1-1997

Healer-Patient Privilege: Extending the Physician-Patient Privilege to Alternative Health Practitioners in California

Betty F. Lay

Follow this and additional works at: https://repository.uchastings.edu/hastings_law_journal

Part of the Law Commons

Recommended Citation
Available at: https://repository.uchastings.edu/hastings_law_journal/vol48/iss3/5

This Note is brought to you for free and open access by the Law Journals at UC Hastings Scholarship Repository. It has been accepted for inclusion in Hastings Law Journal by an authorized editor of UC Hastings Scholarship Repository. For more information, please contact wangangela@uchastings.edu.
Healer-Patient Privilege: Extending the Physician-Patient Privilege to Alternative Health Practitioners in California

by
Betty F. Lay*

Introduction

As history1 and recent trends2 indicate, there is more than one way to practice medicine, and more than one kind of doctor—a term that applies to many practitioners, not just M.D.s, who have completed their medical training and earned a license. Allopathy,3 oste-

* J.D. Candidate, 1997; B.A. 1992, Cornell University. To my husband, Stephen, and my parents and sister, thank you for believing in the power of love and health.

1. Herbs, meditation, massage, and acupuncture have been used for therapeutic purposes for thousands of years in Asia despite the arrival of Western medicine. Homeopathy, a form of pharmacology, originated in late 18th century Germany and continues to be popular in technologically advanced western Europe. Allopathic medicine has been the dominant form of medical care in the United States since the early 20th century, after the development of antiseptics in the 19th century paved the way for the effectiveness of drugs and surgery. Prior to the development of antiseptics, less invasive forms of medicine, such as naturopathy, osteopathy, and chiropractic, were recognized as forms of conventional care. See Jeanne Rattenbury, The Other Healthcare Reform, CHICAGO, Jan. 1995, at 62, 64.

2. A Harvard study published in the New England Journal of Medicine in 1993 found that 34% of Americans polled had used one or more alternative therapies within a year's time. The estimated number of visits, 425 million, to such providers, was nearly 10% greater than the number of visits to traditional primary-care physicians that year. David M. Eisenberg et al., Unconventional Medicine in the United States: Prevalence, Costs, and Patterns of Use, 328 New. Eng. J. Med. 246, 246-52 (1993); see also Sabin Russell, HMOs Try Dose of Alternative Medicine, S.F. CHRON., Jan. 22, 1996, at A1, A4. See generally ALTERNATIVE MEDICINE: THE DEFINITIVE GUIDE 3-5 (The Burton Goldberg Group ed., 1995) (describing conventional medicine's inadequate treatment for chronic disease) [hereinafter ALTERNATIVE MEDICINE].

3. Allopathy, or "rational-empirical medicine," is the form of medicine practiced by physicians and surgeons (M.D.s). Oscar Janiger & Philip Goldberg, A Different Kind of Healing 23-24 (1993). Its main tools are drugs and surgery. This form of medical care began evolving toward its currently dominant position in American medical history when the Carnegie Foundation for the Advancement of Teaching published the Flexner Report in 1910. This survey established a system of standardized training, licensing, accreditation, and regulation for U.S. medical schools. Thereafter, only graduates of the newly-accredited medical schools were granted the degree of Medical Doctor and al-
Osteopathy, chiropractic, naturopathy, homeopathy, and Traditional Chinese Medicine (TCM) are examples of comprehensive, sometimes

4. Osteopathy is a type of medicine "that helps restore the structural balance of the musculoskeletal system" through a combination of joint manipulation, physical therapy, and postural reeducation. Such physical manipulation improves the functioning of the body's innate self-healing mechanism. Alternative Medicine, supra note 2, at 405. Licensed in all 50 states, American D.O.s (Doctors of Osteopathy) "carry the same license and scope of practice as M.D.s," except that osteopaths' approaches vary in emphasis from the conventional medical approach to manipulative therapy. See id. at 409; Bill Thomson, Looking For Dr. Right: How to Pick the Best Alternative Healthcare Practitioner for You, Nat. Health, Feb. 1997, at 80, 83 [hereinafter Thomson, Looking for Dr. Right].

