. The man confessed to the physician what had happened, even admitting that he had conducted the procedure once before. In the courtroom, the physician recounted all he had seen and heard. With this damning testimony, the defendant was found guilty. On appeal, however, the New York Supreme court ruled "that the statute [privileging communications between physician and patient], both in its letter and spirit protects the confidence thus reposed in the physician and forbids him to betray it." With this, the physician's testimony was thrown out and the conviction was overturned.[18]

For practicing physicians, the lingering uncertainty surrounding physician-patient privilege and its applicability in abortion trials was a major point of concern. On one hand,

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[17] People v. Murphy, 101 N.Y. 126 (1886). For more on privilege in nineteenth-century abortion cases, see Holger-Maehle, *Contesting Medical Confidentiality*, 68-74.

[18] People v. Brower, 53 Hun. 217 (1889); Holger-Maehle, *Contesting Medical Confidentiality*, 70.

privilege had the potential to derail criminal abortion proceedings by denying the courts essential medical testimony. In 1888, at the annual meeting of the American Medical Association, "Iowa physician H.C. Markham argued that as long as there were no changes in the professional relies regarding the giving of evidence in abortion cases, little success could be expected in their prosecution." To Markham, "the penalties aimed at abortionists had hardly any deterrent effect. Rather, the 'party inciting the act' (that is, the pregnant woman or her husband or partner) had to be made to 'fear the consequences.' Medical Evidence in court about the abortion was therefore crucial."[19]

On the other hand, the numerous variations between differing privilege statutes along lingering uncertainties as to how these statutes left many physicians in a precarious situation. In 1899, when a Massachusetts physician was charged for "being an accessory after the fact to a criminal abortion," the *Journal of the American Medical Association* railed against the different laws in various jurisdictions: "In some localities it may come to be perilous to treat [abortion] cases as they occur without reporting all suspicious appearing facts to the authorities, while a mile or two different such revelation would bring liability to heavy damages if not a criminal prosecution. The Massachusetts physician referred to may or may not have been cognizant of a criminal act and guilty of concealing it, but in New York he could not have done otherwise than keep this knowledge to himself."[20]

By the turn of the century, the uncertainty surrounding physician-patient privilege in abortion trials had become a rallying issue for many physicians, who began to campaign for

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[19] Maehle, *Contesting Medical Confidentiality*, 68-69; H.C. Markham, "Foeticide and Its Prevention," *Journal of the American Medical Association* 9 (1888), 806.

[20] "Medical Confidences," *Journal of the American Medical Association* 33 (1899), 1431 quoted in Holger-Maehle, *Contesting Medical Confidentiality*, 71.

new statutes and uniform laws between jurisdictions.[21] In the meantime, physicians developed numerous, often contradictory, strategies to deal with the uncertainties they faced. One medico-legal scholar suggested that "doctors should state abortion cases hypothetically without disclosing the interested parties to an appropriate law officer to obtain specific advice. If the advice was that they were not bound to disclose, they should keep silent. They should not approach a legal officer for advice, however, if they were not prepared to give evidence when told that they had a duty to disclose."[22] Another author recommended that physicians "obey the injunction of the Hippocratic oath" and refuse to testify in any abortion cases unless a judge ordered them to do so.[23] As these abortion cases illustrate, the law regarding privilege communications remained unsettled throughout much of the nineteenth century despite the rapid spread of new statutes that barred medical testimony from the courtroom.

Adding to the confusion was a dearth of information on physician-patient privilege. Neither the new statutes nor the influential precedents established in eighteenth century Britain appeared in the legal literature of the day. The first American treatise on the law of evidence, Zephaniah Smith's short 1810 tract, *A Digest of the Laws of Evidence in Civil and Criminal Cases* made no mention of the common law precedent established in the Duchess of Kingston's trial.[24] Later treatises published in the 1830s offered no mention of the New York

[21] Sturgis, "Correspondence: To the Philadelphia Medical Times," 339.

[22] Holger-Maehle, *Contesting Medical Confidentiality*, 71.

[23] William C. Tait, "The Physician's Obligation to Secrecy," *American Medicine* 4 (1902), 267 quoted in Holger-Maehle, *Contesting Medical Confidentiality*, 71.

[24] Zephaniah Smith, *A Digest of the Laws of Evidence in Civil and Criminal Cases* (Hartford, 1810).

statute nor of any of the other laws protecting medical confidentiality in the courtroom.[25] The fourth American edition of Samuel March Phillips's *A Treatise on the Law of Evidence*, published in 1839 was the first to offer any mention of the New York statute, but this text did not mention any of the other laws on the books. By then, Missouri, Mississippi, Arkansas, and Wisconsin had also adopted similar legislation.[26] None of these treatises cited any relevant case law.

Throughout much of the nineteenth century, the most frequently cited text on the law of evidence was Simon Greenleaf's landmark work, *A Treatise on the Law of Evidence.* First published in 1842, the text found frequent use as a courtroom reference as well as a law school textbook. The treatise was republished sixteen times over the next fifty years. Writing on its influence in 1896, one legal commentator remarked, "the professional approval of [this] work was [so] immediate and constant," that "in the opinions of every Court for the last fifty years occur references to its sections; and even of the errors that are to be found in its pages, it may often be said that they have become law in many jurisdictions because they were put forth in these pages."[27]

An otherwise comprehensive work that covered a wide range of topics related to the law of evidence, including obscure common law precedents and minute developments in the statutory codes of each state, the text had little to say about physician-patient privilege. In the first edition of Greenleaf's landmark treatise, the subject was covered in one brief

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[25] See, for example: Thomas Starkie, *A Practical Treatise on the Law of Evidence* 5th American ed., vol. 2 (Philadelphia, 1834), 228-232.

[26] Samuel March Phillips, *A Treatise on the Law of Evidence* 4th American Ed. (New York, 1839), 279-283.

[27] Simon Greenleaf, *A Treatise on the Law of Evidence* 16th ed. vol. 1 (Boston, 1899), v-vi. New editions of *A Treatise on the Law of Evidence* were published in 1842, 1844, 1846, 1848, 1850, 1852, 1854, 1857, 1858, 1860, 1863, 1866, 1876, 1883, 1892, and 1899.

sentence: "Neither is this protection [privileged communications] extended to medical persons in regard to information, which they have acquired confidentially by attending in their professional characters." To this, Greenleaf added a brief note. He cited the Duchess of Kingston's trial and several other British decisions; the text of the New York statute; Missouri's 1835 statute; and the recently settled case, *Johnson v. Johnson*. Greenleaf did not mention the laws on the books in Wisconsin, Mississippi, or Arkansas. Nor did he mention the recent New York case, *Hewit v. Prime*, which would be frequently cited in late-nineteenth century cases.[28]

Later editions of Greenleaf's *A Treatise on the Law of Evidence* offered little more on the subject of physician-patient privilege. The second edition added a reference to the 1839 case *Hewit v. Prime*. The third and fourth editions added no new information. The fifth edition, published in 1850, featured the first references to physician-patient privilege statutes in Wisconsin and Michigan—laws adopted in 1839 and 1846, respectively. Iowa's statute was mentioned in the 1852 edition. The seventh, eighth, ninth, tenth, eleventh, twelfth, and thirteenth editions added no new text. Not until the fourteenth, fifteenth, and sixteenth editions—published in 1883, 1892, and 1899 respectively—did the book feature any substantive discussion of physician-patient privilege.[29]

By the 1870s, physician-patient privilege began to be regularly referenced in legal treatises, but seldom discussed at length. By this point Francis Wharton had joined Greenleaf among the nation's preeminent scholars of the law of evidence. Like Greenleaf,

[28] Simon Greenleaf, *A Treatise on the Law of Evidence* 1st ed. vol. 1 (Boston, 1842), 283-284.

[29] Ibid.

however, Wharton's magnum opus, *A Commentary on the Law of Evidence in Civil Issues*, offered only a cursory summary of the state of privileged communications in the United States:

> A medical attendant is ordinarily without privilege even as to the communications confidentially made to him by his patient. In the United States, however, statutes, in several jurisdictions, have been passed conferring this immunity, which statutes virtually prohibit physicians from disclosing information the derive professionally from their relations to their patient. The privilege of the statute may be waived by the patient. But it does not apply to testamentary inquiries; and in any view does not protect consultations for criminal purposes. Whether by the Roman common law, a physician is privileged as to matters confidentially imparted to him by a patient, has been much discussed; and the tendency is to assert the inviolability of such secrets.

This section was appended with seven notes. The first cited the Duchess of Kingston's trial along with two, more recent British decisions as proof that there was no physician-patient privilege under common law. This brief section constituted the only mention of physician-patient privilege in Wharton's two-volume, 1,506-page study of American evidence law, indicating that the issue was hardly a major concern for the average practicing lawyer.[30]

Given the lack of textual information on the subject, it is hardly surprising that physician-patient privilege was seldom invoked in the courtroom. Only three cases adjudicated before the 1870s—all occurring in New York—appear in any of these sources.[31] *Johnson v. Johnson* was the first and most frequently cited of these decisions. Legal sources often referenced the Court for the Correction of Errors' 1835 decision as evidence that privilege was intended to protect the patient and that only the patient, and not the physician, could invoke the privilege. Likewise, *Hewit v. Prime* was frequently

[30] Francis Wharton, *A Commentary on the Law of Evidence in Civil Issues* vol. 1 (Philadelphia, 1877), 581-582.

[31] Johnson v. Johnson, 14 Wend. 637 (1835); Hewit v. Prime, 21 Wend. 79 (1839); and People v. Stout, 3 Park. Cr. 670 (1858). Johnson v. Johnson and Hewit v. Prime were both frequently cited cases that established important and lasting precedents. People v. Stout, on the other hand, received only a brief reference in Wharton's *Commentary on the Law of Evidence in Civil Issues* vol. 1., 581.

cited to give evidence that privilege could not be applied to abortion trials. Aside from these few cases, however, privilege remained a relatively inconsequential and seldom used legal doctrine in spite of the rapid spread of new statutes throughout the nineteenth century.

CHAPTER V: CONFIDENTIALITY AND MEDICAL ETHICS IN THE NINETEENTH CENTURY

> "…Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed; and the familiar and confidential intercourse to which physicians are admitted in their professional visits, should be used with discretion, and with the most scrupulous regard to fidelity and honour. The obligation of secrecy extends beyond the period of professional services; —none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by him except when he is imperatively required to do so. The force and necessity of this obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice."
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> *AMA Code of Ethics,* 1847

In 1831, several doctors wrote to the *American Journal of Medical Sciences* asking, "are there certain questions which a medical man in a court of justice may refuse to answer?" It was a novel question—such issues were seldom discussed in the medico-legal literature of the day—and Isaac Hays, the journal's editor, was at a loss as to how to answer this query. Hays examined a variety of different sources including records of the Duchess of Kingston's trial for bigamy and *Wilson v. Rastall* and came to the conclusion that "that medical persons have *no privilege whatsoever*, not to disclose circumstances revealed to them professionally," failing to note that, in New York, such communications were expressly barred by statute.[1]

This makes it all the more surprising that a decade later Hays would go on to become one of the most vocal champions of physician-patient privilege. In the 1840s, Hays took the lead in the drafting of the American Medical Association (AMA)'s *Code of Ethics*—a document that championed physician-patient privilege as the logical extension of physicians' duty to preserve confidentiality. Here, Hays wrote, "Secrecy and delicacy, when required by peculiar circumstances, should be strictly observed… The force and necessity of this

[1] "Medical Jurisprudence," *The American Journal of the Medical Sciences* (May 1831), 523-524. This exchange was reprinted the following year in the *Western Journal of the Physical and Medical Sciences* (1832), 289-291.

obligation are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice." This chapter examines the nineteenth-century developments in medical ethics that led to this important turning point in the history of medical confidentiality and physician-patient privilege.

Hays was not alone in overlooking the early spread of physician-patient privilege. While codification brought physician-patient privilege to numerous states in the early nineteenth century, few scholars took note of the changes taking place. To the legal profession, physician-patient privilege was merely a minor consequence of a larger phenomenon. Lawyers and legal scholars were justifiably more concerned with the broad implications of codification than one specific piece of evidentiary law. At the same time, doctors, also preoccupied with matters of greater significance, often failed to take notice of this seemingly minor medico-legal development.

For much of the early nineteenth century, the medical profession remained conspicuously weak—a result of widespread antimonopoly sentiment as well as legitimate frustrations with substandard medical care that was often harsh and painful.[2] Faced with challenges from irregular practitioners, the weakening of medical licensing laws, and the erosion of American medical education, so called regular practitioners spent much of the mid-nineteenth century testing new methods to bolster the standing of their fledgling profession. These physicians founded numerous medical societies, lobbied for new licensing laws, and established rigorous ethical codes as means to discipline wayward practitioners and wrest control of the profession from their sectarian rivals.[3] Gradually, medical societies such

[2] Rothstein, *American Physicians in the 19th Century*, 26-62; John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Princeton: Princeton University Press, 1997).

[3] For the weakness of the profession during this time period see Rothstein, *American Physicians in the 19th Century*, 63-174; Paul Starr, *The Social Transformation of American Medicine: The Rise of a Sovereign Profession and the Making of a*

as the Medical Society of the State of New York (MSSNY) and the AMA began to see privileged communications as a powerful indicator of professional status. While the legal profession had led the push for physician-patient privilege during the first half of the nineteenth century, physicians would emerge as the most vocal advocates of physician-patient privilege during the last half of the century.[4]

Just as physician-patient privilege found few practical uses in the early nineteenth century courtroom, the new laws enacted in the 1820s and 1830s remained conspicuously absent from the medical literature of the day. While legal treatises increasingly took note of the growing body of statute law, medico-legal texts offered little clarification of questions regarding privileged communications. Throughout this period, Theodric Romeyn Beck remained the preeminent authority on medico-legal subjects. Beck's magnum opus, *Elements of Medical Jurisprudence*, first published in 1823, went through numerous editions, serving as both textbook and desktop reference for generations of American physicians. Considered by many to be the seminal medico-legal work of its time, the book compiled medico-legal writing into one comprehensive volume, featuring sections on disparate issues such as "Doubtful Sex," "Infanticide," or "Persons Found Dead." In each, Beck offered practical advice to would-be medical witnesses, instructing them how to diagnose insanity or detect feigned illnesses. As a practical guide for physicians, *Elements* was revolutionary. Yet the first

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Vast Industry (New York: Basic Books, 1982), 30-78; and Richard Harrison Shryock, *Medical Licensing in America, 1650-1965* (Baltimore: The Johns Hopkins University Press, 1967).

[4] There is a vibrant literature on the history of medical ethics in the United States. The discussion in this chapter draws most heavily upon Baker, *Before Bioethics*; Baker, Caplan, Emanuel, and Latham eds., *The American Medical Ethics Revolution: How the AMA's Code of Ethics Has Transformed Physicians' Relationships to Patients, Professionals, and Society* (Baltimore and London: The Johns Hopkins University Press, 1967); Robert Baker ed., *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Medical Morality in the Eighteenth and Nineteenth Centuries.* Vol. 2*, Anglo-American Medical Ethics and Medical Jurisprudence in the Nineteenth Century* (Dordrecht: Kluwer, 1995); and Donald Konold, *A History of American Medical Ethics, 1847-1912* (Madison: The State Historical Society of Wisconsin, 1962).

edition featured little discussion of evidentiary procedure or the duties of medical witnesses.[5]

This lack of interest in courtroom procedure was characteristic of the medico-legal field as a whole. Though Beck and other medico-legal scholars wrote profusely throughout the early nineteenth century, their scholarship focused primarily upon practical matters and the professional relations between doctors and lawyers and often neglected the medico-legal implications of the physician-patient relationship. For medico-legal scholars, the most pressing contemporary medico-legal issues included forensic toxicology and the diagnosis of insanity. Medico-legal journals were littered with countless articles that detailed new ways to detect poisons and numerous articles debating sometimes-conflicting definitions of insanity.[6] Likewise, medical schools offered little instruction on the duties of physicians in the courtroom. As historian James Mohr has found, "none of the surviving student notebooks from the first two decades of the nineteenth century contained instruction about how the information being conveyed to students was supposed to be presented in actual courts of law."[7]

Moreover, even when medico-legal texts did focus on medical testimony in the courtroom, they neglected to mention the growing body of statute law protecting medical confidentiality in the courtroom. Despite Beck's role in the 1828 revision of New York's legal code, Beck failed to mention the state's new privilege statute in later editions of *Elements of Medical Jurisprudence* and in a speech before the Medical Society of the State of New York

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[5] Theodric Romeyn Beck, *Elements of Medical Jurisprudence* 1st ed. For more analysis of Beck, see Mohr, *Doctors and the Law*, 15-28.

[6] Mohr, *Doctors and the Law*, 57-75.

[7] Ibid., 94.

on the subject of medical testimony in the courtroom.[8] In fact, it was not until the mid-1840s that any medico-legal text even mentioned physician-patient privilege, and, until the 1860s, the vast majority of medico-legal treatises neglected to cover the subject.[9] Given the lack of information on the subject, it is hardly surprising that physicians failed to take note of the earlies privilege statutes.

Though the medical profession remained blind to the growing spread of physician-patient privilege throughout much of the early nineteenth century, this does not mean that doctors took matters of confidentiality lightly. Rather, during this period, physicians slowly came to embrace medical confidentiality as one of the foundational principles of medical ethics—itself an important piece of their larger efforts professionalize and reform American medicine. Physicians routinely swore oaths that they would maintain patients' confidences at all costs and, throughout the nineteenth century, adopted numerous ethical codes that championed medical confidentiality as one the primary tenets of the physician-patient relationship.

Physicians portrayed these oaths as part of a long-standing tradition that dated back millennia to the original Hippocratic oath. In truth, these links were quite tenuous. The modern history of physicians' oaths began in earnest at the University of Edinburgh where,

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[8] Theodric Romeyn Beck, "Annual Address Delivered before the Medical Society of the State of New York, February 6, 1828," and Theodric Romeyn Beck and John B. Beck, *Elements of Medical Jurisprudence* 5th ed., 661.

[9] The first to mention physician-patient privilege was the American edition of William A. Guy's *Principles of Medical Jurisprudence with So Much of Anatomy, Physiology, Pathology, and the Practice of Medicine and Surgery as are Essential to be Known by Lawyers, Coroners, Magistrates, Officers of the Army and Navy, Ect., Ect.* (New York, 1845). This was followed by John J. Ellwell, *A Medico-Legal Treatise on Malpractice and Medical Evidence Comprising the Elements of Medical Jurisprudence* (New York, 1860), 320-322. However, discussion of privilege was far from the norm in most mid-nineteenth-century texts. By the late 1850s, Beck's *Elements of Medical Jurisprudence* was supplanted as the most frequently cited treatise on medical jurisprudence by Francis Wharton and Moreton Stillé's *A Treatise on Medical Jurisprudence* (Philadelphia, 1855). Like Beck's *Elements*, the first edition of Moreton and Stillé's treatise did not discuss privileged communications. Nor was the subject covered in much of the British medico-legal literature of the day. See, for example, Alfred Swaine Taylor, *The Elements of Medical Jurisprudence Interspersed with a Copious Selection of Curious and Instructive Cases and Analyses of Opinions Delivered at Coroners' Inquests* (London, 1843).

from the early 1730s, every physician graduating from the University of Edinburgh Medical School swore:

> [I A.B. do solemnly declare that I will] practice physic cautiously, chastely, and honourably; and faithfully to procure all things conductive to the health of the bodies of the sick; and lastly, and never, without great cause to divulge anything that ought to be concealed, which may be seen or heard during professional attendance.[10]

In the history of medical ethics, the *Edinburgh Oath* proved to be nothing short of revolutionary, especially for later American doctors. Before the *Edinburgh Oath*, graduating physicians had been forced to swear different oath, the *Sponsio Academica*, which mandated that physicians' primary allegiances would always be to the crown and the church.[11] Under this arrangement doctors would have had little reason and no justification to withhold medical secrets in a court of law. The *Edinburgh Oath*, on the other hand, asserted that doctors' foremost duties were to their patients. With this shift came an implication that physicians' duties to their patients could conflict with their obligations to the state and the courts.[12]

This shift did not always bring immediate changes in medical practice. Doctors continued ethically suspect practices such as flyting, in which physicians would publish short treatises defaming rival practitioners and, in the process, often violate the confidences of their patients. Nevertheless, the *Edinburgh Oath* proved extremely influential in the United

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[10] "Edinburgh University Medical Oath, Circa 1732-1735 Onward," quoted in Robert Baker, *Before Bioethics*, 37. The Edinburgh oath may have been based upon the Hippocratic oath, as the Hippocratic oath had been studied at the University of Edinburgh "since at least 1706, when Sir Robert Sibald Published a commentary on Hippocratic texts." The language of the two oaths differed greatly, however, suggesting that at least some of the origins of the *Edinburgh Oath* lay in other developments. See Baker, *Before Bioethics*, 49-51.

[11] The *Sponsio Academica* had been introduced by King James VI in 1587 a means of insuring the loyalty of the academy in a time of struggle between Catholics and Protestants. Queen Elizabeth I was so impressed with the oath that she implemented a similar one at the universities of Oxford and Cambridge. Baker, *Before Bioethics*, 41.

[12] Baker, *Before Bioethics*, 43-45.

States. In the late eighteenth and early nineteenth centuries there were very few American medical schools. The most prominent American physicians were often educated overseas—almost all of them in Edinburgh where, unlike Oxford and Cambridge, lectures were delivered in English. When American physicians founded their own medical schools, they often modeled these programs upon their experiences in Edinburgh. John Morgan and William Shippen modeled America's first medical school, The College of Philadelphia (now the University of Pennsylvania) after the University of Edinburgh. Likewise, in 1767, Samuel Bard created an Edinburgh-style medical college at King's College (Now Columbia).[13] This meant that, by the early nineteenth century, the vast majority of college-educated American doctors would have all sworn some version of the *Edinburgh Oath*, vowing to maintain the confidences of their patients.[14]

For the most part, these physicians took their commitments to medical confidentiality seriously. By the early nineteenth century, incidents of flyting were increasingly rare. Medical texts frequently attested to the importance of medical confidentiality. In a widely published essay, Benjamin Rush, the primary architect of the heroic medicine that dominated regular practice in the United States throughout much of the nineteenth century, argued that the physician-patient relationship "imposes an obligation of secrecy upon [the physician] and thus prevents his making public what he cannot avoid seeing or hearing accidentally in intercourse with the [patient's] family."[15] Moreover, as the actions of Caesar Hawkins in the

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[13] Rothstein, *American Physicians in the 19th Century*, 87-93.

