

sonable and necessary as to time¹³ and area.¹⁴ While subjected to early criticism,¹⁵ the doctrine of partial enforcement is being accepted by an increasing number of courts¹⁶ and leading authorities in the field of contracts.¹⁷

Concededly, the application of the partial enforcement rule will inevitably result in the enforcement of a contract different from that for which the parties bargained.¹⁸ Where the only alternative is to refuse enforcement entirely, however, this objection loses much of its force. Clearly, partial enforcement more nearly effectuates the intent of the contracting parties than does invalidating the covenant in its entirety.¹⁹ To permit partial enforcement of restrictive covenants within the limits of the established public policy prohibiting contracts in restraint of trade does not appear to be an undue extension of equitable principles. While not yet accepted by the majority of courts, the clear trend of the better-reasoned recent cases is toward application of this rule, and the decision of the Supreme Court of Wisconsin in the principal case is a sound one.

EVIDENCE—PHYSICIAN-PATIENT PRIVILEGE EXCLUDES
TESTIMONY REGARDING ACCUSED'S SANITY BY
PSYCHIATRIST OF PUBLIC MENTAL HOSPITAL

Taylor v. United States, 222 F.2d 398 (D.C. Cir. 1955)

Defendant was indicted for grand larceny, robbery, and house-breaking. Prior to trial, a court-appointed psychiatrist,¹ after examining defendant on several occasions, concluded that he was afflicted with severe schizophrenia² and was mentally incompetent to

13. *Whiting Milk Co. v. O'Connell*, 277 Mass. 570, 179 N.E. 169 (1931); *Brannen v. Bouley*, 272 Mass. 67, 172 N.E. 104 (1930); *Edgcomb v. Edmonston*, 257 Mass. 12, 153 N.E. 99 (1926).

14. *Metropolitan Ice Co. v. Ducas*, 291 Mass. 403, 196 N.E. 856 (1935).

15. *Compare* 15 B.U.L. REV. 834 (1935), *with* 32 B.U.L. REV. 224 (1952).

16. *John Roane, Inc. v. Tweed*, 89 A.2d 548 (Del. 1952); *Ceresia v. Mitchell*, 242 S.W.2d 359 (Ky. 1951); *American Weekly, Inc. v. Patterson*, 179 Md. 109, 16 A.2d 912 (1940).

17. 6 CORBIN, CONTRACTS § 1390 (1951); 5 WILLISTON, CONTRACTS § 1660 (rev. ed. 1937); *Williston & Corbin, On the Doctrine of Beit v. Beit*, 23 CONN. B.J. 40 (1949).

18. This was the argument of the dissenting judge in the principal case. *Fullerton Lumber Co. v. Torborg*, 70 N.W.2d 585, 594 (Wis. 1955).

19. It should be noted that if there is any evidence of a deliberate plan to coerce the acceptance of oppressive conditions, the restrictive covenant will be held invalid under either the "divisibility" or "partial enforcement" test. *Fullerton Lumber Co. v. Torborg*, 70 N.W.2d 585, 592 (Wis. 1955); 5 WILLISTON, CONTRACTS § 1660 (rev. ed. 1937).

1. The psychiatrist was appointed under 18 U.S.C. § 4244 (1952), which authorizes the court, on its own motion, to appoint a psychiatrist to examine an accused if there is "reasonable cause to believe" he is mentally incompetent for trial.

2. Schizophrenia is one of the most common of mental illnesses. The schizophrenic, commonly considered to have a "split personality," is generally afflicted with delusions and hallucinations which may result in criminal or anti-social behavior. GUTTMACHER & WEIHOFEN, PSYCHIATRY AND THE LAW 72-85 (1952).

stand trial. The court consequently committed defendant to a public mental hospital for further diagnosis and treatment. After seven months of confinement defendant's competency was certified, and trial was held in the federal district court of the District of Columbia.

