

SECRETS IN THE COURTROOM:  
THE ORIGINS OF PHYSICIAN-PATIENT PRIVILEGE IN AMERICA,  
1776-1920

by

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## THESIS ABSTRACT

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This thesis examines the nineteenth-century 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 thesis seeks to place 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.

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## TABLE OF CONTENTS

Chapter	Page
I. INTRODUCTION .....	1
II. CREATING A PRECEDENT: MEDICAL CONFIDENTIALITY AND THE DUCHESS OF KINGSTON'S CASE.....	8
III. CODIFICATION AND THE ORIGINS OF PHYSICIAN-PATIENT PRIVILEGE.....	34
IV. MEDICAL ETHICS IN THE EARLY NINETEENTH CENTURY .....	55
V. PHYSICIAN-PATIENT PRIVILEGE AND THE MEDICAL PROFESSION IN THE LATE NINETEENTH CENTURY.....	73
VI. PHYSICIAN-PATIENT PRIVILEGE IN THE TWENTIETH CENTURY .....	98
VII. EPILOGUE: MEDICAL CONFIDENTIALITY TODAY .....	117
REFERENCES CITED .....	121

## LIST OF TABLES

Table	Page
1. Physician-Patient Privilege (through 1850) .....	49
2. Physician-Patient Privilege (1850-1875).....	53
3. Physician-Patient Privilege (1880-1906).....	91

# CHAPTER I

## INTRODUCTION

Medical confidentiality mandates that doctors work to protect their clients 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 patient’s 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.

These contradictions are the product of the slow evolution of physician-patient privilege. This study surveys the history of the privilege throughout the nineteenth century, a period when the majority of U.S. states adopted the privilege. Between 1828 and 1906, thirty states, along with the District of Columbia adopted some form of physician-patient privilege. Compared to this period of intense legislative activity, relatively few states adopted the privilege in the twentieth century. With almost all of these nineteenth-century laws still in effect, nineteenth century developments in medical confidentiality continue to shape American law and medical practice in the twenty-first century.



Privileged communications, a legal doctrine allowing specific pieces of evidence to be excluded from the courtroom for the purposes of protecting professional secrets, has long been debated within legal scholarship. In common law jurisdictions, conversations between attorney and client were the first communications to be excluded from court testimony. Legal scholars have found evidence to suggest that attorney-client privilege was infrequently applied to judicial decisions in the early seventeenth century. John Henry Wigmore, one of the most prominent scholars of evidence law in the early twentieth century, stated that “the history of this privilege goes back to the reign of Elizabeth, where the privilege already appears as unquestioned.”<sup>1</sup> While recent scholarship has questioned this facile history of attorney-client privilege, arguing that the privilege did not take its modern form until the early nineteenth century,<sup>2</sup> the first court judges to rule on physician-patient privilege, each stressed that attorney-client privilege had long been recognized as a sound legal doctrine.<sup>3</sup>

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<sup>1</sup> 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* (Boston: Parkhill and Co., 1904), quote at 3193, for a history of attorney-client privilege, see pages 3193-3225.

<sup>2</sup> For an example of this argument, see: Geoffrey Hazard, “An Historical Perspective on Attorney-Client Privilege,” *California Law Review* 66 (1978), pp. 1061-1091.

<sup>3</sup> See Lord Mansfield’s treatment of the attorney, Berkley in the Duchess of Kingston’s Trial for Bigamy: *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: printed for Charles Bathurst, in Fleet-Street, 1776), 120. and Justice Buller’s remarks in *Wilson v. Rastall: Term Reports in the Court of King’s Bench: from*

In comparison to attorney-client privilege, physician-patient privilege has proven far more controversial. A legal guarantee that doctors cannot be compelled to reveal patients' secrets in courts of law, physician-patient privilege is one of the strongest guarantees of medical confidentiality. The privilege implies that doctors' ability to serve their patients effectively and efficiently is more important than the basic functions of law. Accordingly, medical practitioners have often pursued physician-patient privilege as a powerful indicator of the status and esteem of the profession. Legal scholars, on the other hand, have often opposed the privilege, suggesting it only serves as an impediment to the judicial process.

Yet the medical and legal positions on physician-patient privilege were never fixed. 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. 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 challenge to their professional autonomy. Similarly, legal scholars have, at times, embraced physician-patient privilege as a tool to make the judicial process more legible, while, at others, as an unwanted impediment to the judicial process.

Analyzing the medical and legal developments that led much of the United States to adopt physician-patient privilege, this study places the evolution of physician-patient privilege within the larger histories of the professionalization of

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*Michaelmas Term 31<sup>st</sup> George III. 1790 to Trinity Term, 32<sup>nd</sup> George III. 1792. Both Inclusive* (London: 1799) Both will be discussed in later chapters.

medicine and the codification of American law. Over the past thirty years, historians have produced a vibrant scholarship on these issues. The social history of medicine has spawned multiple comprehensive studies of the professionalization of medicine in the nineteenth century,<sup>4</sup> as well as the interrelated histories of medical ethics<sup>5</sup> and the relationship between medicine and the law.<sup>6</sup> To date, however, no scholar has investigated the long and tangled relationship between physician-patient privilege and the medical profession in the United States.<sup>7</sup> For scholars interested in this issue, legal treatises continue to offer the most thorough histories of physician-patient privilege, yet the historical context that shaped the long evolution of physician-patient privilege is largely absent from these studies.<sup>8</sup> This work seeks to

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<sup>4</sup> For discussion of the professionalization of medicine, this study relies primarily upon the works of: 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); John Harley Warner, *The Therapeutic Perspective: Medical Practice, Knowledge, and Identity in America, 1820-1885* (Princeton: University Press, 1986); and William Rothstein's *American Physicians in the Nineteenth Century: From Sects to Science* (Baltimore: Johns Hopkins University Press, 1972).

<sup>5</sup> For discussion of these topics, this study will build upon the work of Robert Baker's *Before Bioethics: A History of American Medical Ethics from the Colonial Period to the Bioethics Revolution* (Oxford: University Press, 2013); and Donald E. Konold, *A History of American Medical Ethics, 1847-1912* (Madison: 1962).

<sup>6</sup> William Novak, *The People's Welfare: Law and Regulation in Nineteenth-Century America* (Chapel Hill: University of North Carolina Press, 1996). Much of my analysis of medico-legal developments is heavily influenced by James C. Mohr's *Doctors and the Law: Medical Jurisprudence in Nineteenth-Century America* (Baltimore: Johns Hopkins University Press, 1996).

<sup>7</sup> Angus Ferguson's *Should a Doctor Tell? The Evolution of Medical Confidentiality in Britain* (Farnham: Ashgate, 2013) offers an overview of similar developments in the United Kingdom.

<sup>8</sup> Of these texts, Wigmore's *On Evidence*, first published over a century ago, continues to be the most comprehensive.

integrate the history of the evolution of these laws with contemporary scholarship on the history of medicine.

Many scholars have asserted that the physician-patient privilege was first invoked during the Duchess of Kingston's trial for bigamy in 1776. Chapter 1 examines this influential court case, focusing on the circumstances that led Caesar Hawkins, the Duchess's surgeon, to ask permission to withhold his patients' secrets. By placing this trial in its historical context, it becomes apparent that Hawkins did not claim privileged communications on behalf of his profession, but rather appealed to his status as a wealthy, aristocratic gentleman. If Hawkins did not advocate for privileged communications on behalf of his profession, the origins of physician-patient privilege must be attributed to later medico-legal developments.

The first statute guaranteeing medical confidentiality was enacted in New York in 1828. Over the next few decades, numerous states followed suit in adopting physician-patient privilege. Chapter 2 examines the wave of legislation that brought physician-patient privilege to much of the United States in the mid-nineteenth century. While scholars have rightly connected physician-patient privilege to the professionalization of medicine,<sup>9</sup> the earliest statutes were initially unnoticed by nineteenth century physicians. Instead, these statutes can be best explained as part of a codification movement that reshaped American law in the early nineteenth century. Codification enabled Americans to amend and reform the common law, producing new or revised statutory codes in numerous states. Each of the physician-

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<sup>9</sup> To the extent that the subject is discussed in histories of medical ethics, such as Konold's *A History of American Medical Ethics* or Baker's *Before Bioethics*, it is usually discussed in this context.

patient privilege statutes enacted in the first half of the nineteenth century were connected to larger codification movements. And yet medical developments in the first half of the nineteenth century gradually brought physician-patient privilege into medical discourse.

A small cadre of physicians sought to monopolize the medical profession in the mid-nineteenth century. In time, these doctors came to see physician-patient privilege as a powerful tool to enhance the status and reputation of the medical profession. Chapter 3 examines the rise of codified medical ethics and medical police that led doctors to embrace, and increasingly advocate for, the spread of physician-patient privilege. By formally acknowledging the privilege in the ethical codes of various local and, eventually, national medical societies, doctors signaled their desire to see the further spread of physician-patient privilege.

In the second half of the nineteenth century, doctors would emerge 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 the statutory protection of medical confidentiality. Chapter 4 examines the advocacy of doctors on both sides of this debate.

Chapter 5 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 over the first two decades of the twentieth century, each time reducing its proscriptive powers. At the same time, legal scholars also emerged as critics of the law. Foremost among these critics, John Henry Wigmore suggested that the privilege should be abolished altogether. 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.

## CHAPTER II

### CREATING A PRECEDENT: MEDICAL CONFIDENTIALITY AND THE DUCHESS OF KINGSTON'S CASE

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

The most common history of physician-patient privilege holds that the privilege was first invoked in 1776 during the Duchess of Kingston's trial for bigamy. Asked to reveal the intimate details of a longtime client, 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; betraying these secrets under any circumstances would damage the welfare of their patients and the honor of their profession. But the judge 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."<sup>1</sup> Since the eighteenth century, this brief aside by Lord Mansfield has been cited as a foundational legal precedent that denied

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<sup>1</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 120.

doctors any inherent claim to privileged communications. Over the course of nineteenth century, as doctors lamented the lack of a formalized physician-patient privilege, this assumption gradually became a staple of medico-legal texts in both Britain and the United States. Legal scholars accepted the same account of the trial's proceedings and celebrated the decision as a triumph of law over obstruction.<sup>2</sup>

In their arguments, both advocates and critics of physician-patient privilege have overlooked the peculiar circumstances surrounding the Duchess's trial. 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. Hawkins, a wealthy and successful surgeon, relied upon his relationships with aristocratic clients to gain social status, adopting the values and styles of the fashionable elite, including notions of gentlemanly honor. 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.

The unique circumstances and timing of the case, however, allowed this brief conversation to be transformed into a lasting legal precedent that seemingly addressed modern notions of medical confidentiality. The trial of a controversial figure in England's highest court naturally drew attention from laypersons and legal scholars alike, and the Duchess's case remains among the best recorded and

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<sup>2</sup> For an example of a legal critique of physician-patient privilege see John Henry Wigmore, *A Treatise on the Anglo-American System of Evidence in Trials at Common Law* 2<sup>nd</sup> ed. vol. 5 (Boston: Little, Brown, and Co., 1923), 201-227.



preserved of the era. Occurring in 1776, the trial took place in the midst of larger transformation of courtroom proceedings. The advent of adversarial criminal trials, with attorneys representing both prosecution and defense led to the formation of standardized rules of evidence. Lord Mansfield (whose ruling has been cited as a rejection of physician-patient privilege) was at the head of this movement; his decisions on numerous other legal issues formed crucial precedents that helped modernize English law. As the notions of gentlemanly honor subsided and the medical profession grew stronger in the early nineteenth century, legal scholars increasingly looked to the Duchess's trial as a legal precedent, ascribing the well-remembered case with modern notions of medical confidentiality and medical ethics.