[14] In 1806, the Medical Society of the County of New York implemented a version of the Edinburgh Oath for new members, though "the unrealistic and unenforceable confidentiality clause was deleted." Baker, *Before Bioethics*, 99-100.

[15] Benjamin Rush, "On the Duties of Patients to their Physicians," in *Sixteen Introductory Lectures, to Courses of Lectures upon the Institutes and Practices of Medicine, with a Syllabus of the Latter…Delivered in the University of Pennsylvania* (Philadelphia, 1811), pp. 336-337. Quoted in Robert Baker, *Before Bioethics*, 90. See also Baker, *Before Bioethics*, 62-93; Chester R. Burns, "Setting the Stage: Moral Philosophy, Benjamin Rush, and Medical Ethics in the United

Duchess of Kingston's trial and Enos Johnson's physician in *Johnson v. Johnson* indicate, doctors were acutely aware of the potential dangers—to honor, reputation, and business—that could arise out of any carelessly revealed secrets. Increasingly, well-educated doctors viewed medical confidentiality as one of the central tenets of the physician-patient relationship even if they did not know about specific statutes that extended this confidentiality into the courtroom.

And yet, although some early nineteenth-century doctors argued vehemently in favor of medical confidentiality, there is little reason to believe that their position was representative of the medical profession as a whole. Esteemed physicians like Benjamin Rush, a signer of the *Declaration of Independence*, would have had little in common with the average practitioner. While writings on medical ethics and confidentiality circulated amongst a small circle of physicians, the vast majority of practitioners would have had little exposure to these ideas.

Until the middle of the nineteenth century, medical education was informal and poorly organized. Medical schools, especially outside of the New York and Philadelphia, were expensive and few. To earn a degree, medical students were required to attend two four-month terms, often in successive years. Depending upon the location and prestige of the school, medical students could expect to pay between $150 and $300 per term. In addition to these fees, students would need to furnish the costs of travel, room, and board. For those who could bear the costs, options were still sparse. In 1810, the United States

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States Before 1846" in *The American Medical Ethics Revolution*, eds. Baker, Caplan, Emanuel, and Latham (Baltimore and London: The Johns Hopkins University Press, 1999), 3-16; L.H. Butterfield, *Letters of Benjamin Rush* (Princeton: Princeton University Press, 1951); George W. Corner, *The Autobiography of Benjamin Rush* (Princeton: Princeton University Press, 1948); and Nathan G. Goodman, *Benjamin Rush: Physician and Citizen, 1746-1813* (Philadelphia: University of Pennsylvania Press, 1934).

contained just six medical schools. With the exception of the University of Maryland, all were clustered in the Northeast. By 1830, the number of medical schools had grown to thirteen. All but three, however, were located in New York, Philadelphia, or New England. Students from outside the northeast would have to move to urban centers, far from home.[16]

For many practitioners, such expenses and hassles were unnecessary. Throughout the early nineteenth century, most American physicians were field-trained, developing their skills through apprenticeships with established local physicians. The typical apprenticeship lasted three years. Fees were negotiated between physicians and apprentices but averaged $100 per year (including room and board). For many established physicians, apprentices served as a source of cheap labor. In addition to their studies, apprentices carried out numerous menial household chores. Likewise, with few pharmacists or apothecaries, the physician's apprentice was frequently tasked with the gathering of necessary roots and herbs as well as the grinding and mixing of drugs. In lieu of a diploma, the mentor furnished the apprentice with a certificate upon completion of his apprenticeship.[17]

Though numerous medical societies enacted provisions to control the quality of medical education, standards of education were erratic and, often, unenforceable. As medical schools proliferated in the early nineteenth century, the quality of these schools varied drastically. While some of the more prestigious medical schools maintained rigorous standards, others were merely diploma mills, churning out graduates regardless of their competency. Apprenticeships were even more difficult to regulate, as medical societies could

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[16] Rothstein, *American Physicians in the 19th Century*, 85-100; Starr, *The Social Transformation of American Medicine*, 37-64; William G. Rothstein, *American Medical Schools and the Practice of Medicine* (Oxford: Oxford University Press, 1987).

[17] Ibid.

do little to disciple substandard or opportunistic educators. By leaving medical education to local, informal arrangements, this system created a diverse medical landscape in which therapeutic and ethical practices varied greatly from region to region.[18]

At the same time, nineteenth-century doctors faced numerous challenges from outside the profession. Thompsonian botanists, hydropaths, and, later, homeopaths and eclectics, all purported to offer alternatives to regular medicine. Though regular physicians considered each of these sects to be quacks, regulars could cite little evidence to show that their treatments were more effective. Furthermore, in many places, especially the small towns and rural outposts of the west, the boundaries between doctors and other practitioners were often poorly defined. Midwives and other non-physician healers conducted many services that have since been controlled by the medical profession. Likewise, folk medicine, home remedies, and patent medicines proliferated throughout the first half of the nineteenth century. Until well into the nineteenth century, family members or lay healers carried much of the nation's primary care within the household.[19] Throughout much of the period, the medical profession remained mired in a series of intra-professional disputes that weakened the professional status of physicians throughout the country. Even if doctors had actively pursued physician-patient privilege, their appeals would have carried little weight.

Nevertheless, nineteenth-century physicians found several means to improve the status of the medical profession. Beginning in the late eighteenth century, wealthy, well-

[18] See John Harley Warner, "The Idea of Southern Medical Distinctiveness: Medical Knowledge and Practice in the Old South," *Sickness and Health in America: Readings in the History of Medicine and Public Health* 2nd ed. (Madison: University of Wisconsin Press, 1985), pp. 53-70.

[19] For an example, see Laurel Thatcher Ulrich, *A Midwife's Tale* (New York: Vintage Books, 1990), 40-71, 165-203.

educated physicians increasingly formed medical societies in the nation's urban centers. In 1780, Boston physicians founded the Massachusetts Medical Society. Likewise, in Philadelphia, a small group of wealthy doctors founded the College of Physicians in 1787. New York had several short-lived medical societies in the late eighteenth century before New York City physicians created the Medical Society of the State of New York (MSSNY). All of these societies were exclusive organizations that limited membership to only the wealthiest and most prestigious physicians. To join Philadelphia's College of Physicians, a doctor needed to be elected by the society's current members. This was so rare that, between 1787 and 1849, only 180 physicians were selected to join the exclusive organization. If a physician were elected to join the College of Physicians, he would then be expected to pay a membership fee of $26.66 and annual dues of $4—prices well out of reach for the average practitioner. The Massachusetts Medical Society was similarly exclusive. Its charter limited membership to seventy physicians, which effectively barred all but the most prestigious Boston physicians.[20]

Initially, these societies largely eschewed ethical regulation. Because of their exclusive nature, members were assumed to be gentlemen of considerable honor. Instead, these organizations used other means to limit medical practice to a small and exclusive group of physicians. One of their favorite tools was the enactment of medical licensing laws. Between 1780 and 1812, Massachusetts, New Hampshire, Connecticut, Maryland, New York, and Rhode Island all granted licensing authority to state medical societies. Yet, for the most part, this legislation lacked any means of enforcement. State medical societies were allowed to issue licenses, but, with the exception of New York, no state mandated any punishment for

[20] Rothstein, *American Physicians in the 19th Century*, 63-68.

unlicensed practitioners. Moreover, these licensing laws proved short-lived. By the end of the 1830s, most had been repealed.[21]

As the medical profession grew in the early nineteenth century, medical societies became more inclusive. From 1781 to 1801 the Massachusetts Medical Society admitted 95 members. In 1803, when the organization lifted its membership cap, 55 new members were admitted. Similarly, the MSSNY reorganized in 1806 so that the society, which was once limited to New York City physicians, now served the broader County of New York. Moreover, while many exclusive societies like Philadelphia's College of Physicians remained prestigious organizations open to only the medical elite, physicians founded larger state and county medical societies that professed represent greater portions of the medical profession. By 1800, most of the northeastern states had a statewide medical society. Forty years later, nearly every state in the union had its own medical society.[22]

As medical societies became more inclusive, these organizations took it upon themselves to regulate doctors' activities. In the early nineteenth century, physicians regularly complained that unscrupulous practitioners were undercutting their fees, limiting their ability to make an honest living. In an attempt to solve this problem, many medical societies imposed fee bills on their members that mandated the going rate for medical services, the charges for distance traveled, and as well as differing rates for rich and poor clients. Almost all regular medical societies instituted fee bills as a necessary condition for membership. These restrictions proved hard to enforce, however, as many fee bills only applied to

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[21] Rothstein, *American Physicians in the 19th Century*, 75; Konold, *A History of American Medical Ethics*, 3-4; Whooley, *Knowledge in the Time of Cholera*, 59-72; Starr, *The Social Transformation of American Medicine*, 58-59; Mohr, *Licensed to Practice*, 9-21.

[22] Rothstein, *American Physicians in the 19th Century*, 70-72.

members of regular medical societies. In the face of widespread competition, physicians in urban areas and other regions with numerous irregular practitioners were often forced to disregard these restrictions altogether.[23]

This led physicians to seek out other forms of regulation and to impose harsher sanctions upon the practitioners who violated the mandates of their local medical society. To do this, medical societies developed what were known as codes of medical police, which might be thought of as lists of rules that all members of the society were theoretically obliged to obey. Upon admission into a medical society, physicians typically swore an oath to abide by those rules and regulations. Societies often mandated that their members refrain from using secret nostrums or patent medicines. Most prohibited consultations with irregular practitioners. Codes of medical police relied upon a system of restorative justice to discipline wayward practitioners. Doctors who violated these codes were threatened with censure and, in extreme cases, expulsion from the medical society. If one member of a medical society believed that another had violated one of the society's rules, the offending practitioner would be called before a disciplinary committee, which would mete out the necessary punishment. [24]

In 1808, the Boston branch of the Massachusetts Medical Society became the first American medical society to adopt a code of medical police. A decade later, "the Connecticut Medical Society published a concise version of the *Boston Medical Police* that was adopted by innumerable municipal, county, and state medical societies from Augusta, Georgia (1822) to Cincinnati, Ohio (1821) to Dover, New Hampshire (1849) and so on

[23] Ibid., 81-82.

[24] Baker, *Before Bioethics*, 112-123. See also Robert Baker, "An Introduction the Boston Medical Police of 1808" in *The Codification of Medical Morality* vol. 2, 25-39.

down the alphabet. Until 1823, the only codes issued by American medical societies were Boston-style, or more commonly, Connecticut-style codes of medical police."[25]

The MSSNY was one of these societies. From 1808 to 1822, members of the medical society observed a code of medical police, which like other early codes of medical police, dealt solely with "physicians' fees and their conduct toward each other,"—as distinguished from their conduct toward patients or the larger society around them. As the New York code evolved over time, the society's bylaws were amended in response to various challenges. In time, however, MSSNY physicians gradually came to view their code of medical police as unenforceable. Like earlier fee bills, the code of medical police dealt only with relations between members of their own specific medical society and could not be used to discipline the professional behavior of non-members, much less the state's numerous irregular practitioners.

Consequently, when the MSSNY code was due to be revised in 1822, the appointed revisers, physicians John Steele and James Manley, convinced their peers that revising the code of police would not advance the society's goals. They argued that the MSSNY needed a new approach altogether, and their fellow members agreed. Felix Pascalis, a New York City physician, joined Steele and Manley to form a committee that immediately began to draft a new code of ethics, rather than a revised code of unenforceable regulations. In 1823, Manley, Steele, and Pascalis presented *System of Ethics* to the MSSNY. The document was adopted with overwhelming support from the society.[26]

System of Ethics marked an important turning point in the history of American medical

[25] Baker, *Before Bioethics*, 104.

[26] Baker, *Before Bioethics*, 112-113.

ethics. Whereas earlier codes of medical police had been focused upon the mundane realities of everyday practice— "consultations, inferences, fees, and quackery"—Manley, Pascalis, and Steele had more lofty ambitions. They added "three new sections notably absent from medical police: a section on the personal character of physicians, a section on the specifications of medical police/ethics in practice, and a section on forensic medical police dealing with the role of the physicians in the courts."[27] While the new document maintained many of the intra-professional restrictions of the society's earlier code of medical police, *System of Ethics* incorporated numerous restrictions on physician-patient interactions that were notably absent from earlier codes of medical police.[28]

Many of these new ideas—most notably the section on personal character and the section on medical ethics—were drawn from a careful study of eighteenth-century moral philosophy, especially the works of Thomas Percival. The committee found in Percival's influential text *Medical Ethics*, the inspiration and justification for their radical expansion of their earlier code of medical police. To Percival, medical ethics constituted "a form of 'professional ethics', which states a physician's moral duties toward three other parties: 1) his patients, 2) his brethren, and 3) the public." This was notably different from earlier codes of medical police, which had addressed, as historian Robert Baker phrased it, only "one item… a practitioner's duties to his fellow practitioners."[29]

By addressing physicians' relationship to society at large, codes of ethics constituted a stronger means of influencing the medical profession as a whole. While adopted by

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[27] Ibid., 115.

[28] Ibid., 112-113.

[29] Ibid., See also, Thomas Percival, *Medical Jurisprudence or a Code of Ethics and Institutes, Adapted to the Professions of Physic and Surgery* (Manchester, 1794); Thomas Percival, *Medical Ethics or a Code of Ethics and Institutes, Adapted to the Professions of Physic and Surgery* (London, 1803).

individual medical societies, codes of ethics purported to apply to all practitioners regardless of their affiliation with local or state medical societies. Nathaniel Davis, the future president of the American Medical Association summarized the difference between codes of medical police and codes of ethics as follows: "A Code of Ethics for our profession must partake… of the nature of a moral essay, developing principles or guidance equally applicable to all places and times, instead of a few simple rules applicable to the members of some particular society."[30] Unlike earlier modes of ethical policing, which pertained only to relations amongst medical practitioners, codes of ethics also aimed to control relations between physicians and patients—some codes of ethics even included mandates to patients as well as physicians.

In adopting the first code of medical ethics, the MSSNY faithfully upheld the basic principles of Percival's *Medical Ethics*. The committee did deviate from Percival's text in several crucial ways, however, including in its treatment of medical confidentiality. In *Medical Ethics*, Percival had argued that doctors should be wary of "false tenderness or misguided conscience" and that no practitioner should let these errors lead him into "withholding any necessary proofs" in a court of justice. To Percival, when called into court, a physician was required "not to conceal any part of what he knows, whether interrogated particularly to that point or not."[31] On the other hand, the MSSNY's new code explicitly mandated that physicians should maintain medical confidentiality at all times:

> A great reserve, and even secrecy respecting the deliberations of a consultation is indispensable. No communication is to be made to the patient or friends but by unanimous order and consent; because, whatever opinions are emitted, become subject to frequent alterations or interventions from mouth to mouth, and may

[30] Nathaniel Davis, *Transactions of the American Medical Association* (1874), 29. Quoted in Baker, *Before Bioethics*, at 95.

[31] Thomas Percival, *Medical Ethics*. This passage was quoted in Robert Baker, "Deciphering Percival's Code," *The Codification of Medical Morality* (Dordrecht: Kluwer, 1993), pp. 179-211, at 190.

> become a source of contradiction perhaps injurious to some of the physicians in attendance.[32]

The authors argued that it was "a matter of justice, necessity and propriety that the business of a surgeon should always be considered of a confidential nature." Moreover, *System of Ethics* suggested that physicians' duties to their patients superseded their obligations to the law and that medical confidentiality should be observed in the courtroom: "Even *secrecy* in certain circumstances, as will be explained hereafter, is the privilege of the faculty, and inviolable even in a court of justice." [33]

System of Ethics abandoned the language of earlier professional regulations by seeking to cast doctors as the benevolent protectors of their patients—and their secrets. In the section on "Forensic Medicine," the authors likened the physician to a Catholic priest, "which admits of no disclosures except in cases of treason and murder." Doctors were privy to a patient's most intimate secrets "such as… the judgment and treatment of syphilitic and gonorrheal disease; the able or disabled state of a person, in limb or constitution; the fallacy of virginity and other circumstances." Honorable physicians were bound to resist revealing any secret that might confer "a degree of shame." Women's secrets were especially in need of protection. Under the new *System of Ethics*, doctors were not allowed to disclose, "whether an apparent pregnancy can be real; the gestation and birth of a child; [or] its parentage, colour, and age."[34]

Published in New York several years before the state adopted its medical confidentiality statute, *System of Ethics* may have influenced Spencer and the other revisers to

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[32] Medical Society of the State of New York, *System of Ethics* (New York, 1823), IX.

[33] Ibid.

[34] Ibid.

incorporate physician-patient privilege into New York's statutory code, a possibility discussed earlier.[35] Regardless of whether the MSSNY's *System of Ethics* influenced the revisers of the New York code, however, the text had a profound impact on the history of medical ethics in the United States. According to historian Robert Baker, "the MSSNY *System of Ethics* reasserts physicians' oath-sworn duty to prioritize the welfare of the patient by obligating physicians to an absolute duty of confidentiality. Courts may probe for the physician's opinion about infanticide, bastardy, paternity, virginity, sexually transmitted diseases, or malingering, but the physician's duty to his patients, like a priest's duty to protect the secrets of the confessional, overrides his obligation to testify on these issues before a court of law."[36] In these respects, the document served as an early model for later ethical codes, including the AMA *Code of Ethics*.

As the condition of the medical profession continued to deteriorate even further in the 1830s and 1840s, doctors increasingly came to regard codes of medical ethics, like that of the MSSNY, as invaluable tools to secure the advancement of the medical profession. In the 1830s numerous medical societies enacted similar ethical regulations of their own, many of which included provisions mandating medical confidentiality.[37] And at the local level, many

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[35] On the origins of the New York law, Maehle states, "The position of the Medical Society of the State of New York on this issue probably had played a role here. In its code of conduct, titled *System of Ethics* (1823), the society had declared that it was 'a matter of justice, necessity, and propriety' that the business of physicians and surgeons should always be considered confidential and that medical secrecy should be 'inviolable even in a court of justice.' Comparing the duty of medical confidentiality with the secret nature of the Catholic confessional, the society required doctors appearing as expert witness in court to remain silent about matters such as questionable pregnancy and paternity, venereal disease, alleged disabilities, virginity and other circumstances that were linked with 'a degree of shame' and 'never mentioned but with an engagement to secrecy.' The 1828 New York statute permitted physicians and surgeons to adhere to this code." Maehle, *Contesting Medical Confidentiality*, 12.

[36] Baker, *Before Bioethics*, 118.

[37] Konold, *A History of American Medical Ethics*, 9-10. These included the Medical Society of Ohio's *Code of Ethics* (1831) as well as the Medical and Chirurgical Faculty of Maryland's *Code of Ethics* (1832).

regular physicians viewed these codes as unequivocal successes. Yet these codes were incapable of addressing many of the problems plaguing medicine on the national scale. Quacks and irregular practitioners thrived in the nation's de-regulated medical marketplace, and medical education continued to decline as increased competition led medical schools to relax standards in attempts to gather a greater share of the available student fees.

These developments greatly troubled regular physicians who saw their inability to control the medical profession as an existential threat. In May of 1845, delegates from medical societies across the country convened in New York City to address the problems facing medical education. While the convention debated several resolutions to reform medical education, the physicians in attendance could not agree on any single measure. As the convention stalled, Isaac Hays, a Philadelphia physician and the editor of the nationally prominent *The American Journal of the Medical Sciences*, voiced the novel suggestion that those assembled should "institute a *National Medical Association*… [to develop] a uniform and elevated standard of requirements for the degree of M.D., [that] should be adopted by all the Medical Schools… and [also standards for] a suitable preliminary education and [a national] code of Medical Ethics."[38] With this, the 250 delegates in attendance quickly moved beyond their stated goal of educational reform, committing themselves instead to sweeping reforms designed to reshape the entire medical profession.[39]

The following year, physicians convened in Philadelphia to draft a constitution for the organization that would become the American Medical Association. Among the first

[38] American Medical Association, "Minutes of the Proceedings of the National Medical Association, Held in the City of New York, in May 1846" in *Minutes of the Proceedings of the National Medical Association, Held in the City of New York, in May 1846, and in Philadelphia in May 1847* (Philadelphia, 1847). Quoted in Baker, *Before Bioethics*, 134. On the Proceedings that led to the formation of the AMA, see Robert Baker, "The American Medical Ethics Revolution" in *The American Medical Ethics Revolution*, 17-51.

orders of business was to draft a formal code of ethics to be followed by all AMA members. To this end, the organization commissioned a committee of several physicians including Isaac Hays and his fellow Philadelphian John Bell. The pair of Philadelphia physicians quickly took the lead in drafting a new code of ethics for the nascent medical society, which they "created… by supplementing… [an] edition of Percival's *Medical Ethics* with material from various other codes."[40] The resulting document was split into three sections, each a "reformulation of Percival's code of ethics as a formal social contract."[41] The first section dealt with "the duties of physicians to their patients, and of the obligations of patients to their physicians." The second covered "the duties of physicians to each other, and to the profession at large." The third and final section outlined "the duties of the profession to the public, and of the obligations of the public to the profession."[42] In each, Hays and Bell faithfully adapted Percival's *Medical Ethics*—with its emphasis on gentlemanly honor— to the realities of American medical practice.[43] One matter on which Bell and Hays diverged from Percival was on the subject of confidentiality. Whereas Percival believed physicians had an obligation to answer any and all questions asked of them in the courtroom, Hays, Bell, and

[40] Baker, *Before Bioethics*, 140. On the origins of the code, Hays stated: "On examining a great number of codes of ethics adopted by different societies in the United States, it was found that they were all based on that by Dr. Percival, and that the phrases of this writer were preserved, to a considerable extent, in all of them. Believing that language which had been so often examined and adopted must possess the greatest merits for such a document as the present, clearness and precision, and having no ambition for the honours of authorship, the Committee which prepared this code have followed a similar course, and have carefully preserved the words of Percival wherever they convey the precepts it is wished to inculcate. A few of the sections are in the words of the late Dr. Rush, and one or two sentences are from other writers." Isaac Hays, "Note to the 1847 Convention" in *The American Medical Ethics Revolution*, 315.