At the trial, in support of defendant's plea of insanity, the psychiatrist previously appointed by the court testified that defendant's conduct while being examined prior to his confinement in the mental hospital strongly indicated that he was insane³ at the time the crimes were committed. A second psychiatrist, who had treated defendant in the mental hospital, then was permitted to testify for the prosecution that defendant had freely admitted during his confinement that he had faked the symptoms of schizophrenia he had exhibited when examined by the court-appointed psychiatrist. Defendant was convicted. On appeal, the Court of Appeals of the District of Columbia held that the information acquired by the hospital psychiatrist was privileged under the local statute,⁴ and that its admission without defendant's consent was reversible error.⁵

The physician-patient privilege,⁶ unrecognized at common law,⁷ was created originally by legislation in New York in 1828⁸ and is presently established by statute in thirty-one states and the District of Columbia.⁹ In view of the extreme diversity of the various statu-

3. The psychiatrist testified that defendant could not distinguish "right and wrong" in any major activity. Brief for Appellee, pp. 12, 13, *Taylor v. United States*, 222 F.2d 398 (D.C. Cir. 1955). The principal case was tried in the district court while the "right-wrong" test of insanity prevailed in the District of Columbia. Subsequently, in *Durham v. United States*, 214 F.2d 862 (D.C. Cir. 1954), 1955 WASH. U.L.Q. 86, the Court of Appeals of the District of Columbia adopted a new test of insanity, under which an accused is not criminally responsible if his action was the result of "mental disease or mental defect."

4. D.C. CODE ANN. § 14-308 (1951).

5. *Taylor v. United States*, 222 F.2d 398 (D.C. Cir. 1955). Additional grounds for reversal stated by the court were the trial judge's improper instructions to the jury and his failure to make a judicial determination of defendant's competency for trial as required by *Gunther v. United States*, 215 F.2d 493 (D.C. Cir. 1954).

6. The term "privilege" is a misnomer. If the patient takes the witness stand he cannot invoke the physician-patient privilege in order to refuse to give testimony. Nor can the physician himself invoke the privilege. The "privilege" is really a power of the patient, by timely objection, to require the physician to refuse to divulge information which is inadmissible under the applicable statute. See Comment, 31 YALE L.J. 529 (1922).

7. The classic statement of the common law view was by 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 any indiscretion whatever.

The *Trial of the Duchess of Kingston*, 20 How. St. Tr. 355, 573 (1776).

The common law view denying any general privilege to communications between physician and patient prevails in the following states: Alabama, Connecticut, Delaware, Florida, Georgia, Illinois, Maine, Maryland, Massachusetts, New Hampshire, New Jersey, Rhode Island, South Carolina, Tennessee, Texas, Vermont, and Virginia.

8. For a discussion of the early statutes, see 8 WIGMORE, EVIDENCE § 2380 (3d ed. 1940).

9. ARIZ. CODE ANN. §§ 23-103, 44-2702 (1939); ARK. STAT. ANN. § 28-607 (1947); CAL. CODE CIV. PROC. ANN. (EVID.) § 1881 (1946); COLO. REV. STAT. §

tory provisions,¹⁰ evaluation of the judicial opinions interpreting the privilege is hazardous.¹¹ The decision in each case must be viewed in light of the particular provisions of the jurisdiction's privilege statute. Thus, a proper determination of the principal case turns on the provisions of the District of Columbia Code, which provides for the privilege in its most familiar form:

[N]o physician or surgeon shall be permitted, without the consent of the person afflicted, or of his legal representative, to disclose any information, confidential in its nature, which he shall have acquired in attending a patient in a professional capacity and which was necessary to enable him to act in that capacity. . . .¹²

Since there was clearly a physician-patient relationship between the hospital psychiatrist and the defendant at the time of the treatment, there were two major questions which confronted the court. First, in order to determine whether the information acquired by the hospital psychiatrist was privileged, the court had to decide whether the relation between a psychiatrist in a public mental hospital and a patient confined therein was the type of "confidential" relation con-