At the time of the trial, however, few people were concerned about the conflicting duties of medical practitioners; the case invoked many more pressing issues. For some, the trial was an indictment of aristocratic vice and the notion that Peers could openly defy the laws of the realm. Others worried what ramifications the court's ruling might have on marriage law.<sup>3</sup> Many more simply looked to the trial as a source of entertainment. For five days, all of London eagerly awaited news of the Duchess's fate. Peers watched the proceedings from Westminster Hall, where, for a steep price, curious spectators could pay to witness the trial. Others followed the proceedings through daily recaps in the London papers. Each day, the spectacle began when lords and ladies, dressed in their finest clothes, made the procession to Westminster Hall. Once King George III had settled into his velvet chair, however, all

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<sup>3</sup> "To the Printer of the *Gazetteer*: Kingston Cause," *Gazetteer* (London, England), March 7, 1776.

eyes turned towards a stout fifty-six year old woman elegantly dressed in black. The Duchess of Kingston arrived with a small party of attendants, physicians, and three women the papers christened, "Iphigenia's Late Procession," a nod to a famed incident in which the Duchess arrived at a masquerade *en deshabelle*. Those expecting outrageous antics were largely disappointed, however. Apart from the dramatic entrance, the Duchess sat calmly through five days of accusations, restraining her sharp wit and theatrical tendencies.<sup>4</sup>

The trial 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. Born Elizabeth Chudleigh, the Duchess of Kingston inherited a minor title. Nevertheless, her father's losses in the South Seas Bubble coupled with his early death left no fortune to inherit. Yet with no money and only a minor title, Chudleigh managed to secure fame and fortune through a series of controversial affairs and marriages. Her rise to the top of British society was complete when an elderly benefactor managed to have Chudleigh, at the age of twenty-three, named maid of honor to Augusta, Princess of Wales. In court, Chudleigh's charm and beauty won her numerous suitors, yet she settled on Augustus John Hervey, a man of modest wealth. In order to maintain Chudleigh's appointment as maid of honor to the Princess of Wales, however, the ceremony was conducted in secret and, at the time, few people learned of the marriage. Shortly after their nuptials, Hervey, a

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<sup>4</sup> "Duchess of Kingston's Trial: Westminster Hall," *Craftsman or Say's Weekly Journal* (London, England), April 20, 1776; and Gillian Russell, *Women Sociability and Theatre in Georgian London* (Cambridge: Cambridge University Press, 2007), 169-173.

lieutenant in the British Navy, shipped off to sea for two years, leaving the Duchess to resume her life at court. During their brief, unhappy marriage, the couple had little contact. Despite the birth of a child, Hervey severed ties with Chudleigh after five years of marriage.<sup>5</sup>

Chudleigh soon became the mistress of Evelyn Pierrepont, the Duke of Kingston-Upon-Hull. Content in her new position, she dropped all claims of marriage to Augustus John Hervey. After a few years, however, it became apparent that the once-impooverished Hervey would soon inherit a fortune and become the Duke of Bristol. Seeing an opportunity to further secure her place in British society, Chudleigh quickly had their brief, clandestine marriage recorded. Though now official, it 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. The jactitation suit was settled in an ecclesiastical court in 1769. 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, Both Hervey and Chudleigh remarried. In 1773, however, her new husband, the Duke of Kingston, passed away, leaving all his property to Chudleigh, the new Duchess of Kingston. Controversy over the Duchess's marital status ensued when, in hopes of nullifying Chudleigh's

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<sup>5</sup> T.A.B Corley, "Chudleigh, Elizabeth," *Oxford Dictionary of National Biography* (Oxford; New York: Oxford University Press, 2004); and Russell, 154-158.

claims to the inheritance, the Duke's nephew, Evelyn Medows, indicted the Duchess for bigamy.<sup>6</sup>

The ensuing trial, set to take place in 1775, quickly captivated the British press. In newspaper headlines, the latest news on the bigamous Duchess often displaced reports of mounting tensions in America. Seeking 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.<sup>7</sup> 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 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."<sup>8</sup> 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

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<sup>6</sup> *Ibid.*, 569.

<sup>7</sup> Dircks, Phyllis T. "Foote, Samuel (*bap.* 1721, *d.* 1777)," *Oxford Dictionary of National Biography* (Oxford: Oxford University Press, 2004); and Russell, 158.

<sup>8</sup> Elizabeth Chudleigh, "Note to the Public," *Public Ledger* (London, England), August 15, 1775.

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.<sup>9</sup>

After several postponements on behalf of the Duchess's failing health, the trial began in April 1776. It quickly became the center of London social life. At her own request, the Duchess was tried as a Peer by the House of Lords. Throughout the trial's first two days, attorneys for both sides argued whether the Duchess's marital status—previously settled in 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."<sup>10</sup> Though the court's ruling stripped Chudleigh of her title as the Duchess of Kingston, recognition of her marriage to Hervey 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.

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<sup>9</sup> "For the Morning Post: To the Duchess of Kingston," *Morning Post and Daily Advertiser* (London, England), August 19, 1775, and Russell, 158-163.

<sup>10</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 154–156.

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.”<sup>11</sup> 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. 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. 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, he managed to convert his personal relationships into prestigious and lucrative appointments, including surgeon to the Prince of Wales and sergent-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

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<sup>11</sup> *Ibid.*, 119.

the time of the trial, Hawkins had reached the apex of a long and distinguished career. For decades, he had cultivated a network of powerful clients, using their patronage to propel him to the top of his profession.<sup>12</sup>

Hawkins's successes came in spite of a gradual weakening of the status of the medical profession. In the sixteenth 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 structure of the medical profession was thrown into disarray in 1704, when William Rose, an apothecary, 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.<sup>13</sup>

For many practitioners, greater competition weakened their professional status and undermined the potential for collective action. The Rose Trial crippled the Royal College, leaving individual practitioners to fend for themselves. At the

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<sup>12</sup> 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* (Oxford and New York: Oxford University Press, 2004).

<sup>13</sup> 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.

same time, a growing market for medical services and increased competition made doctors desperate to enhance their own name. Some used advertisements, authoring catchy jingles and slogans. Others turned to more dubious methods, hiring 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. Contemporary pamphlets and cartoons mocked the inefficacy of physicians with quips like, "While the doctors consult, the patient dies."<sup>14</sup> 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.

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, often garnering 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; a contemporary observer noted:

he 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

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<sup>14</sup> Porter, *Bodies Politic*, 142.



recourse to his advice as a physician, who did not remain desirous of gaining his friendship and enjoying his society as a companion.<sup>15</sup>

Dressed in powdered wigs, satin coats, buckled shoes, and tricorne 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.<sup>16</sup>

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 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 John 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

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<sup>15</sup> 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 Roy Porter, *Bodies Politic* at p. 148.

<sup>16</sup> Rosemary O'Day, *The Professions in Early Modern England, 1450-1800: Servants of the Commonwealth* (Harlow, England; New York: Longman, 2000), 243–247.

he “thought [news of his desire for a divorce] would be less shocking to be carried by and received from, a person she [the Duchess of Kingston] knew, than from any stranger.”<sup>17</sup> 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.<sup>18</sup>

Similarly, Caesar Hawkins’s views toward medical confidentiality embodied contradictions within the developing medical profession. Today, medical confidentiality invokes notions of patients’ rights. In the late eighteenth century, however, medical practitioners were much less committed to maintaining patients’ secrets. In professional disputes between practitioners, physicians and surgeons frequently revealed patients’ names and medical problems to the public.<sup>19</sup> Just four years before Caesar Hawkins invoked “professional honor” in the Duchess’s trial, he engaged in a public debate with Samuel Lee, a well-known surgeon and former

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<sup>17</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 121.

<sup>18</sup> *Ibid.*, 122–125.

<sup>19</sup> Baker, *Before Bioethics*, 53-56.

colleague of Hawkins at St. George's Hospital.<sup>20</sup> 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.<sup>21</sup> 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.<sup>22</sup> 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.

By asking to be absolved from testifying, Hawkins departed from the contemporary norms of his profession. In the eighteenth century, physicians frequently testified in civil and criminal proceedings without objection. Before the trial, for example, several physicians were called in front of the House of Lords to

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<sup>20</sup> John Ranby and Caesar Hawkins, *The True Account of All the Transactions before the Right Honourable the 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: printed for J. and P. Knapton in Ludgate-Street, 1754).

<sup>21</sup> 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* (London, England), February 16, 1773.

<sup>22</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 120.

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."<sup>23</sup> 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.

Hawkins, a successful surgeon who had no reservations about revealing some patients' personal information, would have been acutely aware of the expectations of physicians in courtroom. Because the testimony of physicians and surgeons was frequent and uncontroversial, he likely 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 belief in 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, serving 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 amongst the aristocracy was under attack. While Hawkins could not claim privilege as a medical practitioner, he hoped that his status at the top of

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<sup>23</sup> "Debates in the House of Lords: The Duchess of Kingston's Trial," *Middlesex Journal and Evening Advertiser* (London, England), December 12, 1775 - December 14, 1775.

the profession and close relationships with prominent members of aristocratic society might offer him the privileges of gentlemanly honor. Accordingly, Hawkins's claims to professional honor were not based upon the notion that physicians were obligated to protect the intimate secrets of their patients. Instead, Hawkins argued that his status at the top of English medicine gave him specific privileges that would have been denied to many other practitioners.

Hawkins's appeal to "professional honor" mirrored other claims to confidentiality that arose during the trial. 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. Accordingly, her claims to privileged communications were met with little sympathy; The Lord High Steward refused Fettiplace's request, requiring her to answer all questions.<sup>24</sup>

Next, the prosecution called Lord Barrington. Again, the witness was a close friend of the Duchess and wished to be excused from revealing information revealed to him though 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."<sup>25</sup> Though this appeal, with its references to personal honor, mirrored those made by Hawkins and

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<sup>24</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 126.

<sup>25</sup> *Ibid.*, 127.

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.”<sup>26</sup> Against Lord 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 of him.<sup>27</sup> 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.<sup>28</sup>

In each of these three cases—Hawkins, Fettiplace, and Barrington—the witness desired to withhold information from the court that might incriminate the Duchess, arguing that revealing the Duchess’s secrets would constitute a violation of their honor. In the eighteenth century, honor referred to the recognition of one’s social status. To Samuel Johnson, the word was synonymous with “dignity, high rank,” and “title.”<sup>29</sup> Men and women of honor were expected to abide by a set of

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<sup>26</sup> *Ibid.*

<sup>27</sup> *Ibid.*, 128–129.

<sup>28</sup> *Ibid.*

<sup>29</sup> 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,*

norms that comprised the 'code of honor.' Dictating the rules by under which aristocratic society functioned, "the code of honour was the moral code of the often irreligious man of fashion."<sup>30</sup> It was generally accepted that honor was a unique privilege of aristocratic society, conferring distinct responsibilities and expectations. 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.<sup>31</sup>

Though these rules were often confined to the fashionable elite, historian Donna Andrew has argued that codes of honor were widely accepted both within and outside gentile 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 could and often did conflict with the rule of law.<sup>32</sup> 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.<sup>33</sup>

Likewise, in the courtroom, the assertion that individuals were bound to the norms

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*and An English Grammar.. In Two Volumes.,* The third edition., vol. Volume 1 (London: 1765), 1011.

<sup>30</sup> Donna T Andrew, "The Code of Honour and Its Critics: The Opposition to Duelling in England, 1700-1850," *Social History* 5:3 (1980): 415.

<sup>31</sup> 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.

<sup>32</sup> Andrew, "The Code of Honour and Its Critics," 413.

<sup>33</sup> Donna T Andrew, *Aristocratic Vice: The Attack on Duelling, Suicide, Adultery, and Gambling in Eighteenth-Century England* (New Haven and London: Yale University Press, 2013); V. G Kiernan, "The Duel in Early Modern England: Civility, Politeness and Honour.," *English Historical Review* 120:485 (2005).

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 the deference of his inferiors. For Hawkins and Fettiplace, however, their place in aristocratic society was much more precarious. Neither held an aristocratic title. Surrounded by the most prestigious men and women in English society, both would have been perceived as outsiders. Within the context of the trial, it is hardly surprising that their claims to honor, a privilege of fashionable elites, would have been granted little sympathy.