5. Chiropractic is a form of primary healthcare which is concerned with the proper alignment of the spinal column and the relationship of the body's musculoskeletal structures to the nervous system. Misalignments in the spine, known as subluxations, result in "nerve interference," pain, and possibly weakened immunity in the body. Chiropractors adjust spinal joints to remove subluxations so that normal nerve function can be brought back. Alternative Medicine, supra note 2, at 134. All 50 states permit licensing of chiropractors. See Thomson, Looking for Dr. Right, supra note 4, at 83.

6. Naturopathic medicine utilizes "an array of healing practices," including homeopathy, acupuncture, herbal medicine, hydrotherapy, therapeutic counseling, and nutritional therapy. Alternative Medicine, supra note 2, at 360. Naturopaths (N.D.s) are trained to diagnose and treat patients on a primary-care level. They can prescribe some drugs and perform minor surgery. Generally, they prefer to use a combination of nutrition, herbs, homeopathy (a form of pharmacology), and/or acupuncture to enhance a body's innate healing ability. See id. at 364-65.

Naturopathy flourished in the United States until the 1930s, at which point proponents of allopathy effectively wiped out nearly every form of alternative medicine. "Yet, naturopathic medicine has experienced a resurgence in the last two decades," and approximately 1500 licensed or licensable naturopaths and three naturopathic medical schools currently exist in the United States. Id. at 364-67; Thomson, Looking for Dr. Right, supra note 4, at 83. Naturopaths are licensed in 11 states (no licensing act exists for them in California). Rattenbury, supra note 1, at 62; Thomson, Looking for Dr. Right, supra note 4, at 83.

7. Homeopathy is a low-cost, nontoxic system of medicine based on three principles: (1) "like cures like;" (2) "the more a remedy is diluted, the greater its potency;" and (3) "an illness is specific to the individual." Alternative Medicine, supra note 2, at 272-75. Homeopathy has proven especially "effective in treating chronic illnesses that fail to respond to conventional treatments," and the remedies act to "stimulate the body's natural healing response. . . . [T]he Food and Drug Administration recognizes homeopathic remedies as official drugs and regulates their manufacturing . . . and dispensing." Id. at 272. Currently only Connecticut, Arizona, and Nevada permit licensing of homeopaths, but medical or osteopathic doctors may also offer such services. See Thomson, Looking for Dr. Right, supra note 4, at 83. For a history of homeopathy, see Alternative Medicine, supra note 2, at 277.

8. Used for at least 3000 years, Traditional Chinese Medicine (TCM) is a comprehensive health-care system that coexists with modern Western medicine in China. TCM holds that invisible energy (chi) regulates the mind, body, and spirit, and that the key to
overlapping, systems for diagnosing, treating, and preventing human ailments on a primary-care level.\(^9\) Allopathic, or conventional, medicine has become less satisfactory for treating cancer, mental illness, and acute infections associated with viruses, nutritional and metabolic diseases, chronic degenerative diseases, allergies, and autoimmune diseases.\(^10\) By focusing on intervention rather than prevention, the modern American medical system has engendered a healthcare crisis in which the treatment of chronic disease currently accounts for eighty-five percent of the national healthcare bill.\(^11\) Fortunately, the longstanding rivalry between allopathic medicine and alternative medicine is eroding to yield a more holistic approach to healthcare, such that even primary-care physicians and specialists, recognizing the shortcomings and side effects of conventional therapies, are referring their patients to alternative health practitioners.\(^13\)

good health is to keep the energy flowing freely; obstructed chi leads to disease. Practitioners of TCM claim that they can detect and correct energy blockages before physical ailments arise. Rather than using modern diagnostic tools, Doctors of Oriental Medicine (O.M.D.s) identify health problems by asking questions and studying a patient's tongue and pulse. A tenet of TCM is that each person has an individual constitution that an experienced practitioner can discern for appropriate treatment. TCM's three main forms of treatment are acupuncture, herbs, and massage, but most practitioners specialize in either acupuncture or herbs. O.M.D.s cannot be licensed as physicians in the United States except in New Mexico, but they can practice as acupuncturists and/or herbalists in most states. See Rattenbury, supra note 1, at 62. Thirty-one states permit licensing of acupuncturists, and two states permit licensing of O.M.D.s. Thomson, Looking for Dr. Right, supra note 4, at 82. In California, licensed acupuncturists can serve as primary-care providers. See Rattenbury, supra note 1, at 118.