[41] Baker, *Before Bioethics*, 141.

[42] American Medical Association, *Code of Ethics* (1847) in *The American Medical Ethics Revolution*, 324-334.

[43] Konold, *A History of American Medical Ethics*, 8-9; Baker, *Before Bioethics*, 132-143.

their peers in the AMA believed that a doctor's obligation to maintain confidentiality necessarily extended into the courtroom.

Moreover, by the late 1840s, physicians were increasingly aware that some states' statutory code forbade the disclosure of medical secrets. In the 1845 American edition of William A. Guy's *Principles of Medical Jurisprudence*, a popular British medico-legal treatise, the volume's editor Dr. Charles A. Lee called attention to these statutes, citing an exchange with James Kent, the immensely influential New York legal scholar who had been briefly involved in the codification movement that introduced New York's 1828 statute:

> Union Square, Nov. 3d, 1843.
>
> Dear Sir, —The question you state to me can be satisfactorily answered so far as respects the law of this state.
>
> By the Revised Statutes, Vol. II. p.406, Sec. 73, "No person duly authorized to practice Physic or Surgery, shall be allowed to disclose any information which he may have acquired in attending any patient in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician or to do any act for him as a surgeon.
>
> The protection is complete. The physician is not allowed to disclose such information, whether willing, or not willing.
>
> Yours respectfully,
> James Kent

These passages marked the first time that any of these early statutes appeared in the medico-legal literature of the day.[44]

Lee, however, was not content to merely recount the state of the law in New York. Rather, he issued a challenge to his peers in the medical profession: "We believe it to be the moral right, and the duty of medical men, to refuse to disclose, in a court of justice, secretes

[44] William Augustus Guy, *Principles of Medical Jurisprudence: with so much or anatomy, physiology, pathology, and the practice of medicine and surgery as are essential to be known by lawyers, coroners, magistrates, officers of the army and navy, ect.* 1st American ed. (New York, 1845), 16-17. Some copies of the book were also titled, *Principles of ForensicMedicine.*

intrusted to them in professional confidence, and we have always acted on such belief." Speaking on behalf of his profession, Lee argued that this moral duty greatly exceeded any obligation to the courts might place upon them: "If physicians become the repositories of secrets, under the full conviction, on the part of society, of our moral and professional obligations to hold them sacred,—secrets which otherwise never would have been revealed,--who can believe that there is an earthly power which ought to wring them from us, or which can, if we rightly understand out privileges and duty? If private confidence is thus to be broken upon every imaginary necessity, where is the end of the mischievous consequences that would arise, especially at this day, where every trial is published to the world through the medium of the public prints?" [45]

To Lee, the need for a medical privilege far outweighed the need for attorney-client privilege. "The Lawyer is shielded from the obligation of revealing the secrets of his client, on the ground that it is necessary he should be acquainted with the real facts in the case, for the purpose of conducting the defense, and because life and property are at stake. But we ask," wrote Lee on behalf of physicians, "if character and reputation are not often of equal value, and whether either of the former could be enjoyed without the possession of the latter? So also it may be observed, that the patient communicates freely with his physician for the purpose of judgment; no circumstances whatever, will warrant their publication to the world."[46]

Instead of Percival, Lee grounded his defense of physician-patient privilege in the work of another eighteenth-century moralist, John Gregory, a long-time instructor at the

[45] Ibid.

[46] Ibid.

University of Edinburgh, who had taught numerous American physicians including Benjamin Rush and Samuel Bard. Unlike Percival, Gregory saw the need for medical secrecy as absolute, especially "where women are concerned." "There are certain circumstances of health," Gregory argued, "which, though in no respect connected with her reputation, every woman, from the natural delicacy of her sex, is anxious to conceal, and in some cases the concealment of these circumstances may be of consequence to her health, her interest and her happiness."[47] Lee concluded by citing the Hippocratic Oath, stating "It would not be amiss if the celebrated oath of Hippocrates were still administered to every medical graduate, on receiving his diploma."[48]

Isaac Hays and John Bell took Lee's challenge to heart. The American Medical Association's Code of Ethics echoed Lee's and the MSSNY's broad definition of medical confidentiality, stating: "The obligation of secrecy extends beyond the period of professional services;—none of the privacies of personal and domestic life, no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by [the physician] except when he is imperatively required to do so." To regular physicians, this was not simply a matter of self-policing. The authors of the code explicitly linked these ideals to the growing number of statutes that guaranteed confidentiality in the courtroom: "The force

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[47] For examples of Gregory's writings see John Gregory, *Observations on the Duties and Offices of a Physician, and on the Method of Prosecuting Enquiries in Philosophy* (London, 1770); John Gregory, *Lectures on the Duties and Offices of a Physician* (London, 1772); John Gregory, *John Gregory's Writings on Medical Ethics and the Philosophy of Medicine* (Dordrecht: Kluwer, 1998). A thorough analysis of Gregory's impact on the British and American medical professions can be found in Robert Baker, Dorothy Porter, and Roy Porter eds., *The Codification of Medical Morality: Historical and Philosophical Studies of the Formalization of Western Medical Morality in the Eighteenth and Nineteenth Centuries* Vol. 1 (Dordrecht and Boston: Kluwer, 1995).

[48] The oath as cited by Lee, read: "Whatever, in the course of my practice I may see or hear, even when not invited; whatever I may happen to obtain knowledge of, if it be not proper to repeat it, I will keep sacred and secret within my own breast. If I faithfully observe this oath, may I thrive and prosper in my fortune and profession, end live in the estimation of posterity, or on the breach thereof, may the reverse be my fate." Guy, *Principles of Medical Jurisprudence*, 17.

and necessity of this obligation are indeed so great that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice."[49]

On this and other points, the AMA *Code of Ethics* captured an emerging consensus among members of the regular medical profession. When Bell and Hays presented the document to their peers in Philadelphia, the *Code* was unanimously adopted by the AMA. This marked an important turning point in the history of American medical ethics. In the ensuing decades, the AMA *Code of Ethics* would become one of the defining statements of the regular medical profession. Regulars would use the *Code* as an invaluable tool to mark the differences between themselves and other irregular practitioners. For many, codified medical ethics served as one of the strongest arguments in favor of a regular monopoly over medical practice, partly because regular physicians were expected to follow strict rules and maintain an air of gentlemanly honor, while others did not. At the same time, the document was also a powerful statement of professional autonomy. In professing a standard set of rules and assuming control over the punishment of any violations of these rules, regular physicians staked a claim to the control and regulation of the medical profession—regular physicians would both set and enforce the rules to be followed by the entire medical profession.

For those reasons, the code of ethics also marked a pivotal point in the history of physician-patient privilege. The formal recognition of physician-patient privilege by what would become the nation's most powerful medical society was the culmination of a decades-long process in which physicians came to view privilege as both an essential part of the physician-patient relationship and a useful tool for advancing the status of the medical profession. In the ensuing decades, the same doctors that championed the AMA *Code of Ethics* would publicly advocate for the spread of physician-patient privilege. To these

[49] AMA, "Code of Ethics" (1847).

physicians, privilege was the logical extension of the AMA *Code* and its emphasis on gentlemanly honor. It was also a powerful signal that the ethics and values of the regular physicians carried beyond the medical profession, as it suggested that the physician-patient relationship could be more important than the fact-finding mission of the courts.

CHAPTER VI: PROFESSIONALIZATION AND PRIVILEGE

> Indiscretion, weakness, fear, sin, all seek the family physician as a father confessor. He holds the honor of the patient and the character and social standing of families in his hands. He knows what is unknown in the family itself. In every relation of human life the doctor holds, and holds sacred, the secret history of many families; and carries to the grave with him knowledge which would revolutionize the life of whole communities.
>
> David Cheever, "Privileged Medical Communications," 1904

On December 4, 1880, the *Philadelphia Medical Times* issued a call to arms. In Pennsylvania courtrooms, attorneys and priests were afforded the benefits of privileged communications, but doctors were not. To the journal's editor, the well-respected Philadelphia physician Horatio C. Wood, this glaring omission was a matter of professional pride. "Is not the relation between physician and patient as delicate and as important as that between lawyer and client?" He asked, "Are not the revelations known to be necessary for the ills of the body as worthy of recognition of the law as those believed to be necessary for the cure of the ills of the soul?"[1]

These were rhetorical questions. Wood took for granted that the Pennsylvania doctors who read his journal would share his sentiments. Throughout the mid-nineteenth century, physician-patient privilege had spread quietly throughout the West and Midwest. By 1880, nineteen states or territories had enacted statutes guaranteeing medical confidentiality in the courtroom.[2] Yet, aside from New York, much of the eastern United States remained bound by the common law precedent established in the Duchess of Kingston's trial for

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[1] "Editorial: The Secrets of the Consulting Room," *Philadelphia Medical Times and Register* 11 (December 4, 1880): 147.

[2] A list of statutes enacted before 1882 was compiled in Gartside v. The Connecticut Mutual Life Insurance Company, 76 Mo. 446 (1882). At the time, the states with privilege statutes were: (in the order in which statutes were adopted) New York, Missouri, Arkansas, Michigan, Wisconsin, Iowa, California, Kansas, Nebraska, Dakota, Oregon, Arizona, Minnesota, Indiana, Nevada, Wyoming, Utah, Montana, and Idaho. Mississippi's early privilege statute had disappeared from the state code by this point.

bigamy: doctors would not be granted privileged communications in the courtroom and could be forced to reveal their patients' secrets. To Wood and many other physicians, the absence of physician-patient privilege was deeply troubling because it threatened to undermine doctors' relationships with their patients and because it challenged their sense of professional honor.

As physicians, especially those practicing in the Northeast, sought to bring their states' laws into agreement with their own views on medical ethics, they continued practices that had long proven successful in other policy arenas—they lobbied legislators and courted legal scholars. At the same time, however, the lobbying efforts of Wood and his peers departed from their predecessors in several important ways. Packed into omnibus bills alongside numerous other revisions to the evidentiary codes, the numerous privilege statutes enacted throughout the mid-nineteenth century received little fanfare. Until 1880, few medical journals had even discussed physician-patient privilege. Beginning in the early 1880s, however, journals ran frequent articles discussing the professional benefits and, sometimes, the hazards of physician-patient privilege. By publishing open appeals for legislative action in medical journals, doctors thrust discussion of physician-patient privilege into the public eye.

This chapter examines the medical literature on physician-patient privilege that emerged in the late nineteenth and early twentieth centuries. This was a turbulent time for the medical profession. Institutional changes and technological developments radically reshaped medical practice and challenged its fundamental relationships—both between physicians and their patients as well as between physicians and their peers. Many doctors began to question well-established therapeutic practices, replacing traditional assumptions about disease and healing with modern "strategies grounded in experimental science that

objectified disease while minimizing differences among patients."[3] The rise of Homeopathy and Eclecticism brought still more challenges to regular physicians' hegemony over the medical profession.[4] In response, regular physicians mobilized to enact strict licensing laws as a means to drive homoeopaths and other irregular practitioners out of the medical profession.[5]

As the medical profession changed, so did the discourse on physician-patient privilege. In medical journals and medico-legal treatises, doctors made explicit links between medical confidentiality and larger developments within the profession. For some regular physicians confidentiality and, more broadly, medical ethics offered an invaluable tool that could be wielded against their sectarian rivals. At the same time, however, a small cadre of physicians challenged the AMA's rigid definitions of medical ethics. Some even suggested ethical policing should be abandoned altogether.

Prior to Wood's public call to arms over the issue of physician-patient privilege, other physicians had been active behind the scenes. In his popular 1860 medico-legal treatise, John Elwell, for example, had named several prominent doctors to show that "physicians, as a class, have never given up the idea that they were entitled to the immunities and privileges enjoyed by the attorney, and that their patients were worthy of the same protection as that meted out by the courts to the client of the attorney."[6] Drawing upon this

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[3] Warner, *The Therapeutic Perspective*, 1.

[4] Rothstein, *American Physicians in the Nineteenth Century*, 230-246.

[5] Mohr, *Licensed to Practice*; Starr, *The Social Transformation of American Medicine*, 102-112; Ronald Hamowy, "The Early Development of Medical Licensing Laws in the United States, 1875-1900," *The Journal of Libertarian Studies* 3:1 (1979), 73-119.

[6] John J. Ellwell, *A Medico-Legal Treatise on Malpractice and Medical Evidence Comprising the Elements of Medical Jurisprudence* (New York: Voorhies, 1860), 320-322. Chief among these physicians was Dr. Charles A. Lee who edited the American edition of *Guy's Principles of Medical Jurisprudence.*

tradition, Wood believed that "individual effort by doctors throughout the state" would be the key to securing favorable legislation in Pennsylvania. He prodded his fellow practitioners to "make it a point to see personally, or, if this be impossible, to write urgently to, your representatives in the two legislative bodies, and pledge them if possible."[7]

Wood did not lack familiarity with the lobbying process. The editor and his peers were members of a generation of medical practitioners who had witnessed both numerous challenges and profound gains in medical professionalization. Throughout the mid-nineteenth century, the regular medical profession had weathered challenges from several irregular sects—first from Thompsonian botanists who challenged the regulars' monopoly on medical services, then from homeopaths and eclectics who aimed to upend the hegemony of the regular profession. For many physicians, medical ethics, embodied by the American Medical Association's *Code of Ethics*, served as one of the defining characteristics of regular medicine. Regular physicians viewed members of rival sects as morally irresponsible because of their seemingly dangerous therapeutic practices, but also because of their failure to abide by the same ethical codes and standards. Given that regular practitioners could not prove their therapeutics were any safer than those of their sectarian rivals, medical ethics served as a crucial tool in their efforts to maintain control of the medical profession. Regular physicians used the rhetoric of medical ethics to push state legislatures to enact strict legislation and portrayed tough licensing laws as an answer to the dangers of sectarian medicine.[8]

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[7] "Editorial: The Secrets of the Consulting Room."

[8] For a discussion of the sectarian medicine in the nineteenth century, see Rothstein, *American Physicians in the Nineteenth Century*, 125-174, 217-246; and Starr, *The Social Transformation of American Medicine*, 65-144. For a discussion of the difference in therapeutics between differing sects, see Rothstein and John Harley Warner, *The Therapeutic Perspective*.

To Wood and his colleagues, the fate of regular medicine rested on its ability to work cooperatively with legislators. Just as Wood extolled his colleagues to push for physician-patient privilege, his journal also led a campaign to re-enact medical licensing laws in Pennsylvania.[9] With both licensing and privilege, Wood and his peers in the regular profession sought take control over the regulation of medicine. As Wood put it, the goal of each campaign was to ensure that "the Medical Profession can, if it will, mould legislation in regard to itself."[10]

Wood's proposed statute mirrored other laws already on the books in those states where earlier codification had recognized physician-patient privilege. And like most of those, the language of his proposed bill was modeled directly upon the original New York statute. Wood's proposed law made only one minor alteration to the language of the law. Like the physician-statutes already on the books in Wisconsin, Arkansas, and several other states, [11] Wood amended the New York statute to read:

> No person duly authorized to practice physic or surgery shall be allowed *or compelled* to disclose any information which he may have acquired in attending to any patient in his professional character, and which information was necessary for him to prescribe for such patient as a physician, or do any act as a surgeon.

Wood urged influential physicians to use their personal connections to influence lawmakers in order to pass this bill through the state legislature.[12]

While these methods had long proven successful, Wood's proposed law drew some unlikely criticism. Only two months after Wood's editorial, the journal and its editor felt the

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[9] "Editorial: Medical Legislation," *Philadelphia Medical Times and Register* 11 (January 1, 1881): 205–6.

[10] "Editorial: The Secrets of the Consulting Room."

[11] Wigmore, *On Evidence* 1st Ed., 3348; Sanbourn, "Physician's Privilege in Wisconsin," 141-146.

[12] "Editorial: Medical Legislation," 205–6.

need to respond to a letter that "assault[ed] the position assumed by this journal."[13] Authored by the prominent New York physician Frederick Sturgis, the letter stated bluntly that physician-patient privilege constituted "a gross injustice to all concerned." Sturgis argued that the New York law "converts the family physician into a wolf in sheep's clothing" and suggested that Wood's proposal would do the same. As proof of this claim, Sturgis cited the New York law's applications to his specialty, the treatment of venereal disease, citing a recent article in the *New York Medical Record*. He recounted a case in which a young man, suffering from syphilis, brought his bride-to-be to a doctor to be cured of a minor ailment. Horrified that the unknowing bride might soon be infected, the doctor "took occasion privately to remonstrate very emphatically with the young man, informing him of the evil consequences that were sure to follow." The young man, however, stated that there was nothing to be done: "the invitations are out, and I cannot withdraw." In the end, Sturgis lamented, the doctor's "remonstrance was unheeded, and now the most beautiful young lady the physician had ever seen is suffering with syphilis in a severe form." [14]

New York's confidentiality laws, Sturgis argued, left the physician powerless to stop the spread of disease; "thus, through ignorance on the part of the lady, criminality on the part of the man, and '*professional obligations'* on the part of the medical adviser, was this work accomplished." By recounting the case, Sturgis had effectively inverted the rhetoric often employed by pro-privilege physicians like Wood. To Sturgis, instead of protecting the patient, physician-patient privilege sealed the doctor's lips and prevented him from acting in

[13] "Editorial: Professional Secrets and the Law," *Philadelphia Medical Times and Register*, February 26, 1881, 337.

[14] F.R. Sturgis, "Correspondence: To the Editor of the Philadelphia Medical Times," *Philadelphia Medical Times and Register*, February 26, 1881, 339.

the interests of his clients and society. Rather than protect the physician's honor and elevate the profession, the law transformed the law-abiding physician into a "scoundrel."[15]

Sturgis's fears were only made worse by the spread of medical licensing laws. All of the statutes guaranteeing physician-patient privilege specified that the law applied only to practitioners that were "duly authorized to practice physic or surgery." Increasingly, as licensing laws and the regulation of medical education became more onerous, this phrase meant that the law was applied only to licensed, regular physicians. Homeopaths and eclectics, as well as the numerous quacks who practiced on the peripheries of the medical profession, were exempt from the law. If, as Sturgis believed, the law restricted the physician's ability to serve his patients, its effects were even more harmful because it "gags the mouth of the reputable physician, but permits the gabble of the charlatan."[16]

Horatio Wood responded to Sturgis in a brief editorial published alongside the letter. He countered Sturgis's claim that the law might do harm to the physician's honor, stating that although "occasions would arise in which the law would work hardship, or, possibly, injustice… these cases must be few." More importantly, Wood recast the proposed law as a protection of the physician-patient relationship rather than a hindrance. He argued, "the present code [without a statute]… attempts to make the doctor a legal spy on those who come to him… and report every case of abortion, ect., which comes to his knowledge." Unmoved by Sturgis's arguments, Horatio Wood maintained his position that medical secrets should be beyond reproach. He did, however, alter the language in his proposed

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[15] Ibid.

[16] Sturgis, "Correspondence: To the Editor of the Philadelphia Medical Times," 339. Sturgis's fears were well founded. Almost all courts interpreted "duly licensed" to mean "regular" physicians. Minnesota's statute was quite explicit on the matter. The law read: "A regular physician or surgeon cannot, without the consent of his patient, be examined in a civil action, as to any information acquired in attending to the patient, which was necessary to enable him to prescribe or act for the patient." Wigmore, *On Evidence* 1st ed., Vol 4, 3348.

legislation. Wood struck the word "allowed" from the proposed statute, effectively leaving the decision of whether or not to disclose medical testimony to the discretion of the physician.[17] This gesture signified that the law's intent was, first and foremost, the protection of physicians' independent discretion and honor as distinguished from the protection of the patient's confidence.[18]

Ultimately, the journal's efforts proved unsuccessful. Either Wood was unable to convince his peers of the need to enact a statute, or the state Legislature refused to cooperate. Though the Pennsylvania Legislature would eventually enact a statute in 1895 guaranteeing physician-patient privilege in some cases, the law that went into effect bore little resemblance to the bill Wood had proposed. The new legislation applied only to civil cases and was restricted by the addition of several limiting clauses. It was hardly the ironclad guarantee of professional privilege that Wood had proposed in 1880. Instead, legal scholars and reformers would later tout Pennsylvania's 1895 statute as a model of the kind of moderate and flexible legislation that left the admissibility of evidence in the courtroom to the discretion of judges.[19]

Viewed solely within the context of the rapid expansion of physician-patient privilege, the journal's failure seems rather surprising. This brief exchange between two prominent physicians, however, echoed larger discussions taking place within the medical profession. Just a few decades earlier, Sturgis's position would have been anathema to the values of regular medicine. The fathers of early American medicine—often Edinburgh-

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[17] The newly proposed legislation read, "A person duly authorized to practice physic or surgery shall not be *compelled* to disclose any information."

[18] "Editorial: Professional Secrets and the Law."

[19] Frederick J Stimson, "Privileged Communications to Physicians," *Medical Communications of the Massachusetts Medical Society* 19, no. 1 (1904), 610-611.

educated physicians like Samuel Bard and Benjamin Rush—had long held the maintenance of a patient's confidences to be one of the most sacred duties of a physician even when they themselves did not practice it. Likewise, the founders of the AMA had been reliable champions of physician-patient privilege.

