Protecting the Privacy of the Absent Patient: Rudnick v. Superior Court

Ralph W. Tarr
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The physician-patient privilege has been criticized for being a device which allows the "suppression of useful truth." In response, California has narrowly limited the privilege by grafting onto it a series of exceptions. One of the purposes which the privilege still serves, however, is the protection of the privacy of a patient who is not a party to a civil proceeding. A recent California Supreme Court case, Rudnick v Superior Court, concerned the effectiveness of the privilege statute in accomplishing this purpose. Broadly construing the physician-patient privilege, the court held that when the disclosure of a patient's medical information to a third party is reasonably necessary to the patient's treatment, the third party may assert the privilege on behalf of the absent patient, whether or not the patient has consented to the disclosure. The opinion in Rudnick unfortunately provided little insight into the meaning of the statutory language, "reasonably necessary." Emphasizing the protection of patient privacy, this note will examine the Rudnick decision and its applicability to the rapidly proliferating number and variety of third parties who are privy to confidential medical information. A history of the privilege at both national and state levels will be followed by the argument that for privacy to be efficaciously protected, the Rudnick ruling should be extended beyond mere authorization to include the imposition of a duty upon the third party to assert, and the court to recognize, the privilege on behalf of the absent patient. The final section evaluates the "reasonable necessity" of various third parties who receive confidential medical information.

History

Since 1851, California has recognized the confidentiality of the physician-patient relationship by statutorily providing that information arising from this relationship be privileged from disclosure in civil
matters.\textsuperscript{5} Such a physician-patient privilege was not recognized at common law,\textsuperscript{6} and its first statutory appearance in America was in New York's 1828 Field Code.\textsuperscript{7} California's statute, patterned after the New York provision, guarded "against the possibility of [the patient's] feelings being shocked or his reputation tarnished by . . . subsequent disclosure [of his medical condition]."\textsuperscript{8}

The early California position, expressed in former Code of Civil Procedure section 1881(4), was arguably adequate to protect the privacy of the patient's communications to his physician, given the nature of the physician-patient relationship and the standard practice of medicine at the time. During that period, California had a basically rural society which allowed a very personal relationship to develop between the patient and his physician. The physician was more than merely a healer of physical illness. He was a family friend, attending to a wide range of problems and often receiving payment in kind or none at all. In those times the physician was truly a general practitioner.

The nature of this relationship has radically changed since 1851.\textsuperscript{9}

\textsuperscript{5} "A licensed physician or surgeon shall not, without the consent of his patient, be examined as a witness, as to any information acquired in attending the patient, which was necessary to enable him to prescribe or act for the patient." Cal. Stat. 1851, ch. 5, § 398 at 114 (codified at CAL. CODE CIV. PROC. § 1881 (West 1966) (repealed 1966, West Supp. 1975)). The former privilege statute will be referred to as section 1881. Section 1881 also contained the marital, lawyer-client, clergyman-penitent, government, and reporter privileges. The physician-patient privilege is now codified in CAL. EVID. CODE §§ 990-1007 (West 1966 & Supp. 1975).

\textsuperscript{6} "If a surgeon was voluntarily to 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 the land he is bound to do, will never be imputed to him as any indiscretion whatever." 8 Wigmore, supra note 1, § 2380, at 818, quoting The Duchess of Kingston's Trial, 20 How. St. Trials 355, 573 (1776) (Mansfield L.C.J.); C. McCORMICK, EVIDENCE, § 98, at 212 (2d ed. 1972) [hereinafter cited as McCORMICK]. England still follows this case, as do most of the British Commonwealth countries. 26 HALSbury'S LAWS OF ENGLAND (3d ed. 1959) Medicine and Pharmacy 11. Most European countries, however, have long recognized the privilege. "Under the Civil Law, communications between a physician and his patient were at all times considered confidential and sacred. Without the consent of the patient, the physician could not disclose at any time, either in court or elsewhere, any information regarding the health or physical condition of the patient which he acquired in his professional capacity. Today, in most European countries, the relationship of physician and patient is completely protected by a cloak of privilege." C. DeWITT, PRIVILEGED COMMUNICATIONS BETWEEN PHYSICIAN AND PATIENT 9 n.1 (1958) [hereinafter cited as DeWITT].

\textsuperscript{7} "No person authorized to practice physic or surgery shall be allowed to disclose any information which he may have acquired in attending any patient, in a professional character, and which information was necessary to enable him to prescribe for such patient as a physician, or to do any act for him as a surgeon." McCORMICK, supra note 6, § 98 at 212 n.3, quoting N.Y. Rev. Stat. tit. 3 § 73 (1829).

\textsuperscript{8} In re Estate of Flint, 100 Cal. 391, 397, 34 P. 863, 864 (1893).

\textsuperscript{9} California Assembly Select Committee on Medical Malpractice, Preliminary
The once personal relationship between physician and patient has yielded to the inclusion of numerous third parties in the normal course of treatment. Rapid urbanization and population growth have dramatically increased the physician's workload and thus the physician is required to keep a greater volume of records and to employ various medical and non-medical personnel to assist him in that task. Further, with increased specialization in the medical field it has become necessary more frequently for the general practitioner to refer patients to specialists. Similarly, the advent of computers and other data analyzing and storage systems has resulted in increases in the amount and availability of information to greater numbers of medical and non-medical personnel. Another factor in this expansion of persons involved in the normal course of treating a patient has been the extensive government regulation of drugs. In many cases a patient (or his physician) must communicate the patient's medical information to a licensed pharmacist to acquire needed medication. Government agencies have also become actively involved in protecting the public against the effects of certain medical conditions and to that end require physicians to report the incidence of communicable diseases or illnesses which might result in a patient's unexpected loss of consciousness. Finally, the skyrocketing cost of medical care requires that all but a very few in this country purchase some form of medical insurance to meet those costs, and recovery under a policy necessitates that the physician transmit the patient's medical information to the insurance company.

As this proliferation of third parties privy to confidential data acquired in the context of the physician-patient relationship began to gain momentum, an increasing amount of information lost the protection of the confidentiality provision. This problem arose because form-
er section 1881(4) spoke only in terms of the "physician or surgeon" and did not include nurses, interns, pharmacists and other third parties who received the patient's medical information in the normal course of treatment. Although the courts in California liberally construed the physician-patient privilege in favor of the patient as to the scope of the communications covered, they strictly construed section 1881(4) as to the persons who came within its provisions. Green v. Superior Court was the leading case on this point. In Green, the husband in a divorce action involving child custody subpoenaed several pharmacists from whom the wife had purchased her prescription drugs. The pharmacists appeared without their records and refused to testify concerning the nature and strength of the drugs they had dispensed to the wife. When they were found guilty of contempt, the pharmacists sought review of the order. The court of appeal affirmed the contempt order, holding that the pharmacists were not authorized by section 1881(4) to assert the physician-patient privilege on behalf of their customers.

In 1965 the California legislature responded to the societal trend toward a greater number and variety of third persons in the physician-patient relationship in the process of repealing section 1881 and replacing it with an entire chapter of the Evidence Code which sets out the various privileges in much greater detail. The current physician-patient

puterized data banks and the immense amount of detailed information requested by government, insurance companies and employers—confidentiality of patient-physician communications and patient medical records has been endangered."

14. See note 5, supra.
18. There was an alternative reason in this case for the pharmacists being refused permission to assert the privilege. The wife had placed her fitness to care for the children in issue and therefore the "patient-litigant" exception to the privilege applied, eliminating her physician-patient privilege as to this issue. (This exception was included in former section 1881(4) and is now codified at Cal. Evid. Code § 996 (West 1966). As a result, even if the court had found that the pharmacists were authorized to assert the privilege, there would have been no privilege to assert in Green.
privilege statute, as contained in Evidence Code sections 990 through 1007, defines "confidential communication" to include information given to third parties in the normal course of treatment. Thus, as long as information was generated by the physician-patient relationship, the fact that it was acquired by certain third parties does not prevent the protection of the patient's privacy.

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Despite this statutory clarification, the precise boundaries of the newly expanded privilege remain undefined. Some circumstances, though, are clearly either appropriate or inappropriate for application of the privilege. For example, if the patient is the plaintiff and has placed his health in issue, the physician-patient privilege does not apply. If, on the other hand, the patient is the defendant and the plaintiff has attempted to place the defendant's health in issue, the privilege may be asserted. In this case the defendant can refuse to testify concerning confidential matters and can prevent either his doctor or a third party from doing so. There is a third possibility, however. In this situation the patient is not a party to the suit, is even perhaps unaware that the suit is pending, and a party to the suit attempts to discover or introduce into evidence confidential communications between the patient and his

20. "As used in this article, 'confidential communication between patient and physician' means information, including information obtained by an examination of the patient, transmitted between a patient and his physician in the course of that relationship and in confidence by a means which, so far as the patient is aware, discloses the information to no third persons other than those who are present to further the interest of the patient in the consultation or those to whom disclosure is reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the physician is consulted, and includes a diagnosis made and the advice given by the physician in the course of that relationship." Cal. Evid. Code § 992 (West Supp. 1975).

21. This relationship exists only when a person "consults a physician or submits to the examination by a physician for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his physical or mental or emotional condition." Cal. Evid. Code § 991 (West 1966).