153-1-7 (1953); D.C. CODE ANN. § 14-308 (1951); IDAHO CODE ANN. § 9-203 (1947); IND. ANN. STAT. § 2-1714 (Burns 1946); IOWA CODE ANN. c. 31, § 622.10 (1946); KAN. GEN. STAT. § 60-2805 (1949); KY. REV. STAT. § 213.200 (1953); LA. REV. STAT. ANN. § 15:476 (1950); MICH. STAT. ANN. § 27-911 (1938); MINN. STAT. ANN. § 595.02 (West 1945); MISS. CODE ANN. § 1697 (Supp. 1954); MO. REV. STAT. § 491.060 (1949); MONT. REV. CODES ANN. §§ 93-701-4, 94-8801 (1947); NEB. REV. STAT. §§ 25-1206, 25-1207 (1943); NEV. COMP. LAWS § 8974 (Supp. 1949); N.M. STAT. ANN. § 20-1-12 (1953); N.Y. CIV. PRAC. ACT § 352 (Supp. 1942), § 354 (Supp. 1946); N.Y. CRIM. CODE § 392 (1939); N.C. GEN. STAT. § 8-53 (1953); N.D. REV. CODE §§ 31-0106, 31-0107 (1943); OHIO CODE ANN. § 2317.02 (Supp. 1953); OKLA. STAT. ANN. tit. 12, § 385 (Supp. 1954); ORE. REV. STAT. § 44.040 (1953); PA. STAT. ANN. tit. 28, § 328 (1930); S.D. CODE §§ 36.0101, 36.0102 (1939); UTAH CODE ANN. § 78-24-8 (1953); WASH. REV. CODE ANN. §§ 5.60.060, 10.52.020 (1951); W. VA. CODE ANN. § 4992 (1955); WIS. STAT. § 325.21 (1953); WYO. COMP. STAT. ANN. § 3-2602 (1945).

10. The physician-patient privilege is limited to civil actions in six states: California, Idaho, Oregon, Pennsylvania, South Dakota, and Utah. See statutes cited in note 9 *supra*. In Louisiana the privilege apparently is restricted to criminal cases. *Rhodes v. Metropolitan Life Ins. Co.*, 172 F.2d 183 (5th Cir. 1949), *cert. denied*, 337 U.S. 930 (1949). In West Virginia the privilege applies only in justice of the peace courts. *Mohr v. Mohr*, 119 W. Va. 253, 193 S.E. 121 (1937). In the remaining jurisdictions cited in note 9 *supra*, the privilege is applicable both in civil and criminal actions.

The statutes also vary as to the subject matter of the privilege. Compare KAN. GEN. STAT. § 60-2805 (1949), with WIS. STAT. § 325.21 (1953). As to the provisions for waiver of the privilege, compare MO. REV. STAT. § 491.060 (1949), with NEV. COMP. LAWS § 8974 (Supp. 1949).

11. Dean Wigmore is especially caustic in his criticism of the privilege. 8 WIGMORE, EVIDENCE §§ 2380-91 (3d ed. 1940). This view is prevalent among legal scholars generally. See, e.g., Chafee, *Privileged Communications: Is Justice Served or Obstructed by Closing the Doctor's Mouth?* 52 YALE L.J. 607 (1943); DeWitt, *Medical Ethics and the Law*, 5 WESTERN RES. L. REV. 5 (1953); Purring-ton, *An Abused Privilege*, 6 COLUM L. REV. 388 (1906).

12. The statute further provides that the privilege is inapplicable in criminal cases in which the accused is charged with injuring or causing the death of a human being, if the disclosure is found to be needed in the interests of "public justice." D.C. CODE ANN. § 14-308 (1951).

templated by the statute.¹³ Secondly, if such relation was found to be confidential, and the information acquired therefrom was held to be privileged, then the court had to determine whether defendant had waived his privilege by permitting the court-appointed psychiatrist to testify regarding his mental condition.

In support of its contention that the physician-patient privilege was inapplicable, the prosecution relied on numerous cases which have refused to recognize the privilege when the physician involved was not selected by the patient.¹⁴ In such cases, however, the physician was not employed to *treat*, *i.e.*, to prescribe a remedy for the patient, but merely to *examine* him preparatory to testifying in a subsequent trial as to his physical or mental condition. The courts in such a situation have readily concluded that the patient would not impart any "confidential" data if he knew that the physician intended to divulge in court any information obtained.¹⁵ In cases in which the physician's function was actually to treat the patient the majority of courts have considered the source of the physician's employment as immaterial to the determination of the confidentiality of the relation.¹⁶ In only two states have courts held the privilege inapplicable because of the lack of a "confidential" relation when the patient was treated by a physician not of his own choosing.¹⁷

13. Although not discussed by the court, another issue involved was whether defendant's admissions to the hospital psychiatrist were "necessary" for treatment as provided in the statute. Courts generally have not required strict proof that the information was "necessary" for treatment. See, *e.g.*, *Pennsylvania Co. v. Marion*, 123 Ind. 415, 23 N.E. 973 (1890); *Gilham v. Gilham*, 177 Pa. Super. 328, 110 A.2d 915 (1955). Seemingly, such an attitude should be particularly appropriate in psychiatric cases, in which anything the patient reveals may be material to treatment. See GUTTMACHER & WEIHOFEN, *PSYCHIATRY AND THE LAW* 77 (1952). Chafee has argued for a broad interpretation of the "necessary" provision in the statutes, as the patient should not be expected to tell his story to his physician "with the circumspection of a lawyer drawing pleadings." Chafee, *supra* note 11, at 614.