In the midst of the trial's fifth and final day, a fourth witness also asked to be absolved from testifying. Unlike the witnesses before him, however, William Berkley, Augustus John Hervey's attorney, framed his query around a well-established legal precedent. Dating back to the late sixteenth century, attorney-client privilege had been an accepted custom in English courtrooms. In contrast to earlier claims to privileged communications, Berkley drew upon centuries of legal



practice maintaining that attorneys could not be required to testify against the interests of their clients.<sup>34</sup> Before judges or attorneys asked Berkley a single question, he immediately stated,

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.<sup>35</sup>

While Berkley, like other witnesses, framed his request around notions of honor, his appeal differed from earlier requests by nodding to established legal precedents. 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.<sup>36</sup> 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 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.<sup>37</sup>

Here, Mansfield's rhetoric differed markedly from his responses to earlier requests for privileged communications. Instead of immediately dismissing the claim, he

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<sup>34</sup> A history of attorney-client privilege can be found in Wigmore, *On Evidence* 1<sup>st</sup> ed., 3194-3256.

<sup>35</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 146.

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

acknowledged the privilege, but maintained that it did not apply in this instance. Berkley was allowed only to answer questions regarding his conversations with Anne Craddock, another witness, and did not reveal confidential information entrusted in him by his client, Augustus John Hervey.<sup>38</sup> Modern legal scholars might suspect that the first mention of physician-patient privilege would resemble this exchange between Mansfield and Berkley—a careful and measured evaluation of legal principles, seeking to define the limits of established privileges. Yet the differences are telling. Hawkins’s appeal did not draw upon the established expectations of his profession. Instead, Hawkins based his claims on notions of gentlemanly honor and aristocratic privilege.

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. 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 indiscretion whatsoever”<sup>39</sup>—emphasized a conflict between Hawkins’s legal and professional duties. Though neither Mansfield nor Hawkins would have

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<sup>38</sup> *Ibid.*, 146–147.

<sup>39</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*, 120.

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 John Hervey.<sup>40</sup> 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 Lord 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.<sup>41</sup> 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

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<sup>40</sup> *Ibid.*, 121.

<sup>41</sup> James Oldham and William Murray Mansfield, *The Mansfield Manuscripts and the Growth of English Law in the Eighteenth Century*, vol. 1 (Chapel Hill: University of North Carolina Press, 1992), 201.

transformations taking place in contemporary law, Mansfield often used his position on the 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.<sup>42</sup>

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.<sup>43</sup> 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

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<sup>42</sup> *Ibid.*, 1:197.

<sup>43</sup> "Debates in the House of Lords: The Duchess of Kingston's Trial" *Middlesex Journal and Evening Advertiser* December 12, 1775 - December 14, 1775; and "Debates in the House of Lords: The Duchess of Kingston's Trial," *Middlesex Journal and Evening Advertiser*, December 14, 1775 - December 16, 1775.

challenge to the authority and autonomy of Britain's ecclesiastical courts.<sup>44</sup> Others worried that the trial might challenge the legality of divorces in England.<sup>45</sup>

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.<sup>46</sup> 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.<sup>47</sup> 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

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<sup>44</sup> "For the Morning Post: Kingston Cause," *Morning Post and Daily Advertiser* (London, England), January 2, 1776.

<sup>45</sup> "To the Printer of the Gazetteer: Kingston Cause," *Gazetteer* (London, England), March 7, 1776.

<sup>46</sup> "Classified Ads," *General Evening Post* (London, England), April 30, 1776 – May 2, 1776; and Russell, 168-174.

<sup>47</sup> *The Trial of Elizabeth Duchess Dowager of Kingston*.

as precedent to show that surgeons had no legal claim to confidentiality and could be compelled to testify in court.<sup>48</sup> Reprinted several times throughout the late-eighteenth century, Hargrave's collection demonstrates that legal scholars almost immediately began using the Duchess's trial as a source for legal precedent.

This process fits neatly into the larger history of the radical transformation of legal procedure that took place during the eighteenth century. The advent of adversarial criminal trials with attorneys representing both prosecution and defense led to the formalization of rules for the admissibility of evidence.<sup>49</sup> 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.<sup>50</sup> 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

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<sup>48</sup> Francis Hargrave, *A Complete Collection of State-Trial and Proceedings for High-Treason and Other Crimes and Misdemeanors* Vol. 11 (London: T. Wright, 1776), 504.

<sup>49</sup> 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): 221-67; J. H Langbein, "Historical Foundations of the Law of Evidence: A View from the Ryder Sources," *Columbia Law Review* 96:5 (1996): 1168-1202.

<sup>50</sup> Leonard MacNally, *The Rules of Evidence on Pleas of the Crown* (London: J Butterworth, 1802), 247-248.

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.<sup>51</sup>

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 transformed from a referendum on 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 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, 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 the privileges for an entire profession. Under this interpretation, Hawkins

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<sup>51</sup> 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 Gray”s Inn, Esq. Barrister at Law*, vol. 2 (London: printed for T. Cadell, Strand; and Whieldon and Butterworth, Fleet-Street, 1793), 719.

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.<sup>52</sup> While these 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.<sup>53</sup> 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.

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<sup>52</sup> For an example of this argument, see 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.

<sup>53</sup> Ferguson, *Should A Doctor Tell?*



## 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)

In the United States, the origins of physician-patient privilege can be traced to the early nineteenth century. In 1800, no common law jurisdiction in Britain or the United States recognized physician-patient-privilege. The precedent established in the Duchess of Kingston’s trial remained unchallenged until 1828, when New York became the first state to recognize medical confidentiality in the courtroom. By the 1850s, numerous states had followed New York’s example, incorporating physician-patient privilege into their newly revised legal codes.

The proliferation of these statutes can be attributed primarily to developments within the legal profession rather than the medical profession. The early nineteenth century brought increasing demand for codification, the process of collecting and restructuring the law into an easily accessible legal code. The effects of this legal movement were myriad and diverse—most fall beyond the scope of this study.<sup>1</sup> Yet one product of codification was the advent and rapid spread of

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<sup>1</sup> General studies of the codification movement can be found in numerous legal surveys, including Kermit Hall’s *The Magic Mirror: Law in American History* 2<sup>nd</sup> ed. (New York: Oxford University Press, 2009) or Lawrence Friedman’s *A History of American Law* 3<sup>rd</sup> ed. (New York: Simon and Schuster, 2005). Charles Cook, *The American Codification Movement: A Study of Antebellum Legal Reform* (Westport:

physician-patient privilege. By challenging the basic assumptions of the old common law system, codification provided the impetus to reexamine established legal doctrines, including well-established legal precedents such as Lord Mansfield's ruling on physician-patient privilege. At the same time, many of the greatest proponents of codification actively sought to revise and reshape American law. New York's influential statute on physician-patient privilege was enacted as part of a sweeping revision of that state's judicial code. Likewise, all of the ensuing statutory guarantees of medical confidentiality were incorporated into the statute books through codification.

This chapter charts the evolution of physician-patient privilege during the early nineteenth century, focusing on the legal developments that facilitated the rapid spread of the privilege. For historians of medicine and the law, this period poses several dilemmas. On its face, the rapid spread of physician-patient privilege would seem to suggest that privileged communications must have been an important, and oft-discussed topic throughout the first half of the century. Yet it was not. Instead, the privilege remained an arcane and seemingly inconsequential legal doctrine, certainly not a high profile issue. In fact, the issue of physician-patient privilege nearly vanished from both legal and medical discourse. Many of the earliest statutes were enacted without fanfare and physician-patient privilege was seldom exercised in the courtroom.

Despite the lack of interest from nineteenth-century scholars, however, the legislation enacted during first half of the century would prove extremely

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Greenwood Press, 1981) offers a thorough discussion of the codification movement and its effects on American law.

influential. The laws themselves offered a powerful challenge to established legal precedent, providing the groundwork for future legislation. Many later laws merely parroted the language of these early statutes. At the same time, legal interpretations of Lord Mansfield's ruling further hardened into an unbending legal precedent that applied to all jurisdictions without a statute. By the middle of the nineteenth century, the fault lines between privileged and non-privileged communications had been well established.

Until 1828, medical witnesses throughout the United States were, in theory, governed by the precedent established in the Duchess of Kingston's trial for bigamy. While American legal records from the early nineteenth century are fleeting and often incomplete, later legal scholarship suggests that the matter was seldom considered in American courtrooms. The few instances in which medical confidentiality was invoked in the courtroom demonstrate that American courts were often unable to reach a consensus on the issue. *Sherman v. Sherman*, a 1793 divorce case, upheld the precedent established in the Duchess of Kingston's trial when a doctor's testimony was allowed despite the fact that "all he could testify came to his knowledge in confidence." Later legal scholars have cited this case as proof that the precedent "would probably have been acknowledged as a common-law principle in every American court."<sup>2</sup> Other sources suggest, however, that some courts were willing to grant physicians privileged communications. The Medical Society of the State of New York's 1823 *System of Ethics* claimed that, in 1800, the Pennsylvania legislature barred the disclosure of medical secrets in the courtroom

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<sup>2</sup> Wigmore, *On Evidence* 1<sup>st</sup> ed., 3348.

on the grounds that these communications were analogous to privileged communications between priest and penitent.<sup>3</sup> Neither of these cases ever came to be considered a source of precedent.

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, had been 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.<sup>4</sup>

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. Within a few decades of the Duchess's trial, the historical meaning of the brief exchange between Mansfield and Hawkins had changed drastically.

Buller's speech articulated what has become the modern reading of the trial—that Mansfield denied Hawkins physician-patient privilege, establishing a precedent for all common law jurisdictions. In doing so, this conversation between judge and

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<sup>3</sup> Medical Society of the State of New York, *System of Ethics*, 17-18.

<sup>4</sup> *Term Reports in the Court of King's Bench: from Michaelmas Term 31st George III. 1790 to Trinity Term, 32nd George III. 1792.*, 760.

witness 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*.<sup>5</sup>

Nineteenth-century legal scholars typically cited these cases as a source of binding legal precedent that precluded everyone but legal professionals from privileged communications. In 1804, Thomas Peake’s *A Compendium on the Law of Evidence* cited Mansfield to argue, “[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.”<sup>6</sup> Similarly, Samuel March Phillips’ popular evidence manual cited both Mansfield and Buller.<sup>7</sup> In this way, evidence manuals lifted brief asides from justices Mansfield and Buller, transforming them into de

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<sup>5</sup> Charles A. Boston, “The Law of Evidence Concerning Communications Between Patient and Physician,” in *Medical Jurisprudence, Forensic Medicine and Toxicology* 2<sup>nd</sup> ed., v. 1, edited by Rudolph A. Withaus (New York: 1906), 92.

<sup>6</sup> Thomas Peake, *A Compendium on the Law of Evidence. With an Appendix of Cases* (London: 1804), 175.

<sup>7</sup> S. M. Phillips, *A Treatise on the Law of Evidence: First American Ed., from the Second London Ed. With Notes and References to American Authorities, to Which is Added the Theory of Presumptive Proof* (New York, 1816), 104.

facto laws.

At the same time, these texts preserved and, in some cases, introduced much of the language and rhetoric associated with physician-patient privilege. Mansfield and Hawkins' discussion of "professional honor," for example, was echoed in later legal discussion of physician-patient privilege. In his 1804 treatise, Peake paraphrased Mansfield, "We should certainly think the friend, or the physician, who voluntarily violated the confidence reposed in him, acted dishonorably; but he cannot withhold the fact, if called upon by a court of justice."<sup>8</sup> In doing so, Peake emphasized physicians' conflicting duties—to their patients and to the pursuit of justice in the courtroom—that would form the basis for future discussion of physician-patient privilege. Likewise, by including Buller's lamentation against the lack of physician-patient privilege in his treatise, legal scholar Samuel March Phillips suggested that there was growing support for the adoption of physician-patient privilege.<sup>9</sup> Today, with an abundance of legal and medico-legal literature readily available, these minor developments may seem trivial. Yet in the early nineteenth century, legal treatises were often the only available writings on physician-patient privilege. Accordingly, the language and examples these texts used could, and did, have powerful effects on the ways in which later scholars and legislators viewed the privilege.

New York's adoption of physician-patient privilege provided a case in point. The New York statute, the first of its kind was heavily influenced by the language

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<sup>8</sup> Peake, 175.