22. Cal. Evid. Code § 996 (West 1966). This exception is referred to as the "patient-litigant" exception.


24. "Subject to Section 912 and except as otherwise provided in this article, the patient, whether or not a party, has a privilege to refuse to disclose, and to prevent another from disclosing, a confidential communication between the patient and physician if the privilege is claimed by: (a) The holder of the privilege; (b) A person who is authorized to claim the privilege by the holder of the privilege; or (c) The person who was the physician at the time of the confidential communication, but such person may not claim the privilege if there is no holder of the privilege in existence or if he is otherwise instructed by a person authorized to permit disclosure." Cal. Evid. Code § 994 (West 1966 & Supp. 1975).
physician which were passed in the normal course of treatment to a third person who is a party to the action. It is unclear what safeguards exist for the privacy of the patient when this confidential information is threatened with public revelation in a civil action in which the patient

25. The possibility of the interposition of various constitutional arguments following the authority of Griswold v. Connecticut, 381 U.S. 479 (1965), to the effect that the physician-patient privilege is in a "zone of privacy" and thus is a part of the constitutional right of privacy found by Justice Douglas within the so-called "penumbras" of the Bill of Rights, is beyond the scope of this note. Suffice it to say that the California Supreme Court recognized the possibility of such an argument in dicta in In re Lifschutz, 2 Cal. 3d 415, 431-432, 467 P.2d 557, 567, 85 Cal. Rptr. 829, 839 (1970): "We believe that a patient's interest in keeping such confidential revelations [to a psychotherapist] from public purview, in retaining this substantial privacy, has deeper roots than the California statute and draws sustenance from our constitutional heritage. In Griswold v. Connecticut, the United States Supreme Court declared that 'various guarantees [of the Bill of Rights] create zones of privacy', and we believe that the confidentiality of the psychotherapeutic session falls within one such zone. Although Griswold itself involved only the marital relationship, the open-ended quality of that decision's rationale evidences its far-reaching dimension." (citations omitted) Nevertheless, the court in Lifschutz expressed some doubt as to whether this language could be analogized to the physician-patient privilege. Id. at 434 n.20, 467 P.2d at 570, 85 Cal. Rptr. at 842. For further discussion of Lifschutz, see Louisell & Sinclair, Forward: Reflections on the Law of Privileged Communications—The Psychotherapist-Patient Privilege in Perspective, 59 CALIF. L. REV. 30 (1971) [hereinafter cited as Louisell & Sinclair]; 3 CONN. L. REV. 599 (1971); 49 TEXAS L. REV. 929 (1971). Further, California in 1972 added a right of privacy to its constitution: "All people are by nature free and independent, and have certain inalienable rights, among which are those of enjoying and defending life and liberty; acquiring, possessing, and protecting property; and pursuing and obtaining safety, happiness, and privacy." CAL. CONST. art. I, § 1 (West Supp. 1975). A discussion of the amendment's ramifications is also beyond the scope of this article.

26. The physician is under both an ethical and a legal duty not to disclose professional confidences outside of the courtroom. The Hippocratic Oath contains the following pledge: "All that may come to my knowledge in the exercise of my profession or outside of my profession or in daily commerce with men, which ought not to be spread abroad I will keep secret and will never reveal." The AMA "Principles of Medical Ethics" contains a similar statement: "A physician may not reveal the confidences entrusted to him in the course of medical attendance, or the deficiencies he may observe in the character of patients, unless he is required to do so by law or unless it becomes necessary in order to protect the welfare of the individual or of the community." In re Lifschutz, 2 Cal. 3d 415, 429 n.9, 467 P.2d 557, 565-66, 85 Cal. Rptr. 829, 837-38 (1970), quoting AMERICAN MEDICAL ASSOCIATION, PRINCIPLES OF MEDICAL ETHICS, § 9. In addition, the California Business and Professions Code imposes a legal duty on the physician to guarantee the privacy of the patient outside the courtroom: "The willful betraying of a professional secret constitutes unprofessional conduct within the meaning of this chapter," CAL. BUS. & PROF. CODE § 2379 (West Supp. 1975). Unprofessional conduct is punishable by loss of license. CAL. BUS. & PROF. CODE §§ 2360, 2361 (West Supp. 1975). On the other hand, the California Supreme Court recently held that under certain circumstances a doctor or psychotherapist is under both an ethical and a legal duty to disclose such confidential matter. Citing the ethical standard articulated in section 9 of the AMA "Principles of
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is not a party. This note will discuss whether the third party has the authority to assert the privilege on the patient's behalf, and further, whether the third party has a duty to do so.

The first issue was faced directly in Rudnick v. Superior Court. Plaintiff and petitioner, Jacqueline Rudnick, brought a products liability action against Atlas Chemical Industries, Inc. and the Stuart Company. She sought $350,000 for damages allegedly resulting from her ingestion of the drug Dialose Plus at her doctor's direction and according to defendant manufacturer's instructions for proper use. Plaintiff alleged that the drug contained oxyphenisatin acetate, which induced symptoms of jaundice and hepatitis requiring medical treatment including hospitalization.

During discovery, plaintiff properly served defendant's custodian of records with a subpoena duces tecum in an attempt to depose the custodian and examine all records relating to adverse reactions caused by the drug. At the deposition in Wilmington, Delaware, the custodian of records refused to produce the adverse reaction reports on the ground that they constituted confidential information and that the defendants had no right to waive the physician-patient privilege protecting the records from disclosure. Thereupon plaintiff moved for an order compelling defendants to produce some fifty drug reaction reports. The trial court granted this motion but limited the information required by its order to the names and addresses of the doctors submitting the reports.

Plaintiff then sought a writ of mandate directing the trial court to compel defendants to produce the reports. When the court of appeal...
denied the plaintiff's application for a writ, the California Supreme Court granted a hearing and issued an alternative writ in order to consider the novel question "whether a third party recipient of confidential information from a physician may assert the physician-patient privilege."

Before the high court, petitioner first argued that since the reports were not "actual medical files" they were not confidential and were thus discoverable. The petitioner next argued that if the reports were confidential, the physician-patient privilege had been waived when the physicians forwarded the reports to the drug companies. Should this argument also fail, plaintiff alleged further that the drug company did

31. In a memorandum opinion the California Court of Appeal, Fifth Appellate District, stated: "The petition for writ of mandate is denied without prejudice to a further showing, if the petitioner is so advised, that the individual patients who are the subject of the requested medical reports waived the physician-patient privilege. (Marcus v. Superior Court, Henard v. Superior Court.)" (citations omitted) 5 Civil No. 2189 (Cal. Ct. App. Fifth App. Dist. Jan. 11, 1974).

In Marcus v. Superior Ct., 18 Cal. App. 3d 22, 95 Cal. Rptr. 545 (1971), a medical malpractice action was brought alleging negligence in administering an angiogram to plaintiff. The trial court granted a motion to quash plaintiff's subpoena of the doctor and hospital for medical records of their patients who had been given the same test by the doctor in the hospital. At the same time, the trial court issued an order compelling defendants to produce the names and addresses of the patients. The court of appeal issued a writ of prohibition at the request of defendants against enforcement of the trial court's order because revealing the names and addresses would reveal information protected by the physician-patient privilege—that is, confidential information about the ailments of the named patients.

In Henard v. Superior Ct., 26 Cal. App. 3d 129, 102 Cal. Rptr. 721 (1972), the plaintiff brought a products liability action and sought from defendant drug company its adverse reaction reports concerning the drug in question; defendant delivered them to the plaintiff, but the reports contained only the initials of the reporting doctors. Plaintiff sought a writ of mandate ordering the trial court to compel disclosure of the doctors' names. The court of appeal issued the writ on the bases that only the patients' identities, not the doctors', needed to be protected, and that the various doctors could assert the physician-patient privilege to protect their patients during subsequent individual depositions.

32. 11 Cal. 3d at 928, 523 P.2d at 647, 114 Cal. Rptr. at 607. The court affirmed that "the writ of mandate is a proper remedy for reviewing discovery procedures," stating that "[w]e were impelled to issue the alternative writ in this case because we are presented with a question of first impression which is of general importance to the trial courts and to the profession, and in conjunction with which general guidelines can be laid down for future cases." (citations omitted) The question of first impression is set out in the text.

33. 11 Cal. 3d at 928, 523 P.2d at 647, 114 Cal. Rptr. at 607.


not have standing to assert the privilege, as it was not a "holder of the privilege" within the meaning of Evidence Code section 994.36 Finally, petitioner asserted that her only alternative, should the trial court's order stand, would be to travel all over the country deposing the fifty doctors who had submitted the reports. Plaintiff claimed that this situation "would impose a severe, and in many cases, a prohibitive financial burden on the plaintiff" as she conducted necessary discovery because each of the doctors would pose the physician-patient privilege, requiring the plaintiff to engage in further litigation to compel discovery. Without these individual depositions, the reasoning continued, plaintiff's burden of demonstrating that each patient had waived the privilege, as the court of appeal required, would be insurmountable, as she did not even have the names of the patients. On the other hand, plaintiff argued, access to the reports would lower the cost of discovery by allowing her to select doctors whose depositions would be valuable to her case.

Defendant drug companies responded to plaintiff's first argument, that only "actual medical files" are confidential, by contending that even the revelation of the names and addresses of the patients would constitute communication of the confidential information protected by the privilege; thus, the companies insisted, the adverse reaction reports had to be held confidential. Second, citing Evidence Code section 912(d)37 and arguing that the adverse reaction reports were "reasonably necessary" for the proper treatment of the patients involved, defendants denied that there had been a waiver of the physician-patient privilege when the doctors forwarded the reports to the companies. The reasoning behind this argument was that an adverse reaction report enables a company to determine whether or not there is a cause and effect relationship between use of the drug and the symptoms exhibited by the patient following use. When that question has been determined and communicated to the doctor, the doctor may proceed properly to treat the patient. Defendants argued further that even if the reports were not "reasonably necessary" to the treatment of the patient, there was no waiver because only the holder of the privilege38 can waive it,39 and

37. "A disclosure in confidence of a communication that is protected by a privilege provided by Section . . . 994 (physician-patient privilege), when such disclosure is reasonably necessary for the accomplishment of the purpose for which the . . . physician . . . was consulted is not a waiver of the privilege." CAL. EVID. CODE § 912(d) (West 1966). See Return to Alternate Writ of Mandamus at 7-10, Rudnick v. Superior Ct., 11 Cal. 3d 924, 523 P.2d 643, 114 Cal. Rptr. 603 (1974).
38. "As used in this article, 'holder of the privilege' means: (a) The patient when he has no guardian or conservator. (b) A guardian or conservator of the patient when the patient has a guardian or conservator. (c) The personal representative of the patient if the patient is dead." CAL. EVID. CODE § 993 (West 1966).
39. CAL. EVID. CODE § 912(a) (West 1966).
there was no evidence that the patients had expressly waived the privilege by authorizing release of the information to the drug companies. To petitioner's third point, defendants responded that under section 994 of the Evidence Code they were parties "to whom disclosure [had been] reasonably necessary for the transmission of the information or the accomplishment of the purpose for which the physician [had been] consulted," and that therefore they had standing to assert the privilege on behalf of the patients. Fourth, the companies responded to plaintiff's allegation of excessive burden by asserting that defendant's abstracts of the fifty reports had provided plaintiff with all the information necessary for her action, including data on age, sex, race, and geographical area of residence of each patient, a generalized summary of the patient's symptoms and the doctor's opinion regarding how the drug caused or contributed to the patient's symptoms. Defendants argued that if the plaintiff needed more information, she could seek it during depositions of the doctors, at which time the doctors could consult their patients as to whether the patients wished to waive the privilege. Finally, they submitted that if the writ were granted, physicians, fearing civil liability for disclosure, would be discouraged from sending reaction reports. This result would be contrary to public policy in that such reports assist in the continual evaluation of drugs and have in the past led to the withdrawal of harmful drugs from the market, the replacement of deleterious ingredients, and the dissemination of augmented warnings to both physician and patient concerning possible adverse reactions.