14. *Catoe v. United States*, 131 F.2d 16 (D.C. Cir. 1942); *Commonwealth v. DiStasio*, 294 Mass. 273, 1 N.E.2d 189 (1936); *Simecek v. State*, 243 Wis. 439, 10 N.W.2d 161 (1943). See Brief for Appellee, pp. 47-52, *Taylor v. United States*, 222 F.2d 398 (D.C. Cir. 1955).

15. In addition to the cases cited in note 14 *supra*, well-reasoned opinions are found in *People v. Glover*, 71 Mich. 303, 38 N.W. 874 (1888); *People v. Austin*, 199 N.Y. 446, 93 N.E. 57 (1910); *Leard v. State*, 30 Okla. Crim. 191, 235 Pac. 243 (1925); *State v. Miller*, 177 Wash. 442, 32 P.2d 535 (1934).

16. *Gerick v. Brock*, 210 P.2d 214 (Colo. 1949); *State v. Townsend*, 146 Kan. 982, 73 P.2d 1124 (1937); *Vermillion v. Prudential Ins. Co.*, 230 Mo. App. 993, 93 S.W.2d 45 (1936); *Garrett v. City of Butte*, 69 Mont. 214, 221 Pac. 537 (1923); *Mehegan v. Faber*, 158 Wis. 645, 149 N.W. 397 (1914). In *Munz v. Salt Lake City R.R.*, 25 Utah 220, 70 Pac. 852 (1902), the court adopted the rather extreme position that there was a "presumption" of confidentiality in any situation involving a physician-patient relation.

17. *Munzer v. Blaisdell*, 183 Misc. 773, 49 N.Y.S.2d 915 (Sup. Ct. 1944), *aff'd*, 269 App. Div. 970, 58 N.Y.S.2d 359 (1st Dep't 1945); *Lumpkin v. Metropolitan Life Ins. Co.*, 75 Ohio App. 310, 62 N.E.2d 189, *aff'd*, 146 Ohio St. 25, 64 N.E.2d 63 (1945). Conflicting results have been reached, however, within each of these jurisdictions. See, in opposition to the cases cited, *Westphal v. State*, 191 Misc. 688, 79 N.Y.S.2d 634 (Ct. Cl. 1948); *Lamarand v. National Life & Accident Ins. Co.*, 58 Ohio App. 415, 16 N.E.2d 701 (1937).

In finding the relationship between defendant and the hospital psychiatrist to be "confidential" within the meaning of the statute, the court in the instant case has adopted a sound view. In determining confidentiality the judicial inquiry should be directed, not merely to the source of the physician's employment, but to the entire context of the relationship between physician and patient. Furthermore, in a factual situation such as that in the instant case, there are strong policy considerations to justify the finding of a confidential relationship. The most frequently asserted justification for the physician-patient privilege is that a patient will hesitate to reveal his ailments to a physician if he knows that his disclosures will not remain confidential.¹⁸ While the validity of such reasoning is doubtful in regard to most illnesses,¹⁹ psychiatric cases appear to be in a special category.²⁰ The psychiatrist must have the complete confidence of his patient in order to evoke the highly personal data which is often needed to prescribe proper treatment.²¹ The possibility that such information could be publicly revealed would be an effective deterrent to the patient's disclosures. Where the patient is confined in a mental hospital pending trial, as in the principal case, the very purpose of his confinement—diagnosis and treatment of his mental condition—would be thwarted if the patient even suspected that the information would be subsequently divulged in court.

Conceding, then, that the court properly found that there was a confidential relation between defendant and the hospital psychiatrist, and that the information acquired by the latter was privileged, the further question, whether defendant impliedly waived the privilege by permitting the court-appointed psychiatrist to testify to his mental condition, is presented. It is in this area of implied waiver that the main judicial controversy regarding the physician-patient privilege has centered. The apparent conflict in the decisions is partially attributable to the dissimilarity of the various statutory provisions. The absence of any provision for waiver in a statute has been inter-

18. See, e.g., *Jacobs v. City of Cedar Rapids*, 181 Iowa 407, 164 N.W. 891 (1917); *Green v. Terminal R.R.*, 211 Mo. 18, 109 S.W. 715 (1908).