9. Historically, there have been several “schools” or approaches to the practice of medicine, including allopathy, osteopathy, chiropractic, homeopathy, the eclectic, and naturopathy. 71 Op. Cal. Att’y Gen. 54 (1988). For an informative discussion of these types of alternative therapies and their historical underpinnings, see generally ANDREW WEIL, HEALTH AND HEALING (1995).

10. See Weil, supra note 9, at 83-84 (discussing shortcomings of allopathic medicine); see generally JOHN ROBBINS, RECLAIMING OUR HEALTH (1996) (challenging the conventional medical establishment's biases and arguing that the establishment abuses its power); ALTERNATIVE MEDICINE, supra note 2, at 3-11 (advocating alternative medicine as the solution to treating and preventing chronic disease).

11. See ALTERNATIVE MEDICINE, supra note 2, at 3-5. For an informative discussion about the cost-ineffectiveness of the American healthcare system and how it performs in comparison to other countries' systems, see ROBBINS, supra note 10, at 2-4.

12. See ROBBINS, supra note 10, at 182-202 (exposing the “medical monopoly” the American Medical Association has maintained over the American healthcare system, to the exclusion of alternative care); Weil, supra note 9, at 12-25 (explaining a spectrum of alternative healing practices and comparing them to allopathic medicine). See also HARRIET BEINFIELD & EFREM KORNGOLD, BETWEEN HEAVEN AND EARTH: A GUIDE TO CHINESE MEDICINE 23 (1991) (discussing the narrowing of the Western institution of medicine and corresponding disenfranchisement of naturopathy, homeopathy, and herbology as forms of mainstream medicine in the early 20th century).

13. See Weil, supra note 9, at vii-viii (discussing the establishment of the Office of Alternative Medicine by the National Institutes of Health (NIH) and creation of holistic
As the meaning of "practicing medicine" evolves to include unconventional types of medicine, it is reasonable to ask whether a patient in such a "healer-patient" relationship should expect his or her communications to an alternative health practitioner to remain confidential, even in the courtroom. An evidentiary privilege such as that afforded to patients of traditional physicians (M.D.s) "permits its holder to prevent the discovery or introduction in judicial proceedings of confidential relational communications." Because [an evidentiary] privilege may result in the exclusion of highly probative evidence, the policy underlying it presents a potential conflict with the policy of judicial proceedings to resolve disputes accurately.

To date, no California appellate court has held the physician-patient privilege to apply to alternative health practitioners. Although few claim that patients choose medical care based on the availability of the physician-patient privilege, patients do expect some measure of confidentiality. The fact that patients are increasingly entering into what may be characterized as physician-patient relationships with alternative healthcare providers raises concerns of fairness because the statutory privilege applies only to patients' communications with medical doctors. A patient may seek an alternative healthcare pro-

14. See infra Part II.C for a discussion of the meaning of the "practice of medicine."
15. This Note will use the term "healer-patient relationship" to refer to the relationship between a patient and a healer existing for the purpose of the diagnosis or treatment of a mental or physical ailment. "Healer" shall include not only M.D.s but also homeopaths, naturopaths, acupuncturists, chiropractors, osteopaths, and other healthcare providers, whether licensed or not.
17. Id.
18. See id. at 664-65 (pointing out that opponents of the physician-patient privilege claim that shyness or the threat of embarrassment do not cause people to "avoid needed medical care in the absence of a privilege").
19. This American expectation of privacy has been noted:
American society places a high value on individual rights, autonomous decision making, and the protection of the private sphere from governmental or other intrusion. Concerns about privacy transcend the healthcare setting. Americans believe that their privacy rights as consumers are not adequately protected. In a 1993 Harris poll on consumer privacy conducted for Equifax, Inc., 78% of the respondents indicated their concern about threats to privacy.
vider for treatment of an ailment which a physician could also treat, but under current California law, the privilege would apply only to the relationship involving the physician.  