Thus, the court was faced with four different public policy arguments. Arguments for denial were (a) the protection of the privacy of patients who are not involved in the suit; (b) the maintenance of the confidential relationship between physician and patient; and (c) the reception by drug companies of feedback on the quality of their drugs. The argument in favor of the writ was the protection of a plaintiff's interest in discovery of all relevant matter necessary to the successful conduct of an action.

In deciding the issue, the supreme court held that:

a disclosure in confidence by a physician, with or without the con-


41. The Food and Drug Administration does not require physicians to make adverse reaction reports concerning drugs already approved and licensed for marketing. With respect to "Investigative New Drugs," though, before a physician receives permission to participate in the limited use of the drug he must agree to submit reports of all adverse reactions. 21 C.F.R. § 312.1 (Form FD-1572, para. 6) (1974). Drug companies, on the other hand, are under an obligation to report periodically the efficacy and side effect of their drugs to the FDA. 21 C.F.R. § 310.301 (1974). Any company which fails adequately to investigate its drugs or fully to report the nature and extent of the adverse effects they produce is liable to criminal prosecution. Compare 21 U.S.C. § 331(e) (1970) with 21 U.S.C. § 333 (1970).
sent of the patient, of communications protected by the physician-patient privilege to a third party to whom disclosure is reasonably necessary for the accomplishment of the purpose for which the physician is consulted confers upon the third person the right to claim the physician-patient privilege on behalf of the patient. In other words, that third person thereby becomes "[a] person who is authorized to claim the privilege by the holder of the privilege" within the meaning of section 994.42

The court then issued a peremptory writ vacating the order below and directing the trial court to reconsider its decision to allow plaintiff to discover the names and addresses of the doctors.

In arriving at this holding, the court concluded as to petitioner's first argument, lack of confidentiality, that because the communication was originally made in confidence by a patient to his physician it "remains a confidential communication subject to privilege unless the privilege is waived by the patient as provided in section 912."43 Thus, whether or not there is a confidential communication as defined by section 992 "is determined at the time the information is communicated to or ascertained by the physician."44

In response to petitioner's waiver and lack of standing arguments, the court enunciated guidelines for deciding whether or not there had been a waiver of the privilege and whether or not the companies were authorized to assert the privilege on behalf of the patients. First, the court looked to Evidence Code section 994, which specifies who may claim the privilege. It concluded that since the defendant companies were neither the holders of the privilege (as defined in Evidence Code section 993) nor the physicians who received the communications, they would have to demonstrate that they were "persons authorized to [assert the privilege] by the patient[s]."45 Since there was no indication in the record that the patients had expressly authorized the defendants to assert the privilege on their behalf, the court considered whether or not authorization could be implied as a matter of law.46 Writing for a unanimous court, Justice Sullivan relied on Evidence Code section 912(d), which states that there is no waiver when disclosure to a third party is "reasonably necessary for the accomplishment of the purpose for which the . . . physician . . . was consulted." Extrapolating from this language, Justice Sullivan concluded that there had been a constructive authorization of the third parties to assert the privilege in the patients' behalf.47 The reasoning here requires a major judicial inference because

42. 11 Cal. 3d at 932, 523 P.2d at 649-50, 114 Cal. Rptr. at 609-10.
43. Id. at 930, 523 P.2d at 648, 114 Cal. Rptr. at 608.
44. Id.
45. Id. at 929, 523 P.2d at 648, 114 Cal. Rptr. at 608.
46. Id.
47. Id. at 932, 523 P.2d at 649, 114 Cal. Rptr. at 609.
the statutes do not explicitly state that the absence of a waiver will constitute an authorization to assert the privilege.

The earlier case of *Kramer v. Policy Holders Life Insurance Association*, 48 decided under the old statute, cast doubt upon such a connection between waiver and persons who may claim the privilege. In *Kramer* the physician had a stenographer-office nurse present when he examined the patient. The question was whether the doctor could assert the privilege or whether the privilege had been waived because the disclosure had been made in the presence of the third party. The court held that there had been no waiver and stated that it was not necessary to decide whether the stenographer could also claim the privilege. 49 Nonetheless the court in *Kramer* referred to a series of decisions in other jurisdictions holding that there was no waiver when the presence of the third party was apparently necessary, and that the doctor could assert the privilege but the third party could not. 50

Justice Sullivan’s inference that absence of a waiver constitutes a constructive authorization of the third party to assert the privilege is consistent, however, with the expressed intent of the legislature: Subdivision (d) [section 9121 may change California law. Green v. Superior Court held that the physician-patient privilege did not provide protection against disclosure by a pharmacist of information concerning the nature of drugs dispensed upon prescription. 51

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49.  *Id.* at 386, 42 P.2d at 672.
50.  *Id.* at 393-95, 42 P.2d 670-72; see also Cross, *Privileged Communications Between Participants in Group Psychotherapy*, 1970 L. & Soc. ORDER 191, 193-94.
51.  CAL. EVID. CODE § 912, Law Revision Comm’n Comment (West 1966) (citation omitted). The portion preceding that quoted in the text reads as follows: “Subdivision (d) is designed to maintain the confidentiality of communications in certain situations where the communications are disclosed to others in the course of accomplishing the purpose for which the lawyer, physician, or psychotherapist was consulted. For example, where a confidential communication from a client is related by his attorney to a physician, appraiser, or other expert in order to obtain that person's assistance so that the attorney will better be able to advise his client, the disclosure is not a waiver of the privilege, even though the disclosure is made with the client's knowledge and consent. Nor would a physician's or psychotherapist's keeping of confidential records necessary to diagnose or treat a patient, such as confidential hospital records, be a waiver of the privilege, even though other authorized persons have access to the records. Similarly, the patient's presentation of a physician's prescription to a registered pharmacist would not constitute a waiver of the physician-patient privilege because such disclosure is reasonably necessary for the accomplishment of the purpose for which the physician is consulted. See also Evidence Code § 992. Communications such as these, when made in confidence, should not operate to destroy the privilege even when they are made with the consent of the client or patient. Here, again, the privilege holder has not evidenced any abandonment of secrecy. Hence, he should be entitled to maintain the confidential nature of his communications to his attorney or physician despite the necessary further disclosure.”
In keeping with this expression of legislative intent, the court in *Rudnick* declared *Green v. Superior Court* invalid under the new statutes.

Justice Sullivan responded to petitioner's fourth argument, that, without the writ, discovery would be excessively burdensome, by restating the basic principle that "there can be no discovery of matter which is privileged." Thus, it matters little how burdensome or even impossible discovery becomes, if it is denied pursuant to the valid exercise of the physician-patient privilege.

The new standard which the court proceeded to announce in *Rudnick* is that where disclosure to a third party, by either the patient or his physician, was "reasonably necessary" for the accomplishment of the purpose for which the patient consulted the physician, the third party may assert the privilege on behalf of an absent patient regardless of whether or not the patient has consented to the disclosure. If the communication was not "reasonably necessary," however, there are two possibilities. The first is that the patient consented to the disclosure either impliedly or expressly. In this case, he will be deemed to have waived the privilege under the provisions of section 912(a), and there will be no privilege for the third party to assert. The second possibility is that the patient did not consent to the disclosure and thus did not waive the privilege. In this situation, if the patient is a party, he may prevent disclosure by the third party under the provisions of section 994. Moreover, if the patient is not a party to the action, the third party cannot assert the privilege on the patient's behalf, however, the court either on its own motion or on defendant's motion may exercise


54. Accord, *Henard v. Superior Ct.*, 26 Cal. App. 3d 129, 133, 102 Cal. Rptr. 721, 724 (1972): "While the argument that the doctor-patient privilege can be successfully invoked by a third party may be sound in cases where the disclosure of the privileged information necessarily destroys the privilege, it has no validity in a case where, as here, the privilege can be effectively asserted by those entitled to do so."

55. This conclusion is consistent with the statutory language and the court's reasoning. There still is a privilege because the patient has not waived it, yet the third party not being "reasonably necessary" for treatment, cannot be found to have implied authorization to assert the privilege on the patient's behalf. The result is a privilege with no one to assert it. The court thus recognizes the practice of allowing the trial court, either sua sponte or on motion of a party, to protect the privilege. 11 Cal. 3d at 933 n.12, 573 P.2d at 651, 114 Cal. Rptr. at 610. However, the privacy of the patient is most precarious under these circumstances because there is no certainty that either the court or the parties will raise the objection. The necessity for an affirmative duty of the court to be vigilant in guarding the absent patient's privacy, then, becomes clear. See text accompanying notes 100-106 infra.
its discretion to protect the absentee holder of the privilege.56

Policy Considerations

The California courts have articulated a two-fold purpose for the physician-patient privilege:57 (1) to encourage the patient’s full disclosure to his physician of all information necessary for proper diagnosis and treatment;58 (2) “to preclude the humiliation of the patient that might follow disclosure of his ailments.”59

In contrast, the common law rule rejecting any such privilege for communications between a physician and his patient was grounded on the theory that “disclosure of the whole truth was essential to the proper administration of justice and that the need for it far outweighed any considerations of professional confidence.”60 It is unquestionably true that relevant factual material will be denied discovery or introduction when the privilege is properly asserted.

Therefore, in deciding whether or not to recognize a physician-patient privilege, the legislature must weigh the necessity for confidentiality in the physician-patient relationship and the interests of the patient in maintaining the privacy of his body against the interests of justice in the discovery of all relevant evidence. The next two sections of this note discuss the balancing of these conflicting interests, first in jurisdictions other than California, and then in California.

Other Jurisdictions

Common law scholars have sharply criticized the physician-patient privilege,61 favoring full disclosure of all relevant information at trial.