Furthermore, the regular medical profession had taken matters of confidentiality very seriously at least through the 1870s. In 1869, for example, the New York Academy of Medicine (NYAM), expelled James Marion Sims, arguably the most famous gynecological surgeon in the world, for violating a patient's confidentiality. Sims had invoked the ire of his fellow physicians when he published a letter in the *New York Times* detailing the health of one of his patients, the Shakespearian actor Charlotte Cushman. Aimed at clarifying uncertainty and quelling public speculation over the actor's health, Sims' letter stated bluntly that Miss Cushman "had had for some time a little indurated gland that gave her great medical anxiety." [20] To his peers, Sims's letter constituted a grave violation of professional ethics. The NYAM's Committee of Ethics censored Sims for violating two tenets of the AMA's *Code of Ethics*. In their letter, they claimed Sims had not only revealed the secrets of a patient, but also had violated the AMA's prohibition on advertising by publicly declaring himself to be Cushman's physician. With the evidence published in the *New York Times*, Sims could hardly muster a solid defense. The NYAM Committee of Ethics "declared that the charges against Dr. J. Marion Sims are fully sustained." As punishment, Sims was to be "reprimanded by the president of the Academy" and forced to apologize. Not wanting to

[20] James Marion Sims, "Miss Charlotte Cushman's Health," *New York Times* (October 3, 1869). Today, Sims is most famous for his unethical experiments on enslaved patients. See, Baker, *Before Bioethics*, 245-255.

subject himself to the indignity of apologizing to the society, Sims refused, at which point, he was expelled from the NYAM. [21]

Seemingly minor by modern standards, the punishment is indicative of the ways in which nineteenth century physicians thought about medical ethics. To his peers, Sims's most egregious crime was not the violation of his patient's confidences, but rather publicly defying the standards of professional medicine. Accordingly, the punishment was intended to offer justice to the victims of the indiscretion—Sims's fellow practitioners—not his patient, Charlotte Cushman. Within the small community of nineteenth-century medicine, the punishment was daunting. Rather than face the humiliation of public reprimand and a forced apology, Sims, arguably the most famous surgeon in the United States, fled to Europe.[22]

As this brief episode demonstrates, nineteenth-century physicians took ethical standards and policing very seriously. For the regular profession of the mid-nineteenth century, doing so was essential to their survival. Prior the development of bacteriology and scientific medicine in the last decades of the nineteenth century, regular physicians could not convincingly argue that their therapeutics were any more effective than the therapeutics their sectarian rivals. This meant that medical ethics—especially when sanctioned by the state, as in the case of physician-patient privilege—proved to be one of the only legitimate arguments regular physicians could make to justify their claims to a monopoly over the profession. Bans on advertising and secret medicines only applied to regular physicians and served as a means of differentiating these doctors from members of rival sects. Likewise, promises of confidentiality, especially when supported by statutory law, helped distinguish ethical, regular

[21] Committee on Ethics of the New York Academy of Medicine, date unknown. Quoted in Robert Baker, *Before Bioethics*, 108-109.

[22] Robert Baker, *Before Bioethics*, 108-109.

medicine from its competitors. According to regulars, irregular quacks and charlatans were not bound to any oath or code of conduct and instead callously gambled with their patients' lives in pursuit of greater profits. Patients who consulted with regulars, in contrast, could count on them to protect their confidences.

Over the course of the last few decades of the nineteenth century, however, the regular position began to change. The debate between Wood and Sturgis was not an isolated incident, but rather serves as a powerful example of a gradual breakdown in regulars' united commitment to their stated code of medical ethics. During the 1880s and 1890s, similar arguments played out in numerous medical journals as physicians debated physician-patient privilege in several states. In these debates, physicians served as both advocates and critics of the privilege. Supporters of physician-patient privilege embraced mid-nineteenth-century notions of medical ethics. They saw practitioners' relationships with their clients as the fundamental building block upon which the medical profession was built. To these physicians, the practitioner was responsible first and foremost to his patient; all other relationships—to fellow practitioners, to society, and even the law—were secondary and could not be advanced at the expense of individual patients. Critics of the privilege, on the other hand, held that some relationships were more important than the physician's relations with specific patients, emphasizing that medical practitioners had a duty to protect the health and morality of the public even if that meant betraying the confidences of individual patients.

For proof, critics repeatedly cited the moral quandary that often faced physicians in venereal cases, the same kind of case cited by Sturgis. Within those cases physicians could find all of their often-conflicting obligations: their duty to protect women as respectable gentlemen, their responsibility to maintain the darkest secrets of their patients, and their

obligation to protect the public by preventing of the spread of disease. Sturgis and other critics cited cases in which husbands selfishly risked infecting their wives with syphilis and other contagious diseases, despite the warnings of their physicians. To critics, medical confidentiality bound the doctors' tongues, enabling the spread of disease and vice. Though these instances were likely very rare—the literature of numerous contemporary legal scholars demonstrated that the privilege was most often applied to insurance and personal injury suits—critics found them especially troubling.[23]

Proponents of medical confidentiality and physician-patient privilege were no less hyperbolic. For many of these physicians, their obligation to secrecy stemmed from something deeper than the AMA *Code of Ethics* or statutory law. Daniel Strock, the architect of a proposed New Jersey statute, attributed doctors' respect of patient's confidences to "the innate sense of honor that is so conspicuous a component of the character of the true physician."[24] Likewise, Louis Gompertz, a Connecticut physician, suggested that many physicians would merely violate the law if it compelled them to betray their patients' secrets: "there are among us, not a few who would be tempted to risk judicial censure or punishment rather than make public, without the patient's consent, the information acquired in confidence from him."[25] To many, such physicians were not only victims of an unjust system

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[23] Sturgis, "Correspondence." For more examples of this genre, see E. Castelli, "The Professional Secret in Reference to Marriage," *American Medicine* 10 (September 16, 1906), 477-478; L. Stevenard, "The Professional Secret in Syphilis and Marriage," *American Journal of Urology* (1916), 33-37; and Austin O'Malley, "The Professional Secret and Venereal Diseases," *American Medicine 20* (December 1916), 837-843. On the types of litigation in which privilege was used, see Greenleaf, *A Treatise on the Law of Evidence* 16th ed. (Boston, 1899), 385-386; Wigmore, *On Evidence* 1st ed., vol. 4, 3352-3353; Dewitt, *Privileged Communications Between Physician and Patient*, 33. Dewitt estimated that, in the early twentieth century, as much as ninety percent of the cases in which privilege was invoked were injury litigation, contested wills, or life insurance cases.

[24] Daniel Strock, "The Patient's Secret," *Philadelphia Monthly Medical Journal* 1:6 (June 1899), pp. 327-329 at p. 327.

[25] Louis M. Gompertz, "Confidential Communications Between Patient and Physician: The Law Relative Thereto," *New York Medical Journal* (December 28, 1912), 1333-1334.

that pitted doctor's ethical duties against the mandates of the court but also heroes worthy of praise. In 1893, Austin Flint, a noted physician who served as president of the NYAM and the AMA, wrote that any penalties arising out of physicians' refusal to divulge medical secrets in the courtroom would only serve as testament "to the honor of the profession and to humanity."[26]

Others gave long-winded odes to Hippocrates, linking contemporary medico-legal issues to supposedly ancient traditions. Strock began his "Plea for the Physician on the Witness Stand" by stating: "It was Hippocrates about 2,500 years ago, who put in concrete form the rules of medical practice that had been observed, no doubt even for ages before his time." In doing so, the advocates of physician-patient privilege glossed over millennia of medical developments. From ancient Greece to nineteenth-century America, they argued, doctors had always maintained the same relationship to their patients: "the medical profession of civilized countries have preserved inviolate the secrets learned in the performance of their duties."[27] To Samuel C. Busey, the president of the Medical Society of the District of Columbia, the various privilege statutes adopted throughout the nineteenth century were to be celebrated as they added "force and fiat to the decree of the medical profession, which has always and everywhere throughout the civilized world resisted compulsory disclosure in open court."[28]

During the final decades of the nineteenth century, major advancements in scientific medicine promised new therapeutic practices and engendered increased popular support for

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[26] Austin Flint, *Medical Ethics and Etiquette: The Code of Ethics Adopted by the American Medical Association, with Commentaries* (New York, 1893), 209-210. See also, Maehle, *Contesting Medical Confidentiality*, 24.

[27] Strock, "The Patient's Secret," 327.

[28] Samuel C. Busey, "The Code of Ethics," *Journal of the American Medical Association* 34 (1900), 256. Quoted in Maehle, *Contesting Medical Confidentiality*, 24.

regular medicine. At the same time, the development of the hospital as the primary location of medical practice opened new avenues for regulars to control the medical profession. In certain fields— including obstetrics, gynecology, ophthalmology—therapeutic advancements and the restructuring of medical practice enabled some practitioners to specialize in certain procedures. Occurring across the late nineteenth century and into the twentieth century, each of these developments supported regulars' claims to a monopoly over the medical profession. They underpinned regulars' attempts to reform medical education, to enact strict licensing laws, and to expel irregulars from professional organizations.[29]

As regular physicians found new arguments to support their control over the medical profession, some began to see medical ethics as a restriction on the freedoms of physicians rather than as a protection. Few physicians embraced this position as wholeheartedly as James Marion Sims. Disgraced in the early 1870s for his violations of medical ethics, Sims found new life in the ensuing decade as an ardent critic of ethical policing. By the late 1870s, Sims had so successfully rehabilitated his image that he was elected President of the American Medical Association. He did not, however, win this position through conciliation with the AMA's most ardent supporters of medical ethics. Instead, Sims retrenched his position as a critic of medical ethics. To Sims, the rapid transformation of American medicine in the late nineteenth century had rendered the *Code of Ethics* obsolete. In his 1876 Presidential address, he characterized the *Code* as "a dead letter" and "an instrument of torture and oppression [for] prosecuting a fellow [AMA] member."[30] Though Sims failed, as president, to substantially alter the *Code*, other physicians quickly adopted the cause. In New

[29] Rothstein, *American Physicians in the Nineteenth Century*, 249-326. Rothstein contends that, more than anything else, it was this technological advancement which ended the period of sectarian medicine.

[30] James Marion Sims, *AMA Presidential Address* (1876), quoted in Robert Baker, *Before Bioethics* (2013), 199.

York, dispute over the *Code*'s prohibition on collaboration with irregular practitioners led to the formation of a rival national medical association. Its founder boldly claimed that the offshoot society would contain "no medical politics and no medical ethics."[31]

Debate over medical ethics plagued the AMA throughout the rest of the nineteenth century, eventually forcing the organization to revise its *Code of Ethics*. In 1903, the AMA retitled the document, *Principles of Medical Ethics*. In most cases, the revisers maintained the language of the original, though they limited its proscriptive capacities by removing any reference to penalties for violations of its core principles. More importantly, the election of a vocal critic of ethical policing as president of the AMA and the revision of the society's *Code of Ethics* signaled a major shift in physicians' views on medical ethics. Increasingly, physicians embraced what historian Robert Baker has termed laissez-faire medical ethics—the notion that decisions regarding what practices are ethical should be left to individual practitioners. Though the revised document maintained a guarantee of patients' secrets, the debates over medical confidentiality and physician-patient privilege that occurred throughout the last two decades of the nineteenth century were profoundly influenced by this new rhetoric. Critics of physician-patient privilege embraced laissez-faire medical ethics, arguing that physicians were often faced with contradictory ethical mandates and that no overarching ethical code or law could address these dilemmas adequately.[32]

Proponents of the privilege were influenced by these larger debates as well. The physicians who argued vehemently in favor of physician-patient privilege were alike in several ways. All were ardent regulars. Often, these physicians came of age during the 1850s

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[31] Francis Delafield, "President's Address: Proceedings of the Association of American Physicians," *Journal of the American Medical Association* 7(1): 16. Quoted in Robert Baker, *Before Bioethics,* 205.

[32] Baker, *Before Bioethics,* 199-231.

and 1860s, at the height of sectarian medicine. Like Horatio Wood, they came almost exclusively from the highest ranks of the medical profession. Daniel Roberts Brower, a noted psychologist and the primary architect of a proposed Illinois statute, for example, held multiple teaching positions in several different medical schools and served as a consulting physician at several Chicago hospitals. Throughout his long and successful career, Brower published numerous articles on nervous and mental disorders, served terms as the president of the Chicago and Illinois State Medical Societies, and accumulated three law degrees.[33] Likewise, Daniel Strock urged his colleagues in New Jersey to adopt a statute guaranteeing physician-patient privilege while serving as President of the Camden County Medical Society and the New Jersey Sanitary Association.[34] As leaders of the profession, these physicians often had enough personal clout to influence both legislators and their fellow physicians.

Day-to-day realities of medical practice led others to retain a commitment to physician-patient privilege. At a meeting of the Medico-Legal Society of Chicago, four different physicians attested that they or a peer had been forced to reveal patients' secrets in court. For Dr. R. W. Bishop, compelled testimony cost him his client and a sizeable check. All four physicians heartily supported Dr. Brower's proposed statute, and the proposal was put before the Illinois legislature.[35]

Defenders of the privilege remained strong enough through the turn of the twentieth century to secure additional legislative victories. Between 1860 and 1880, ten more states followed New York by enacting statutes codifying physician-patient privilege. The 1880s and

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[33] *History of Medicine and Surgery in Chicago* (Chicago: 1920), 111; Samuel T. Wiley, *Biographical and Portrait Cyclopedia of Montgomery County, Pennsylvania* (Philadelphia: Biographical Publishing Company, 1895), 585-604.

[34] Strock, "The Patient's Secret," 327-329.

[35] John Ridlon, "Medico-Legal Society of Chicago," *The Chicago Medical Recorder 12* (1897), 81.

1890s brought another flurry of legislative activity on this issue. Ohio, Washington, North Carolina, Oklahoma, Colorado, Pennsylvania, West Virginia, Hawaii, Utah, Alaska, and the District of Columbia all enacted statutes. In 1899, Arkansas became the first state to extend the privilege to trained nurses. By the turn of the century, twenty-six states or territories had extended privileged communications to medical practitioners. In the early twentieth century, Mississippi and the District of Columbia adopted physician-patient privilege as did the newly acquired territories of the Philippines and Puerto Rico. Additional lobbying campaigns successfully placed bills before the state legislature in Illinois, Connecticut, and New Jersey.[36]

Table 2: Physician-Patient Privilege (1850-1875)

State/Territory	Date Enacted
Iowa	1851
Indiana	1852
California	1853
Kansas	1855
Nebraska	1858
Dakota, Oregon	1862
Arizona	1864
Minnesota	1866
Nevada, Wyoming	1869
Montana	1871
Idaho	1875

Still, legislative victories continued to prove elusive in the South and Northeast. With the exception of New York, and later Pennsylvania, states in the West claimed the majority of statutes into the twentieth century. Moreover, when compared to earlier legislation, many

[36] Sturgis, "Correspondence"; Francis W. Shain, "When Is a Physician Legally Exempt from Testifying to Confidential Communications Made to Him by His Patient?," *Medical News* 42 (January 20, 1883): 70–72; Cheever, "Privileged Medical Communications"; Arthur N. Taylor, *The Law in Its Relations to Physicians* (New York: D. Appleton & Co., 1904), 488–491.

of these new statutes had limited applications. Pennsylvania's law limited physician-patient privilege to civil suits. Washington D.C.'s statute did not apply to "evidence in criminal cases in which the accused is charged with causing the death of or inflicting injuries upon a human being." The North Carolina Statute included a provision that allowed the judge to "compel [a physician's] disclosure [of medical secrets] if in his opinion [the information] is necessary to a proper administration of justice."[37]

Table 3: Physician-Patient Privilege (1880-1906)

State/Territory	Date Enacted
Ohio	1880
Washington	1881
North Carolina	1885
Oklahoma	1890
Colorado	1891
Pennsylvania	1895
West Virginia, Hawaii	1897
Utah	1898
Alaska	1900
District of Columbia	1901
Mississippi	1906

David Cheever, a renowned surgeon and Harvard professor, sought to extend physician-patient privilege to previously resistant New England. In 1903, he stood before the Massachusetts Medical Society and offered "A Plea for a Change in the Massachusetts Law." His speech, part of a panel on privileged communications, marked the culmination Cheever's two-year lobbying effort to enact a statute guaranteeing medical confidentiality. Cheever's rhetoric echoed the successful appeals of earlier advocates of physician-patient privilege. He linked medical confidentiality to ancient traditions, invoking the Hippocratic Oath and Roman law. In his address, Cheever

[37] Wigmore, *On Evidence* 1st Ed., 3348-3349.

passionately argued that the state's current laws placed the physician in a precarious situation. To Cheever, medical men were entrusted with great secrets; betraying these secrets under any circumstances would damage the welfare of their patients and the honor of their profession. Physicians' dual obligations to their patients and to the courts, Cheever argued, meant that "the doctor in a court of law is in a false position—false in proportion to his sense of honor." By invoking a physician's gentlemanly honor, Cheever suggested that physicians were bound to a code of ethics that placed them above the law, maintaining that "some [physicians] would go to prison rather than betray a confidence."[38] To Cheever, the only solution to this problem was the adoption of a new privilege statute that would protect medical practitioners from the need to reveal their patients' secrets.

Cheever was optimistic that such legislation was within reach. In his eyes the United States fell into two camps with respect to privilege: states like Massachusetts that followed English common law, forcing practitioners to testify and betray their honor; and others that followed New York by privileging communications between physician and patient.[39] For Cheever and other physicians who came of age during the Civil War, the list of states protecting the physician in the courtroom had doubled over the course of their practice. Even more promising, similar legislative victories appeared attainable in Illinois and several other states.[40] With Cheever's advocacy and the promise of similar victories elsewhere, the *Journal of the American Medical Association* stated hopefully that "this [would] be the beginning of a change in the laws of Massachusetts." If Massachusetts were to enact a statute, many

[38] David W. Cheever, "Privileged Medical Communications," *Medical Communications of the Massachusetts Medical Society* 19, no. 1 (1904), pp. 583-586.

[39] *Ibid.*

[40] Ridlon, "Medico-Legal Society of Chicago," 74–82.

physicians hoped this legislative victory would set the stage for similar legislation across the Northeast. [41]

Cheever seemed to be on the verge of successfully securing a new statute. Two years had passed since he first read his paper to the State Medical Society. During that time, he had managed to convince the councilors of the society to compile a panel of medico-legal experts to discuss and potentially draft a new law. Cheever knew that physicians in Illinois had executed similar strategies to great effect, using medical and medico-legal society meetings to successfully draft new legislation. At the Illinois conference, the few legal scholars in the room acquiesced to physicians' demands, and the new bills were quickly ushered to the state legislature.[42] Cheever's proposal—a bill that would allow physicians to divulge medical secrets only with the patient's consent, in malpractice suits, or to "expose crime"—mirrored this recent legislation by offering several amendments to lessen the perceived negative effects of these laws.[43]

The panel's final two speakers, however, were unimpressed by this proposal. Following Cheever, Walter Soren, a Brookline attorney, gave a speech on "The Workings of the New York Law." The paper charted the evolution of court rulings on New York's medical confidentiality law, highlighting several legal dilemmas brought about by the statute. Through a detailed and extensive list of court cases, Soren demonstrated that the New York courts—seventy years after the law's adoption—were still unclear regarding whose communications were protected by the statute and what communications were considered

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[41] "Medical News," *Journal of the American Medical Association* 34 (June 1903).

[42] Ridlon, "Medico-Legal Society of Chicago."

[43] Cheever, "Privileged Medical Communications," 586.

"necessary" to prescribe to patients. Furthermore, while Cheever had framed his discussion around the law's relation to a physician's honor, Soren stated that "the statute has been considered [by the courts] as passed solely for the protection of the patient and has been construed liberally in his favor." Instead of a crucial protection of physicians' honor, Soren's analysis of recent New York court rulings depicted the proposed statute as a morally ambiguous law that could both protect and harm physicians.[44]

While Soren's paper challenged Cheever's assertion that the proposed law would serve primarily to protect physicians, the panel's final speaker challenged the notion that a new statute would provide practical utility to any parties. In a paper titled "Privileged Communications to Physicians," Frederick Stimson, a Dedham attorney, outlined the differences between the laws of various states. Rather than addressing the matter as a medical issue, Stimson recast the debate as a contest between statutory law and common law. Common law, Stimson argued, was preferable for all parties because it gave judges the discretion to judge each case individually. Speaking "for [his] profession," Stimson promised the assembled physicians that, under common law jurisdictions, there been no—or at least very few—instances where physicians had been compelled to testify. Judges were flexible in relation to the specifics of each case, often relieving physicians of their duty to testify. Instead of a challenge to physicians' honor, Stimson recast the malleability of the common law system as a benefit to physicians.[45]

At the conclusion of the panel, the Medical Society of Massachusetts declined to draft a new statute. The decision—won through the successful challenges of the attorneys,

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[44] Walter Soren, "The Workings of the New York Law," *Medical Communications of the Massachusetts Medical Society* 19, no. 1 (1904), pp. 587-605.

[45] Stimson, "Privileged Communications to Physicians."

Soren and Stimson—marked a landmark victory for a new cadre of legal scholars who challenged the utility of medical confidentiality laws. A few years earlier it had seemed as though lawyers and judges were largely content to yield to physicians, allowing the medical profession to enact laws and to regulate medical ethics. In Illinois, for example, a judge had been willing to support physician Daniel Brower's proposed privilege statute, even though he believed that "no one felt the necessity for a law making communications to physicians privileged."[46] The arrival of a new generation of legal scholars, however, upset the cooperative relationship between doctors, lawyers, and judges. These new legal scholars would become the most vociferous critics of the privilege, railing against it at any opportunity.[47] Their literature and its effects on medico-legal discourse will be discussed in the next two chapters.

Yet Cheever's failure to change Massachusetts law also revealed the deepening of a schism within the medical profession. A few decades earlier, the medical profession's failure to rally around one of its own in the face of criticism from outsiders would have been unthinkable. By the turn of the century, however, it had become clear that doctors were no longer united in their support of physician-patient privilege. Cheever, the ardent regular never wavered. To him, physician-patient privilege and codified medical ethics served as a means to distinguish the regular practitioner from the quack. As scientific medicine took hold of the profession in the early twentieth century, however, these distinctions became less important. Increasingly popular, the laissez-faire medical ethics of J. Marion Sims and his followers led many physicians to question the utility of physician-patient privilege and

[46] Ridlon, "Medico-Legal Society of Chicago," 81.

[47] Of this new literature, John Henry Wigmore's *On Evidence* would prove the most influential.

medical ethics.