This Note addresses the question of whether a patient should be allowed to invoke the physician-patient privilege with respect to communications made to an alternative health practitioner, in light of the practical reality that alternative health practitioners in California and across the nation are treating and diagnosing patients within the meaning of the statutory privilege. Part I highlights the mainstreaming of alternative medicine in the United States. Part II provides an overview of the physician-patient privilege and the legal status of alternative health practitioners in California. Part III examines alternative legal schemes for preserving the confidentiality of such communications, such as the existence of voluntary ethical codes of conduct and the state constitutional right to privacy. Part IV evaluates the merits of applying the privilege to the alternative healthcare setting. Finally, Part V proposes a model revision to the California Evidence Code's physician-patient privilege.

I. The Surging Interest in Alternative Medicine

The cornerstone of holistic health practice is individual responsibility. Holistic medicine originated as a self-help remedy suited to the days when people did not have ready access to hospitals, ambulances, and health maintenance organizations (HMOs).

A Harvard study published in the New England Journal of Medicine in 1993 stirred the interest of patients, physicians, and HMOs alike with its findings that thirty-four percent of Americans polled had used one or more alternative therapies within a year's time. The study found that the estimated number of visits, 425 million, to such providers was nearly ten percent greater than the number of visits to traditional primary-care physicians that year. Moreover, seventy-two percent of the patients who used the alternative therapies did not inform their physicians about seeking these treatments. The estimated expenditures for the therapies totaled $13.7 billion, $10.3

20. See infra Part II (discussing the physician-patient privilege generally).
21. See infra Part I (discussing surging interest in alternative medicine).
22. For example:
   [A] traditional doctor in China need carry only a few needles and gather local herbs from the countryside to minister to his patients . . . . [A]fter the revolution in 1949 many thousands of “barefoot doctors” were trained to serve the unmet needs of the Chinese people for medical care. This equipped ordinary people with the tools to gain control of their own lives.
   BEINFIELD & KORNGOLD, supra note 12, at 7 (comparing Eastern and Western models of medicine).
23. See Eisenberg, supra note 2, at 246-52.
billion of which patients paid out-of-pocket. Most of these individuals sought relief from chronic, non-life-threatening conditions such as back pain, allergies, arthritis, and insomnia.24 A similar San Francisco Bay Area poll conducted in May of 1995 found that forty-one percent of Bay Area residents had sampled alternative medical remedies in the previous year.25

As part of this shift in American healthcare towards alternative therapies, full-service primary healthcare facilities are springing up across the nation, offering both standard and alternative treatments, including bodywork, botanical medicine, biofeedback, guided imagery, acupuncture, and nutritional counseling.26 These new clinics, called “integrated centers,”27 allow a patient to see an alternative practitioner only after a licensed physician (M.D.) has examined the patient for serious illnesses that require conventional treatment.28

Driven by patient interest as well as by their survival instincts, HMOs across the country also are beginning to incorporate alternative therapies into their programs; some have established separate “alternative medicine” clinics which typically offer services such as acupuncture, herbal therapy, nutrition counseling, yoga, and guided imagery techniques.29 Some major health insurers are covering alter-
native therapies such as acupuncture and chiropractic care on a limited basis.  

Alternative medicine is less expensive to administer than Western allopathic treatments for several reasons. First, alternative medical treatments generate few, if any, harmful side effects. Nutrition counseling, biofeedback, herbal remedies, and non-invasive procedures such as massage and acupuncture, are cheaper to administer than conventional therapies such as surgery. Second, some suggest that patients who are interested in alternative medicine may tend to be healthier in the first place. Finally, alternative providers focus on preventive care, thereby reducing future health costs for both the patient and HMO. In keeping with the increased consumer and professional interest in self-care, more health food stores exist in the United States today than in 1990, many of them carrying a complete line of herbal products, food supplements, and homeopathic remedies.
Even conventional pharmacies and chain drugstores carry products touted as “natural remedies.”

The federal government has shown increasing support for alternative healthcare. In 1992, Congress authorized the National Institutes of Health (NIH) to establish the Office of Alternative Medicine (OAM) to support research to investigate the effectiveness of alternative therapies and provide public information about alternative practices. The NIH has devoted a sizable portion of funds to specific divisions to research, for example, whether t'ai chi can improve elderly movement, whether acupuncture can stem cravings for drugs, and whether transcendental meditation can curb heart attacks. In 1996, the Food and Drug Administration took acupuncture needles off its list of unproven “investigational” devices, thereby facilitating health insurance coverage for acupuncture.