56. 11 Cal. 3d at 932-33, 523 P.2d at 650, 114 Cal. Rptr. at 610.
58. See, e.g., McRae v. Erickson, 1 Cal. App. 326, 331-32, 82 P. 209, 211-12 (1905) quoting In re Bruendl’s Will, 102 Wis. 47, 78 N.W. 169 (1899): “[the privilege] facilitate[s] and make[s] safe full and confidential disclosure by patient to physician of all facts, circumstances, and symptoms, untrammled by apprehension of their subsequent and enforced disclosure and publication on the witness-stand, to the end that the physician may form a correct opinion, and be enabled safely and efficaciously to treat his patient.” To McCormick, this is the only valid purpose of the privilege: “The encouragement of freedom of disclosure by the patient so as to aid in the effective treatment of disease and injury. To attain this objective, the immediate effect of the privilege is to protect the patient against the embarrassment and invasion of privacy which disclosure would entail.” MCCORMICK, supra note 6, § 98, at 213.
60. DeWitt, supra note 6, at 10.
61. See, e.g., MCCORMICK, supra note 6, § 101, at 212; 8 WIGMORE, supra note 1, §§ 2380, 2380a, at 818, 829; Chafee, Privileged Communications: Is Justice Served
Professor Wigmore saw the privilege as meaning "little but the suppression of useful truth." In coming to this conclusion, Wigmore applied four conditions precedent to the granting of any privilege:

1. The communications must originate in a confidence that they will not be disclosed.
2. This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.
3. The relation must be one which in the opinion of the community ought to be sedulously fostered.
4. The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of litigation.

Wigmore denied the existence of all but the third requirement in the physician-patient relationship. First, he asserted that except in the cases of criminal abortion and venereal disease, the patient does not consider the information confidential and, in fact, makes little effort to maintain its secrecy. Second, he contended that the possibility of disclosure in court would not deter a patient from making a full disclosure of his symptoms to his doctor. Finally, as to condition four, Wigmore was strongly committed to full disclosure of all relevant matter to facilitate accurate fact finding. He rarely acknowledged that the injury which disclosure caused to a particular relationship could outweigh the benefits to be gained for the correct disposal of litigation. Thus, Wigmore was inclined to oppose the concept of privilege in general.

McCormick echoed the arguments of Wigmore and concluded that


62. 8 WIGMORE, supra note 1, § 2380a, at 831.
63. Id. § 2285, at 527.
64. Id. § 2380a, at 829-30.
65. Louisell & Sinclair, supra note 25, at 54-55, criticized this strong inclination in the "eminent evidence scholars whose distaste for the privileges stems from a focus on the social importance of accurate fact finding in litigation and from the conviction that confidentiality in virtually all relationships must give way to compulsory testimony. It seems, however, that such stress on the undeniable value of accurate fact finding and full disclosure of relevant information has led certain modern commentators to ignore the significance for human freedom of well-considered privileges for confidential communications. Moreover, the necessity for compelled disclosure of confidential communications is no longer great, if it ever was. Often the communication pertains to an objective fact, the ascertainment of which, if actually of import in deciding an issue, is feasible through analysis of sources extrinsic to the confidential communication. Given the tremendous development in the availability and utilization of discovery proceedings, the need for forced disclosure of confidential communications is even less compelling."
experience "has demonstrated that the privilege in the main operates not as the shield of privacy but as the protector of fraud." He urged its abandonment.06

McCormick and Wigmore shared the opinion that the physician-patient privilege statutes owe their survival to a misplaced reliance by state legislatures on an alleged analogy between the physician-patient relationship and the attorney-client relationship.67 Both commentators distinguished the two relationships on the basis of motivation at the time of consultation. When the patient consults his physician, they thought, he seeks treatment of his illness. Because he is usually not then mindful of future disclosure of those conditions in a courtroom, such a possibility does not contribute substantially to a withholding of information from his physician. On the other hand, a client usually consults his attorney with the possibility of litigation in mind, and in the absence of a privilege protecting him against future disclosure, he would be more likely to be deterred from providing all the data the attorney needs to prepare the case adequately.

These views prevailed in the committee of the American Law Institute, and their Model Evidence Code contained no physician-patient privilege. When the recommendations were presented to the membership at large, however, there was such support for the privilege that the draft was rewritten, and the privilege appeared in the final 1942 Code.68 Even as amended, the Model Evidence Code contained a series of limitations on the privilege designed to alleviate some of the injustices which critics had attributed to it.69 As it turned out, the code's importance was limited to academic debate. It failed to gain acceptance in the legal community and was not adopted by any state legislature.70

In 1948, the National Conference of Commissioners on Uniform State Laws set out to reform the law of evidence and used the Model Evidence Code as a starting point. The 1950 meeting of the conference resulted in the elimination once more of the physician-patient privilege, but the conference reversed itself in 1953 and voted to recognize the privilege.71 Thereafter, the conference included in its Uniform Rules of Evidence Rule 27, which provided for the privilege in essentially the

66. McCORMICK, supra note 6, § 105, at 228.
67. McCORMICK, supra note 6, § 105, at 224-25; 8 WIGMORE, supra note 1, § 2380a, at 830-31. Caution must be used in analogizing from authority for one privilege to another because of the essentially different policy questions involved. In re Lifshutz, 2 Cal. 3d 415, 434 n.20, 467 P.2d 557, 570, 85 Cal. Rptr. 829, 842 (1970).
68. 19 ALI PROCEEDINGS 183-217 (1942); MODEL CODE OF EVIDENCE rules 220-223 (1942).
70. DEWITT, supra note 6, at 19-20.
71. Id. at 20.
same language used in Rules 220-223 of the Model Evidence Code.\textsuperscript{72} Although Rule 27 was included, however, it was enclosed in brackets; apparently the conference was reluctant to recommend that states adopt the privilege.\textsuperscript{73} Professor McCormick endorsed the Uniform Rules as a step in the right direction, as he felt that they eliminated the principal abuses of the privilege.\textsuperscript{74}

The Advisory Committee on the Federal Rules of Evidence provided yet another arena for the privilege debate.\textsuperscript{75} The committee, which drafted the rules for the United States Supreme Court, eliminated the physician-patient privilege, stating that "the exceptions which have been found necessary in order to obtain information required by the public interest or to avoid fraud are so numerous as to leave little if any basis for the privilege."\textsuperscript{76} The Proposed Federal Rules of Evidence did, however, include a psychotherapist-patient privilege.\textsuperscript{77}

The Proposed Federal Rules were promulgated by the Supreme Court on November 20, 1972, and were transmitted to Congress by the Chief Justice on February 5, 1973, to become effective on July 1 of that year. Congress erected a roadblock, however, by enacting a statute under which the rules would become effective only upon the legislature's

\textsuperscript{72} 8 WIGMORE, supra note 1, § 2380, at 820 n.5.

\textsuperscript{73} McCormick, Some High Lights of the Uniform Evidence Rules, 33 TEXAS L. REV. 559, 571 (1955).

\textsuperscript{74} McCormick, supra note 6, § 105, at 226-27. See note 88 & accompanying text infra.

\textsuperscript{75} The Federal Rules of Civil Procedure exempt privileged material from discovery. See FED. R. CIV. PROC. 26(b)(1). FED. R. CIV. PROC. 35(b) provides for a waiver of the privilege where the plaintiff requests a copy of the physical examination of plaintiff conducted by defendant's physician, but does not contain a definition of what is privileged. Prior to the enactment of the Federal Rules of Evidence, "the rules of evidence applicable in the United States District Courts var[ied] with the state in which the court [sat] and the nature of the case. In civil cases the Federal Rules of Civil Procedure [Rule 45(a)] prescribe[ed] admission of evidence when either a federal statute or rule of evidence or a state rule of evidence applicable in a state court of general jurisdiction would admit it. Thus, if a doctor-patient privilege [was] abrogated by any of these three, it need not [have been] recognized in federal civil cases." Whitford, The Physician, the Law, and the Drug Abuser, 119 U. PA. L. REV. 933, 938 (1971). See notes 80-83 and accompanying text, infra, for a discussion of the effect of the Federal Rules of Evidence.


express approval.\textsuperscript{78} Thereafter Congress passed its own version of the rules and President Ford signed them in law on January 2, 1975.\textsuperscript{79} In this process, article V, which concerns privileges, was completely rewritten. The new article eliminates specific sections on the various privileges and substitutes a single provision\textsuperscript{80} which requires the federal courts to follow the common law rules unless the state in which the court sits has a specific provision for the privilege in question. If such provision exists, the district court is to observe the state statute. The rationale behind this change, the House Committee on the Judiciary explained, was that there is no federal interest strong enough to justify deviation from the state law and that inclusion of specific federal rules of privilege would encourage forum shopping.\textsuperscript{81} The effect of the law, then, is that the privilege does not exist unless specifically provided for by state law. At present, thirty-eight states and the District of Columbia have passed statutes changing the common law and recognizing a physician-patient privilege,\textsuperscript{82} while the other twelve have not.\textsuperscript{83}

The statutes do vary widely as to the scope of the information which they cover and the persons who come within their purview.\textsuperscript{84} It is


\textsuperscript{80} "Except as otherwise required by the Constitution of the United States or provided by Act of Congress or in rules prescribed by the Supreme Court pursuant to statutory authority, the privilege of a witness, person, government, State or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience. However, in civil actions and proceedings, with respect to an element of a claim or defense to which State law supplies the rule of decision, the privilege of a witness, person, government, State or political subdivision thereof shall be determined in accordance with State law." FED. R. EVID. 501.

\textsuperscript{81} "The rationale underlying the proviso is that federal law should not supersede that of the States in substantive areas such as privilege absent a compelling reason. The Committee believes that in civil cases in the federal courts where an element of a claim or defense is not grounded upon a federal question, there is no federal interest strong enough to justify departure from State policy. In addition, the Committee considered that the Court's proposed Article V would have prompted forum shopping in some civil actions, depending upon differences in the privilege law applied as among the State and federal courts. The Committee's proviso, on the other hand, under which the federal courts are bound to apply the State's privilege law in actions founded upon a State-created right or defense, removes the incentive to 'shop'." H.R. REP. No. 93-650, 93d Cong., 1st sess. 9 (1973).

\textsuperscript{82} Compare 8 WIGMORE, supra note 1, § 2380, at 819-27 n.5 with Louisell & Sinclair, supra note 25, at 32 n.11 for listings of the statutes by state. See generally McCORMICK, supra note 6, § 98, at 212-13.

\textsuperscript{83} Those states are Alabama, Connecticut, Delaware, Florida, Georgia, Maryland, Massachusetts, Rhode Island, South Carolina, Tennessee, Texas, and Vermont. See 13 ST. Louis U.L.J. 459 n.5 (1969).

\textsuperscript{84} A particularly interesting statute is that of North Carolina: "Provided, that
interesting to note also that five of the states have enacted statutes creating a physician-patient privilege since 1960. Thus, state legislatures have not heeded the scholarly exhortations to abandon the privilege. The criticism has been effective, however, in fostering limitations on the privilege similar to those found in the Uniform Rules of Evidence.