19. 8 WIGMORE, EVIDENCE § 2380a (3d ed. 1940); *Purrington, An Abused Privilege*, 6 COLUM. L. REV. 388 (1906).

20. A note in 47 NW. U.L. REV. 384 (1952), reports an Illinois circuit court case, *Binder v. Ruvell*, Civil No. 52C2535, D. Ill., June 24, 1952, which recognized a privilege for a patient's communications to a psychiatrist in an alienation of affections case. The case is extraordinary since Illinois has no physician-patient privilege statute. The court reasoned that the consultations between patient and psychiatrist are more nearly analogous to a confessional between priest and penitent than to the ordinary physician-patient relation.

21. GUTTMACHER & WEIHOFEN, PSYCHIATRY AND THE LAW 270-72 (1952). In stressing the need of the privilege in psychiatric cases, the authors state:

The psychiatric patient confides more utterly than anyone else in the world. He lays bare not only what his words directly express; he lays bare his entire self, his dreams, his fantasies, his sins, and his shame.

Id. at 272.

preted by some courts as an expression of "legislative intent" to have no implied waiver of the privilege.²² Other statutes providing for waiver in certain situations are interpreted, under the *exclusio alterius* maxim of construction, as excluding the possibility of a waiver of the privilege in situations not expressly recognized in the statute.²³ In addition, some courts insist that the privilege statute should be strictly construed because it is in derogation of common law,²⁴ while others assert that the statute is remedial and entitled to liberal construction.²⁵ Thus, the judicial confusion is apparent.

Courts are generally agreed that there is an implied waiver of the privilege when the patient, voluntarily testifying in his own behalf, details the nature of his illness and the information which he had furnished to his physician.²⁶ Similarly, the introduction of the physician's testimony by the patient waives the privilege to the extent of permitting the opponent to cross-examine the physician as to any information acquired during the course of treatment.²⁷ If a patient, after joint treatment by two or more physicians, introduces the testimony of one of the physicians, most courts find a waiver of the privilege as to the other physicians present during the treatment.²⁸ When the treatment is by two or more physicians at different times, the courts are not agreed as to whether the patient impliedly waives the privilege by consenting to the testimony of one of the physicians. A majority of courts have held that the privilege is not waived in such a case, reasoning that the intent of the patient was only to waive the privilege as to the particular physician who was permitted to testify.²⁹

22. *Smart v. Kansas City*, 208 Mo. 162, 105 S.W. 709 (1907); *Larson v. State*, 92 Neb. 24, 137 N.W. 894 (1912).

23. See, e.g., *Arizona & N.M. Ry. v. Clark*, 235 U.S. 669 (1915) (interpreting Arizona law); *Pennsylvania R.R. v. Durkee*, 147 Fed. 99 (2d Cir. 1906) (interpreting New York law).

24. *Baltimore & O.R.R. v. Morgan*, 35 App. D.C. 195 (1910); *Armstrong v. Topeka Ry.*, 93 Kan. 493, 144 Pac. 847 (1914).

25. *Jacobs v. City of Cedar Rapids*, 181 Iowa 407, 164 N.W. 891 (1917); *Munz v. Salt Lake City R.R.*, 25 Utah 220, 70 Pac. 852 (1902).

26. *Woods v. Incorporated Town of Lisbon*, 150 Iowa 433, 130 N.W. 372 (1911); *Apter v. Home Life Ins. Co.*, 266 N.Y. 333, 194 N.E. 846 (1935). When the patient testifies only to general statements regarding his ailments, such testimony is usually not interpreted by the courts as a waiver of the privilege. *Arizona & N.M. Ry. v. Clark*, 235 U.S. 669 (1915) (interpreting Arizona law); *Green v. Town of Nebagamain*, 113 Wis. 508, 89 N.W. 520 (1902).

27. *Maas v. Laursen*, 219 Minn. 461, 18 N.W.2d 233 (1945); *State v. Litteral*, 227 N.C. 527, 43 S.E.2d 84 (1947).