Cheever never accepted these changes. He had come of age in an era in which regular physicians united against common foes—irregular practitioners and quacks. Until the end of his career, Cheever always identified himself as "a follower of the old leaders who allowed the term 'regular,' but scorned all other appellations." By the twentieth century, however, these distinctions no longer seemed relevant. Upon his retirement in 1907, the elderly physician took the opportunity to address his colleagues one last time. Cheever acknowledged that his views on irregular practitioners and medical ethics made him a "*fossil*," yet he cautioned his peers to remember him "as an enduring reminder of what is past."[48] As Cheever and his peers retired, the medical profession lost its most vocal advocates of physician-patient privilege. Over the next two decades, professional journals and society meetings would continue to host heated debates between physicians and lawyers over the utility of physician-patient privilege. These gatherings, however, often brought diminishing returns. In the face of powerful criticism from legal scholars and with dwindling support amongst the medical ranks, the spread of physician-patient privilege slowed substantially in early twentieth century.

[48] "Testimonial to David W. Cheever: February 25, 1907" (Boston: David Clapp & Son, 1907), 24-27.

CHAPTER VII: PRIVILEGE IN THE TURN OF THE CENTURY COURTROOM

> As to the policy of the privilege and extending it, there can only be condemnation. The chief classes of litigation in which it is invoked are actions on policies of life insurance, where the deceased's misrepresentations as to health are involved; actions for corporal injuries, where the plaintiff's bodily condition is to be ascertained; and testamentary actions where the testator's mental condition is in issue. In all of these cases, the medical testimony is 'the most vital and reliable,' 'the most important and incisive' and is absolutely needed for purposes of learning the truth. In none of them is there any reason for the party to conceal the facts except to perpetrate a fraud upon the opposing party, and in the first two of these classes the advancement of fraudulent claims is notoriously common… In wills, policies and personal injuries, the privilege, where it exists, is known in practice to be a serious obstacle to the ascertainment of truth and a useful weapon for those interested in suppressing it. Any extension of it to other jurisdictions is to be earnestly deprecated.
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> John Henry Wigmore, Greenleaf's *A Treatise on the Law of Evidence*, *1899*

Until the mid-1870s, physician-patient privilege remained an obscure and seldom-used rule of evidence. Legal records show—in spite of the rapid spread of new privilege statutes throughout the mid-nineteenth century—that privilege was rarely invoked in the courtroom. Beginning in the mid-1870s, however, three simultaneous developments transformed physician-patient privilege into an important and controversial legal doctrine: first was the growth of life insurance; second was a sudden spike in the number of industrial accidents along with a corresponding increase in tort actions for personal injury or wrongful death; and third was an increase in the application of privilege in contested will cases. According to one twentieth-century legal commentator these three categories comprised as much as ninety percent of the litigation in which privilege was invoked.[1]

Collectively, these three developments transformed the meaning of the law: privilege was no longer an arcane rule of evidence that occasionally appeared in divorce proceedings

[1] DeWitt, *Privileged Communications Between Physician and Patient*, 33.

and criminal abortion trials, but rather a high stakes matter that had important implications for American business. As a result, over the final decades of the nineteenth century, privilege came under increasing scrutiny. At first courts offered a broad reading of physician-patient privilege. Privilege statutes were celebrated as valuable protections of patients' deepest secrets and construed to cover a wide range of communications between doctor and patient. In time, however, as the problematic applications of physician-patient privilege in insurance, injury, and will cases became more apparent, legal scholars came to see privilege as an impediment to the judicial process. Eventually, these legal scholars would emerge as the foremost critics of physician-patient privilege.

No development drastically altered the history of physician-patient privilege as much as the rapid growth of life insurance in the late nineteenth century. Life insurance was hardly a new enterprise in 1870s—the first American insurance companies dated back to the late eighteenth century, growing out of the more established fields of fire and marine insurance. Efforts to create a profitable insurance industry had foundered, however, in the early nineteenth century, as companies struggled to get accurate actuarial data and to reach enough customers to cover the risks inherent to the enterprise. But beginning in the 1840s, improvements in actuarial calculations along with the development of mutual life insurance companies based on new business models that enabled companies to start up with lower amounts of capital facilitated small-scale growth. Still, legal regulations tethered the growing insurance industry under a large, complicated bureaucracy. With the exception of several Southern companies that specialized in underwriting slaves, growth remained limited through the 1850s.[2]

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[2] Shepard B. Clough, *A Century of American Life Insurance: A History of the Mutual Life Insurance Company of New York, 1843-1943* (New York: Columbia University Press, 1946); Sharon Ann Murphy, *Investing in Life: Insurance in Antebellum America* (Baltimore: Johns Hopkins University Press, 2010); Morton Keller, "The Judicial System

The staggering loss of life sustained in the Civil War transformed Americans' attitudes toward death—and also toward life insurance.[3] The once foundering insurance industry boomed in the aftermath. Over one hundred new life insurance companies were established between 1865 and 1870. In 1862, the cumulative value of American life insurance in force totaled $160 million. By 1870, the total was $1.3 billion (in 1860 dollars).[4] Financial collapse in the 1870s led to a slight decline in the insurance industry as many of the smaller companies founded in the preceding decade went bankrupt. Renewed growth in the 1880s was led by a few massive firms—New York Life, Equitable, and Mutual—and, in the 1890s, the "big three" were joined by Prudential and Metropolitan. By 1900, these five firms effectively dominated the insurance market. Together, they commanded $5 billion worth of insurance while the next largest twenty companies combined commanded only $2 billion.[5]

As these massive firms rose to the top of the insurance industry, they gradually expanded the role of the insurance company in law and politics. According to historian Morton Keller, these giant firms formed "a unique corporate group," one whose "managers were more inclined to think in political and ideological terms than other executives of the time. They claimed for themselves and for their companies a trustee-like, quasi-public function; they entered into intricate financial alliances with banks, trust companies, and investment banking houses; and they participated actively in state and national politics."[6]

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and the Law of Insurance," *Business History Review* 35:3 (Autumn, 1961), 317-335; and Viviana A. Rotman Zelizer, *Morals and Markets: The Development of Life Insurance in the United States* (New York: Columbia University Press, 1979). The influence of insurance in the growth of American capitalism is explored in Jonathan Levy, *Freaks of Fortune: The Emerging World of Capitalism and Risk in America* (Cambridge, MA: Harvard University Press, 2012).

[3] Drew Gilpin Faust, *This Republic of Suffering: Death and the American Civil War* (New York: Vintage, 2009).

[4] Murphy, *Investing in Life*, 8.

[5] Keller, "The Judicial System and the Law of Insurance," 319.

[6] Ibid.

With all of this activity came increased demands on these companies' legal counsel. At first, in the smaller insurance firms of the 1860s, legal services had been provided by external, part-time consultants. Beginning in the mid-1880s, however, the biggest firms started to hire their own specialized lawyers, and, as a result, these companies became increasingly litigious. In the final decades of the nineteenth century, these firms became more inclined than ever "to contest suits to their judicial conclusion" and the number of insurance cases before state courts skyrocketed. One expert counted only about one hundred insurance trials before 1870. Between 1888 and 1910, the big five alone accounted for as many as 750 cases.[7]

This litigation opened new avenues for medical testimony in the courtroom. Insurance companies regularly employed medical questionnaires and physical examinations as a means to identify and avoid the riskiest individual investments. To remain profitable, life insurance companies weighed individuals' medical histories against actuarial tables. The company gambled that they would receive more by investing premiums over the life of the insured than they would eventually be required to pay out when the insured died. Individuals with greater risk factors such as chronic ailments were often faced with higher premiums or denied access to insurance altogether. When life insurance companies suspected that they had been defrauded by individuals who had refused to disclose some pre-existing illness, the companies refused to pay out, leading the beneficiary to file suit against the company. The resulting litigation led to a series of cases that repeatedly tested physician-patient privilege in the late nineteenth century.[8]

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[7] Keller, "The Judicial System and the Law of Insurance," 321-322; Charles F. Knight, *The History of Life Insurance in the United States to 1870* (Philadelphia, 1920), 158.

[8] See, for example Edington v. Mutual life Insurance Co. of NY, 22 Sickels 185 (1876); Edington v. Aetna Life Insurance Co., 32 Sickels 564 (1879); Linz v. Massachusetts Mutual Life Insurance Co., 8 Mo. App. 363 (1880);

As a result of this litigation, life insurance attorneys became the first experts on physician-patient privilege. While most evidence manuals from the 1870s and earlier offered at best an erratic and incomplete record of the various statutes protecting medical communications in the courtroom, lawyers representing life insurance corporations in state courts gradually compiled more complete lists of relevant statutes and cases. In the 1882 case *Gartside v. Connecticut Mutual Life Insurance Co.*, lawyer Jacob Klein offered the first comprehensive list of statutes enacted in the United States.[9] This list was then cited in several evidence manuals, greatly expanding the information available on physician-patient privilege. At the same time, insurance lawyers studied and catalogued the numerous precedents governing the applications of privilege in the courtroom. In another case, the presiding judge opined that attorneys for life insurance companies "[have] probably collected all of the decisions that have an immediate bearing upon [physician-patient privilege]."[10] By the mid-1880s, this information was readily available to any practicing lawyer and most legal treatises featured lengthy examinations of the various statutes protecting medical communications in the courtroom.

As information on physician-patient privilege became more accessible, the privilege found increasing use in other classes of litigation—most frequently tort actions for injuries or wrongful death.[11] Through the first-two thirds of the nineteenth century, powerful forces

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Grattan v. Metropolitan Life Insurance Co., 35 Sickels 281 (1880); Gartside v. Connecticut Mutual Life Insurance Co., 76 Mo. 446 (1882); Penn. Mutual Life Insurance Co. v. Wiler, 100 Ind. 92 (1884); Connecticut Mutual Life Insurance Co. v. Union Trust Co., 122 U.S. 250 (1884); Westover v. Aetna, 99 N. Y. 55 (1885); Brown v. Metropolitan Life Insurance Co., 65 Mich. 306 (1887); Adrevano v. Mutual Reserve F. Life Association, 34 Fed. 870 (1888); Boyle v. Northwestern Mutual Relief Association, 95 Wis. 312 (1897); Nelson v. Nederland Life Insurance Co., 110 Iowa 600 (1900); Price v. Standard Life Insurance & Accident Insurance Co., 90 Minn. 264 (1903); and Metropolitan Life Insurance Co. v. Brubaker, 78 Kan. 146 (1908).

[9] Gartside v. Connecticut Mutual Life Insurance Company, 76 Mo. 446 (1882).

[10] Linz v. Massachusetts Mutual Life Insurance Company, 8 Mo. App. 363 (1880).

[11] For examples, see Mott v. Consumers' Ice Co., 52 How. Pr. 244 (1877); Grand Rapids & Indiana Railroad Co. v. Martin, 41 Mich. 677 (1879); McKinney v. Grand St. P.P. & F.R. Co., 59 Sickels 352 (1887); Kling v.

limited tort actions, especially on the part of employees.[12] The continuation of an eighteenth-century culture of deference and paternalism led many would-be tort actions to be settled outside of court. Rather than suing employers, injured workers were more likely to ask for assistance often in the form of less strenuous work as watchmen or clerks. Second, factory owners were loath to hire prospective employees who seemed litigious or in any way troublesome—"in isolated Northern mill towns, suing an employer often meant jeopardizing not only one's employment prospects, but one's housing, church membership, and even access to town poor relief."[13] The combination of these two factors was especially powerful in the mining industry—one of the most dangerous trades in nineteenth-century America—where a few companies controlled much of the labor market and "often collaborated among themselves on hiring practices."[14]

On top of these challenges, the law itself posed significant obstacles to any successful accident case. In early accident litigation, nineteenth-century courts held the plaintiff to an almost impossibly high burden of proof. The standard assumption was that accidents were a part of everyday life and that "any loss from accident must lie where it falls."[15] In order to recover damages litigants were required to prove that fault rested

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Kansas City, 27 Mo. 231 (1887); Feeney v. Long Island Railroad Co., 71 Sickels 375 (1889); Munz v. Salt Lake R.R., 25 Utah 220 (1902); Noelle v. Hoquiam Lumber & S. Co., 47 Wash. 519; Green v. Terminal R.R., 211 Mo. 18 (1908); Hilary v. Minneapolis Street Railway, 104 Minn. 432 (1908).

[12] On the history of tort law, this chapter relies upon G. Edward White, *Tort Law in America: An Intellectual History* (Oxford: Oxford University Press, 1999); John Fabian Witt, *The Accidental Republic: Crippled Workingmen, Destitute Widows, and the Remaking of American Law* (Cambridge and London: Harvard University Press, 2004), especially 22-70; and Barbara Young Welke, *Recasting American Liberty: Gender, Race, Law and the Railroad Revolution, 1865-1920* (Cambridge: Cambridge University Press, 2001), especially 81-124. See also, John Fabian Witt, "From Loss of Services to Loss of Support: The Wrongful Death Statutes, the Origins of Modern Tort Law, and the Making of the Nineteenth-Century Family," *Law and Social Inquiry* 25 (2000), 717-755.

[13] Witt, *The Accidental Republic*, 55.

[14] Ibid.

[15] Oliver Wendell Holmes Jr., *The Common Law* (Boston, 1881), 94-95.

completely on the defendant and not on chance or on any negligence on the part of the plaintiff. As one judge stated, the defendant was liable for damages only if the plaintiff had exercised "extraordinary care, so that the accident was inevitable."[16] At the same time, prevailing standards of courtroom procedure further stacked the deck against prospective litigants. The rules of evidence, as administered in many nineteenth century courtrooms, "barred testimony from precisely those most likely to know what had happened: the parties, any real parties in interest, any interested witnesses, and the husbands and wives of these parties."[17] This meant that, in many cases, the injured worker, "unable to testify on his own behalf, relied by necessity on the testimony of his fellow employees, all of whom would presumably be reluctant to testify against their employer if they wished to keep their jobs on good terms."[18] Finally, a scarcity of lawyers in the geographical regions most beset by industrial accidents—mining towns in the West and mill towns in the East—limited the potential for accident litigation throughout most of the nineteenth century.[19]

All of this had the cumulative effect of preventing injury litigation. Throughout much of the nineteenth century, lawyers and judges "paid little attention to the problem of unintentional injury" and tort law continued to lag behind the more established fields of property law and the law of contracts. [20] In fact, it was not until 1859, when Francis Hillard

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[16] Brown v. Kendall, 60 Mass. 292 (1850); for another example of the exacting standards needed to prove fault in early injury litigation, see: Farewell v. Boston and Worcester Railroad, 45 Mass. 49 (1842).

[17] Witt, *The Accidental Republic*, 56.

[18] Ibid.

[19] Ibid., 59-62. See also Lawrence Friedman, "Civil Wrongs: Personal Injury Law in the Late 19th Century," *American Bar Foundation Research Journal* (1987), 351-378; Lawrence Friedman and Thomas D. Russell, "More Civil Wrongs: Personal Injury Litigation, 1901-1910," *American Journal of Legal history* 34 (1990), 195-314.

[20] Witt, *The Accidental Republic*, 6. For a discussion of the major debates in nineteenth century legal history, see Tomlins, *Law, Labor, and Ideology in the Early American Republic*; Horwitz, *The Transformation of American Law, 1780-1860*; and Novak, *The People's Welfare*.

published the first treatise on the law of torts, that any legal text covered the subject in detail.[21] Beginning in the late 1860s, however, several important changes brought the law of torts to the fore.

The first development was a surge in the number of practicing attorneys. Between 1870 and 1900, "the number of lawyers jumped by almost 150 percent… and the ratio of lawyers to individuals in the paid workforce increased from 1 in 307 to [1 in] 256."[22] Many of these new attorneys came from second generation immigrant families, creating "new cadres of lawyers with close connections to the kinds of working-class communities from which personal injury plaintiffs were disproportionately likely to come."[23] Growth within legal profession fueled increased competition and lawyers increasingly turned toward accident litigation as novel means to eke out a living. Between 1870 and 1890, "the number of accident suits being litigated in New York City's state courts grew almost eightfold; by 1910, the number had grown again by more than a factor of five." Elsewhere, the shift was even more staggering. In Cook County Illinois, one legal commenter reported and eight hundred percent increase in injury litigation between 1875 and 1896. By the early twentieth century, the rise in injury litigation was so great that some feared it might completely "block [courts'] calendars" and "impede administration in all other branches of law."[24]

The second major development was the rapid expansion of American railroads. Few developments so radically reshaped American life during this period as the proliferation of

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[21] Francis Hillard, *The Law of Torts, or Private Wrongs* (Boston, 1859).

[22] Witt, *The Accidental Republic*, 59.

[23] Ibid., 61.

[24] Ibid., 59.

railroads and streetcars. These new modes of transport fundamentally altered the national landscape and new towns and settlements emerged along transportation networks. At the close of the Civil War American railroad networks were patchy and incomplete. Many lines in the South had been destroyed by the Union army, and only a handful of railways extended beyond the industrial North. By contrast, in 1890, railways crisscrossed the entire nation. Between 1880 and 1890, "total railroad mileage in the United States had almost doubled from 87,801 miles to 163,3562 miles. In those same years, the number of passengers carried more than doubled from just under 241 million in 1881 to over 498 million in 1890."[25] Likewise, railroads and streetcars enabled the separation of home and work. By 1890, streetcars carried over two billion passengers per year, which meant that the average urban American took more that 100 streetcar rides per year. By 1917, inhabitants of American cities took over 260 streetcar rides per year.[26] Perhaps the first big business, railroads transformed American financial institutions as well as the relationship between government and corporate interests. Railroad companies were not tethered to specific towns or cities. Rather, like insurance firms, they were large often-faceless corporations that hired scores of accountants, lawyers, and lobbyists to do their bidding in courts and government.

More than anything else, however, railroads fundamentally transformed Americans' attitudes toward the risks and dangers of everyday life. By their very nature, early railroads were inherently unsafe. Trains ran on along an immense web of tracks that spanned the entire nation. For many stretches, a single track carried trains in both directions. Any failure in communication between oncoming trains was certain to end in catastrophe. Likewise,

[25] Welke, *Recasting American Liberty*, 15.

[26] Ibid., 16-18.

tracks were seldom protected by any sort of barrier, and, as a result, wildlife, livestock, and passerby were sometime struck by passing trains. Entering and exiting railcars brought another set of dangers as it was common practice for passengers to jump from moving trains as their destination approached. These dangers led to myriad injuries and deaths. In 1901, 5,270 passengers as well as 12,707 "other persons" were injured or killed on American railways. Railway accidents "peaked in 1913, with 16,942 passengers and 19,198 'others' injured or killed."[27]

If railroads were dangerous, streetcars were even more deadly. The combination of fast speeds, cross traffic, and the unpredictability of city streets led to numerous accidents. In the year 1899 alone, Massachusetts streetcars injured or killed as many as 1,616 passengers and 800 bystanders. In 1902, more than 43,000 Americans were injured or killed in streetcar accidents.[28] As railroad and streetcar accidents became more common, so did personal injury litigation. In 1880, Boston had no more than "a dozen or so suits filed in superior court alleging damage caused by negligent operation of a horsecar." Two decades later, "however, [Boston had] 800 personal injury cases involving streetcars in personal court."[29]

As Americans turned to the courts in search of redress for injuries and lost wages, physicians were increasingly called to testify to the scope and scale of various injuries and ailments. This created numerous avenues for the use of physician-patient privilege in the courtroom. In fact, the privilege was so frequently invoked in railroad and streetcar injury cases, that railroad lawyers—like their peers in the field of life insurance—became experts on

[27] Ibid.

[28] Ibid., 16.

[29] Witt, *The Accidental Republic*, *59*.

the applications of physician-patient privilege and how to evade it. Several railroad attorneys even published articles in the largest medical journals of the day where they offered physicians detailed descriptions of the state of the law regarding privileged communications.[30]

Altogether, as a result of these developments the number of privilege cases before state courts ballooned. More privilege cases were decided in the 1870s and 1880s than in the previous five decades combined. Moreover, as privilege became a common feature of insurance cases and tort actions, it was also used with increasing regularity in other classes of litigation—most frequently contested will cases.[31] In these trials, physicians were often called to testify to the mental competency of the deceased testator.[32] Such cases were hardly new. Contested wills were a constant in nineteenth-century courtrooms and the subject of wills had long been a staple of medical jurisprudence.[33] For much of the nineteenth century, however, the medico-legal literature on the subject of wills and insanity made little note of physician-patient privilege.[34] It was not until the 1880s that privilege was used with any

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[30] Tracy C. Becker, "Observations Concerning the Law of Privileged communications Between Physician and Patient as Applicable to the Duties of Railroad Surgeons." *Journal of the American Medical Association* (May 30, 1896), 1065-1067. Clark Bell, "The Duty and Responsibility of the Attending Physic in Cases of Railway Surgery." *Medico-Legal Journal* 14 (1896), 7-14.

[31] Loder v. Whelpley, 66 Sickels 239 (1888); Matter of Coleman, 66 Sickels 220 (1888); Hoyt v. Hoyt, 67 Sickels 493 (1889); Morris v. Morris, 119 Ind. 341 (1889); and Re Will of Breundl, 102 Wis. 45. (1899); for more on the medico-legal issues arising in these cases, see: Mohr, *Doctors and the Law*, 22, 45, 60-66, 82, 176.

[32] On nineteenth-century definitions of insanity and the treatment of the mentally ill, see: William G. Rothstein, "A Historical Analysis of the Treatment of the Mentally Ill" in Rothstein, ed. *Readings in American Health Care: Current Issues in Socio-Historical Perspective* (Madison: University of Wisconsin Press, 1995), 281-283; Gerald Grob, *Mental Institutions in American: Social Policy to 1875* (New York: Routledge, 2004); Gerald Grob, *The Mad Among Us: A History of the Care of America's Mentally Ill* (New York: Free Press, 2011); and David Rothman, *The Discovery of the Asylum: Social Order and Disorder in the New Republic* (Boston: Little, Brown & Co., 1971).

[33] Nineteenth-century Medical jurisprudence focused heavily on the subject of insanity. See, for example: Beck, *Elements of Medical Jurisprudence* and Francis Wharton and Moreton Stillé, *A Treatise on Medical Jurisprudence* (Philadelphia, 1855).