California

California is among those states which have statutorily changed the common law rule and recognized a physician-patient privilege. As noted above, the first such law in California was passed in 1851 and was in effect continuously until 1965, when the legislature repealed the original act and replaced it with Evidence Code sections 990 to 1007. These sections, patterned after Rule 27 of the Uniform Rules of Evidence, retain the physician-patient privilege but include twelve exceptions designed to eliminate certain situations in which injustice has resulted from its use. At the same time the new sections provide the protection of the privilege to a broader range of people.

The significance of *Rudnick v. Superior Court* is its interpretation that these new statutes also increased the range of people who may be authorized to claim the privilege on behalf of the patient.

In order to effectuate fully the policies upon which the privilege is based, third parties must have not only the authorization but also the

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86. See note 5 supra.
88. "[P]ersonal injury cases, services in aid of a crime or tort, criminal proceedings, damage actions for criminal conduct of the patient, will contests, malpractice cases, disputes as to the intention of the patient as to a writing affecting property, validity of same, commitment proceedings, restoration proceedings, certain required reports, proceedings to terminate a license or privilege." *McCormick*, supra note 6, § 105, at 227 n.95.
89. *Id.* § 105, at 226-27.
90. 11 Cal. 3d 924, 523 P.2d 643, 114 Cal. Rptr. 603 (1974).
duty to assert the privilege to protect the absent patient's privacy. Further, the courts must have a concurrent duty to recognize the privilege. In defense of these contentions this note will consider the threshold issue of authorization and will then articulate why affirmative duties of assertion and recognition are necessary.

Authorization

In recognition of the policy decision made by the legislature in favor of confidentiality of the physician-patient relationship, California courts have consistently construed the privilege statutes in favor of the patient. To this end, courts generally take care to protect the privacy of individual patients by precluding the matching of identities with illnesses. In a footnote specifically directed to the trial court, the California Supreme Court in Rudnick enumerated specific tests for the proper disclosure of either identity or condition. First, if disclosing the patient's name would reveal his condition, the privilege would not be violated. If the converse is true, however, and revelation of the patient's name within the context of the case would inevitably lead to connection of his illness with his name, the privilege would be violated, and disclosure should not be allowed. Second, if disclosure would reveal the nature of an illness but not the identity of the patient, disclosure of the information would not violate the privilege. Although the opinion does not mention the converse of this situation, the court strongly implies, and its reasoning would seem to require, that it is considered a violation of the privilege to permit disclosure of the ailments in a context in which such revelation would invariably result in the patient's identity being connected with those conditions.

Because the legislature and the courts are careful to protect the patient's privacy to this extent, it seems reasonable that a third party who has obtained confidential information in the normal course of


94. The reason the court may not have mentioned the converse in footnote 13 is that in Rudnick the drug company had received adverse reaction reports from all over the country, and thus, disclosure of ailments alone in this context would not likely be connected with the patient's identity. Thus, this logical possibility did not suggest itself in this case.
treatment should be able to assert the privilege on the patient's behalf. Otherwise, the patient would have an extensive right without adequate means of asserting it. In such a situation the efficacy of the right would be in serious question.

Thus, the policy base upon which Rudnick rests is quite sound. In this era, when large concentrations of population, modern computer technology, and the specialized state of the medical art make the participation of numerous third parties more than reasonably necessary to accomplish the purpose for which the physician was consulted, the patient's privacy may be properly protected only by empowering such third parties to assert the privilege to protect the patient in his absence.

**Duty**

Such authorization was found by an Arizona court dealing with a statute even more restrictive than California's. In *Tucson Medical Center Inc. v. Rowles*, the plaintiff brought an action for medical malpractice against the Tucson Medical Center, alleging that the hospital had been negligent in not providing her with an obstetrician when her own obstetrician was delayed and she developed complications while waiting to give birth. Plaintiff sought the hospital records indicating where the staff obstetrician had been during plaintiff's emergency. The court held that defendant hospital could assert the physician-patient privilege on behalf of those patients whose records would be included and who were not parties to the action. The court concluded:

Despite the fact that A.R.S. § 12-2235 provides only that a physician or surgeon shall not be examined as to privileged information, our decision above that hospital records are covered by the physician-patient privilege mandates that the hospital assert this privilege when neither the patient nor his physician are parties to the proceeding. To hold otherwise would deprive a patient of the confidentiality granted him by A.R.S. § 12-2235 simply because neither he nor his physician have any interest in the outcome of the proceedings. Moreover, we feel obligated to carry this reasoning one step further and hold that when the holder of the physician-patient privilege is absent from the proceedings with no opportunity to assert the privilege, it is incumbent upon the trial court to frame its discovery orders in a manner which will protect

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95. DeWitt, supra note 6, at 229.
96. "In a civil action a physician or surgeon shall not, without the consent of his patient, be examined as to any communication made by his patient with reference to any physical or supposed physical disease or any knowledge obtained by personal examination of the patient." Ariz. Rev. Stat. Ann. § 12-2235 (1956). This statute was amended subsequent to the case discussed in the text to permit consent by a guardian or a conservator and to include mental conditions. Ariz. Rev. Stat. Ann. § 12-2235 (Supp. 1974).
an absent patient. . . . It would be absurd to hold that our legis-

lature intended that one unable to assert the privilege because of

his absence from the proceedings has a lesser right to confidential-

ity under A.R.S. § 12-2235 than one who is a party to the proceed-

ings.98

Thus, the Arizona court went beyond a finding of authorization to

conclude that the third party and the court have an obligation to

effectuate the privilege. To protect adequately the privacy of the absent

patient, California's legislature and courts must take this extra step.

Given the broader coverage of its privilege statute, California is in an

even stronger position than was Arizona to impose this affirmative duty

on third parties and the courts when the patient is not present. Unfortu-

nately, the court in Rudnick used the word "may" to refer to both

assertion by the third party and protection of the absent patient's privacy

by the court.99 This language makes the patient's right dependent upon

the broad discretion of a third party or of the court, and as a result fails

to assure that the right will be accorded to the patient. Thus, the

Rudnick court should have used the word "shall" to alert both third

parties and courts, who might otherwise fail to act to protect the absent

patient, that they have a duty to do so.

With regard to at least some specified situations, the California

legislature seems clearly to have intended to impose such an affirmative
duty on the courts.100 Section 916 of the Evidence Code101 applies only
to situations in which the patient is absent and neither a party nor the

person from whom the information is sought is a person authorized to

claim the privilege.102 The language of section 916 is ostensibly manda-
tory;103 however, the only court to comment on this section concluded
that it gave the trial judge discretion to recognize the privilege.104

98. Id. at 429, 520 P.2d at 523.
99. 11 Cal. 3d at 933, 523 P.2d at 650, 114 Cal. Rptr. at 610.
101. "(a) The presiding officer, on his own motion or on the motion of any party,

shall exclude information that is subject to a claim of privilege under this division if:

(1) The person from whom the information is sought is not a person authorized to

claim the privilege; and (2) There is no party to the proceeding who is a person au-
thorized to claim the privilege. (b) The presiding officer may not exclude information

under this section if: (1) He is otherwise instructed by a person authorized to permit

disclosure; or (2) The proponent of the evidence establishes that there is no person au-
102. Id.
103. "The presiding officer . . . shall exclude . . . ." Id.

Rptr. 482, 499-500 (1966) (attorney-client privilege): "Where the attorney fails to as-
sert the privilege when he should, the judge may exclude the information that is subject
to a claim of privilege on his own motion." (citation omitted) (emphasis added) The
Similarly, although the court in *Rudnick* did not mention section 916 in its opinion, it considered precisely the same set of circumstances to which the statute applies and concluded that "the appropriate court, in its discretion and on its own motion, may protect an absentee holder of the privilege who has not waived it." The courts, then, have failed to give effect to the legislative intent expressed in this statute. Therefore, the legislature should amend section 916 to express more strongly its intent by the insertion of language specifically stating that the courts have an affirmative duty to recognize the privilege. At the same time, the legislature should extend application of the statute to even those cases in which a person authorized to claim the privilege is present. Such an extension of the court's duty to recognize the privilege would merely provide an added degree of protection by assuring the absent patient's privacy regardless of whether or not a third party asserts the privilege.

precedent value of this decision, however, may be slight. First, this statement is dictum because the court concluded that even though the communications in question were never intended to be confidential in the first place, appellants had elicited the information by other means and could not be prejudiced by an erroneous order sustaining the privilege. Second, the issue arose when the trial judge excluded testimony by an attorney regarding communications with his former client, the cross-defendant (who was neither present nor represented by counsel), after the attorney failed to claim the attorney-client privilege. Both the trial court and the appellate court clearly misread section 916. The attorney was unquestionably a "person authorized to claim the privilege," under section 954, and, therefore, section 916 did not even apply to the facts presented by the case.

105. 11 Cal. 3d at 932-33, 523 P.2d at 650, 114 Cal. Rptr. at 610. See text accompanying notes 54-56, supra. It is unclear whether the court in *Rudnick* was construing section 916 or was unaware of its existence and applicability.

106. The reluctance of the courts to treat the language of Evidence Code section 916 as mandatory probably arises from the presence of Evidence Code section 918: "A party may predicate error on a ruling disallowing a claim of privilege only if he is the holder of the privilege ..." This section has the effect of immunizing the trial judge from error where he has incorrectly refused to recognize the privilege and the holder of the privilege is not a party to the action. If, on the other hand, the judge in such a situation had incorrectly recognized the privilege, either party could argue on appeal that the trial court had committed reversible error in excluding relevant evidence. Thus, when sections 916 and 918 are read side by side, it is clear that the safer course for a trial judge to pursue when in doubt is to deny recognition of the privilege. As noted in the text, this fact ultimately results in the thwarting of the clear legislative intent embodied in section 916 that recognition of the privilege by the trial court to protect the absent patient's privacy be mandatory.

107. South Dakota employs such language to impose a similar duty on its courts. "In all cases where it shall appear to the court that any person who is not present nor represented at the hearing should be protected in his right to have any communication made under the confidential relations provisions of §§ 19-2-1 to 19-2-5 [§ 19-2-3, physician-patient privilege], inclusive, excluded, it shall be the duty of the court to make such objections and orders for such purpose as to the court may seem necessary." S.D. Compiled Laws Ann. § 19-2-9 (1967).