Likewise, alternative medicine is gaining acceptance at the state level. Forty-one states require health insurers to offer chiropractic coverage, and six (California, Florida, Montana, Nevada, New Mexico, and Oregon) require insurers to offer access to the services of acupuncturists. Even the Internal Revenue Service has lent indirect credence to the mainstreaming of alternative medicine by ruling that acupuncture and chiropractic care are alternative medical practices which qualify as legitimate medical deductions.

35. See Gordon, supra note 13, at 257.
36. See Japsen, supra note 30, at 140 (Parts 1 and 2). In August 1995, a House subcommittee approved a budget of $7.5 million for fiscal year 1996 for the NIH's Office of Alternative Medicine (OAM), an appropriation reflecting an upward trend from an initial grant of $2 million in 1992 and a 1995 grant of $5.4 million. See id.

The OAM has spent nearly $1.7 million to support the establishment of two research centers. One, at the University of Seattle, will explore alternative treatment of AIDS. Another, the Minnesota Medical Research Foundation, will examine alternative therapies for addiction disorders. See Firshein, supra note 24, at 30. As of June 1996, the OAM had awarded NIH grants of $800,000 to $1 million to 10 major institutions, including Stanford, University of California at Davis, and Columbia, to study unconventional treatments. See Tom Philp, The New Medicine: Mainstream, Nontraditional Worlds Seek Common Ground, SACRAMENTO BEE, June 2, 1996, at A1, A10 (listing institutions receiving grants and their intended research specialties).

37. See Firshein, supra note 24, at 30.
38. See Philp, Birth of a New Medicine, supra note 30, at A12 (providing chronology of state and national events supporting unconventional therapies).
39. See Firshein, supra note 24, at 31. In California, “acupuncturists are considered primary healthcare professionals and can see any patient without a physician's referral.”
40. See Griffin, supra note 30, at 106.
II. The Legal Setting

A. Physician-Patient Privilege Generally

"Historically, common law did not recognize communications between physician and patient as privileged."41 In California, the privilege is statutory42 and serves a dual purpose. First, it precludes the humiliation of the patient that might follow disclosure of his or her ailments. Second, it encourages the patient’s complete disclosure to the physician of all information necessary for effective diagnosis and treatment.43 “The rules of privilege are designed to protect personal relationships and other interests where public policy deems them more important than the need for [probative] evidence.”44 A party to a proceeding may obtain discovery regarding any relevant, unprivileged matter,45 but to the extent a privilege applies, it bars discovery of even relevant information.46

Commentators have challenged the rationale that the privilege is necessary for the protection of public health. “First, there is no evidence that public health or the availability or quality of healthcare has suffered in states which do not recognize the [physician-patient] privilege.”47 Second, it is erroneous to presume that patients are knowledgeable about privilege law or that they give its application some thought before revealing their ailments to physicians.48 In addition, it

43. See CAL. EVID. CODE §§ 990-1007 (Deering 1997); City & County of S.F. v. Superior Court, 231 P.2d 26, 28 (Cal. 1951); Palay v. Superior Court, 22 Cal. Rptr. 2d 839, 843-44 (Cal. Ct. App. 1993).
44. Palay v. Superior Court, 22 Cal. Rptr. 2d at 844 (quoting In re Troy, 263 Cal. Rptr. 869, 875 (Cal. Ct. App. 1989) (internal citation omitted)). Privileges “must be strictly construed and accepted ‘only to the very limited extent that permitting a refusal to testify or excluding relevant evidence has a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth.’” Trammel v. United States, 445 U.S. 40, 50-51 (1980) (quoting Elkins v. United States, 364 U.S. 206, 234 (1960) (Frankfurter, J., dissenting)).
45. See Palay v. Superior Court, 22 Cal. Rptr. 2d at 842-43; CAL. CIV. PROC. CODE § 2017(a) (Deering 1997); CAL. EVID. CODE § 911 (Deering 1997).
46. See CAL. CIV. PROC. CODE § 2017(a) (Deering 1997); Rudnick v. Superior Court, 523 P.2d 643, 647-48 (Cal. 1974).
is unlikely that patients reasonably expect their communications with physicians to be kept confidential in a modern medical system which relies on third party reimbursement and the sharing of information among specialists working on the same case.\textsuperscript{49} Third, the exceptions to the privilege tend to override the rule in most of the cases in which the privilege is likely to be asserted.\textsuperscript{50} Finally, the exercise of the privilege may prove to be harmful to patients, as in malpractice actions where the privilege is used to prevent the admission of evidence regarding the treatment of other patients and, inferentially, the physician’s possible misconduct.\textsuperscript{51} Notwithstanding these arguments against establishing a physician-patient privilege, courts and legislatures in the United States have chosen to recognize the privilege.