<sup>9</sup> Phillips, 104.

and rhetoric of these early cases and evidence manuals. By enacting the first statutory guarantee of physician-patient privilege, the proponents of the New York law were directly responding to the arguments of Buller and other legal scholars. The statute was enacted as part of a larger movement to codify and simplify the New York's legal system. By the 1820s, centuries of legislation and court rulings, coupled with poor record keeping, had created a myriad, sometimes-contradictory body of laws. For lawyers and legislators, it was often difficult to determine which statutes and which rulings applied to specific cases. Many legal scholars believed that codification, a process that would replace the judicial interpretation of the common law system with a more precise and proscriptive legal code, offered an ideal solution. Accordingly, in 1821, the New York legislature sought to rewrite the state constitution. Gathering in Albany, delegates to the New York state constitutional convention "abrogated" the sections of the states' common law and statutory codes that were "repugnant" to the principles of American governance.<sup>10</sup>

Still, the vague language of New York's new constitution only added to the complications surrounding the state's law. Advocates of codification believed that the state legislature, representing the interests of the public, should be entrusted with the ability to consolidate and, in some cases, rewrite the offending laws. In 1824, the state legislature commissioned a three-man committee to "alter the phraseology" of the states codes and increase the legibility off the state's statutory

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<sup>10</sup> Cook, 155.

law.<sup>11</sup> 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, another prominent New York Attorney.<sup>12</sup>

New York governor DeWitt Clinton quickly emerged as a powerful and outspoken advocate of codification. In 1825, he successfully lobbied to expand the committee's task, empowering the revisers 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 state legislature. Entrusting the committee with these unprecedented powers, Governor Clinton sought nothing short of a complete overhaul of New York's legal system. Before the state legislature, Clinton boldly asserted 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." Clearing the revisers to extend their powers far beyond the scope of previous committees, 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."<sup>13</sup>

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<sup>11</sup> *New York State Constitution of 1821*, Article 6, Section XIII; Mohr, *Doctors and the Law*, 78.

<sup>12</sup> Mohr, *Doctors and the Law*, 79.

<sup>13</sup> Charles Z., Lincoln, ed. *Message from the Governors, Comprising Executive Communications to the Legislature...* 11 vols. (Albany, 1909), II:90, quoted in Cook, 138.



Not everyone on the committee shared Governor Clinton's lofty ambitions, however. 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. By 1827, John C. Spencer, a promising young New York lawyer, had replaced Wheaton. Compared to his predecessors, Spencer was wholeheartedly dedicated to the codification process. Spencer shared the governor's belief that codification would solve the state's legal problems. Both had no qualms about upending established English precedents in their efforts to Americanize the common law. With Clinton's blessing, Spencer quickly took control of the committee, authoring numerous laws and working tirelessly to secure their passage through the state legislature.<sup>14</sup>

Thus, by 1827, all three positions had been filled by young attorneys who favored codification and the committee had been entrusted with unprecedented legislative power. 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. At the same time, they made numerous substantive changes to New York's laws. For example, New York's *Revised Statutes* made abortion after quickening a crime and radically reformed 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

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<sup>14</sup> Mohr, *Doctors and the Law*, 79; Cook, 140-150.

without controversy.<sup>15</sup>

In this manner, physician-patient privilege was quietly and unceremoniously added to the statute books. The revisers split New York's statutes into five categories, presenting each separately to the state legislature. In 1828, alongside numerous other provisions pertaining to criminal law, the revisers presented the state legislature with the first statute guaranteeing physician-patient privilege. 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.<sup>16</sup>

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.<sup>17</sup>

The revisers, however, were keenly aware that the new law 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.*

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<sup>15</sup> *Ibid.*

<sup>16</sup> New York (State), Benjamin Franklin Butler, John Duer, and John Canfield Spencer, *Revised Statutes of the State of New York, Passed During the Year One Thousand Eight Hundred and Twenty Eight... Printed and Published Under the Direction of the Revisers, Appointed for that Purpose* (Albany, Packard & Van Bentuysen, 1829), 409.

<sup>17</sup> Mohr, *Doctors and the Law*, 79; Cook, 140-150.

*Rastall*, stating, “[Justice] 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.” Likewise, the revisers offered British legal scholar Samuel March Phillips as another advocate of favor of physician-patient privilege. The statute was modeled upon attorney-client privilege and passed alongside a companion statute that extended the privilege to communications between priest and penitent. Yet the revisers saw the need to privilege medical communications as more pressing than the need to privilege attorney-client relations:

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 adopted up the rhetoric that had developed in courtrooms and legal texts, stressing physicians’ conflicting duties to their patients and the law. They feared that physicians, if torn between the two, would choose to honor their obligations to their patients, 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 physicians’ desire to protect their patients and the support of prominent legal scholars, 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.”<sup>18</sup> To lawmakers, this reasoning must have been convincing. The statute itself drew little criticism, and the state legislature enacted the law alongside the rest of the revisers’ amendments to the criminal code.

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. It is possible that the revisers were pushed to enact physician-patient privilege by one or several influential physicians. Recent scholarship has shown that the revisers sought the council of Theodoric Romeyn Beck, for guidance on revised code’s application to medical policy. Beck, an Albany physician, was perhaps the foremost scholar of medical jurisprudence in first half of the nineteenth century. 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. Though much of the communications 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:

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<sup>18</sup> *Commissioners on Revision of the Statutes of New York* (Albany: 1836), III, 737.

Albany, Sept. 11, 1828

I have prepared various Sections against medical malpractice according to your 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.”<sup>19</sup> 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. All of this information would seem to suggest that Beck’s guidance prompted the revisers to insert a statute guaranteeing physician-patient privilege into the revised code.

Yet a closer examination of Beck’s publications provides no evidence that he directly pushed for the adoption of physician-patient privilege. 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

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<sup>19</sup> Mohr, *Doctors and the Law*, 81.

courtroom, but again did not mention privileged communications.<sup>20</sup> 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 *Principles of Medical Ethics* Beck did mention the precedent established in the Duchess of Kingston's trial, but failed to mention New York's medical confidentiality law.<sup>21</sup>

Another possibility is that a small group of 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* (This document would prove influential in the history of American medical ethics, and will be discussed in Chapter 3). Comparing physicians to Catholic priests, *System of Ethics* suggested that physicians' were obliged to maintain patients' 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.<sup>22</sup>

Yet if the revisers solicited the advice of either Beck or the MSSNY, they chose not to present this information to the state legislature. Instead, the Revisers' Notes suggest that the New York statute was prompted by nineteenth-century legal

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<sup>20</sup> Beck, *Elements of Medical Jurisprudence* 1<sup>st</sup> Ed. (Albany: 1823); Beck, "On Medical Evidence," *New York Medical and Physical Journal* 7 (1828), 9-34.

<sup>21</sup> Theodric Romeyn Beck and John B. Beck, *Elements of Medical Jurisprudence* 5<sup>th</sup> ed. v. 2 (Albany: 1835), 661.

<sup>22</sup> Medical Society of the State of New York, *System of Ethics* (New York: 1823); Baker, *Before Bioethics*, 112-123.

scholarship. The language in the revisers' notes echoed the language of earlier court cases and legal manuals. The revisers specifically referred to physicians' "professional honor" and cited Buller and Phillips, both prominent legal scholars. 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. Moreover, while much of the legislation proposed by Beck was placed in the medical section of the code, New York's physician-patient privilege law was included in the state's evidentiary code, a topic on which neither Beck nor the MSSNY likely would 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.

Whatever the motivations of the Revisers, the New York statute quickly influenced other states to follow suit (see Table 1). Missouri passed a law guaranteeing physician-patient privilege in 1835. Mississippi enacted a statute the

following year.<sup>23</sup> By 1840, both Arkansas and Wisconsin had enacted statutes. 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.<sup>24</sup>

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. The language of most of these subsequent statutes mirrored the New York law. Mississippi, for example, adopted the New York statute word-for-word. Other states made minor alterations. Moreover, the revisers of later codes often had connections to

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

<sup>23</sup> The Mississippi Statute appears in the state’s *Revised Statutes of the State of Mississippi* (Jackson, MI: 1836), 1052. Yet the statute was short-lived. 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* 1<sup>st</sup> 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 WL 10036).

<sup>24</sup> *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.



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.<sup>25</sup>

Only Wisconsin and Arkansas made changes that might affect the application of the law. 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."<sup>26</sup>

Legal scholars have attributed this change in language to the authors' desire to limit the power of the privilege.<sup>27</sup> At the same time, however, these statutes would become models for doctors in their later attempts to lobby for physician-patient privilege because their language left decisions about whether to disclose patients' secrets to individual physicians.

In the 1840s, legal developments in New York facilitated the further spread of physician-patient privilege. The state adopted a new constitution in 1846. One of

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<sup>25</sup> Alfred Lucking, "Privileged Communications to Physicians," *Physician and Surgeon: A Professional Medical Journal* 20 (1898), 493-496.

<sup>26</sup> *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.

<sup>27</sup> John B. Sanbourn made this argument in his article, "Physician's Privilege in Wisconsin" *Wisconsin Law Review* 1 (Madison: 1922), 141-146.

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.”<sup>28</sup> Like earlier codification movements, the newly appointed revising committee sparked controversy amongst 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, the committee was headed by David Dudley Field, a young New York attorney who would quickly rise to prominence as America’s foremost proponent of codification.<sup>29</sup>

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 in which cases were brought and pleaded before the state’s courts, arguing that the states’ myriad common law precedents should be replaced with a uniform and easily accessible code of procedure. In 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 challenged the fundamental principles of American law. Field took issue with the jargon and Latin that underpinned nineteenth-century legal procedure, sometimes suggesting radical changes. 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 new code “was a colossal affront to the common- law

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<sup>28</sup> *Laws of the State of New York* (1848), c. 379. Quoted in Friedman, 293.

<sup>29</sup> Friedman, *A History of American Law*, 293-298.

tradition.”<sup>30</sup> While the state legislature rejected some of Field’s more radical proposals, the bulk of Field’s Code was accepted into law in 1848.<sup>31</sup>

Field’s Code did not change New York’s medical confidentiality law. The 1848 revisions of the New York code maintained the state’s statute on physician-patient privilege. The New York revisions, however, sparked a new wave of codification that brought similar statutes to numerous jurisdictions, especially in the Western United States (see Table 2). Compared to the older eastern states, the American west featured a young, progressive bar; greater exposure to civil law; and less established common law traditions—characteristics that made these states especially receptive to codification. Missouri adopted Field’s Code in 1849. California followed suit in 1851. 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 Carolina, Utah, Colorado, Oklahoma, and New Mexico had all adopted Field’s Code of Civil Procedure.<sup>32</sup>

Some of these jurisdictions, like Missouri and Wisconsin had already adopted physician-patient privilege. In these states the existing statutes were incorporated into the new Code of Civil Procedure. In many more jurisdictions, however, physician-patient privilege was adopted alongside Field’s Code. Among other states, California, Kansas, and Indiana adopted physician-patient privilege in this manner. At the same time, however, numerous states rejected the Field’s controversial code

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<sup>30</sup> *Ibid.*, 293.

<sup>31</sup> *Ibid.*, 293-298.

<sup>32</sup> *Ibid.*

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.<sup>33</sup>

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. 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 where codification failed to take hold. By the latter

**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

<sup>33</sup> Friedman, 293-298; Frederick J. Stimson, “Privileged Communications to Physicians,” *Medical Communications of the Massachusetts Medical Society v. 19:1* (Boston: 1904), pp. 607-617, at 608.

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.

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 medical issue, and, in doing so, they would bring physician-patient privilege into the public eye.

## CHAPTER IV

### MEDICAL ETHICS IN THE EARLY 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.” —*AMA Code of Ethics* (1847)

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, the group to which the privilege had the most significance, often failed to take notice of this medico-legal development. By mid-century, however, the professional landscape had changed dramatically. When the American Medical Association convened for the first time in 1847, physician-patient privilege had become so accepted and commonplace that physicians could no longer ignore it. The privilege was formally acknowledged in the organization’s *Code of Ethics*, marking an important turning point in the history of medical confidentiality.

This chapter examines the nineteenth-century developments in medical ethics that led doctors to embrace physician-patient privilege. Faced with challenges

from irregular practitioners, the medical profession remained conspicuously weak throughout much of the period. At the same time, standards in medical education declined precipitously in the early nineteenth century. Many of the nation's medical schools became little more than diploma mills. These developments sparked a series of reforms aimed at improving the status of the medical profession. Medical societies instituted licensing laws, fee bills, and codes ethics as means to discipline wayward practitioners and wrest control of the profession from their sectarian rivals. Gradually, medical societies such as the Medical Society of the State of New York 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.