108. This statement assumes that an affirmative duty has been imposed on the
With regard to third parties, California places only the physician under an affirmative statutory duty to assert the privilege. Unfortunately, this statutory provision is very specifically worded to include only the physician who received or made the confidential communication. Had the legislature envisioned the full ramifications of its decision to reverse the Green case and allow a third party to assert the privilege, it would most probably have imposed the same affirmative duty on a third party as it does on the physician. The purpose of the statute admits of no distinction between a physician and a third party who satisfies the Rudnick rule. The statute is designed to guarantee that the physician will assert the privilege whenever the law allows him to do so, in order to maintain the patient's confidences. Because it is the patient's privacy that is at stake, it makes little difference who has the information. If that person is permitted by law to assert the privilege, he should be under a duty to do so. It must be emphasized that the imposition of such an affirmative duty is directed at only one side of the scale, the policy favoring protection of the patient's privacy. As has been pointed out previously, the privilege derogates to some extent from the policy favoring discovery and consideration by the trier of fact of all relevant evidence. Naturally, this problem is enhanced by the recognition of an affirmative duty to assert the privilege. If the balance is to be struck in

third party also. If none has been imposed, then the duty on the court would be the sole protection.

109. "The physician who received or made a communication subject to the privilege under this article shall claim the privilege whenever he is present when the communication is sought to be disclosed and is authorized to claim the privilege under subdivision (c) of Section 994." CAL. EVID. CODE § 995 (West 1966). For a case decided under former section 1881(4) of the Code of Civil Procedure in which the physician asserted the privilege to protect his absent patient, see Costa v. Regents of Univ. of Calif., 116 Cal. App. 2d 445, 463-64, 254 P.2d 85, 96 (1953). Costa was cited with approval on this point in Marcus v. Superior Ct., 18 Cal. App. 3d 22, 24-25, 95 Cal. Rptr. 545, 547 (1971) (decided under the new statutes).

110. A necessary corollary to this affirmative duty to assert the privilege in court may well be a statutory duty imposed upon the third party, like that imposed upon the physician, to protect the confidentiality of the patient's medical information outside the courtroom. Aside from the interests of the patient in his privacy the interests of justice require that the assertion of the physician-patient privilege not result in the information being public everywhere but in court. Such a situation is threatened, for example, by the development of data processing enterprises which store medical information for insurance companies. One of many such companies has stored in its computers medical backgrounds on some 12 million persons with that number growing by 40,000 per year. Insurance Data Bank Attacked As Abuse of Confidentiality, 7 HOSPITAL PRACTICE, August 1972, at 47. The California Medical Association has "sought action to prohibit the use of medical information for any purpose other than the evaluation of the specific insurance claim in question, and to withdraw approval of the all-inclusive blanket consent form that patients sign when they apply for insurance benefits." 119 CALIFORNIA MEDICINE, December 1973, at 45.

111. See text accompanying note 60 supra.
favor of the patient's privacy, this mandatory assertion must not become merely a shield behind which the third party takes refuge to thwart the interests of justice. Protecting the plaintiff's interest in discovery under these circumstances requires the court to scrutinize the information in question carefully to determine whether some form of disclosure can be permitted which neither reveals the patient's identity nor provides sufficient factual data for the identity to be ascertained through subsequent investigation.\textsuperscript{112}

This dilemma could be eased at least partially if physicians were scrupulously careful to transmit data only to third parties who are reasonably necessary to the patient's treatment. Furthermore, the physician should satisfy himself at the outset that disclosure to the third party of the patient's identity along with his medical information is itself reasonably necessary to the third party's role in the normal course of treatment.\textsuperscript{113} If the third party himself has no knowledge of the patient's identity, the question of privilege simply would not arise, and the patient's privacy would be effectively protected.

**Applicability of the Rudnick Rule to Other Third Parties**

The court in *Rudnick* provided little insight into the meaning of the phrase "reasonably necessary to accomplish the purpose for which the physician was consulted." Nevertheless, with the large number of third parties who are privy to confidential information in the normal course of the patient's treatment, the courts are likely to be faced with cases seeking to have this phrase defined. The following is a discussion of those third parties whose "reasonable necessity" for the accomplishment of the purpose for which the patient consulted his physician might well be challenged by a party attempting to discover the patient's medical information.

**Pharmacists**

The court in *Rudnick* adopted the Senate Judiciary Committee's analysis that presentation of a prescription to a pharmacist by either the doctor or the patient would not constitute a waiver of the physician-patient privilege because the pharmacist is "reasonably necessary" to the fulfillment of the physician's purpose.\textsuperscript{114} Thus, in declaring that the new statutes had rendered *Green* invalid,\textsuperscript{115} the court identified pharmacists

\textsuperscript{112} See text accompanying notes 92-94 supra.

\textsuperscript{113} For example, does the receipt of the patient's name assist the drug company in evaluating and utilizing adverse reaction reports?

\textsuperscript{114} 11 Cal. 3d at 932, 523 P.2d at 650, 114 Cal. Rptr. at 610; CAL. EVID. CODE § 912(d) Law Revision Comm'n Comment (West 1966).

\textsuperscript{115} 11 Cal. 3d at 932, 523 P.2d at 650, 114 Cal. Rptr. at 610.
as third parties who would be able to assert the privilege within the Rudnick rule.

Hospitals

Further investigation reveals that the Senate Judiciary Committee did not intend that entries in hospital records constitute a waiver;\(^{116}\) therefore, hospitals would also appear to be eligible to assert the privilege.\(^{117}\) According to the official comment to Evidence Code section 912: "Nor would a physician's or psychotherapist's keeping of confidential records necessary to diagnose or treat a patient, such as confidential hospital records, be a waiver of the privilege, even though other authorized persons have access to the records."\(^{118}\) Further evidence of legislative intent that hospital records be privileged information is found in Evidence Code section 1156, enacted at the same time as the privilege sections.\(^{119}\) Section 1156 authorizes in-hospital committees to conduct mortality and morbidity studies but specifically designates as privileged any medical information disclosed to such committees with or without the patient's consent.\(^{120}\) Presumably, these expressions of legislative intent were intended to protect information that is inherent to the practice of medicine in a hospital. Further evidence of legislative intent may be found in the legislative history of Evidence Code section 912, which was enacted as part of a larger package of amendments to the Evidence Code in 1966. The purpose of section 912 was to codify the common law privilege of confidentiality in the context of medical records. The comment to section 912 states that the section is intended to provide a uniform rule for the admissibility of medical records and to protect the confidentiality of patient information. The section is based on the common law privilege of confidentiality in the context of medical records and is intended to provide a uniform rule for the admissibility of medical records and to protect the confidentiality of patient information. The section is based on the common law privilege of confidentiality in the context of medical records and is intended to provide a uniform rule for the admissibility of medical records and to protect the confidentiality of patient information. The section is based on the common law privilege of confidentiality in the context of medical records and is intended to provide a uniform rule for the admissibility of medical records and to protect the confidentiality of patient information. The section is based on the common law privilege of confidentiality in the context of medical records and is intended to provide a uniform rule for the admissibility of medical records and to protect the confidentiality of patient information.
intent should serve as guides to courts seeking to define reasonable necessity.\textsuperscript{121}

**Physician Evaluation Committees**

Peer review committees\textsuperscript{122} provide a rapidly proliferating group of "third parties" involved with the question of privilege. Such committees evaluate the qualifications, fitness, and character of fellow physicians, particularly with regard to the extension of hospital staff privileges. To perform their responsibilities properly these committees must review the records of specific patients whom the physician under investigation has treated.\textsuperscript{123} The legislature has relieved such committees of the necessity of asserting the physician-patient privilege by statutorily providing that their records be confidential and thus immune from discovery. This protection also extends to local medical societies' medical review committees, which consider medical malpractice suits and advise liability insurance carriers as to the defensibility of such actions.\textsuperscript{124}

\textsuperscript{121} See Marcus v. Superior Ct., 18 Cal. App. 3d 22, 95 Cal. Rptr. 545 (1971). In Marcus, the court went beyond the trial court decision that plaintiff was precluded from discovering hospital records, to hold that the names and addresses of the patients involved were also privileged from discovery. See note 31 supra.


\textsuperscript{123} To encourage the disclosure of information to these committees the California legislature passed a statute relieving one of any liability for such disclosure: "In addition to the privilege afforded by Section 47, there shall be no monetary liability on the part of, and no cause of action for damages shall arise against, any person on account of the communication of information in the possession of such person to any hospital, hospital medical staff, professional society, medical or dental school, or professional licensing board, when such communication is intended to aid in the evaluation of the qualifications, fitness or character of the practitioner of the healing arts and does not represent as true any matter not reasonably believed to be true." Cal. Stat. 1974, ch. 1086, § 1, at 796 (codified at CAL. CIV. CODE § 43.8 (West Supp. 1975)).

\textsuperscript{124} "Neither the proceedings nor the records of organized committees of medical staffs in hospitals having the responsibility of evaluation and improvement of the quality of care rendered in the hospital or medical review committees of local medical societies shall be subject to discovery." CAL. EVID. CODE § 1157 (West Supp. 1975). Matchett v. Superior Court, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974), held that section 1157 prohibits the discovery of files of a medical staff committee, but it does not prevent the discovery of a hospital's administrative records. Thus here is another potential source of invasion of the absent patient's privacy. The crucial nature to the absent patient of the protection accorded to the peer review committee by section 1157 and Matchett is suggested by the holding in a Missouri Court of Appeals decision, Klinge v. Lutheran Medical Center of St. Louis, 518 S.W.2d 157 (Mo. Ct. App. 1974), that the physician could not assert the physician-patient privilege to prevent a staff committee from reviewing patient records for the purpose of evaluating the physician's performance.
Similarly, the legislature has created a specific protection for the records and proceedings on nonprofit medical foundations, composed of physicians who evaluate doctors and determine for the government and private health insurance carriers the validity of benefit claims submitted by physicians for their services.\textsuperscript{126}

**Health Insurance Companies**

Health and accident insurance companies also frequently receive confidential information arising from the physician-patient relationship. Applying the Rudnick test, one must first determine whether or not disclosure to these insurance carriers is "reasonably necessary for the accomplishment of the purpose for which the physician was consulted."\textsuperscript{126} If it is "reasonably necessary," then the insurance company should be able to assert the privilege to protect the privacy of the absent patient whose medical information the carrier holds.\textsuperscript{127} The rapidly increasing costs of medical care today require all but the most affluent to carry some form of health insurance or to depend upon public health care services.\textsuperscript{128} From an economic standpoint, then, it may be argued...

\textsuperscript{125} "Except in actions involving a claim of a provider of health care services for payment for such services, the prohibition relating to discovery or testimony provided by Section 1157 shall be applicable to the proceedings or records of an organized committee of any nonprofit medical care foundation which is a component or subsidiary of a medical society, and which is organized in a manner which makes available professional competence to review health care services with respect to medical necessity, quality of care, or economic justification of charges or level of care." \textsc{cal. evd. code} § 1157.5 (West Supp. 1975).