There are two analytical approaches to balancing the conflict between the policy of protecting the sanctity of the physician-patient relationship and the policy of admitting highly probative evidence: the “utilitarian or instrumental school”\textsuperscript{52} and the “deontological or humanistic school.”\textsuperscript{53} The utilitarian approach “considers the utility of a privilege to the relationship it seeks to protect and the relationship’s value to society” and contends that the privilege “is necessary to permit the patient to develop confidence in the physician so that a candid revelation of all the facts necessary for accurate diagnosis and appropriate treatment will occur.”\textsuperscript{54} This approach assumes “not only that the patient is aware of the applicable law of privilege and considers that law before consulting with a physician, but also that the patient would avoid

\textsuperscript{50} See Goldberg, supra note 47, at 790-800. Exceptions and waivers are discussed infra Part II.B.
\textsuperscript{51} See Goldberg, supra note 47, at 794-800.
\textsuperscript{52} Dean Wigmore’s views characterize the utilitarian approach to privilege: Wigmore viewed privileges as obstructions to the truthfinding process that must be justified by their benefit to an important relationship. He thus imposed four requirements for recognition of a relational 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.

\textsuperscript{53} Id.
\textsuperscript{54} Id. at 663-64.
treatment or withhold information necessary for effective treatment [and diagnosis] in the absence of a privilege."

The deontological approach argues that "disclosure of confidences revealed in certain relationships is of itself wrong," and that "society should recognize the dignity of the individual by protecting the . . . physician-patient relationship from unnecessary intrusions." Thus, recognizing the physician-patient privilege calls for a value judgment regarding the proper relationship between the individual and society. For example, one may point to a causal connection between the ideas of privacy and democracy as an empirical justification for the deontological view of the privilege.

Although the California Evidence Code does not explicitly adopt either the utilitarian or the deontological approach, California courts appear to endorse both approaches in stating that the physician-patient privilege is meant to protect the personal relationship between a patient and physician and to encourage the patient's free disclosure of facts to enable the physician to treat the illness. California Evidence Code section 990 defines the term "physician" as "a person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation." As this Note will explain, practicing "medicine" in California is an activity legally restricted to physicians and surgeons who have been licensed pursuant to the California Medical Practice Act. Thus, an alternative health practitioner who is not certified as a physician or surgeon (i.e., M.D.) is not practicing "medicine" within the meaning of the Evidence Code and cannot invoke the physician-patient privilege.

The term "authorized," as used in the Evidence Code's physician-patient privilege, also carries significance because it indicates the California Legislature's desire to grant the privilege to licensed physicians. This Note will discuss how alternative health practitioners who meet state certification requirements effectively meet the "authorization" requirement of the Evidence Code. If alternative health practitioners can be shown to be practicing "medicine" in common sense terms, and

55. Id.
56. Id. at 664-65.
57. See id. at 665-66. Deontological proponents rarely, if at all, "contend that privacy in the physician-patient relationship should be absolute." Concerns such as "protection of the public from incompetent physicians, the prevention of harm that the patient has threatened to third persons, or the correct adjudication of child custody questions may . . . outweigh privacy concerns." Id. at 666-67.
58. See CAL. EVID. CODE §§ 990-1007 (Deering 1997).
60. CAL. EVID. CODE § 990 (Deering 1997) (emphasis added).
if these individuals also are licensed in their healing arts, the physician-patient privilege should become instead a “healer-patient” privilege.