Though the number of physician-patient privilege statutes increased throughout the early nineteenth century, these laws remained, for the most part, surprisingly absent from medical or legal scholarship. In the absence of a specialized literature on privileged communications, legal treatises on evidence offered physicians and lawyers the most reliable source of information on local medical confidentiality laws. Published with increasing regularity throughout the early nineteenth century, these texts often professed to offer a definitive list of local statutes and landmark cases. Yet, until the latter half of the nineteenth century, no American scholar attempted to catalog the complete rules of evidence. Instead,

attorneys were forced to rely upon American editions of British treatises.<sup>1</sup> Not surprisingly, these texts often failed to offer complete and accurate depictions of American law. The list of statutes in one publication could, and often did, contradict the list of another publication. Some statutes, such as Mississippi's medical confidentiality law, escaped comment altogether.<sup>2</sup>

Perhaps for these reasons, few medical men seem to have understood the laws surrounding privileged communications or their own obligations in the courtroom. While medical scholarship suggests that these issues arose frequently and were "very important," even purported experts on the subject had a limited understanding of the cases and statutes that defined the status of privileged communications. In the early 1830s, for example, numerous 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?" The journal's editors responded by haphazardly compiling scraps of text from other publications, splicing bits of text into two rambling and incoherent pages. With the exception of a brief introduction, the entirety of the text was lifted directly from transcripts of the Duchess of Kingston's trial and *Wilson v. Rastall*. The article gave little context for either court case and made no mention of New York's medical confidentiality law.

Based upon these sources, the journal editors concluded "that medical persons have

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<sup>1</sup> See, for example, the American edition of Thomas Starkie's *A Practical Treatise on the Law of Evidence and Digest of Proofs in Civil and Criminal Proceedings* (Philadelphia: 1834). For a critique of Starkie's work and its application to American law, see: "Notices of New Books," *American Jurist and Law Magazine* 12 (Boston: July and October, 1834), 547-548.

<sup>2</sup> Missing from most legal sources, the Mississippi statute can be found in *Revised Statutes of the State of Mississippi* (Jackson: 1836), 1052.



*no privilege whatever*, not to disclose circumstances revealed to them professionally; and that the only communications privileged are those to their legal advisers entrusted with those communications as such.”<sup>3</sup>

Similarly, medico-legal texts offered little clarification of questions regarding privileged communications. In 1823, Theodric Romeyn Beck, the foremost American medico-legal scholar, authored *Elements of Medical Jurisprudence*. As a practical guide for physicians, *Elements* was revolutionary. Considered by many to be the seminal medico-legal work of its time, the book compiled contemporary 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. Yet the first edition featured little discussion of evidentiary procedure or the duties of medical witnesses.<sup>4</sup>

This lack of interest in courtroom procedure was characteristic of the medico-legal field as a whole. For these scholars, the most pressing contemporary medico-legal issues included forensic toxicology and the diagnosis of insanity. Contemporary medico-legal journals were littered with countless articles that detailed new ways to detect poisons and numerous articles debating sometimes-

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<sup>3</sup> “Miscellaneous Intelligence,” *Western Journal of the Physical and Medical Sciences* 5 (1832), 289-291; “Medical Jurisprudence,” *The American Journal of the Medical Sciences* (May, 1831), 523-524.

<sup>4</sup> Theodric Romeyn Beck, *Elements of Medical Jurisprudence* 1<sup>st</sup> ed. For more analysis of Beck, see: Mohr, *Doctors and the Law*, 15-28.

conflicting definitions of insanity.<sup>5</sup> 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, often neglecting the medico-legal implications of the physician-patient relationship.

Nevertheless, during this period, physicians slowly embraced medical confidentiality as one of the foundational principles of medical ethics. As early as the late eighteenth century, well-educated, urban doctors in the United States and Britain began to show a general awareness and acceptance of notions of medical confidentiality. From around 1730 through the early twentieth century, every physician graduating from the University of Edinburgh medical school swore an oath to “practice physic cautiously, chastely, and honourably... and never, without great cause to divulge anything that ought to be concealed, which may be seen or heard during professional attendance.”<sup>6</sup> In the history of medical ethics, the *Edinburgh Oath* was nothing short of revolutionary. Its predecessor, the *Sponsio Academica*, had mandated that physicians’ primary allegiances would always be to the crown and the church. 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

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<sup>5</sup> Mohr, *Doctors and the Law*, 57-75.

<sup>6</sup> “Edinburgh University Medical Oath, Circa 1732-1735 Onward,” quoted in Robert Baker, *Before Bioethics*, 37.

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.<sup>7</sup>

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 model proved extremely influential in the United 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. Well-to-do physicians such as Samuel Bard and Benjamin Rush were educated at Edinburgh and would have sworn versions of the Edinburgh Oath. 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) on their experiences abroad. Likewise, in 1767, Samuel Bard, one of the foremost physicians of the early republic, created an Edinburgh-style medical college at King's College (Now Columbia).<sup>8</sup> 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.

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<sup>7</sup> Baker, *Before Bioethics*, 43-45.

<sup>8</sup> Rothstein, 87-93.

For the most part, contemporary physicians took these commitments seriously. 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.”<sup>9</sup> Increasingly, well-educated doctors viewed medical confidentiality as one of the central tenets of the physician-patient relationship.

Though 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

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<sup>9</sup> 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: Bradford and Innskeep, 1811), pp. 336-337. Quoted in Robert Baker, *Before Bioethics*, 90.

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 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.<sup>10</sup>

For many practitioners, however, these 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.<sup>11</sup>

Though numerous medical societies enacted provisions to control the quality of medical education, standards of education were erratic and, often, unenforceable.

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<sup>10</sup> Rothstein, 85-100.

<sup>11</sup> *Ibid*, 85-87.

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 do little to discipline 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.<sup>12</sup>

At the same time, contemporary 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

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<sup>12</sup> For example, the South developed notions of a distinct therapeutic identity. 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* 2<sup>nd</sup> ed. (Madison: 1985), pp. 53-70.

of the nation's primary care within the household.<sup>13</sup> 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.<sup>14</sup> Beginning in the late eighteenth century, wealthy, well-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).<sup>15</sup>

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

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<sup>13</sup> For an example of this phenomena, see Laurel Thatcher Ulrich's discussion of the medical profession in *A Midwife's Tale* (New York: Vintage Books, 1990). Paul Starr elaborates on the relationships between physicians and lay healers in *The Social Transformation of American Medicine*.

<sup>14</sup> My discussion of the weakness of the medical profession in the chapter is culled from Starr, Rothstein, and Warner.

<sup>15</sup> Rothstein, 63-68.

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, effectively barring all but the most prestigious Boston physicians.<sup>16</sup>

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 unlicensed practitioners. Moreover, these licensing laws proved short-lived. By the end of the 1830s, most had been repealed.<sup>17</sup>

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. The MSSNY reorganized in 1806 as a society that served the county of New York, pulling in new members from outside the city

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<sup>16</sup> *Ibid.*

<sup>17</sup> Rothstien, 75; Konold, 3-4.



limits. 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.<sup>18</sup>

As medical societies became more inclusive, these organizations increasingly took it upon themselves to regulate doctors' activities and to police medical ethics. Physicians frequently complained that unscrupulous practitioners were undercutting their fees, limiting their ability to make an honest living. Accordingly, medical societies frequently imposed fee bills 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 members of regular medical societies. Physicians in urban areas and other regions with numerous irregular practitioners were often forced to disregard these restrictions altogether.<sup>19</sup>

Codes of medical police constituted a second form of control over the medical profession. Upon admission into a medical society, physicians would often swear an oath to abide by a series of rules and regulations. Societies often mandated that their members refrain from using secret nostrums or patent medicines. Most prohibited

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<sup>18</sup> Rothstein, 70-72.

<sup>19</sup> *Ibid.*, 81-82.

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. Like fee bills, however, these restrictions only applied to members of specific medical societies. Codes of medical police could not be used to discipline irregular practitioners.<sup>20</sup>

By contrast, codes of ethics constituted a much stronger means of control over the medical profession. While adopted by 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."<sup>21</sup> Unlike earlier modes of ethical policing, which pertained only to relations amongst medical practitioners, codes of ethics expressed notions about the ways in which physicians interacted with their patients.

As regular physicians increasingly deemed fee bills and codes of medical

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<sup>20</sup> Baker, *Before Bioethics*, 112-123.

<sup>21</sup> Nathaniel Davis, *Transactions of the American Medical Association* (1874), 29. Quoted in Baker, *Before Bioethics*, at 95.

police inadequate, medical societies frequently instituted codes of ethics. The MSSNY provided a case in point. From 1808 to 1822, members of the medical society had observed a code of medical police. When the code was to be revised in 1822, however, the revisers, John Steele and James Manley, demurred. Steele and Manley were able to convince their peers that the code of police was in need of a complete overhaul. Instead of reforming the code of medical police, members of the MSSNY opted to draft a new code of ethics. Felix Pascalis, a New York City physician joined Steele and Manley and the committee immediately began drafting a new code of ethics.<sup>22</sup>

The following year, Manley, Steele, and Pascalis presented *System of Ethics* to the MSSNY. The document was adopted with overwhelming support from the society, making the MSSNY the first American medical society to publish its own code of ethics. 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. The 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 become a source of contradiction perhaps injurious to some of the physicians in attendance.<sup>23</sup>

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<sup>22</sup> Baker, *Before Bioethics*, 112-113.

<sup>23</sup> Medical Society of the State of New York, *System of Ethics* (New York: 1823), IX.

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.”<sup>24</sup>

*System of Ethics* and other similar codes abandoned the language of earlier professional regulations, seeking to cast doctors as the benevolent protectors of their patients. The authors likened the physician to a Catholic priest. Doctors were privy to a patient’s most intimate secrets “such as... the judgment and treatment of syphilitic and gonorrhoeal 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;<sup>25</sup>

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 incorporate physician-patient privilege into New York’s statutory code. Regardless of whether the MSSNY’s *System of Ethics* influenced the revisers of the

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<sup>24</sup> *Ibid.*

<sup>25</sup> *Ibid.*

New York code, however, the text had a profound impact on medical ethics in the United States. As the condition of the medical profession deteriorated even further in the 1830s and 1840s, doctors turned to medical ethics as a powerful tool for the advancement of the regular profession. In the 1830s numerous medical societies enacted ethical regulations, including provisions mandating medical confidentiality. The Codes of Ethics of the State Medical Society of Ohio in 1831, the Medical and Chirurgical Faculty of Maryland in 1832 all mandated that physicians' maintain their patients' confidences.<sup>26</sup>

At the local level, many regular physicians viewed these codes as unequivocal successes. Yet these codes failed to address some of the problems plaguing medicine on the national scale. Quacks and irregular practitioners thrived in the de-regulated medical marketplace. Likewise, 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. In May of 1845, delegates from medical societies across the country convened in New York City to address the problems facing medical education. The convention proposed several resolutions to address the problem. More importantly, the delegates appointed committees to form a national medical organization. Two years later, these committees convened in Philadelphia to draft a constitution for the organization that would become the American Medical Association. The 250 delegates in attendance quickly moved beyond their stated goal of educational reform, instead advocating sweeping reforms designed to

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<sup>26</sup> Konold, 9-10.

reshape the entire medical profession. In 1847, the new organization adopted a code of ethics similar to the MSSNY's *System of Ethics*.<sup>27</sup>

The authors of the American Medical Association's *Code of Ethics* based their document on the writings of Thomas Percival's *Medical Ethics*. Percival, an eighteenth century moralist had authored *Medical Ethics* as a practical guide for his son, an aspiring physician.<sup>28</sup> When Isaac Hays presented the code to the AMA convention in 1847, he stated that the committee had retained Percival's original language whenever possible. 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."<sup>29</sup>

By contrast, the American Medical Association's *Code of Ethics* echoed the MSSNY's broad definition of medical confidentiality, stating: "The obligation of secrecy extends beyond the period of professional services;—none of the privacies

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<sup>27</sup> *Ibid.*, 8-9.