\textsuperscript{126} 11 \textsc{cal. 3d} at 933, 523 P.2d at 650, 114 \textsc{cal. rprr.} at 610.

\textsuperscript{127} \textit{Id.}

\textsuperscript{128} Whether those receiving public social services have the right to confidential medical records is beyond the scope of this article because of the complexity of that issue. The current controversy in that area arises from the necessity for government to monitor the efficiency and effectiveness of its programs. The balancing of patient confidentiality against government accountability involves many considerations which could best be developed elsewhere. Suffice it to say that reports by physicians to government social service agencies are specifically made confidential by \textsc{cal. welf. & inst'n code} § 10850 (West Supp. 1975) and therefore are not within the scope of the public documents exception to the physician-patient privilege found in \textsc{cal. evd. code} § 1006 (West 1966). See also note 146, infra. \textsc{cal. welf. & inst'n code} § 5328 (West Supp. 1975) makes confidential all information and records obtained in providing services under various mental health programs. In \textsc{county of riverside v. superior ct.}, 42 \textsc{cal. app. 3d} 478, 116 \textsc{cal. rprr.} 885 (1974), the appellate court upheld the refusal by an alcoholism crisis and referral center to turn over its records to the State Board of Chiropractic Examiners in connection with its investigation of a chiropractor who was voluntarily receiving treatment at the center. The court rejected the board's argument that it should be included under \textsc{cal. welf. & inst'n code} § 5328 (f) (West Supp. 1975), excepting disclosure to the courts where necessary to the administration of justice, on the basis that it was investigating an accusation seeking suspension or revocation of the chiropractor's license and alleging habitual intemperance to...
that health insurance is within the realm of “reasonable necessity.” Because health insurance companies acquire the patient’s medical reports as part of the delivery of health care, the companies should be able to assert the privilege on behalf of the absent patient. To hold otherwise would be to endorse the proposition that those who are wealthy enough to pay for their medical care without the purchase of health insurance have a greater right to privacy than those who cannot shoulder these costs. Such a conclusion is inimical to public policy in an egalitarian society.

Once it is concluded that disclosure to a health insurance company is reasonably necessary for the accomplishment of the purpose for which the physician was consulted, it is immaterial under the Rudnick test whether or not the patient has expressly or impliedly authorized such disclosure.120

Life Insurance Companies

Another third party which collects and stores medical files is the life insurance company. With regard to transmittal of medical information to these entities, there is no sound basis for the argument that the disclosure is within the normal course of treatment of the patient.

Thus, following Rudnick, the question is whether or not the patient

such an extent as to incapacitate him for the performance of his professional duties. The court concluded that had the legislature intended such an exception for administrative agencies it would have specifically provided therefor. County of Riverside v. Superior Ct., 42 Cal. App. 3d 478, 481, 116 Cal. Rptr. 886, 888 (1974). See also CAL. UNEMP. INS. CODE § 2714 (West Supp. 1975) which provides that medical records obtained in the administration of the State Disability Insurance Program shall remain confidential and shall not be published or open to public inspection except “to the extent necessary for the proper administration of [the State Disability Insurance Program] or to the extent necessary for the proper administration of public social services pursuant to the Welfare and Institutions Code . . . .” This act was passed to protect the confidentiality of reports of independent medical examiners concerning disability insurance claims. CAL. UNEMP. INS. CODE § 2111 (West Supp. 1975) imposes a misdemeanor penalty for unauthorized disclosure.

129. See Hassard, Privileged Communications; Physician-Patient Confidences in California, 90 CALIFORNIA MEDICINE, June 1959, at 411. The author, the general counsel for the California Medical Association, anticipated the tension to which the text refers: “With the rapid growth of health insurance, the instances in which a physician is required to divulge confidential information to a third party have drastically increased. In these cases the patient’s economic interests require disclosure. Frequently, his medical interests may call for nondisclosure and hence, a conflict exists.” 1d. at 418.

130. In fact, in many cases the patient signs no authorization or waiver because it is often the physician who becomes eligible for payment directly from the insurance carrier. An example would be a Blue Shield policyholder being treated by a Blue Shield member doctor.
has consented to the disclosure.\textsuperscript{131} A patient must invariably sign a waiver at the time he applies for a life insurance policy. If the waiver is valid, there is no privilege for either the patient or the life insurance company to assert.

When faced with the question of the validity of these waiver clauses, the California courts have held that although "[t]he privilege may be waived . . . it must clearly appear there is an intention to waive, and a court will not run to such conclusion"\textsuperscript{132} but will in fact strictly construe the waiver. Even applying this strict standard, courts have held such waivers valid.\textsuperscript{136} The only case law on the point, however, involves suits arising from actions on the policy itself, and under the new Evidence Code the privilege would not be assertable in such actions in any case.\textsuperscript{135}

One could argue that the life insurance agreement is an adhesion contract and that therefore the patient does not give his consent to disclosure "without coercion" as is required for a waiver of the privilege under Evidence Code section 912(a).\textsuperscript{136} Life insurance contracts do

\textsuperscript{131} "Except as otherwise provided in this section, the right of any person to claim a privilege provided by Section . . . 994 (physician-patient privilege) . . . is waived with respect to a communication protected by such privilege if any holder of the privilege, without coercion, has disclosed a significant part of the communication or has consented to such disclosure made by anyone." \textsc{Cal. Evid. Code} \textsection{} 912(a) (West 1966).


\textsuperscript{134} In Turner v. Redwood Mut. Life Ins. Ass'n, 13 Cal. App. 2d 573, 575, 57 P.2d 222, 223 (1936), the court held the following provision without effect as to subsequent communications between the signor and his physicians: "I hereby authorize any doctor at any time to give to said association any information he or she may have regarding me." \textit{Id.} at 577-78, 57 P.2d at 223. In support of this holding the court cited a series of decisions from other jurisdictions which, while refusing to give prospective effect to such a waiver, did recognize its validity as to medical communications made prior to the patient's signing. \textit{Id.} at 576-77, 57 P.2d at 223-24. Torbenson v. Family Life Ins. Co., 163 Cal. App. 2d 401, 403, 329 P.2d 596, 597 (1958), found the following provision valid: "To Whom it May concern: I hereby authorize and request you to disclose any and all information and records concerning my condition when under observation by you, if requested to do so [by the life insurance company]."

\textsuperscript{135} "There is no privilege under this article as to a communication relevant to an issue concerning the condition of the patient if such issue has been tendered by . . . (c) Any party claiming as a beneficiary of the patient through a contract to which the patient is or was a party . . . ." \textsc{Cal. Evid. Code} \textsection{} 996 (West 1966).

\textsuperscript{136} The discussion of waiver herein is also applicable to health insurance contracts should the court refuse to accept the notion that disclosure of the confidential information to health insurance companies is "reasonably necessary."
bear the heavy stamp of adhesion. They customarily provide standard terms over which there is no bargaining and concerning which there is little variation from company to company. As a result, it is highly unlikely that an applicant for life insurance knowingly and understandingly accepts a waiver clause. Furthermore, even if he does understand the waiver, the average citizen's need for life insurance prevents his exercising free choice in accepting it.

Nevertheless, the court is not likely to find the waiver clause invalid as against public policy, as such a clause is essential to the insurance industry. Without the waiver, physicians, who have both ethical and legal responsibilities to maintain the confidences of their patients, must refuse to release information to the life insurance companies. As a result, life insurance companies would not have access to the information required to assess properly the insurability of the applicant-patient.

The recognition of a limited waiver is equally infeasible. Although Evidence Code section 994(b) provides that the privilege may be claimed by "a person who is authorized to claim the privilege by the holder of the privilege," the only context in which an express authorization to claim the privilege could be given to a life insurance company would be in conjunction with either an implied or an express consent to disclosure. Thus, by the provisions of Evidence Code section 912(a), to which section 994 is specifically made subject, any time a patient gave an express authorization to claim the privilege he would be waiving the privilege at the same time, thus rendering the authorization ineffectual.

Express authorization, which the Rudnick court sought initially, can be given only within the terms of Evidence Code section 912(d). Again, under the Rudnick rule, an express authorization to claim the privilege may be extended only to a third party to whom disclosure is "reasonably necessary," for in that instance the fact that the patient has expressly or impliedly consented to disclosure is immaterial. This situation is the only one in which a limited waiver is possible, as the patient is considered to have waived his privilege only with regard to that third party and not for all times and in all places. Under any other circumstances, as in the case of life insurance contracts, the seal of secrecy is considered to have been broken; because the information has not been


139. 11 Cal. 3d at 929, 523 P.2d at 647-48, 114 Cal. Rptr. at 607-08.
maintained in confidence by the patient outside the courtroom, the 
patient will not be allowed to prevent its disclosure inside the court-
room.\textsuperscript{140}

Thus, in signing an application for life insurance to guarantee the 
security of his survivors, the applicant is required to surrender his 
privacy.\textsuperscript{141} This result is somewhat harsh in view of the fact that the 
patient has not truly evidence abandonment of secrecy\textsuperscript{142} any more 
than he does when he presents his prescription to a pharmacist. It is 
reasonable that the applicant would expect that his physician would 
release information in confidence to the life insurance company and that 
the company, rather than making that information public, would use it 
for the limited purpose of ascertaining the applicant's insurability under 
the policy. Given the economic desirability of life insurance, the legisla-
ture should encourage its procurement and not require that its acqui-
sition be made at the price of privacy. An amendment to section 912 of 
the Evidence Code is necessary to prevent such disclosure from constitu-
ting a waiver.

Government Agencies

Physicians are also required to disclose patient data to various 
governmental agencies. One such reporting requirement directs physi-
cians to report the incidence of specified infectious, contagious and 
communicable diseases to the State Department of Public Health.\textsuperscript{143} 
Although such reporting benefits the community as a whole, it also may 
well assist the physician in adequately treating his patient, particularly in 
the case of large scale outbreaks, which provide significant amounts of 
current data concerning a specific disease. Therefore, it seems feasible to 
conclude that such reporting is reasonably necessary for the treatment of 
the patient, and that the government agency may assert the physician-
patient privilege within the \textit{Rudnick} rule. Moreover, this conclusion 
serves sound public policy, for it would not be equitable that an illness

\textsuperscript{140} 6 \textit{CALIFORNIA LAW REVISION COMM'N, REPORTS, RECOMMENDATIONS & 
STUDIES, TENTATIVE RECOMMENDATIONS AND STUDIES RELATING TO THE UNIFORM RULES OF 
EVIDENCE}, 262 (1964).