28. *Doll v. Scandrett*, 201 Minn. 316, 276 N.W. 281 (1937); *Morris v. New York, O. & W. Ry.*, 148 N.Y. 88 (1895); *Cretney v. Woodmen Accident Co.*, 196 Wis. 29, 219 N.W. 448 (1928). *Contra*, *Jones v. City of Caldwell*, 20 Idaho 5, 116 Pac. 110 (1911).

29. *Baltimore & O.R.R. v. Morgan*, 35 App. D.C. 195 (1910); *Missouri & N.A.R.R. v. Daniels*, 98 Ark. 352, 136 S.W. 651 (1911); *Acme-Evans Co. v. Schnepf*, 214 Ind. 394, 14 N.E.2d 561 (1938); *Johnson v. Kinney*, 232 Iowa 1016, 7 N.W.2d 188 (1942); *United States Fidelity & Guaranty Co. v. Hood*, 124 Miss. 548, 87 So. 115 (1920); *Larson v. State*, 92 Neb. 24, 137 N.W. 894 (1912).

A substantial number of courts, however, perceiving the obvious opportunities for fraud, have held that a waiver of privilege as to one physician also waives the privilege as to others, regardless of the separation in time of their treatments.³⁰ The instant case is somewhat unique in that defendant could not have successfully invoked a privilege as to the testimony of the court-appointed psychiatrist even if he had so desired, since the psychiatrist's function was merely to examine defendant in order to determine his competency for trial.³¹ Thus, defendant did not technically waive his privilege by introducing the testimony of the court-appointed psychiatrist. The question remains, however, whether defendant's introduction of the testimony of the court-appointed psychiatrist eliminated any further need for secrecy regarding his mental condition, and therefore, as a matter of fairness, constituted an implied waiver of the privilege to object to the hospital psychiatrist's testimony.

Courts which have refused to imply a waiver of the privilege in situations similar to that in the instant case have justified their decisions under the familiar doctrine that waiver is a voluntary, intentional relinquishment of a known right. This rationale, however, overlooks the forceful consideration that an implied waiver should be found, regardless of intention, when the patient's conduct has been such that it would be both illogical and unjust to permit him to assert the privilege.³² The privilege is not designed, after all, to give the patient complete control of the presentation of evidence regarding his physical or mental condition; rather, it is established to enable the patient to prevent public disclosure of matters of personal confidence. It must be remembered that the application of the privilege results in the exclusion of reliable, relevant—often essential—evidence; it is only when there is a strong social utility in the furtherance of the privilege that the exclusion of such evidence can be justified. There is certainly no justification for a rule under which a patient may permit a physician favorable to his case to testify regarding his ailments and then to assert a privilege when any other physician who treated him seeks to contradict such testimony.³³ Therefore, it

30. *Armstrong v. Topeka Ry.*, 93 Kan. 493, 144 Pac. 847 (1914); *State v. Sapp*, 356 Mo. 705, 203 S.W.2d 425 (1947); *Steinberg v. New York Life Ins. Co.*, 263 N.Y. 45, 188 N.E. 152 (1933); *McUne v. Fuqua*, 42 Wash. 2d 65, 253 P.2d 632 (1953).

31. See text supported by notes 14-15 *supra*.

32. 8 WIGMORE, EVIDENCE § 2388 (3d ed. 1940); MCCORMICK, EVIDENCE 219 (1954).

33. The leading proposed evidence codes contain provisions which would exclude the privilege in a situation such as was present in the principal case. See MODEL CODE OF EVIDENCE rules 220(1), 223(3) (1942); UNIFORM RULES OF EVIDENCE rule 27 (1953); WIGMORE, CODE OF EVIDENCE rule 216, art. 7(5) (3d ed. 1942).

Citing the principal case as an example of an overly broad interpretation of the privilege, the new Model Penal Code provides:

would seem that the court in the instant case should have ruled that defendant's introduction of the testimony of the court-appointed psychiatrist constituted an implied waiver of his privilege to object to the testimony of the hospital psychiatrist.

A statement made by a person subjected to psychiatric examination or treatment . . . for the purposes of such examination or treatment shall not be admissible in evidence against him in any [criminal] proceeding on any issue other than that of his mental condition but it shall be admissible upon that issue, whether or not it would otherwise be deemed to be a privileged communication.

MODEL PENAL CODE § 409, comment at 201 (Tent. Draft No. 4, 1955).