<sup>28</sup> For more analysis of the AMA's reading of Percival, see: Robert Baker, "Deciphering Percival's Code," in *The Codification of Medical Morality: Historical and Philosophical Studies of the Formation of Western Medical Morality in the Eighteenth and Nineteenth Centuries, Vol. 1: Medical Ethics and Etiquette in the Eighteenth Century* (Dordrecht, 1993), pp. 179-211.

<sup>29</sup> 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.

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 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.”<sup>30</sup>

The evolution of these codes of medical ethics in the first half of the nineteenth century would prove to be one of the most important developments in the evolution of medical confidentiality. For the first time, doctors began to speak publicly in favor of physician-patient privilege. In doing so, these physicians seized a once-arcane legal doctrine and recast it as a key tenet of medical ethics. The formal recognition of physician-patient privilege by what would become the nation’s most powerful medical society in 1847 marked an important turning point. While doctors had little to say about physician-patient privilege in the early nineteenth century, by the final decades of the century, they would emerge as the foremost proponents of the privilege.

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<sup>30</sup> American Medical Association, *Code of Ethics of the American Medical Association [Reprinted from the American Edition]* (Oxford: John Henry Parker, 1849).

## CHAPTER V

### PHYSICIAN-PATIENT PRIVILEGE AND THE MEDICAL PROFESSION IN THE LATE NINETEENTH CENTURY

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.

Massachusetts physician, David Cheever, 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?"<sup>1</sup>

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, eighteen states or territories had

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



enacted other statutes guaranteeing medical confidentiality in the courtroom.<sup>2</sup> 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 bigamy. Doctors would not be given privileged communications in the courtroom and could be forced to reveal their patients secrets. To Wood and many other physicians, the absence of a statute guaranteeing 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, increasingly 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. By publishing open appeals for legislative action in medical journals, doctors thrust discussion of physician-patient privilege into the public eye. Until 1880, few journals had ever mentioned the issue. Statutory guarantees of physician-patient privilege were often enacted with little fanfare, packed into omnibus bills alongside numerous other revisions to the evidentiary codes. Beginning in the early 1880s, however, journals ran frequent articles discussing the professional benefits and, sometimes, the hazards of physician-patient privilege.

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<sup>2</sup> A list of statutes enacted before 1882 was compiled in *Gartside v. The Connecticut Mutual Life Insurance Company* (76 Mo. 446, 1882 WL 10036).

This chapter examines the medical literature on physician-patient privilege that became increasingly common throughout the late nineteenth and early twentieth centuries. Often, journals made explicit links between medical confidentiality and larger developments within the profession. Just as doctors debated the value of physician-patient privilege, institutional changes and technological developments radically reshaped medical practice and challenged its fundamental relationships—both between physicians and with their patients. Doctors began to question established therapeutic practices. In response to the rise of irregular practitioners, regular physicians mobilized to enact strict licensing laws and reform medical education.<sup>3</sup> A small cadre of physicians challenged contemporary notions of medical ethics by suggesting that ethical policing should be abandoned altogether. As the medical profession changed, so did the discourse on physician-patient privilege.

When Horatio Wood called on his peers to push for physician-patient privilege, he initiated one of the first public lobbying campaigns on behalf of physician-patient privilege. Yet, in many ways, Wood's efforts echoed earlier attempts to gain statutory guarantees of medical confidentiality. By 1880, Doctors had long worked closely with state legislators to enact statutory guarantees of medical confidentiality. Citing the several prominent medical scholars in his 1860 treatise, for example, the medico-legal scholar John Elwell stated, "physicians, as a

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<sup>3</sup> For analysis of regular physicians' drive to enact licensing laws during this period, see James C. Mohr, *Licensed to Practice: The Supreme court Defines the Medical Profession* (Baltimore: Johns Hopkins University Press, 2013). The transformation of the medical profession in the late nineteenth century is discussed at length by Rothstein and Starr.

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.”<sup>4</sup> Drawing upon this 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.”<sup>5</sup>

Neither Wood nor the journal lacked familiarity with the lobbying process. Wood 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

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<sup>4</sup> John J. Ellwell, *A Medico-Legal Treatise on Malpractice and Medical Evidence Comprising the Elements of Medical Jurisprudence* (New York: Voorhies, 1860), 320-322.

<sup>5</sup> “Editorial: The Secrets of the Consulting Room.”

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, portraying tough licensing laws as an answer to the dangers of sectarian medicine.<sup>6</sup>

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, the journal was also leading the charge to re-enact medical licensing laws in Pennsylvania.<sup>7</sup> The journal's concurrent attempts to reshape Pennsylvania medicine and to take control of several crucial medico-legal issues reflected a deep-seated belief that "the Medical Profession can, if it will, mould legislation in regard to itself."<sup>8</sup> Wood's views echoed those of earlier architects of physician-patient privilege. He hoped to enact a law that mirrored New York's medical confidentiality law. Wood's proposed law made only one minor alteration to the language of the New York statute. Like the physician-statutes already on the books in Wisconsin, Arkansas, and several other states,<sup>9</sup> Wood amended the New York statute to read:

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<sup>6</sup> For a discussion of the sectarian medicine in the nineteenth century, see Rothstein, *American Physicians in the Nineteenth* and Starr, *The Social Transformation of American Medicine*. For a discussion of the difference in therapeutics between differing sects, see Rothstein and John Harley Warner, *The Therapeutic Perspective*.

<sup>7</sup> "Editorial: Medical Legislation," *Philadelphia Medical Times and Register* 11 (January 1, 1881), 205-6.

<sup>8</sup> "Editorial: The Secrets of the Consulting Room."

<sup>9</sup> Wigmore, *On Evidence* 1<sup>st</sup> Ed., 3348; Sanbourn, 141-146.

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.

In order to pass this bill through the state legislature, Wood urged influential physicians to use their personal connections to influence lawmakers.<sup>10</sup>

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 need to respond to a letter that "assault[ed] the position assumed by this journal."<sup>11</sup> Authored by the prominent New York physician Frederick Sturgis, the letter argued that physician-patient privilege constituted "a gross injustice to all concerned." To Sturgis, the New York law and Wood's proposed legislation, "converts the family physician into a wolf in sheep's clothing." 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

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<sup>10</sup> "Editorial: Medical Legislation," 205–6.

<sup>11</sup> "Editorial: Professional Secrets and the Law," *Philadelphia Medical Times and Register* (February 26, 1881), 337.

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."<sup>12</sup>

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 inverted the rhetoric often employed by physicians like Wood. To Sturgis, instead of protecting the patient, physician-patient privilege sealed the doctor's lips, preventing him from acting in the interests of his clients and society. Rather than protect the physician's honor, the law transformed the virtuous physician into a "scoundrel."<sup>13</sup>

To Sturgis and to numerous other physicians, the developing movement to restrict medical practice compounded these fears. 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

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<sup>12</sup> F.R. Sturgis, "Correspondence: To the Editor of the Philadelphia Medical Times," *Philadelphia Medical Times and Register* (February 26, 1881), 339.

<sup>13</sup> *Ibid.*

harmful because it “gags the mouth of the reputable physician, but permits the gabble of the charlatan.”<sup>14</sup>

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 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.<sup>15</sup> This gesture signified that the law’s intent was, first and foremost, the protection of physicians independent discretion, hence his honor.<sup>16</sup>

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

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<sup>14</sup> Sturgis, 339.

<sup>15</sup> The newly proposed legislation read, “A person duly authorized to practice physic or surgery shall not be *compelled* to disclose any information.”

<sup>16</sup> “Editorial: Professional Secrets and the Law.”

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.<sup>17</sup>

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 American medicine—often Edinburgh-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.

Although there were undoubtedly numerous examples in which physicians failed to live up to these lofty promises, in general, the regular medical profession took matters of confidentiality very seriously. In 1869, for example, the New York Academy of Medicine (NYAM), expelled James Marion Sims, the nation's most prominent gynecologist, 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

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<sup>17</sup> Stimson, 610-611.



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."<sup>18</sup> 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 affair was quickly settled. 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 subject himself to the indignity of apologizing to the society, Sims refused, at which point, he was expelled from the NYAM.<sup>19</sup>

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 crime—Sims's fellow practitioners. Within the small community of nineteenth-century medicine the

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<sup>18</sup> James Marion Sims, "Miss Charlotte Cushman's Health," *New York Times* (October 3, 1869).

<sup>19</sup> Committee on Ethics of the New York Academy of Medicine, date unknown. Quoted in Baker, *Before Bioethics*, 108-109.

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.<sup>20</sup>

As this brief episode demonstrates, nineteenth-century physicians took ethical standards and policing very seriously. For the regular profession of the mid-nineteenth century, this was essential to their survival. Prior to developments in bacteriology and scientific medicine that occurred 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 claims 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 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.

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 shift in

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<sup>20</sup> Baker, *Before Bioethics*, 108-109.

regulars' views on 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. Within this example, 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. Late-nineteenth-century medical journals featured numerous articles with titles such as, "Venereal Disease and the Medical Secret," "The Professional Secret in Reference to Marriage," or "The Professional Secret in Syphilis and Marriage." Frederick 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 malpractice suits—critics found them especially troubling. In a reversal of the traditional rhetoric surrounding medical confidentiality, these practitioners argued that physician-patient privilege and codified medical confidentiality constituted not a protection of physicians' professional status, but rather a direct challenge to the honor of their profession.<sup>21</sup>

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."<sup>22</sup> 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

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<sup>21</sup> E. Castelli, "The Professional Secret in Reference to Mairrage," *American Medicine* 10 (September 16, 1906), 477-478; L. Stevenard, "The Professional Secret in Syphilis and Marriage," *American Journal of Urology* (1916), 33-37; Austin O'Malley, "The Professional Secret and Venereal Diseases," *American Medicine* 20 (December, 1916), 837-843; and Sturgis, "Correspondence."

<sup>22</sup> Daniel Strock, "The Patient's Secret," *The Philadelphia Monthly Medical Journal* 1:6 (June, 1899), 327.

public, without the patient's consent, the information acquired in confidence from him."<sup>23</sup>

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."<sup>24</sup>

In the final decades of the nineteenth century, however, radical transformations within the medical profession led a small cadre of physicians to begin to challenge the basic principles behind these laws. Throughout much of the nineteenth century, there had been little development in medical science. Toward the close of the century, however, major advancements in scientific medicine promised new therapeutic practices and engendered increased popular support for 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—

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<sup>23</sup> Louis M. Gompertz, "Confidential Communications Between Patient and Physician: The Law Relative Thereto," *New York Medical Journal* (December 28, 1912), 1333-1334.

<sup>24</sup> Daniel Strock, 327.

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.<sup>25</sup>

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* obsolete. In his 1876 Presidential address, he characterized the *Code of Ethics* as "a dead letter" and "an instrument of torture and oppression [for] prosecuting a fellow [AMA] member."<sup>26</sup> Though Sims failed, as president, to substantially alter the code, other physicians quickly adopted the cause. In New York, dispute over the *Code's* prohibition on

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<sup>25</sup> Starr, Rothstein.

<sup>26</sup> James Marion Sims, *AMA Presidential Address* (1876), quoted in Baker, *Before Bioethics*, 199.

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.”<sup>27</sup>

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 Code, *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 Code 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

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<sup>27</sup> Francis Delafield, “President’s Address: Proceedings of the Association of American Physicians,” *Journal of the American Medical Association* 7(1): 16. Quoted in Baker, *Before Bioethics*, 205.

contradictory ethical mandates and that no overarching ethical code or law could address these dilemmas adequately.<sup>28</sup>

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 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.<sup>29</sup> 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.<sup>30</sup> As leaders of the profession, these physicians often had enough personal clout to influence both legislators and their fellow physicians.

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<sup>28</sup> For more on the Revision of the AMA code, see: Baker, "The Anti-Code Revolt," *Before Bioethics*, 199-231.

<sup>29</sup> *History of Medicine and Surgery in Chicago* (Chicago: 1920), 111; Samuel T. Wiley, *Biographical and Portrait Cyclopaedia of Montgomery County, Pennsylvania* (Philadelphia: Biographical Publishing Company, 1895), 585-604.

<sup>30</sup> Strock, 327-329.