[34] See, for example, Isaac Redfield, *The Law of Wills, Embracing Also, The Jurisprudence of Insanity: The Effect of Extrinsic Evidence; The Creation and Construction of Trusts, So Far as Applicable to Wills; With Forms and Instructions for*

frequency in will cases. This suggests that the prevalence of privilege in these trials was more likely a byproduct of the widespread use of privilege in other classes of litigation and a growing awareness of privilege in general. Nevertheless, the use of privilege in numerous will cases in the 1880s and 1890s led to several important precedents that helped to shape the emerging consensus surrounding physician-patient privilege.[35]

As privilege cases grew in number and frequency in the final decades of the nineteenth century, courts were repeatedly asked to weigh in on the applications of various privilege statues. Among the first of the numerous life insurance cases to flood state courts in the 1870s and 1880s, *Edington v. Mutual* and *Edington v. Aetna* illustrate the ways in which these cases raised new questions about physician-patient privilege. In 1867 and 1868, Wilbur Diefendorf purchased multiple life insurance policies—one from the Mutual Life Insurance Company of New York and another from the Aetna Life Insurance Company. Before signing a contract with either company, Diefendorf was required to fill out a questionnaire documenting his medical history and to undergo a medical exam. In each application, Diefendorf was asked whether he had suffered from any severe sickness or disease within the last seven years. In one application, Diefendorf admitted to an "attack of rheumatism years ago" and to some "nervous difficulty and diarrhea." In the other application, Diefendorf simply answered, "No." These irregularities went unnoticed at the time and Diefendorf signed a contract with each company, regularly paying his premiums. In 1871,

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Preparing Wills (Boston, 1860). Redfield's book served as the standard text on wills in the United States throughout much of the nineteenth century. See also Isaac Ray, *A Treatise on the Medical Jurisprudence of Insanity* (Boston, 1838); and Francis Wharton, *A Monograph on Mental Unsoundness* (Philadelphia, 1855).

[35] On the history of inheritance and wills, see Hendrik Hartog, *Someday This Will All Be Yours: A History of Inheritance and Old Age* (Cambridge, MA: Harvard University Press, 2012). On the adjudication of metal competence in nineteenth-century will cases, see James C. Mohr, "The Paradoxical and Embattled Retreat of the 'Unsound Mind': Evidence of Insanity and the Adjudication of Wills in Nineteenth-century America," *Historical Reflections/Réflexions Historiques* 1:24 (October 1998), 415-435.

Diefendorf died. The cause of death was listed as "nervous apoplexy," thought to be "the result of some disease or diseases of long standing, and not any sudden cause." Believing that they had been defrauded, both Mutual and Aetna refused to pay. Diefendorf's beneficiary, William Edington filed lawsuits to recover from each company. [36]

The ensuing legal drama took eight years to resolve as each suit found its way to the New York Supreme Court. The crux of each trial was whether the insurance companies could summon Diefendorf's physicians to testify. By the mid-1870s, physician-patient privilege had been affirmed in several New York cases and it was widely accepted that physician-patient privilege could be invoked by the patient to protect medical secrets. But what happened when the patient died? Did the protections of physician-patient privilege confer to the patients' heirs or beneficiaries? In each trial, the New York courts were forced to weigh in on these and other questions as the life insurance companies called multiple doctors to the stand.

The conclusions reached in each trial highlighted lingering uncertainties surrounding New York's privilege statute. In *Edington v. Mutual*, the first case to come before the New York Supreme Court, the court greatly limited the testimony that Diefendorf's physicians were allowed to give. The court ruled that "the protection which the law gives to communications made in professional confidence does not cease upon the death of the party." Accordingly, the court barred Diefendorf's long-time physician from revealing any confidential information about his one-time client. Moreover, the court celebrated physician-patient privilege as "a just and useful enactment." To limit the applications of the privilege, the presiding justices argued, would "destroy confidence between the physician and the patient, and… might tend very much to prevent the advantages and benefits which flow

[36] Edington v. Mutual Life Insurance Co., 22 Sickels 185 (1876); Edington v. Aetna, 32 Sickels 564 (1879).

from this confidential relationship." Accordingly, they continued, the privilege "should receive a liberal interpretation and not be restricted by any technical rule."[37]

Three years later, in *Edington v. Aetna*, however, the same justices reversed course, arguing that the privilege ought to be limited in scope. When Aetna's attorneys called two physicians to testify, the court overruled objections from Edington's counsel. One physician was allowed to testify that Diefendorf "did not appear like a well man; that he was sick, weak, and had the appearance of debility; that his step was slow and languid, and his voice low and feeble; that he appeared like a feeble man, a man out of health; that at times he appeared better, and at other times worse, and that on the whole his progress was downward, to the time of his death; and that from time to time he discovered eruptions and pimples upon his face, which he described." This information, the justices argued, was readily apparent to any and all who came across Diefendorf. Privilege, they argued, should be limited to the "confidential communications of a patient to his physician, and also such information as a physician may acquire of secret ailments by an examination of the person of his patient." They pointed out that the privilege did not exist under common law and, accordingly, argued that "it should not, therefore, be made broader by construction than the language of the statute plainly requires." Given too liberal a reading, the justices cautioned, privilege had the potential "to embarrass the administration of justice."[38]

As these two cases demonstrate, numerous questions about the potential applications of physician-patient privilege remained into the 1870s and it was possible for the courts to take widely divergent views on the subject. In time, however, as more cases came before the

[37] Edington v. Mutual Life Insurance Co., 22 Sickels 185 (1876).

[38] Edington v. Aetna, 32 Sickels 564 (1879).

courts, lawyers and judges gradually came to a consensus as to how privilege was to be interpreted in courts of law. The judicial decisions reached in these early cases were important in establishing the potential applications of physician patient privilege. In many cases, the rulings of states courts were every bit as important as the statutes themselves. As one legal commentator noted, "the law is well settled that when the highest court in the state construes a statute of that state, the construction so placed thereon becomes as much a part and parcel of the statute as if specifically incorporated therein, and when the legislature re-enacts the statute, it adopts the construction so made by the courts."[39]

Moreover, the numerous similarities between various privilege statutes meant that rulings in one jurisdiction were often interpreted and applied in myriad other jurisdictions—the same legal scholar noted, "where the legislature of one state adopts literally the statute of another state, the courts of the adopting state will likely feel constrained to follow the decisions of the highest court in the parent state construing such statute."[40] Because the vast majority of privilege statutes were modelled after New York's 1828 statute, the rulings of the New York Supreme Court often set precedent for much of the United States. *Edington v. Mutual Life Insurance Co.*, for example, was cited in over one hundred later cases and at least nineteen different jurisdictions.[41]

While individual statutes varied slightly, these insurance cases over time produced definite patterns in states that had privilege statutes on the books. Courts in those states almost universally agreed on three important principles: that the privilege belonged to the

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[39] DeWitt, *Privileged Communications Between Physician and Patient*, 66.

[40] Ibid.

[41] These were: New York, Puerto Rico, Texas, Washington, Colorado, Delaware, Indiana, Michigan, Missouri, New Jersey, Oregon, Utah, Arizona, California, North Dakota, Virginia, Vermont, and Wisconsin. Edington has also been cited in federal trials.

patient (and not the physician); that the privilege was intended to protect the physician-patient relationship; and that this purpose required a broad range of communications between physician and patient to be protected.

In most cases courts were unwilling to severely limit the applications of various privilege statutes. From the earliest cases, courts overwhelmingly agreed that the privilege belonged to the patient and not the physician. This was the ruling the courts reached in *Johnson v. Johnson* and, from the 1830s, this interpretation was upheld whenever the privilege was invoked in court. Even in Wisconsin, where the state's privilege statute merely stated the no physician or surgeon "shall be compelled" to testify—language that some interpreted as evidence that the statute protected the physician—the courts repeatedly ruled that the law was intended solely to protect patients.[42] Such protections did not require patients to know about the privilege or have any expectation that their secrets would remain confidential even in courts of law.[43]

Likewise, courts repeatedly ruled that the intent of privilege statutes was to protect medical secrets and that this was a worthwhile goal. In 1880, for example, the influential Court of Appeals of New York ruled that the purpose of the privilege "was to enable a patient to make known his condition to his physician without the danger of any disclosure by him; which would annoy the feelings, damage the character, or impair the standing of the patient while living or disgrace his memory while dead."[44] To this end, the courts generally protected a broad range of communications. Some courts "held that *all* information obtained

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[42] Sanbourn, "Physician's Privilege in Wisconsin," 141-146.

[43] "The statutory rule of law stands upon the statute book and is to be dispensed alike to those familiar with or ignorant of its existence and applicability," opined the presiding judge in People v. Stout, 3 Park. Cr. 670 (1858).

[44] Grattan v. Metropolitan Co., 80 N.Y. 297 (1880).

by the physician in course of his professional employment is privileged, however unimportant it may have been in enabling the physician to render his service."[45] In the 1877 case *Mott v. Consumers' Ice Co.*, for example, New York courts had refused to allow doctors' financial records ("the bare record of the number of patients visited by the doctor and the number and amount of fees received by him") to be admitted as evidence.[46] In general, most state courts "were extremely liberal in their decisions involving the interpretation and application of [physician-patient privilege]."[47] In general, the courts in the statute states took privilege seriously and resisted arguments to limit its applications. In a particularly forceful statement of that position, a New York judge asserted that any narrowing of the statute's meaning would "annul the statute and permit it to be evaded"[48]

In time, however, it became apparent that privilege had the potential to act as a shield for various acts of fraud and deception. In one case, a woman who had fallen in the street sued the Village of Oneida for damages including umbilical hernia, prolapse of the uterus, as well as numerous bruises. Representatives of the village called the plaintiff's physician of ten years who testified that the hernia predated the accident. This information was excluded from the record, however, and the village was ordered to pay $2,500 in damages.[49] In another Michigan case, a nurse sued her former charge, winning $1,500 compensation for injuries allegedly inflicted by her violent patient. On appeal, however, the

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[45] DeWitt, *Privileged Communications Between Physician and Patient*, 71. For cases, see: Grattan v. Metropolitan Co., 80 N.Y. 297 (1880); Renihan v. Dennin 103 N. Y. 573 (1886); Pennsylvania Co. v. Marion, 123 Ind. 415 (1889).

[46] Mott v. Consumers' Ice Co. (1877). Indiana courts in particular were especially liberal in their interpretation of the state's privilege statute. DeWitt, *Privileged Communications Between Physician and Patient*, 71-72.

[47] DeWitt, *Privileged Communications Between Physician and Patient*, 67.

[48] Grattan v. Metropolitan Life Insurance Co., 80 N.Y. 297 (1880).

[49] Nelson v. Village of Oneida, 156 N.Y. 219 (1898); Holger-Maehle, *Contesting Medical Confidentiality*, 19.

court learned that the plaintiff had confessed these injuries to her physician before she took care of the defendant. This testimony, initially barred from the courtroom under the guise of privileged communications, prompted the Michigan Supreme Court to reverse the earlier decision, ordering a new trial. In doing so, the court issued a word of caution, admonishing courts "to see to it that the statute [privileging communications between physician and patient] is not used as a mere guard against exposure of the untruth for a party, and that the rule intended as a shield is not turned into a sword."[50]

The early-twentieth-century legal critic Zechariah Chafee cited numerous other cases in which the enforcement of physician-patient privilege seemed to hamper the judicial process. In one case, a drunk accident victim was able to fraudulently recover damages because his attending physicians were unable to testify. In another, a widow sought to receive an insurance claim for the wrongful death of her husband, but because her husband's physician—the only witness who could attest to the cause of death—was barred from testifying, she was unable to recover damages.[51]

Gradually, courts began to call for a stricter interpretation of their privilege statutes. In 1887, the New York Court of Appeals ruled that it was the responsibility of the party invoking the privilege "to bring the case within the provision." Parties that wished to bar communications on grounds of privilege needed to prove that 1) "the information which he seeks to exclude was acquired by the witness in attending the patient in a professional

[50] Campau v. North (1878). Critics of physician-patient privilege latched on to this metaphor of privilege as a "shield and sword." In another case, the presiding judge chided a defense attorney who attempted to invoke physician-patient privilege, "The patient cannot use this privilege both as a sword and shield, to waive when it injures to her advantage and wield when it does not." State v. Depoister, 21 Nev. 107 (1891). See also Pierson v. People (1880).

[51] Zechariah Chafee Jr., "Progress of the Law," *Harvard Law Review* 35:6 (1921), pp. 673-714. See also: Soren, "The Workings of the New York Law," 601.

capacity" and 2) that this information "was necessary to enable him to act in that capacity."[52] In 1889, the New York courts ruled that an objection needed to be voiced to bar testimony.[53]

At times, the courts' broad interpretation of physician-patient privilege bordered on farce. On June 28, 1893, an Iowa man awoke to find his horse Bravo suffering from pneumonia. At eight AM, the man telegraphed for Dr. Miller, the local veterinarian. The veterinarian received the message at one PM, and, by four thirty arrived at the stables where he was unable to save the ailing horse. The horse owner then sued the telegraph company arguing that the delayed message was to blame for Bravo's death. On cross examination, the company's counsel asked Dr. Miller what information was conveyed in that telegram. Objection to this line of questioning was sustained on grounds of physician-patient privilege, "but on appeal it was held that the privilege conferred by the Iowa code on communications by patient to physician does not apply to communications made by a horse, or more fairly speaking, to veterinarians."[54]

Throughout the late nineteenth century, courts were repeatedly asked to consider whether various specialists were covered by physician-patient privilege. In 1877, Missouri courts denied claims that pharmacists were covered by the privilege.[55] Likewise, in 1893, Missouri courts denied dentists' claims to privileged communications. This decision was later

[52] People v. Schuyler (1887).

[53] Hoyt v. Hoyt (1889).

[54] Henderschott v. Western Union Telegraph Company, 106 Iowa 529 (1898). Quote: Purrington, "An Abused Privilege," 395.

[55] Brown v. Hannibal & St. J. R. R., 66 Mo. 588 (1877). This decision was confirmed by New York courts in 1903. Deutschmann v. Third Ave. R. R., 87 App. Div. 503.

confirmed by rulings in Iowa, Michigan, and Mississippi.[56] Courts repeatedly ruled that Christian scientists were not considered physicians under various privilege statutes.[57] Over time, courts would reject claims to privileged communications by chiropractors, x-ray operators, undertakers, hospital dieticians, army corps sergeants in prophylaxis, interns, medical students, laboratory technicians, gymnasts, naturopaths, electrotherapists, mechanotherpaists, physiotherapists, osteopaths, and masseuses.[58] With each of these decisions the courts narrowed the potential applications of physician-patient privilege. In time,

the Michigan Supreme Court explicitly limited the privilege to "general practitioners, and to those whose business as a whole comes within the definition of 'physician' or 'surgeon.'"[59] To this end,

the Supreme Court of Rhode Island defined a physician as someone "who practices the art of healing disease and preserving health; a prescriber of remedies for sickness and disease. He is presumed to be familiar with the anatomy of the human body in its entirety; to understand the science of physiology and the laws of hygiene, and to be able to minister, as

[56] State v. Fisher, 24 S. W. 167 (1893); Cherokee v. Perkins, 118 Iowa 405 (1902); People v. De France, 28 L. R. A. 139 (1895); and Gulf M. & N. Railroad v. Willis, 171 Miss. 732 (1934).

[57] Kansas City v. Baird, 92 Mo. App. 204 (1902); People v. Cole, 219 N. Y. 98 (1916); Estate of Mossman, 119 Cal. App. 404 (1931).

[58] S. H. Kress and Company v. Sharp, 156 Miss. 693 (1930); O'Brien v. General Acc. Rire and Life Insurance Co., 42 F. 2d 48 (1930); Prudential Insurance Co. v. Kozlowski, 226 Wis. 641 (1938); Chadwick v. Beneficial Life Insurance Company, 54 Utah 443 (1919); First Trust Co. v. Kansas City Life Insurance Co., 79 F. 2d. 48 (1935); Culver v. Union Pacific R. R., 112 Neb. 441 (1924); Borosich v. Metropolitan Life Insurance Co., 191 Wis. 239 (1926); Sparer v. Travelers' Insurance Co., 185 App. Div. 861 (1919); Block v. People, 125 Colo. 36 (1951); Palmer v. O'Hara, 359 Pa 213 (1948); Joyner v. State, 181 Miss. 245 (1938); State Board v. Scherer, 221 Ind. 92 (1942); People v. Mari, 260 N. Y. 383 (1933); O'Neill v. Board of Regents, 272 App. Div. 1086 (1947); Kennington v. Blake, 135 Md. 320 (1919); State v. Sawyer, 36 Idaho 814 (1923); State v. Stoddard, 215 Iowa 534 (1932); People v. Dennis, 271 App. Div. 526 (1946).

[59] People v. De France, 28 L. R. A. 139 (1895).

far as may be, to the relief of pain, disease, and physical ailments of all sorts and kinds whatsoever."[60]

While insurance suits, injury litigation, and testamentary actions made up the bulk of legislation in which privilege was invoked, other, more sensational cases often captured the headlines. Critics of physician-patient privilege were quick to point to instances in which privilege protected the most disreputable criminals. In one case, a Nevada man tried and convicted for the attempted rape of a seven-year-old girl sought to use physician-patient privilege as a means to get his conviction overturned. He argued that the testimony of a physician who had examined the victim and confirmed that she had sustained injuries as a result of the attempted rape should be thrown out under Nevada's privilege statute as the doctor had prescribed for and treated her as a patient. While unsuccessful in overturning the conviction, this argument managed to elicit a dissenting opinion from Nevada Supreme Court Justice J. Bigelow and horrified many legal commentators.[61] William Archer Purrington, the barrister for the New York State and County Medical Societies and vehement critic of physician-patient privilege, cited this case as evidence that privilege protected "ravishers" from justice.[62]

The 1880 New York case *Pierson v. People* raised even more grave concerns about the potential uses of physician-patient privilege. At trial, William Pierson, accused of murder, appealed to the court to bar the testimony of the poisoned victim's physician on the grounds that these communications were privileged by the New York statute. The judge was

[60] State v. Beck, 21 R. I. 288 (1899).

[61] State v. Depoister, 21 Nev. 107 (1891).

[62] Purrington, "An Abused Privilege."

unsympathetic, however, stating, "the purpose for which the aid of this statute is invoked in this case, is so utterly foreign to the purposes and objects of the act, and so diametrically opposed to any intention which the Legislature can be supposed to have had in the enactment, so contrary to an inconsistent with its spirit, which most clearly intended to protect the patient and not to shield one who is charged with his murder, that in such a case the statute is not to be so construed as to be used as a weapon of defense to the party so charged, instead of a protection to his victim."[63] The judge was not merely dissatisfied with Pierson's attempted use of physician-patient privilege. Instead, he took aim at the privilege itself, stating, "there has been considerable difficulty in construing this statute, and yet it has not been under consideration in many reported cases. It was more fully considered in the *Edington case* than in any other or all others. It may be so literally construed as to work great mischief, and yet its scope may be so limited by the courts as to subserve the beneficial ends designed without blocking the way of justice. It could not have been designed to shut out such evidence as was here received, and thus protect the murderer rather than to shield the memory of his victim."[64]

As criticism from the bench mounted in the final two decades of the nineteenth century, even in states that protected physician-patient communications by statute, the legal profession increasingly united in opposition to physician-patient privilege. In non-statute states, physician-patient privilege remained a contentious issue. In jurisdictions that remained beholden to common law tradition, courts continually refused to privilege medical

[63] Pierson v. People (1880).

[64] Ibid.

communications.[65] The position of those states was bolstered by a series of cases in Britain that repeatedly affirmed the (albeit misunderstood) precedent established in the Duchess of Kingston's trial for bigamy.[66] Moreover, where statutes did exist, critics of physician-patient privilege argued in favor of a narrow interpretation of the privilege that limited its applications to a few select cases.[67]

Legal treatises, which had once treated the privilege with ambivalence or not at all, were now united in condemnation. The sixteenth and final edition of Greenleaf's *A Treatise on the Law of Evidence*, published in 1899, captured the emerging legal consensus:

> As to the policy of the privilege and extending it, there can only be condemnation. The chief classes of litigation in which it is invoked are actions on policies of life insurance, where the deceased's misrepresentations as to health are involved; actions for corporal injuries, where the plaintiff's bodily condition is to be ascertained; and testamentary actions where the testator's mental condition is in issue. In all of these cases, the medical testimony is 'the most vital and reliable,' 'the most important and incisive' and is absolutely needed for purposes of learning the truth. In none of them is there any reason for the party to conceal the facts except to perpetrate a fraud upon the opposing party, and in the first two of these classes the advancement of fraudulent claims is notoriously common. In none of these cases need there be any fear that the absence of the privilege will subjectively hinder people from consulting physicians freely (which is, as we have seen, the true reason for maintaining the privilege for clients of attorneys); the injured person would still seek medical aid, the injured person would still submit to a medical examination, and the dying testator would still summon physicians to his cure. In wills, policies and personal injuries, the privilege, where it exists, is known in practice to be a serious obstacle to the ascertainment of truth and a useful weapon for those interested in suppressing it. Any extension of it to other jurisdictions is to be earnestly deprecated."[68]

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[65] Campau v. North, 39 Mich. 606 (1878); People v. Lane, 101 Cal. 513 (1894); Springer v. Byram, 137 Ind. 15 (1894); Prader v. National Masonic Acc. Association, 95 Iowa 149 (1895); for more cases, see, DeWitt, *Privileged Communications Between Physician and Patient*, 10.

[66] Earl of Falmouth v. Moss, 11 Price 455 (1822); Rex v. Gibbons, 1 C. & P. 97 (1823); Greenough v. Gaskell, 1 M. & K. 99 (1833); Greenlaw v. King, 1 Beav. 137 (1838); Russell v. Jackson, 9 Hare 387 (1851); Anderson v. Bank of British Columbia, 2 L. R. Ch. D. 644 (1875); and Wheeler v. Le Merchant, 17 L. R. Ch. D. 675 (1881).