\textsuperscript{141} Even if the patient is deceased, which is the most logical possibility because 
a claimant would probably be seeking to discover the information about how the insurance 
company has settled previous cases involving similar illnesses or accidents, there 
still may be an interest of the patient's estate in confidentiality which the law will recog-
nize. \textit{See \textit{CAL. EVID. CODE}} § 993(c), \textit{Law Revision Comm'n Comment} (West 1966).

\textsuperscript{142} See note 51 supra.

\textsuperscript{143} "All physicians . . . visiting any sick person, in any hotel, lodginghouse, 
house, building, office, structure, or other place where any person is ill of any infec-
tious, contagious, or communicable disease, shall promptly report that fact to the health 
officer, together with the name of the person, if known, the place where he is confined, 
and the nature of the disease, if known." \textit{CAL. HEALTH & S. CODE}} § 3125 (West 1970).
report which benefits the public should result in an individual’s loss of privacy. Such a personal loss serves no societal purpose.

Nonetheless, the Evidence Code specifically excludes use of the privilege in situations involving required reports to state agencies when those reports are open to public inspection. Among contagious disease reports, Title 17 of the California Administrative Code, which sets forth the list of contagious diseases that must be reported, makes only venereal disease reports confidential. Thus, the implication is that the other disease reports are open to the public. Sections 211 and 211.5 of the California Health and Safety Code do make “special morbidity and mortality studies” specifically confidential. Nevertheless, the California Attorney General has expressed doubt that “the Department's continuous receipt of information concerning cases of contagious disease is a ‘special investigation’ within the meaning of section 211 . . . .” Thus, there seems to be an inadvertent gap in the law which should be filled by making all contagious disease reports confidential.

It is true that the state government could refuse to make public such information by asserting its privilege under Evidence Code section 1040. The assertion of the privilege under such circumstances would be permissible and would not violate the California Public Records

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144. “There is no provision under this article as to information that the physician or the patient is required to report to a public employee, or as to information required to be recorded in a public office, if such report or record is open to public inspection.” Cal. Evid. Code § 1006 (West 1966).


147. “[The State Department of Health] shall cause special investigations of the sources of morbidity and mortality and the effects of localities, employments, conditions and circumstances on the public health and it shall perform such other duties as may be required in procuring information for state and federal agencies regarding the effects of these conditions on the public health.” Cal. Health & S. Code § 211 (West 1970). Section 211.5 makes records collected under section 211 confidential. Id. § 211.5.

148. 51 Op. Cal. Atty Gen. 217 (1968). The opinion concluded that the State Board of Public Health may provide local blood banks with the identities of persons known to be infected with viral hepatitis if such information be maintained in confidence and be used only to screen potential donors.

149. “A public entity has a privilege to refuse to disclose official information, and to prevent another from disclosing such information, if the privilege is claimed by a person authorized to do so . . . .” Cal. Evid. Code § 1040(b) (West 1966).
Act because medical records are specifically exempted from disclosure under the Act. This privilege, however, belongs to the government and may be asserted regardless of how the patient or his physician treats the information in question. Therefore, should the government agency choose not to assert its privilege, there would be no protection of the absent patient's privacy, as there would be no physician-patient privilege for the court to recognize.

A second reporting requirement provides that physicians are to make written report to the local health department concerning any patient who has a disorder characterized by lapses of consciousness. The local health officer is to forward this report to the State Department of Health, which in turn makes it available to the State Department of Motor Vehicles for use in determining eligibility of the patient to be licensed to operate a motor vehicle. The code section requiring such reporting also specifically prescribes that the information shall be kept confidential.

Finally, the California Penal Code contains a requirement that physicians report to law enforcement agencies any injuries inflicted by deadly weapons or arising from the commission of a crime, or any non-accidental injury to a minor. Failure to do so is punishable as

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151. Cal. Gov't Code § 6254(c) (West Supp. 1975) excludes from required public disclosure "[p]ersonnel, medical, or similar files, the disclosure of which would constitute an unwarranted invasion of personal privacy . . . ." But see 55 Op. Cal. Atty Gen. 369 (1972) which concludes that the required reporting of therapeutic abortion information under California Health and Safety Code section 25955.5 does not come within the purview of this exception, because section 25955.5 "itself protects 'personal privacy' by prohibiting the inclusion of the identification of any person having an abortion." Id. at 370.
153. One solution to this problem would be to require the government to assert its privilege. However, this alternative may have undesirable ramifications in the area of government secrecy in a free society.
154. Cal. Health & S. Code § 410 (West Supp. 1975). The State Department of Health defines these disorders. Id. Examples of afflictions which have been so designated are "neurological disorders, senility, diabetes mellitus, cardiovascular disease, alcoholism or excessive use of alcohol sufficient to bring about blackouts (retrograde amnesia for their activities while drinking)." Cal. Admin. Code tit. 17, § 2572.
a misdemeanor. Unmistakably, should these reports result in criminal prosecution, the physician-patient privilege would be inapplicable. In a civil action, if the reports are not characterized as public documents, the patient may assert the privilege if he is a party. In this case, the privilege is available even though the disclosure was not reasonably necessary to the patient's treatment, provided that the patient did not consent to the disclosure. Penal Code section 11105 specifically states that records may be released by the Attorney General from the State Bureau of Criminal Identification and Investigation files to certain law enforcement agencies "for the due administration of the laws, and not for the purpose of assisting a private citizen in carrying on his personal interests or in maliciously or uselessly harassing, degrading or humiliating any person." Therefore, the privilege is still available to the patient, and if the patient is not a party, the court becomes the instrumentality for the protection of his privacy under the Rudnick rule.

Drug Companies

The California Supreme Court in Rudnick made no finding as to whether disclosure of adverse reaction information to drug companies is reasonably necessary to accomplish the purpose for which a patient consulted his physician. Instead, the court remanded the case to the trial court to make this determination. It would seem that these adverse reaction reports meet the test which the trial court is to apply in making its decision. In view of the fact that only the reports of patients who have had adverse reactions are sent, only those patients who have a direct interest in the feedback from the drug company to the physician are involved. As was posited in Rudnick, the drug company is able to


161. This statement assumes that the information has not become public in a prior criminal proceeding. It is also assumed that criminal conduct was not in fact involved, in which case the privilege may be eliminated by either Cal. Evid. Code § 997 (West 1966) (treatment sought to plan, commit, or escape detection or apprehension after, commission of a crime or tort) or Cal. Evid. Code § 999 (West 1966) (conduct of the patient which constitutes a crime).


163. This would not prevent introduction of reports made by the physician pursuant to Cal. Pen. Code § 11161.5 (West 1970 & Supp. 1975) in any civil action in which a minor plaintiff alleged willful child abuse, because the minor plaintiff would be the holder of the privilege and could waive it. Furthermore, the patient-litigant exception contained in Cal. Evid. Code § 996 (West 1966) would control, thus eliminating the privilege.
provide the physician with an opinion as to the relationship between the patient's symptoms and his taking the drug in question only after receipt of the physician's adverse reaction report. Thus, it can reasonably be argued that the patient is directly benefited by the disclosure, since in this way a physician may obtain the information reasonably necessary to the adequate treatment of a patient who has had an adverse reaction. At the same time, the benefit of such reports is shared by the public at large, particularly because idiosyncratic reactions are discovered after use of the drug by the public, even though the drug has undergone detailed testing prior to Food and Drug Administration licensing. This public benefit creates a strong policy argument in favor of finding the disclosure "reasonably necessary." Moreover, the question of the availability of confidential medical information held by third parties is apparently being raised with increasing frequency. If a drug company cannot assure a physician that it will maintain the confidentiality of the reports, the physician might refuse to send them, fearing civil liability or loss of license. Thus, the drug company might not receive the information it needs to fulfill the legal obligation which it owes both the FDA and the public to improve the quality of its product and to provide adequate warnings as to its use. In this eventuality, both the patient with an adverse reaction and the public at large would be endangered. Therefore, the drug company, which receives adverse reaction reports in the normal course of treatment of the patient, should be permitted to assert the physician-patient privilege to protect the privacy of the absent patient.

Authorizing the drug company to assert the privilege would not prevent the plaintiff from obtaining evidence necessary for the prosecution of his action. The court in Rudnick sought merely to protect the patient from having his identity matched with his confidential medical information. Thus, unless the patient's identity would necessarily be revealed thereby, a plaintiff would be entitled to discover the adverse reaction reports, or abstracts from them, and the names of the submitting physicians. This material would provide the plaintiff with the information he requires as to the contraindications of the drug and the company's notice of them. The usefulness of such information would not be enhanced by the inclusion of the patients' names.

Plaintiff in Rudnick argued that discovery of the actual reports in the possession of the drug company would prevent her from having to bear the excessive burden of deposing physicians all over the United States. The court rejected this argument on the ground that the patient's

165. See text accompanying notes 92-94 supra.
interest in privacy outweighed the plaintiff's monetary interest. This conclusion is consistent with the underlying policy of the privilege, because each patient would have the choice to waive or assert the privilege if his doctor were subpoenaed. Were this not the rule, neither the patient nor the drug company's custodian of records would have the means to maintain the confidentiality of the patient’s medical data. It is true that some patients may wish to testify on behalf of the plaintiff or otherwise provide information. Nonetheless, such a waiver of privacy should be within the discretion of the patient himself.

Conclusion

Rudnick v. Superior Court extended the coverage of the physician-patient privilege by recognizing the ability of certain third parties to assert the privilege on behalf of a nonparty patient whose medical information is threatened with disclosure in the courtroom. This extension followed the apparent intent of the legislature and is warranted by the threat to the patient's privacy presented by the existence of a rapidly increasing number of third parties whose receipt of medical information is “reasonably necessary for the accomplishment of the purpose for which the patient consulted [his] physician.”

The full effect of this decision will not be known until further litigation has defined the term “reasonably necessary” and thereby identified those third parties who meet the Rudnick test. It is clear at this point, however, that the decision in Rudnick has significantly advanced the right of every individual to confidential medical treatment. Although Rudnick allows third parties to assert the privilege, it places no duty upon them to do so. It is hoped that the courts or the legislature will now give this right some substance by requiring the third party to assert the privilege on behalf of the patient, just as a physician is obliged to do, and by requiring the courts to recognize the privilege. Only then will the physician-patient privilege be a reliable and effective shield against public disclosure in court of the physical ailments and deficiencies of the absent patient.

Ralph W. Tarr*

166. See text accompanying note 52 supra.
* Member, Third Year Class