At the same time, the day-to-day realities of medical practice led many practitioners to embrace their message. 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.<sup>31</sup>

Throughout the late nineteenth century, these powerful physicians and their allies managed to secure numerous legislative victories (see Table 3). Between 1860 and 1880, ten more states followed New York by enacting statutes codifying physician-patient privilege. The 1880s and 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. Similarly, 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, the newly acquired Philippines and Puerto Rico adopted physician-patient privilege. Additional lobbying campaigns successfully placed bills before the state legislature in Illinois, Connecticut, and New Jersey.<sup>32</sup>

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<sup>31</sup> "Medico Legal Society of Chicago," *The Chicago Medical Recorder* 12 (1897), 81.

<sup>32</sup> 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; David W. Cheever, "Privileged Medical Communications," *Medical Communications of the Massachusetts Medical Society* 19, no. 1 (1904), 583–586.; Arthur N. Taylor, *The Law in Its Relations to Physicians* (New York: D. Appleton & Co., 1904), 488–491.

Still, legislative victories proved 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 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.”<sup>33</sup>

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

Nevertheless, many physicians viewed these statutes as a harbinger of future success. Following these legislative victories, Daniel Cheever, a renowned surgeon and Harvard professor, sought to bring physician-patient privilege to New England.

<sup>33</sup> Wigmore, *On Evidence* 1<sup>st</sup> Ed., 3348-3349.

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 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.”<sup>34</sup>

To Cheever, the only solution to this problem was the adoption of a new statute guaranteeing medical confidentiality to protect medical practitioners from the need to reveal their patients’ secrets. In Cheever’s eyes the United States fell into two camps with respect to this issue: states like Massachusetts that followed English common law, forcing practitioners to testify and betray their honor; and others that

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<sup>34</sup> Cheever, 583-586.

followed New York by privileging communications between physician and patient.<sup>35</sup> 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.<sup>36</sup> 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 physicians hoped this legislative victory would set the stage for similar legislation across the Northeast.<sup>37</sup>

Cheever seemed to be on the verge of successfully securing a new statute. Two years had passed since Cheever 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. Within the previous two decades, 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

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<sup>35</sup> *Ibid.*

<sup>36</sup> John Ridlon, "Medico-Legal Society of Chicago," *Chicago Medical Recorder* 12 (June 1897), 74–82.

<sup>37</sup> "Medical News," *Journal of the American Medical Association* 34 (June 1903).

ushered to the state legislature.<sup>38</sup> 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.<sup>39</sup>

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 "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.<sup>40</sup>

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

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<sup>38</sup> Ridlon, "Medico-Legal Society of Chicago."

<sup>39</sup> Cheever, "Privileged Medical Communications," 586.

<sup>40</sup> Walter Soren, "The Workings of the New York Law," *Medical Communications of the Massachusetts Medical Society* 19:1 (1904), pp. 587-605.

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 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.<sup>41</sup>

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, 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 Brower’s proposed statute, even though he believed that “no one felt the necessity for a law making communications to physicians privileged.”<sup>42</sup> The arrival of a new generation

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<sup>41</sup> Stimson, “Privileged Communications to Physicians.”

<sup>42</sup> “Medico Legal Society of Chicago,” 81.

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.<sup>43</sup> Their literature and its effects on medico-legal discourse will be discussed in the next chapter.

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 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

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<sup>43</sup> Of this new literature, John Henry Wigmore's *On Evidence* would prove the most influential.

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.”<sup>44</sup> 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 medical confidentiality laws. 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.

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<sup>44</sup> *Testimonial to David W. Cheever: February 25, 1907* (Boston: David Clapp & Son, 1907), 24-27.



## CHAPTER VI

### PHYSICIAN-PATIENT PRIVILEGE IN THE TWENTIETH CENTURY

There is but one form in which the argument for the privilege can be put with any semblance of plausibility, and in that form it doubtless commonly presents itself to the view of medical men jealous for their position. —John Henry Wigmore, *On Evidence* (1904)

In the early twentieth century, criticism of physician-patient privilege—from both the legal and medical professions—became increasingly vocal. As Frederick Stimson's arguments against David Cheever's proposed Massachusetts statute demonstrate, legal scholars found the application of physician-patient privilege in the courtroom unnecessarily onerous. Medico-legal developments the late nineteenth and early twentieth centuries brought new institutions and new types of legislation to which the privilege could not be easily applied. Insurance, malpractice, and worker's compensation cases proved especially difficult to adjudicate with liberal use of physician-patient privilege. Accordingly, numerous states, prompted by this new criticism, began to rewrite their civil codes, limiting the applications of physician-patient privilege.

Some legal critics went even further, however, arguing that physician-patient privilege was inherently unjust. To these legal scholars, the privilege impeded courts' ability to ascertain the truth. Moreover, they argued that physician-patient privilege failed to improve doctor-patient relations—physicians would get all the necessary information to properly treat their patients regardless of whether their communications were privileged. John Henry Wigmore, the most influential of these critics, suggested that physician-patient privilege merely served as a means to

improve the professional status of the medical profession—often at the expense of justice. Accordingly, he argued that the privilege should be abolished altogether.

At the same time, however, some physicians continued to push for new statutes, but these efforts often proved unsuccessful. As many doctors embraced laissez-faire medical ethics, critics like Frederick Sturgis, the New York physician who spoke out against Horatio Wood's proposed Pennsylvania statute, became more numerous. In the early twentieth century, many physicians argued that the privilege put doctors in a precarious situation, sometimes preventing physicians from acting ethically. To these doctors, physician-patient privilege and, more broadly, the AMA's code of medical ethics increasingly seemed like antiquated relics of the nineteenth century.

The nineteenth-century statutes that granted physicians privileged communications had been enacted in response to specific medico-legal problems including: 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 these nineteenth-century trends.<sup>1</sup> New institutions added complications to the doctor-patient relationship. Railroad companies and other large corporations hired their own doctors. Many physicians wondered whether their primary allegiance should be to their corporate employers or their patients. What should a doctor do when his

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<sup>1</sup> The transformation of American society in this period has long interested historians. See: Robert H. Wiebe, *A Search for Order: 1877-1920* (New York: Hill and Wang, 1967). For discussion of the impacts of these changes on the medical profession, see: Starr and Rothstein.

patient sues the company writing signing his checks? Physicians debated these ethical dilemmas in professional journals.<sup>2</sup> As personal injury cases became more frequent in the late nineteenth and early twentieth centuries, these discussions frequently found their way into the courtroom, where physicians and lawyers were often uncertain how to apply physician-patient privilege.<sup>3</sup>

Similarly, 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.<sup>4</sup> Like the intrusion of corporations into medical care, the reorganization of the hospital brought new ethical dilemmas 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

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<sup>2</sup> Clark Bell, “The Duty and Responsibility of the Attending Physician in Cases of Railway Surgery,” *Medico-Legal Journal* 14 (1896), pp. 7-14; Clark Bell, “The Future of Railway Surgery,” *Medico-Legal Journal* 14 (1896), pp. 202-206.

<sup>3</sup> Barbara Young Welke, *Recasting American Liberty: Gender, Race, Law, and the Railroad Revolution, 1865-1920* (Cambridge: University Press, 2001); Tracy C. Becker, “Observations Concerning the Law of Privileged Communications Between Physician and Patient, as Applicable to the Duties of Railway Surgeons,” *Journal of the American Medical Association* (May 30, 1896), pp. 1065-1067.

<sup>4</sup> Starr, *The Social Transformation of American Medicine*.

the purposes of clinical instruction and hospital administration are concerned.”<sup>5</sup>

Likewise, the emergence of insurance companies brought numerous trials necessitating medical testimony.<sup>6</sup>

The application of physician-patient privilege to injury lawsuits and insurance claims provoked numerous unwanted complications. One legal scholar 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.”<sup>7</sup> The legal critic, Zachariah Chafee cited several cases in which the enforcement 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. Because her husband’s physician was the only witness who could attest to the cause of death and was barred from testifying, she was unable to recover damages for the accidental death of her husband.<sup>8</sup> In his examination of the applications of physician-patient privilege, Walter Soren concluded, “the working of

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<sup>5</sup> Edmund Andrews, “The Secrets of Hospital Patients,” *Journal of the American Medical Association* (January 7, 1899), pp. 3-4.

<sup>6</sup> Starr, *The Social Transformation of American Medicine*.

<sup>7</sup> W.A. Purrington, “An Abused Privilege,” *Columbia Law Review* 35:6 (June, 1906), pp. 388-422.

<sup>8</sup> Zacheriah Chafee Jr., “Progress of the Law,” *Harvard Law Review* 35:6 (1921), pp. 673-714.

the New York law of privileged communications is a little hard on life and accident insurance companies.”<sup>9</sup>

In response to these cases, legal scholars suggested reform. Many scholars echoed Stimson’s claim that the judicial authority of the common laws was preferable to the strict provisions of statutory law. W.A. Purrington concluded, “if these statutes be not repealed altogether they should be modified so as not to enable the unscrupulous to suppress in evidence what is no secret outside the court room.”<sup>10</sup> Numerous states amended their statutes, limiting the applications of physician-patient privilege. In 1909, for example, the Michigan legislature passed an amendment to the state’s physician-patient privilege statute, limiting its applications to malpractice suits. Likewise, in 1923, Minnesota amended its statute to allow a physician to testify to “the pregnancy of his patient without her consent.”<sup>11</sup>

The evolution of California’s physician-patient privilege statute provides a powerful example of the transformation of these laws in the early twentieth century. The law mirrored many of the other statutes enacted in the mid-nineteenth century. Limited to civil actions, it barred “a licensed physician or surgeon” from disclosing “any information acquired in attending the patient which was necessary to enable him to act for the patient.” By early twentieth century, however, many had come to

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<sup>9</sup> Soren, “The Workings of the New York Law,” 601.

<sup>10</sup> Purrington, “An Abused Privilege.”

<sup>11</sup> Wigmore, *A Treatise on the Anglo-American System of Evidence in Trials at Common Law Including the Statutes and Judicial Decisions of All Jurisdictions of the United States and Canada* 4<sup>th</sup> ed., vol. 8 (Boston: Little, Brown and Co., 1940), 805.

view the one-sentence, 1853 law as inadequate. In 1917, the state legislature amended the statute, adding a waiver that could be executed by deceased patients' spouses or children and provisions barring the privilege from wrongful death and personal injury suits. The resulting law, a tangled mess of legalistic jargon, effectively rendered the earlier statute illegible to all but the savviest legal scholar.<sup>12</sup>

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 in evidence law. First published in 1904, his magnum opus, *A Treatise on the Anglo-American System of Evidence in Trials at Common Law*, quickly became the definitive work in the field. The first edition of *On Evidence* consisted 3842 pages split into four volumes. Over the course of the twentieth century, however, the text would be reprinted numerous times, eventually spanning ten volumes. In the first edition of *On Evidence*, Wigmore dedicated nineteen pages

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<sup>12</sup> The new law read: "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. 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." All but the first sentence was added in 1917 (Wigmore, *On Evidence* 4<sup>th</sup> ed., 804).

to the history physician-patient privilege, offering medical and legal scholars the most complete history of the privilege available.<sup>13</sup>

By the turn of the century, the legal treatise was hardly a new medium. In the latter half of the nineteenth century, legal scholars had produced dozens of treatises on evidence. Simon Greenleaf's oft-cited treatise, first published in 1842 was largely representative of the genre. In a brief note on physician-patient privilege, Greenleaf offered a one-sentence synopsis of the contemporary state of the law: "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." The remainder of the text was dedicated to detailed footnotes documenting every case and precedent that related to physician-patient privilege. Rather than editorializing on the propriety of specific legal doctrines, Greenleaf sought to present the state of contemporary law in an objective manner.<sup>14</sup>

Like Greenleaf and many of his predecessors, Wigmore offered a comprehensive overview of the current state of the law. Yet once the facts were laid bare, Wigmore took a decidedly different strategy and tone. While previous legal treatises had chronicled the rise of physician-patient privilege with a list of statutes and the dates they were enacted or modified, Wigmore sought to explain how this

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<sup>13</sup> Wigmore, *On Evidence 1<sup>st</sup> ed.*; William R. Roalfe, *John Henry Wigmore: Scholar and Reformer* (Evanston: Northwestern University Press, 1977).