[67] See, for example: Pierson v. People, 34 Sickels 424 (1880); Purrington, "An Abused Privilege;" Purrington, "A Recent Case of Physician's 'Privilege,'" 9 *Bench and Bar* 48 (1907), 52; and Bach, "The Medico-Legal Aspect of Privileged Communications," 10 *Medico-Legal Journal* 33 (1892).

[68] Simon Greenleaf, *A Treatise on the Law of Evidence* 16th ed. (Boston, 1899), 385-386.

With this came one of the most important turning points in the history of physician-patient privilege. The problematic applications of privilege in insurance cases, injury litigation, and testamentary actions in the late nineteenth century courtroom transformed the legal consensus regarding physician-patient privilege—what had once been a minor and inconsequential rule of evidence was now seen as an unnecessary impediment the legal process and, in many cases, it was considered a grave injustice. In the ensuing decades, this legal criticism would become the foremost obstacle to the further spread of privilege statutes. Throughout the twentieth century, legal scholars, outraged by the applications of privilege in the courtroom, would work to limit the spread of new statutes and, in time, to revise or repeal the statutes already on the books.

CHAPTER VIII: CRITICISM AND REFORM IN THE TWENTIETH CENTURY

> Certain it is that the practical employment of the privilege has come to mean little but the suppression of useful truth, —truth which ought to have been disclosed and would never have been suppressed for the sake of any inherent repugnancy in the medical facts involved.
>
> John Henry Wigmore, *On Evidence*, 1904

> There are occasions… when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected because the physician has knowledge obtained through the confidences entrusted to him as a physician of a communicable disease to which the healthy individual is about to be exposed.
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> American Medical Association, *Principles of Ethics*, 1912

In retrospect, the nineteenth-century evolution of physician-patient privilege was relatively steady and constant. Between 1828 and 1905, thirty-one different jurisdictions adopted privilege statutes. Physicians, at first largely uninvolved in the spread of privilege, eventually came to appreciate privilege laws as powerful indicators of their own professional status, and they successfully lobbied for the adoption more privilege statutes. During the closing decades of the nineteenth century, a series of court cases transformed privilege from an arcane and seldom-used legal doctrine into a high-stakes legal matter. Even as most of the nation's physicians came to embrace the privilege, members of the bar and bench began to resent it. What began as a minor offshoot of legal codification reforms came to be regarded by many lawyers as a pernicious obstruction of the legal process.

By contrast, the twentieth-century history of physician-patient privilege took fewer twists and turns. As medico-legal developments brought more new legislation and more kinds of cases to which the privilege could not be easily applied, the legal profession increasingly united in opposition to the privilege. Legal critics, led by John Henry Wigmore, the era's preeminent expert on the law of evidence, fashioned novel means to test the

efficacy of various evidentiary privileges. To these legal scholars, all privileges represented dangerous impediments to the courts' search for truth. Such privileges could be justified only if the public good created by the privilege outweighed the damage of refusing necessary evidence. Physician-patient privilege, they argued, needed to be limited and perhaps even abolished because it failed that test.

At the same time, some doctors continued to push for new statutes. And yet, as many physicians embraced laissez-faire medical ethics in the early twentieth century, these efforts proved largely unsuccessful. To the new generation of physicians who emerged in the early twentieth century, privilege was no longer a powerful indicator of the status and influence of the medical profession, but rather an unnecessary and dangerous check on doctors' professional autonomy. To these doctors, physician-patient privilege and, more broadly, the AMA's *Code of Ethics* increasingly seemed like antiquated relics of the nineteenth century.

The evolution of physician-patient privilege in the twentieth-century was profoundly shaped by these two developments. Legal criticism, when combined with the ambivalence of the medical profession, effectively stopped the spread of physician-patient privilege, and new statutes became increasingly rare. At the same time, numerous states—prompted by criticism emerging from bench and bar—began to rewrite their civil codes. Nearly every state that had adopted physician-patient privilege in the nineteenth century amended their privilege statute to include new waivers and clauses that limited the privilege to specific classes of litigation. Finally, over the course of the twentieth century, legal reformers led efforts to systematize and standardize the law of evidence. In doing so, they incorporated the legal critiques of noted scholars and staunch critics of physician-patient privilege into new policies—most

notably the Federal Rules of Evidence, which was adopted in 1975 and did not include physician-patient privilege.

The nineteenth-century statutes that granted physicians privileged communications had been enacted in response to specific medico-legal problems—doctors' conflicting loyalties to their patients and the law, uncertainty over the admissibility of specific pieces of testimony in the courtroom, and a desire for a more precise and proscriptive legal code. A period of rapid change, the early-twentieth century brought numerous developments that challenged those nineteenth-century trends. Large corporations such as railroads, mining companies, and insurance corporations increasingly hired their own physicians, creating new ethical dilemmas—did these companies have any legal right to patients' medical records? These discussions frequently found their way into the courtroom, where physicians and lawyers were often uncertain as to how to apply physician-patient privilege.[1]

Likewise, the transformation of hospitals in the late nineteenth and early twentieth centuries profoundly shaped discourse over medical confidentiality. Throughout much of the nineteenth century, hospitals had served as houses of last resort, where the poor and destitute received palliative care. By the turn of the century, however, the advent of professional nursing and antiseptic surgery had remade the hospital into the primary locus of both treatment and medical research.[2] In a hospital setting, medical confidences were no longer shared between physicians and patients alone. Rather, such secrets became known the myriad nurses and medical students who carried out many of the day-to-day tasks involved

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[1] Becker, "Observations Concerning the Law of Privileged Communications;" Bell, "The Duty and Responsibility of the Attending Physician in Cases of Railway Surgery"; and Clark Bell, "The Future of Railway Surgery, *Medico-Legal Journal v. 14* (1896), pp. 202-206. On company doctors, see: Starr, *The Social Transformation of American Medicine*, 200-206.

[2] Starr, *The Social Transformation of American Medicine*, 145-179; Charles E. Rosenberg, *The Care of Strangers: The Rise of America's Hospital System* (Baltimore: The Johns Hopkins University Press, 1995).

in hospital care. Moreover, a shift from the nineteenth-century norm of one-to-one relations between physician and patient toward more team-oriented therapeutics necessitated the creation and preservation of more extensive medical records. In this way, the reorganization of the hospital brought new ethical dilemmas that doctors had to confront, creating exceptional cases where "the professional honor and the legal obligation… to preserve the patient's secrets" no longer applied. By entering the hospital, physicians argued, "the patient… necessarily and properly assumed to waive all claim to privacy so far as the purposes of clinical instruction and hospital administration are concerned."[3]

Most of all, however, the application of physician-patient privilege to injury lawsuits and contested life insurance claims continued to provoke unwanted complications. By the early twentieth century, the potential injustices posed by the applications of privilege in injury litigation were readily apparent to all parties. On such cases, William Archer Purrington, a lawyer representing the New York State and County Medical Societies, remarked, "It needs no argument to show the unfairness, if not dishonesty, as a general rule, of those who bring actions to recover damages for their physical injuries, yet will not permit the best evidence of the nature and extent of those injuries to be put before the jury."[4] Few were as critical as the presiding judges in these cases. In one Missouri case, the presiding judge called attention to "the [numerous, well-known] scandals in beating down the truth arising from too harsh and literal interpretation [of privilege statutes]."[5] Another Utah justice

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[3] Edmund Andrews, "The Secrets of Hospital Patients," *Journal of the American Medical Association* (January 7, 1899), pp. 3-4.

[4]Allan McLane Hamilton and Lawrence Godkin eds., *A System of Legal Medicine* vol. 1 (New York, 1894), 626. Purrington was consulted as a contributor in the volume. Purrington's opposition to physician-patient privilege is well documented. See also, Purrington, "An Abused Privilege;" and Purrington, "A Recent Case of Patient's 'Privilege.'"

[5] Epstein v. Pennsylvania Railroad, 250 Mo. 1 (1913).

decried privilege as "a perversion of justice, if not an absolute travesty."[6] As criticism mounted from bench and bar, many began to call for sweeping reforms of the various privilege statutes in effect.[7]

Few scholars influenced this discourse as much as John Henry Wigmore. Born in 1863, Wigmore rose to prominence in the early twentieth century as the nation's foremost expert on the law of evidence. Described by peers as a "simple-minded man who combined exceptional industry with a clear mind, broad interests and a methodical approach," Wigmore had a gift for classification and organization.[8] As a young scholar writing in the 1890s, he had tried his hand at editing an edition of Greenleaf's *A Treatise on the Law of Evidence*—long viewed as the standard text on American evidence law. In doing so, Wigmore worked to retain Greenleaf's original language as much as possible and to ensure the long-running text, which was first published in 1842, remained up-to-date with notes of the most recent cases and statutes. In the margins, however, Wigmore diverged from the standard fare of nineteenth-century legal treatises. Here, he offered numerous editorial comments and suggested avenues for the future of American evidence law.[9]

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[6] Dahlquist v. Denver & Rio Grande Railroad, 52 Utah 438 (1918).

[7] Dewitt, *Privileged Communications Between Physician and Patient*, 31-39; Meyer v. Supreme Lodge, Knights of Pythias, 178 N.Y. 63 (1904); Olson v. The Court of Honor, 100 Minn. 117 (1907); Maine v. Maryland Casualty Co., 172 Wis. 35 (1920); Harpman v. Devine, 133 Ohio St. 1 (1937); Boyles v. Cora, 232 Iowa 822 (1942); and Randa v. Bear, 50 Wash. 2d 415 (1957).

[8] William L. Twining, *Rethinking Evidence: Exploratory Essays* 59-60 (1990). Quoted in Imwinkelried, *The New Wigmore: Evidentiary Privileges*, xvii. On Wigmore and his towering role in the field of evidence, see also: William R. Roalfe, *John Henry Wigmore: Scholar and Reformer* (Evanston: Northwestern University Press, 1977); Andrew Porwancher, *John Henry Wigmore and the Rules of Evidence: The Hidden Origins of Modern Law* (Columbia, MO: University of Missouri Press, 2017); and George F. James, "The Contribution of Wigmore to the Law of Evidence," *University of Chicago Law Review* 8:1 (December 1940), 78-87.

[9] Greenleaf, *A Treatise on the Law of Evidence* 16th ed. (Boston, 1899).

Wigmore's magnum opus, *A Treatise on the Anglo-American System of Evidence in Trials at Common Law*, first published in 1904 and 1905, followed through on this promise. In the text, Wigmore sought to compile the "warring masses of judicial precedents" that made up the law of evidence into one comprehensive work. In doing so, he sought "to expound the Anglo-American law of evidence as a system of reasoned principles" and "to furnish all the materials for ascertaining the present state of the law in the [United States'] half a hundred independent jurisdictions."[10] To Wigmore, the need for a new, modern take on the law of evidence was most glaring when it came to the law of privileges. Long a harsh critic of all privileges, Wigmore found physician-patient privilege especially loathsome.[11]

With sarcasm and cutting wit, *On Evidence* argued vehemently against physician-patient privilege. Wigmore laid out the most important arguments in favor of the privilege—the notes of the revisers to the New York code, which offered the original justification for physician-patient privilege, and the more recent judicial decision in *Edington v. Aetna*. Accepting these sources as the best evidence that medical communications ought to be privileged, Wigmore then set out to deconstruct and dismiss each piece of evidence one-by-one.[12] In doing so, Wigmore fashioned novel means to test the efficacy of various evidentiary privileges. To Wigmore, privileges, which by definition impeded courts' ability to ascertain the truth, could only be justified if they met four criteria: 1) the privileged communication needed to originate in confidence; 2) this confidentiality had to be absolutely necessary for the relationship in question; 3) the protected relationship had to be performing

[10] Wigmore, *On Evidence* 1st ed. vol. 1, xiii.

[11] See for example Wigmore's editorial comments in Greenleaf, *A Treatise on the Law of Evidence* 16th ed., 385-386.

[12] Wigmore, *On Evidence* 1st ed. vol. 4, 3347-3366.

a public good; 4) and the damage inflicted by disclosing privileged information needed to be greater than the injury caused by denying this information to the courts. If a privilege failed to meet any one of these criteria, then the privilege could not be justified.[13]

In regard to the first criteria, Wigmore argued that most medical secrets did not really "originate in confidence." If patients did not view their medical conditions as secrets, then there would be no need to maintain medical confidentiality in the courtroom. To this point, Wigmore argued that most diseases and injuries were readily apparent. With the exception of venereal diseases and criminal abortions, he asserted, there "is hardly a fact in the categories of pathology in which the patient himself attempts to preserve any real secrecy." As these laws had never been intended to protect abortionists and other criminals, Wigmore reasoned, their application in the courtroom constituted an unjust and unnecessary impediment to the legal process.[14]

Likewise, to the second point, Wigmore argued that privilege was hardly necessary to protect the physician-patient relationship. Here, he reasoned that if doctors were capable of treating patients without the trust engendered by physician-patient privilege, as physicians did in all states without a privilege statute, then surely there was no need for privilege at all. Moreover, Wigmore argued, "even where the disclosure is actually confidential, it would none the less be made though no privilege existed." To Wigmore, it was absurd to suggest that a patient might endanger his or her own life out of fear that any information confided in a physician could be used as testimony in a court of law. Patients would always seek medical attention whether they knew their communications were privileged or not. To this point,

[13] Ibid., 3350-3352.

[14] Ibid., 3350.

Wigmore concluded with a sarcastic quip, "Is it noted in medical chronicles that after the privilege was established in New York, the floodgates of patronage were let open upon the medical profession and long-concealed ailments were then for the first time brought forth to receive the blessings of cure?"[15]

To the third point, Wigmore asked, "Is the [physician-patient] relation one that should be fostered?" Here, Wigmore gave an unequivocal yes— "that the relation of physician and patient should be fostered, no one will deny." Yet the privilege could be justified only if the injury caused to the physician-patient relationship by disclosure of medical secrets was greater than the "injury to justice" caused by non-disclosure. On this fourth point, Wigmore suggested that physicians' arguments for the privilege fell apart. Like Mansfield more than a century before him, Wigmore acknowledged that medical confidentiality had long been an important part of the physician-patient relationship and that to disclose medical secrets outside of the courtroom would be wrong. Revealing these secrets in the courtroom was another matter and would never be held against a physician— "the physician, being called upon only rarely to make disclosures, is not consciously affected in his relationship with the patient. "In truth," Wigmore concluded, each of these criteria except the last "may justly be answered in the negative…There is nothing to be said in favor of the privilege, and a great deal to be said against it." He suggested that states should remove physician-patient privilege from the statute books and that "the adoption of it in any other jurisdictions is earnestly to be deprecated."[16]

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[15] Ibid., 3350-3351.

[16] Ibid., 3351-3352.

In the decades following the publication of *On Evidence,* both legal and medical scholars frequently cited Wigmore as the definitive authority on the law of evidence. To this day, many legal scholars have accepted Wigmore's four instrumental criteria as the best test for whether specific communications should be privileged, and the United States Supreme Court has repeatedly cited Wigmore's four criteria as a means to test the use of various evidentiary privileges at the federal level.[17]

Wigmore's critique was so forceful that anyone who continued to advocate for physician-patient privilege felt the need to confront his arguments. In 1913, for example, William Chandler, a physician from South Orange, New Jersey, urged his state's medical society to push for the legislative recognition of physician-patient privilege, as so many of his nineteenth-century counterparts had done. Chandler urged his peers to "refer the matter back to [the society's] legislative committee." With "a united effort… by the [medical] profession," Chandler hoped "to place New Jersey with those other States, which have decided to protect professional honor, conserve the confidence necessary to obtain health or preserve life, and above all to secure the dispensation of justice with the *least injury* and the *greatest beneficence* to the whole commonwealth."[18]

Even in this impassioned speech, however, Chandler was forced to acknowledge the new challenges facing his cause in the wake of Wigmore's treatise. Legislators increasingly rejected physician-patient privilege because "it makes physicians a *privileged class*"—one of

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[17] See for example Jaffee v. Redmond, 518 U.S. 1 (1996); or Swidler and Berlin v. United States, 524 U.S. 399 (1998); Imwinkelried, *The New Wigmore: Evidentiary Privileges*, 444-445.

[18] William J. Chandler, "Privileged Communications," *Journal of the Medical Society of New Jersey* (July 1913), pp. 67-71, at 71. A decade earlier another New Jersey physician Daniel Strock lobbied for similar statute. Strock's appeals were similar to those of David Cheever, Horatio Wood, Daniel Roberts Brower, or any of the other regular physicians who lobbied for physician-patient privilege throughout the nineteenth century. Strock, "The Patient's Secret."

Wigmore's harshest critiques of the privilege—and because "it would in too many instances defeat the ends of justice."[19] Unwilling to completely reject the arguments of "Dean Wigmore," however, Chandler repurposed Wigmore's four criteria in his speech. To Chandler, physician-patient privilege was justified because it met all four criteria necessary to justify privileged communications. But Chandler's plea fell upon deaf ears, and New Jersey failed to enact a new statute.

By early twentieth century, moreover, many physicians themselves were beginning to agree with Wigmore. Dating back to the 1880s, there had long been doctors opposed to physician-patient privilege and, more broadly, codified medical ethics. By 1900, however, dissatisfaction with the AMA's *Code of Ethics* had reached a boiling point. The most vocal critics of the *Code* took issue with the consultation provision, a clause that prohibited cooperation with irregular practitioners. Yet when John Allen Wyeth, the AMA president, called upon the organization to repeal the provision in 1902, reformers seized the opportunity to make wholesale revisions to the *Code*. The following year, a committee appointed to revise the *Code of Ethics* produced a new document, titled *Principles of Medical Ethics*. While the 1903 revision retained much of the original language of the 1847 *Code*, *Principles* removed several of the more offensive provisions. The new document removed the controversial consultation provision, omitted any mention of the public's obligations to physicians, and relaxed restrictions on the use of patent medicines and proprietary drugs.[20]

More importantly for the politics of medical confidentiality, *Principles* stripped the code of any regulatory mechanisms. In the Preface to the new code, the revisers noted that

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[19] Chandler, "Privileged Communications," 69-70.

[20] AMA, *Principles of Medical Ethics* (1903). For more analysis of the 1903 revisions, see: Konold, *A History of American Medical Ethics,* 68-75 and Baker, *Before Bioethics*, 215-218.

they "deemed it wiser to formulate the principles of medical ethics without definite reference to code or penalties." Accordingly, they maintained that the new *Principles of Medical Ethics*, in stark contrast to the old AMA *Code*, would be merely "suggestive and advisory." The policing of ethical infractions was "thus left to the respective state and territorial societies." These societies were free to "form such codes and establish such rules for the professional conduct of their members as they may consider proper, provided, of course, that there shall be no infringement of the established ethical principles of this Association."[21] Supporters of the new *Principles of Medical Ethics* argued that the new document was preferable to the old *Code of Ethics* because it left individual physicians free to make decisions in accordance with their own standards of medical ethics. "Character must be the foundation upon which ethical action is to be built," a Colorado physician declared. "Proper conduct among men and affairs must be left to the man, his tact, his judgment, his education and his experience."[22]

Yet this sentiment did not completely resonate throughout the medical profession. Despite support for some of the revisions incorporated into *Principles of Medical Ethics*, many physicians felt the new document erred too far in favor of laissez-faire medical ethics. As a series of high-profile quarrels rocked the medical profession, critics of the new code began to rail against its lack of disciplinary authority. In 1909, when Frank Lydston, a Chicago gynecologist, openly challenged the integrity of George H. Simmons, the AMA Secretary-General, many physicians began to call for a second revision of the code. Led by Simmons, this group of physicians successfully lobbied for a second revision of the AMA code, and, in

[21] AMA, *Principles of Medical Ethics* (1903), Preface.

[22] *Denver Medical Times,* quoted in the *Journal of the American Medical Association* 45:1263 and Konold, 69-70.

1912, the AMA adopted a new version of *Principles of Medical Ethics* that restored the society's capacity for ethical enforcement.[23] Yet the second batch of revisions did not abandon laissez-faire ethics altogether. Rather than merely relax the standards of ethical policing, the 1912 *Principles* incorporated laissez-faire ethics into many of the code's provisions.

The treatment of confidentiality was a case in point. Compared to earlier ethical codes, the 1912 *Principles* offered a merely tepid endorsement of medical confidentiality. While the 1847 *Code of Ethics* had praised the protection of patients' secrets as one of the basic tenets of the physician-patient relationship, the laissez-faire medical ethics of the early twentieth century found these restrictions increasingly onerous. Accordingly, the revisers who authored the 1912 *Principles* tempered the proscriptive language of the old *Code of Ethics*. While the 1847 document had mandated that "secrecy and delicacy… should be strictly observed" and that "no infirmity of disposition or flaw of character observed during professional attendance, should ever be divulged by him except when he is imperatively required to do so,"[24] the 1912 *Principles* read:

> There are occasions… when a physician must determine whether or not his duty to society requires him to take definite action to protect a healthy individual from becoming infected because the physician has knowledge obtained through the confidences entrusted to him as a physician of a communicable disease to which the healthy individual is about to be exposed. In such a case the physician should act as he would desire another to act toward one of his own family under like circumstances. Before he determines his course, the physician should know the civil law of his commonwealth concerning privileged communications.[25]

Like earlier versions, this new clause acknowledged the physician's need to maintain the confidences of his patients. Yet the 1912 *Principles* also introduced new ethical duties that

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[23] Konold, 68-75; Baker, *Before Bioethics*, 220-223.

[24] AMA, *Code of Ethics* (1847).

[25] AMA, *Principles* (1912), Chapter I, Section 2.

superseded the physician's obligation to his patient, allowing the physician to exercise his own judgment on a case-by-case basis.

The wording of the 1912 revision revealed a dramatic underlying shift in the AMA's position on privileged communications. The 1847 *Code* had praised privileged communications as a powerful indicator of the importance of professional ethics and medical confidentiality, stating, "the force and necessity of [physicians'] obligation [to maintain their patients' secrets] are indeed so great, that professional men have, under certain circumstances, been protected in their observance of secrecy by courts of justice."[26] By contrast, the 1912 *Principles* urged physicians to be familiar with "the civil law of his commonwealth regarding privileged communications" as means of self-protection, implying that privileged communications were a negative duty that could, and often did, conflict with a physician's obligation to society and impinge upon a his ability to act ethically. This stemmed from a shifting of priorities. The authors of the 1912 *Principles* championed physicians' "service to humanity" rather than their obligations "exclusively to the patient… without exception," as the nineteenth-century champions of medical ethics had done.[27] Thus, "the 1912 concept of professionalism created conceptual space for a professional duty to report infectious diseases to health authorities and even to identify carriers by name."[28]

This change in priorities and ethical practices reverberated throughout all levels of the medical profession. Just as the AMA relaxed its policies on medical confidentiality, individual physicians across the country became more willing than they had been to violate

[26] AMA, *Code of Ethics* (1847).

[27] Flint, *Medical Ethics and Etiquette*, 14.

[28] Baker, *Before Bioethics*, 221.

patients' secrets in service of other, conflicting ethical duties. Increasingly, these relaxed practices brought physicians into conflict with their patients. In 1920, for example, the Nebraska Supreme Court convened to adjudicate a dispute between a doctor and his disgruntled patient. *Simonsen v. Swenson* caught national attention as the first time a court was "called on to determine a physician's liability for voluntarily revealing out of court a patient's confidences."[29] The trouble began when Simonsen, an employee of a telephone company, stopped in Oakland, Nebraska along with several colleagues. In his hotel room one night, he noticed sores across his body. Alarmed and fearing the worst, he sought the counsel of Swenson, a local physician, but the doctor's visit did little to allay Simonsen's fears. After a brief examination, Swenson informed the travelling telephone employee that his sores were most likely indications of syphilis. There was still some cause for optimism, however, as the doctor's hasty examination called for more tests before the diagnosis could be confirmed. Nevertheless, the doctor worried that Simonsen's condition might be contagious and strongly urged the traveler to vacate his hotel room.[30]

Though the diagnosis was distressing, Simonsen elected to ignore the doctor's advice. Instead, he opted to finish his business in town before seeking a second opinion at home. Returning from work the following day, however, Simonsen was alarmed to find his bags packed and waiting in the hall. His room was under quarantine and in the process of being fumigated. When Simonsen sought out the hotel's proprietor to ask what was going on, he was instructed to leave immediately. The telephone employee was distraught. On its own, the diagnosis was enough to cause concern, but his expulsion from the hotel brought

[29] "Liability of a Physician for Revealing out of Court His Patient's Confidences," *Harvard Law Review* 34:3 (January 1, 1921): 312–14.

[30] Simonsen v. Swenson, 104 Neb. 224 (1920).

even more problems: where would he stay as he finished his work? How would he explain these events to his colleagues? The court records fail to indicate how Simonsen managed to negotiate these dilemmas. He did, however, seek a second opinion, later learning that his sores had been nothing more than a false alarm.[31]

In the resulting lawsuit, Simonsen called the physician into court, asking Dr. Swenson to answer for the embarrassment and hardship caused by his mistaken diagnosis. The physician's story did not contradict that of his patient. Both agreed on the same sequence of events, yet the doctor vehemently attested that his actions were justified. Dr. Swenson had long served Mrs. Bristol, the hotel's proprietor, and Mrs. Bristol would frequently refer ailing guests to Swenson. Accordingly, when Simonsen first noticed the symptoms of a mysterious ailment, the proprietor had referred him to the "hotel doctor."[32] Upon examining Simonsen, Swenson immediately feared the worst: the patient was quite probably suffering from syphilis. At that time, physicians believed that the disease was "very readily transmitted in its early stages, and could be carried through drinking cups, eating utensils, and other articles handled or used by the diseased person." To the doctor, therefore Simonsen's condition was not just a personal matter, for his presence at the hotel risked exposing other guests to this loathsome disease. That was why the doctor had pleaded with his patient to leave the hotel and return home.[33]

When Dr. Swenson returned to the hotel the next day, he was dismayed to hear that Simonsen had not left. Concerned, the doctor informed his friend, Mrs. Bristol, that

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[31] Ibid.

[32] Ibid.

[33] Ibid.

Simonsen was "afflicted with a 'contagious disease.'" The doctor instructed Mrs. Bristol "to be careful, to disinfect [Simonsen's] bedclothing, and to wash her hands in alcohol afterwards." Acting on this information, Mrs. Bristol immediately gathered Simonsen's belongings and expelled him from the hotel. Though Simonsen's embarrassment was regrettable, the doctor argued, urgent action had been needed in order to prevent further spread of disease.[34]

When the justices of the Nebraska Supreme Court assembled to adjudicate the dispute, they heard each of these narratives. First Simonsen presented his case, arguing that the doctor acted unethically and that the patient was entitled to damages. Simonsen's attorneys directed the justices toward a Nebraska statute that mandated the revocation of a physician's license upon the "betrayal of a professional secret to the detriment of a patient." The court was unmoved, however. After hearing Swenson's account, the justices ruled in favor of the doctor. In their decision, the justices stated, "no patient can expect that if his malady is found to be of a dangerously contagious nature he can still require it to be kept secret from those to whom, if there was no disclosure, such disease would be transmitted."[35]

To both doctors and lawyers, *Simonsen v. Swenson* was a landmark case. By establishing a precedent through which physicians' legal obligations could be overruled in the name of public health, as one legal scholar remarked, "the case [stood] for the triumph of medical altruism over legal duty."[36] In many ways, the case demonstrated the twentieth-century evolution of American medical ethics and physicians' changing commitment to confidentiality. During this time period, doctors did not completely retreat from their

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[34] Ibid.

[35] Ibid.

[36] Ibid.

obligations to medical confidentiality. Rather, by mid-twentieth century, what had once been one of several central tenets of the physician-patient relationship became merely one of many often-conflicting moral duties that physicians were expected to maintain.

Moreover, by the early twentieth century, medical ethics and physician-patient privilege no longer served the same functions that they once had. In the mid-nineteenth century, doctors had championed medical ethics and physician-patient privilege as one of few powerful indicators of their own professional status. A century later, owing to the myriad changes that had cemented physicians' control over the medical profession, such efforts were no longer necessary. By the 1920s, the sectarian battles of the nineteenth century were ancient history. Physicians had managed to secure stronger licensing laws, reformed medical education, and, all the while, maintained control over the medical profession—weathering incursions from corporations and mutual aid societies. The development of antibiotics and other technological advances in the mid-twentieth century further bolstered the reputation and standing of physicians.[37]

As physicians became less dogmatic in their support for a strict code of medical ethics, they opened space for the critics of physician-patient privilege to dictate policy. The combination of staunch legal criticism, as systematically spelled out in Wigmore's treatise, and the increasing ambivalence of the medical profession, as signaled in the ethical revisions of 1912, had three profound effects on the policy of privilege going forward through the rest of the twentieth century: 1) the spread of privilege stalled and few new statutes were adopted; 2) many states revised their privilege statutes to limit the applications of physician-patient privilege; and 3) legal reformers pushed for uniformity between state and federal legal

[37] Starr, *The Social Transformation of American Medicine*, 198-232.

codes and, in doing so, championed sweeping reforms that threatened to get rid of physician-patient privilege altogether.

As legal scholars railed against physician-patient privilege and the medical profession increasingly embraced laissez-faire medical ethics, the spread of the physician-patient privilege that gained ground throughout the nineteenth century against the precedent established in the Duchess of Kingston's trial slowly came to a halt. With the exception of the territories of Puerto Rico (1911) and the Virgin Islands (1920), no new jurisdictions adopted physician-patient privilege between 1906 and 1925.[38] While the law continued to evolve though judicial interpretation and occasional amendments to these codes, most legal commentators agreed that the spread of privilege effectively stopped by about 1930.[39] Only Kentucky, New Mexico, and Louisiana adopted weak privilege statutes in the mid-twentieth century, but these laws, which applied only to the recording of births and deaths (in the case of Kentucky), to venereal disease and workers' compensation cases (in the case of New Mexico), or to criminal but not civil actions (in the case of Louisiana), bore little resemblance to the strong privilege statutes of the nineteenth century.[40]

At the same time, many states revised their laws in ways that made the privilege less absolute. To judges and legal scholars, the ideal solution to the problematic applications of privilege in life insurance and accident cases was a complete and total repeal of privilege statutes. In most cases, however, it proved far easier to amend and limit the various statutes

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[38] Wigmore, *On Evidence* 3rd ed. Vol. 8, p. 803-805.

[39] DeWitt, *Privileged Communications Between Physician and Patient*, 16.

[40] The Kentucky statutes did, however, create a much stronger psychologist-patient privilege. DeWitt, *Privileged Communications Between Physician and Patient*, 455, 460-461. For an accurate list of statutes in the intervening period, see Wigmore, *On Evidence* 2nd (1923) or 3rd (1940) eds.

in effect.[41] Over the course of the early-twentieth century, numerous jurisdictions amended their statutes, limiting the applications of physician-patient privilege to specific classes of litigation.

In 1900, almost every privilege statute on the books existed in its original form. In general, these statutes were simple, one-sentence provisions that stated clearly and unambiguously that medical secrets could not be revealed in the courtroom.[42] California's statute, first adopted in 1853, was representative of these early laws:

> A licensed physician or surgeon cannot without consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was necessary to enable him to act for the patient.[43]

By the turn of the century, many legal scholars had come to see this statute, along with the myriad others in effect throughout the United States, as woefully outdated. Accordingly, in 1901, the California legislature passed an amendment to the statute that prevented the use of privilege in cases "in which the treatment of the patient by the physician or surgeon is in issue"—an obvious response to the abuse of privilege in malpractice cases. In 1917, the state legislature again amended the statute, adding a waiver that could be executed by deceased patients' spouses or children in addition to provisions barring the privilege from wrongful death and personal injury suits. By 1917, California's privilege statute had evolved from a single sentence that guaranteed physician-patient privilege to read as follows:

> A licensed physician or surgeon cannot without consent of his patient, be examined in a civil action as to any information acquired in attending the patient which was

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[41] For a clear and forceful example of this legal argument, see: Purrington, "An Abused Privilege." See also: Bach, "The Medico-Legal Aspect of Privileged Communications;" and Purrington, "A Recent Case of Patient's 'Privilege.'"

[42] For a complete list of these statutes, see Wigmore, *On Evidence* 1st ed., vol. 4, 3348-3349.

[43] Ibid., 3348.

> necessary to enable him to act for the patient. Provided, however, that after the death of a patient, the executor of his will or the administrator of his estate of the surviving spouse of the deceased, or, if there be no surviving spouse, the children, of the deceased personally, or, if minors, by their guardian, may give such consent, in any action proceeding brought to recover damages on account of the death of the patient; provided, further that where any person brings an action to recover damages for personal injuries, such action shall be deemed to constitute a consent by the person bringing such action that any physician who has prescribed for or treated said person and whose testimony is material in said action shall testify; and provided, further, that the bringing of an action to recover the death of a patient, by the executor of his will, or by the administrator of his estate, or by the surviving spouse of the deceased, or if there be no surviving spouse, by the children personally, or if minors, by their guardian, shall constitute a consent by such executor, administrator, surviving spouse or children or guardian, to the testimony of any physician who attended said deceased.[44]

While the new law severely limited the applications of physician-patient privilege, it also created a tangled mess of legalistic jargon and effectively rendered the earlier statute illegible to all but the savviest legal scholar.[45]

The evolution of privilege in California was hardly exceptional. Over the course of the early-twentieth century, every jurisdiction amended their privilege statute in some form. By mid-century, nearly every state had adopted some form of a waiver through which patients could allow their secrets to be divulged in the courtroom. Some states included implied waivers that were activated in certain classes of litigation or whenever patients made passing reference to their medical records. For example, in 1909, the Michigan legislature passed an amendment to the state's privilege statute, barring the use of privilege in malpractice suits. Likewise, most states added qualifying language that limited privilege to specific kinds of litigation. Many states barred physician-patient privilege from criminal trials. Others adopted provisions that enabled doctors to testify

[44] Ibid.

[45] Wigmore, *On Evidence* 4th ed. vol. 8, 804.

to specific facts. In 1923, for example, Minnesota amended its statue to allow a physician to testify to "the pregnancy of his patient without her consent."[46]

The cumulative effect of all of these changes was to severely limit the applications of physician-patient privilege. At the same time, the fractured nature of these numerous reforms meant that state laws gradually diverged from one another. While the many statutes adopted in the nineteenth century all shared similar language—some were identical to one another—the privilege statutes of the twentieth century often bore little resemblance to one another.

In this way, the evolution of physician-patient privilege mirrored other developments in the history of American law. In general, the statutes and precedents governing courtroom procedure were cobbled together over the course of several centuries in response to disparate factors—codification and other reform movements, landmark cases and novel interpretations of longstanding precedent, as well as the more mundane realities of everyday legal practice. The result was a complicated and varied legal landscape. Standards of legal practice varied between federal and state jurisdictions as well as from state to state. As with physician-patient privilege, the laws of one jurisdiction were often incompatible or at odds with the laws of another.

The lack of uniformity between different jurisdictions had long troubled lawyers and legal reformers alike. Beginning with codification movements in the mid-nineteenth century and continuing through various other schemes and measures, legal scholars had long sought to impose uniformity on courtroom procedure and the law of evidence. More often than not, however, such measures succeeded only in introducing further confusion. All the while

[46] Wigmore, *On Evidence* 3rd ed., 805.

the number of statutes and precedents governing various aspects of courtroom procedure continued to grow. Between 1885 and 1914, "the number of volumes of appellate court cases increased from about thirty-five hundred… to almost nine thousand… thus making the sheer bulk of case law almost overwhelming."[47]

In the mid-twentieth century, legal scholars led a series of reform movements intended to bring order to the sprawling mass of precedents and statutes that comprised the law of evidence. First, in the 1940s, the American Law Institute (ALI)—an organization of progressive attorneys, judges, and law professors—assembled to create a model code of evidence. The stated goal was to examine the laws in effect in every state and to compile a uniform code that blended the diffuse and contradictory statutes of each into a singular volume. The ALI hoped that every state would eventually adopt its *Model Code of Evidence* as its new evidentiary code.

Led by Harvard Law Professor Edmund Morgan, the ALI committee that drafted the *Model Code* was vehemently opposed to the expansion of evidentiary privileges. On the subject of privileged communications, Morgan stated bluntly, "We are hoping to make the rules which deal with the exclusion of evidence as narrow as possible."[48] To this end, the committee used Wigmore's instrumental criteria as a means to test various evidentiary

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[47] Beginning in 1879, the West Publishing Company began cataloging and distributing literature on the various precedents and rules in effect, but "its National Reporter system only made contradictory precedents more available to both sides in a dispute." Likewise, the National Conference of Commissioners on Uniform State Laws, which was founded in 1892, "convinced some states to adopt several uniform statutes, but these measures barely touched the great bulk of the common law." Nor did a standing committee founded by the American Bar Association in 1888 fare any better. Hall, *The Magic Mirror*, 268.

[48] American Law Institute, *Proceedings* 66 (July 1, 1940-June 30, 1941), 66-100. Quote at p. 76. On Morgan's opposition to privilege, see also: Edmund M. Morgan, "Some Observations Concerning a Model Code of Evidence," *University of Pennsylvania Law Register* 89:2 (December 1940), 145-165; Edmund M. Morgan, "Privileged Communications: Law vs. Ethics," Professor Morgan's Address, Edmund M. Morgan Jr. Papers, Special Collections, Jean and Alexander Heard Library, Vanderbilt University. In fact, Morgan's opposition to privileges was so well known as to be included in his obituaries: Charles E. Wyzanski Jr., "Edmund M. Morgan, 1878-1966," Harvard Law Review 97:8 (June 1966), 1537-1540.

privileges, hoping to exclude as many as possible. Though physician-patient privilege was deliberately omitted from every draft, a weak privilege was added before the final document was promulgated "probably to placate the medical profession."[49] The document had little effect on the policy of physician-patient privilege however, as the authors of the ALI's model code could not convince states to adopt the *Model Code* as law.

In the wake of the ALI's failure to initiate substantive reform of the rules of evidence, legal critics became increasingly vocal. Morgan and his peers turned to law journals to champion the *Model Code* and to call for other reforms that might lend some semblance of order to the nation's many separate, often uneven, and sometimes contradictory evidentiary codes.[50] Finally, in the late 1950s, the American Bar Association successfully pressured the United States Judicial Conference to take up the issue. Over the ensuing years, multiple committees of judges, lawyers, and law professors convened to "to study the advisability and feasibility of uniform rules of evidence for use in Federal courts" and, ultimately, to draft a new *Federal Rules of Evidence*.[51]

The Judicial Conference Committee, like the ALI committee before it, regarded privileges as "hindrances which should be curtailed."[52] Citing John Henry Wigmore's "view

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[49] DeWitt, *Privileged Communications Between Physician and Patient*, 20. Morgan's notes merely state that the privilege was added "contrary to the recommendations of the drafting committee." Edmund M. Morgan, "Notes on Proposed Model code of Evidence," Edmund M. Morgan Jr. Papers, Special Collections, Jean and Alexander Heard Library, Vanderbilt University.

[50] The literature calling for and discussing various means of legal reform during this period was voluminous. See, for example: Edmund M. Morgan, "The Future of the Law Of Evidence," *Texas Law Review* 29:5 (May 1951), 587-610; Edmund M. Morgan, "Practical Difficulties Impeding Reform in the Law Of Evidence," *Vanderbilt University Law Review* 14:3 (June 1961), 725-740; Mason Ladd, "Uniform Evidence Rules in the Federal Courts," *Vanderbilt University Law Review* 49:4 (1963), 692-716; David Louisell and Byron M. Crippin Jr., "Evidentiary Privileges," *Minnesota Law Review* 40:4 (1956), 413-436.

[51] Imwinkelried, *The New Wigmore: Evidentiary Privileges*, 222.

[52] Ibid.

that many statutory privileges were largely the product of effective lobbying by special interest groups that wanted the prestige of a privilege, Professor Edward Cleary, the committee's reporter, argued that 'privileges often operated as 'blockades' to the quest for truth… and stated that the effective functioning of the courts required 'invasions of privacy' in the form of judicial rulings rejecting privilege claims."[53] Accordingly, when the Judicial Conference Committee submitted its proposal to Congress, the proposed *Federal Rules* limited the applications of various privileges:

> Rule 5-01: Except as otherwise provided by the Constitution of the United States or provided by act of Congress, and except as provided in these rules and in the Rules of Civil and Criminal procedure, no person has a privilege to:
>
> a) Refuse to be a witness; or
> b) Refuse to disclose any matter; or
> c) Refuse to produce any object or writing; or
> d) Prevent another from being a witness or disclosing and matter or producing any object or writing.[54]

Congress disapproved of the draft's proposed rule on privilege, however, and sent the committee back to the drawing board.

The committee returned with a second proposal that defined nine privileges that would remain protected in federal courts. In their nine exceptions, the committee included privileges between lawyer and client, psychotherapist and patient, husband and wife, as well as a privilege that protected communications to clergy. The committee's second draft also included a rule that expressly prevented the creation of any non-specified privileges. The committee intentionally omitted physician-patient privilege.[55]

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[53] Ibid., 222-223.

[54] Committee on Rules of Practice and Procedure, Preliminary Draft of Proposed Rules of Evidence for the United States District Courts and Magistrates 71 (March 1969).

[55] Federal Rules of Evidence, H.R. Rep. No 93-650, 93rd Congress, 1st Session 28 (1973), rule 501.

This too proved unsatisfactory to Congress. Each house of Congress then drew up its own revisions to the proposed *Federal Rules*. In June of 1973, the House put forward its proposal which included struck out the Judicial Conference Committee's proposed rule on privilege and replaced the nine enumerated privileges with a single rule that essentially left privilege law untouched. The Senate followed, largely endorsing the House's bill, and the bill went to Committee to iron out the minor differences between the House and Senate versions of the bill. When the *Federal Rules of Evidence* were signed into law in 1975, the final version of Rule 501 read:

> Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme court pursuant to statutory authority, the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience: Provided, That in civil actions with respect to a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person government, State, or political subdivision thereof shall be determined in accordance with State law.[56]

Thus, the nation's federal courts remained where they had been since the Constitution went into effect: common law precedents, following judicial interpretations of the Duchess of Kingston case, would continue to bar any parties from invoking a physician-patient privilege.

Since 1975, the status of physician-patient privilege has remained relatively stable. Federal courts, governed by the *Federal Rules of Evidence*, continue to deny all claims to privilege in criminal cases on the grounds of centuries of legal precedent. Most states, on the other hand, observe some form of physician-patient privilege—most often a reworked version of the state's original nineteenth-century legislation that limits the potential applications of privilege to specific classes of litigation.

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[56] Ibid.

Nevertheless, doctors, lawyers, and sometimes patients continue to debate the merits of physician-patient privilege. Those in favor of the privilege continue to argue that it serves as a necessary guarantee of patients' privacy and that it facilitates a healthy doctor-patient relationship. Critics of the privilege, on the other hand, maintain that physician-patient privilege constitutes an unnecessary impediment to the judicial process. And yet, neither side can be content with the current state of the law. The numerous and often contradictory laws that govern the admissibility of medical evidence in different jurisdictions make physician-patient privilege at best a weak protection of patients' medical secrets. These laws—unenforceable in federal courts—do not do enough to ensure patients feel secure that their medical secrets will remain confidential. Yet, as many legal critics assert, the numerous statutes guaranteeing physician-patient privileges still constitute a considerable obstacle to an efficient judicial process.

These conflicts make understanding how and why these laws first came about all the more important. In tracing the evolution of physician-patient privilege over the course of the nineteenth and twentieth centuries, this dissertation shows that the laws that govern medical testimony in the courtroom were cobbled together in response to numerous contradictory impulses—including the advocacy of numerous physicians and medical societies on one hand and the criticism of prominent doctors and legal scholars on the other—and never intended as an ironclad protection of patients' right to privacy. Perhaps for these reasons, policymakers ought to consider reframing the law of privilege not as a matter of professionalization—as these laws have so often been framed—but rather as valuable tool that can be used to safeguard patients' privacy.

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