<sup>14</sup> Simon Greenleaf, *A Treatise on the Law of Evidence in Three Volumes: Revised With Large Editions by William Draper Lewis, Ph.D.* (Philadelphia, Rees Welsh and Co, 1897), 390-391.

egregious doctrine appeared in the books in the first place. To Wigmore, the privilege arose out of the advocacy of “medical men jealous for their profession.”<sup>15</sup>

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—he cited notes of the revisers to the New York code, the original justification for physician-patient privilege, and a more recent judicial decision in the case, *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. To Wigmore, any communication needed to meet four criteria to justifiably qualify as a privileged communication in the courtroom. “A negative answer to any of these questions,” Wigmore suggested, “would leave the privilege without support.”<sup>16</sup>

First, the communication had to “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 disease and injuries were readily apparent. With the exception of venereal diseases and criminal abortions, 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 concluded that

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<sup>15</sup> Wigmore *On Evidence* 1<sup>st</sup> Ed., 3350.

<sup>16</sup> *Ibid.*



their current application in the courtroom constituted an unjust and unnecessary impediment to the legal process.<sup>17</sup>

The second criteria required to justify physician-patient privilege was that secrecy needed to be essential for the proper function of the physician-patient relationship. If doctors were capable of treating patients without the trust engendered by physician-patient privilege, then there would be no need for physician-patient privilege. 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, 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?”<sup>18</sup>

Third, Wigmore asked, “Is the [physician-patient] relation one that should be fostered?” To this point 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-

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<sup>17</sup> *Ibid.*

<sup>18</sup> *Ibid.*

disclosure. On this fourth point, Wigmore suggested, physicians' arguments for the privilege fell apart. Like Mansfield more than a century before, Wigmore acknowledged that medical confidentiality had long been an important part of the physician-patient relationship, and to disclose medical secrets outside of the courtroom would be wrong. Yet doctors' obligations to maintain their patients' secrets should not carry over into the courtroom. "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."<sup>19</sup>

Over the course of the twentieth century, Wigmore's *On Evidence* proved to be one of the most influential works on the evolution of evidence law. Many legal scholars have accepted Wigmore's four instrumental criteria as the best test for whether specific communications should be privileged.<sup>20</sup> In the decades following the publication of *On Evidence*, both legal and medical scholars frequently cited Wigmore as the definitive authority on evidentiary law. Even scholars advocating for physician-patient privilege felt the need to engage with Wigmore.

In 1913, for example, William Chandler, a physician from South Orange, New Jersey, urged his state's medical society to push for physician-patient privilege. A decade after Daniel Strock had unsuccessfully lobbied for a New Jersey statute,

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<sup>19</sup> *Ibid.*, 3350-3352.

<sup>20</sup> Edward J Imwinkelried, *The New Wigmore: A Treatise on Evidence, Evidentiary Privileges* v. 1 (New York: Aspen Law and Business, 2002), 444-445.

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.”<sup>21</sup> Even in this impassioned speech, however, Chandler was forced to acknowledge the new challenges facing his cause. Legislators were increasingly rejecting physician-patient privilege because “it makes physicians a *privileged class*”—one of Wigmore’s harshest critiques of the privilege—and because “it would in too many instances defeat the ends of justice.”<sup>22</sup> 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. Chandler’s plea fell upon deaf ears, however, as New Jersey failed to enact a new statute.

In the early twentieth century, many doctors 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

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<sup>21</sup> William J. Chandler, “Privileged Communications,” *Journal of the Medical Society of New Jersey* (July, 1913), pp. 67-71, at 71.

<sup>22</sup> *Ibid.*, 69-70.

Wyeth, the AMA president, called upon the organization to repeal the provision in 1902, reformers seized the opportunity to make wholesale revisions to the document. 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.<sup>23</sup>

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 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.”<sup>24</sup> Supporters of the new *Principles of Medical Ethics* argued that the new document was preferable

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<sup>23</sup> American Medical Association, *Principles of Medical Ethics of the American Medical Association* (Chicago: 1903). For more analysis of the 1903 revisions, see: Konold, 68-75 and Baker, 215-218.

<sup>24</sup> AMA, *Principles of Medical Ethics* (1903), Preface.

to the old *Code of Ethics* because 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."<sup>25</sup>

Yet this sentiment did not resonate throughout the medical profession. Despite support for some 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 1912, the AMA adopted a new version of *Principles of Medical Ethics* that restored the society's capacity for ethical enforcement.<sup>26</sup> Yet the second batch of revisions did not abandon laissez-faire ethics altogether. Rather than merely relax the standards of ethical policing, the 1913 *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 1913 *Principles* offered a merely tepid endorsement of medical confidentiality. While the 1847 *Code of Ethics* had praised the protection of patients'

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<sup>25</sup> *Denver Medical Times*, quoted in the *Journal of the American Medical Association* 45:1263 and Konold, 69-70.

<sup>26</sup> Konold, 68-75; Baker, *Before Bioethics*, 220-223.

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 1913 *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,”<sup>27</sup> the 1913 *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.<sup>28</sup>

Like earlier versions, this new clause acknowledged the physician’s need to maintain the confidences of his patients. Yet the 1913 *Principles* also introduced new ethical duties that superseded the physician’s obligation to his patient, allowing the physician to exercise his own judgment on a case-by-case basis.

At the same time, the revisions demonstrated a drastic 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’]

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<sup>27</sup> AMA, *Code of Ethics* (1847).

<sup>28</sup> American Medical Association, *Principles of Medical Ethics of the American Medical Association* (Chicago: 1912), Chapter I, Section 2.

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."<sup>29</sup> By contrast, the 1913 *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 shift in relation to medical confidentiality demonstrates the AMA's increasing acceptance of laissez-faire ethics throughout the early twentieth century. The change in 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 were increasingly willing to violate patients' secrets in service of other, conflicting ethical duties. Increasingly, these 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."<sup>30</sup> 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

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<sup>29</sup> AMA, *Code of Ethics* (1847).

<sup>30</sup> "Liability of a Physician for Revealing out of Court His Patient's Confidences," *Harvard Law Review* 34:3 (January 1, 1921): 312-14.

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 traveller to vacate his hotel room.<sup>31</sup>

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 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, learning later his sores were been nothing more than a false alarm.<sup>32</sup>

In the resulting lawsuit, Simonsen called the physician into court, asking Dr. Swenson to answer for the embarrassment and hardship caused by his mistaken

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<sup>31</sup> *Simonsen v. Swenson*, 1920 NE 104 Neb 224.

<sup>32</sup> *Ibid.*



diagnosis. The physician's story did not contradict that of his patients. 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, developing a friendship, and Mrs. Bristol would frequently refer ailing guests to Swenson. Accordingly, when Simonsen first noticed the symptoms of a mysterious ailment, he was referred to the "hotel doctor."<sup>33</sup>

Upon examining Simonsen, Swenson immediately feared the worst: the patient was suffering from syphilis. To make matters worse, contemporary 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, Simonsen's condition was not just a personal matter for his presence at the hotel risked exposing other guests to this loathsome disease. In an attempt to protect the health and safety of the hotel's guests, the doctor pleaded with his patient to leave the hotel and return home.<sup>34</sup>

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 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.

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<sup>33</sup> *Ibid.*

<sup>34</sup> *Ibid.*

Though Simonsen's embarrassment was regrettable, the doctor argued, the doctor needed to act swiftly to prevent further spread of disease.<sup>35</sup>

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 attorney's 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."<sup>36</sup> To doctors and lawyers *Simonsen* 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."<sup>37</sup>

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 had continued throughout the nineteenth century slowly came to a halt. With the exception of the U.S. territories of Puerto Rico (1911)

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<sup>35</sup> *Ibid.*

<sup>36</sup> *Ibid.*

<sup>37</sup> *Ibid.*

and the Virgin Islands (1920), no new jurisdictions adopted physician-patient privilege between 1906 and 1925.<sup>38</sup> While the law has continued to evolve through judicial interpretation and occasional amendments to these codes, the wave of legislation that produced many of the physician-patient privilege statutes still in effect today had come to a close.

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<sup>38</sup> Wigmore, *On Evidence* 4<sup>th</sup> ed., 803-805.

## CHAPTER VII

### EPILOGUE: MEDICAL CONFIDENTIALITY TODAY

In February 2004, conflict arose as Planned Parenthood challenged the legality of the legality of the *Partial-Birth Abortion Ban Act*. The 2003 law, Planned Parenthood argued, was unconstitutional, as the procedure was often medically necessary and, therefore, the ban violated women's constitutional right to have an abortion. The Bush administration, searching for evidence to support the anti-abortion claim that most of these procedures occurred on healthy women, subpoenaed the medical records of 2,700 women who had received abortions through Planned Parenthood. Clinics and hospitals in six states—California, New York, Kansas, Missouri, Washington, and Pennsylvania—were to send their patient records to the federal government.<sup>1</sup>

According to the Justice Department, the acquisition of patient records was legal because federal law "does not recognize a physician-patient privilege." In spite of objections from reproductive rights advocates, U.S. District Judge Richard Conway Casey found the Justice Department's arguments convincing, mandating that Planned Parenthood turn over its patient records.<sup>2</sup> In the weeks that followed, however, several federal courts ruled in favor of Planned Parenthood. "There is no

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<sup>1</sup> Howard Markel, "When Big Brother Invades the Examining Room," *New York Times* (March 16, 2004), Terry Freiden, "US Drops fight to Get Abortion Records," *CNN Law Center* (June 1, 2004); Robert Pear and Eric Lichtblau, "Administration Sets Forth a Limited View on Privacy," *New York Times* (March 6, 2004), and Steve Hymon, "U.S. Subpoenas Records of Abortion Repipients," *Los Angeles Times* (February 27, 2004).

<sup>2</sup> Pear and Lichtblau, "Administration Sets Forth a Limited View on Privacy."

question that the patient is entitled to privacy and protection," Judge Phyllis J Hamilton stated, "Women are entitled to not have the government looking at their records."<sup>3</sup> Likewise, U.S. chief District Judge Charles Kocoras "halted an attempt to subpoena records of about forty patients who had received abortions at Northwestern Memorial Hospital in Chicago," stating that these requests violated Illinois' medical confidentiality laws.<sup>4</sup> In response to mounting criticism from professionals and public alike, the Bush administration eventually relented.

This brief episode illustrates several major changes that have transformed debates over medical confidentiality during the past century. No longer debated solely by doctors and lawyers, physician-patient privilege has now entered public discourse. The medical confidentiality, however, laws of the nineteenth century were enacted at the behest of professionals—doctors and legal scholars—not the public. While sporadic newspaper articles referenced medical confidentiality,<sup>5</sup> indicating that patients likely expected their doctors to preserve their secrets, there is little evidence to suggest the public actively pushed for legislation on the issue. When physicians—even the eminent gynecologist James Marion Sims—violated patient confidentiality, there was seldom any public outcry. By contrast, nearly every major American newspaper covered the protracted court battle between the Justice Department and Planned Parenthood.

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<sup>3</sup> Pear and Lichtblau, "Administration Sets Forth a Limited View on Privacy."

<sup>4</sup> Hymon, "U.S. Subpoenas Records of Abortion Recipients."

<sup>5</sup> See, for example, coverage of a proposed Illinois statute in "Abbreviated Telegrams," *The Rock Island Argus* (December 8, 1896).

Nevertheless, this 2004 case demonstrates several continuities in the debate surrounding physician-patient-privilege. 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. While the Bush administration could point to the lack of a federally recognized physician-patient privilege, owing to a legal precedent established in 1776, proponents of the privilege could point to myriad state laws mandating that doctors observe their patients’ confidences at all times. Uncertainty surrounding medical confidentiality laws—a byproduct of the long and fractured history of physician-patient privilege in America—enables both proponents and critics of medical confidentiality to claim that the law is on their side.

Though notions of medical confidentiality have increasingly become linked to contemporary issues such as reproductive rights—a topic worthy of further study—much of the rhetoric surrounding physician-patient-privilege echoes the arguments of earlier debates. 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. As such, the numerous statutes guaranteeing physician-patient privilege constitute a considerable obstacle to an efficient judicial process. At the same time, however,

these laws—unenforceable in federal courts—do not do enough to ensure patients feel secure that their medical secrets will remain confidential.

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