Before a physician-patient privilege may apply, a relationship between physician and patient must exist at the time of the communication, as when a patient “consults a physician or submits to an examination by a physician” to secure diagnosis, or when he seeks “preventive, palliative, or curative treatment of his physical, mental, or emotional condition.” “The relationship of a physician and patient [also may] exist between a medical or podiatry corporation . . . and the patient to whom it renders professional services.”

The protected communication may be any information “transmitted between a patient and his physician in the course of that relationship,” so long as the patient communicates such information to the physician in a confidential manner, or at least intends to do so. For example, if the patient discloses the information to third persons who are not “reasonably necessary” to further the patient’s interest in consultation or treatment, the communication will fall outside the privilege. Eavesdroppers, however, are not permitted to testify regarding the communication.

As defined by statute, the term “physician” means not only a person authorized to practice medicine, but also a person “reasonably believed by the patient to be [so] authorized.” Thus, the privilege protects patients from reasonable mistakes as to “unlicensed practitioners.”

The holder of the privilege may be the patient, the patient’s guardian or conservator, or the patient’s personal representative if the patient is deceased. “Unless otherwise instructed by a person au-

62. See CAL. EVID. CODE § 992 (Deering 1997).
63. California Business and Professions Code section 2038 defines “diagnose” or “diagnosis” as: “any undertaking by any method, device, or procedure whatsoever, and whether gratuitous or not, to ascertain or establish whether a person is suffering from any physical or mental disorder.” CAL. BUS. & PROF. CODE § 2038 (Deering 1997).
64. CAL. EVID. CODE § 991 (Deering 1997). The statute makes no distinction between consultations made for the purpose of diagnosis and consultations made for the purpose of treatment. See id.
65. Id.
66. Id.
67. CAL. EVID. CODE § 992 (Deering 1997).
68. See id. § 994 (Law Revision Commission Comments).
69. Id. § 990.
70. Id. § 990 (Law Revision Commission Comments).
71. CAL. EVID. CODE § 993 (Deering 1997). Under subdivision (c), the personal representative need not make an affirmative showing that the benefit to the estate in maintaining confidentiality outweighs the interest in disclosure. Rather, the privilege “remains inviolate” until the personal representative waives the privilege “by word or deed.” Rittenhouse v. Superior Court, 1 Cal. Rptr. 2d 595, 599 (Cal. Ct. App. 1991).
Authorized to permit disclosure,” the person who was the patient’s physician at the time of the confidential communication is obligated “to claim the privilege on behalf of the patient.”

B. Exceptions and Waiver

The California Evidence Code sets forth a number of exceptions to the physician-patient privilege. For example, the privilege may not apply in a proceeding in which the patient himself or herself tenders an issue concerning the patient’s medical condition, as when the patient brings a personal injury action. When the patient’s condition is in issue, neither a party claiming through the patient nor the patient’s beneficiary may claim the privilege. No privilege applies if the patient sought or obtained the physician’s services to “enable or aid anyone to commit or plan to commit a crime or a tort.” The privilege is inapplicable in a criminal proceeding or in a civil proceeding to recover damages for the patient’s criminal conduct, whether or not felonious. The privilege does not shield information that the physician or patient is required to report to a public employee or to record in a public office. The Evidence Code also provides for an exception for any “communication relevant to an issue of breach . . . of a duty arising out of the physician-patient relationship.” Finally, the privilege does not operate if the communication is relevant to an issue concerning a deceased patient’s intention regarding a “deed of conveyance, will, or other writing” that the patient had executed.

In general, waiver of the physician-patient privilege occurs 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.” Such consent to disclosure includes “any statement or other

73. See CAL. EVID. CODE § 996 (Deering 1997). “The patient-litigant exception precludes one who has placed in issue his physical condition from invoking the privilege on the ground that disclosure of his condition would cause him humiliation. He cannot have his cake and eat it too.” City & County of S.F. v. Superior Court, 231 P.2d 26, 28 (Cal. 1951).
75. Id. § 996 (Deering 1997).
76. Id. § 997.
77. See id. § 998.
78. See id. § 999.
79. See id. § 1006.
80. Id. § 1001.
81. Id. § 1002.
82. Id. § 912(a).
conduct of the holder of the privilege indicating consent to the disclo-

For example, "failure to claim the privilege in any proceeding in which the holder has the legal standing and opportunity to claim the privilege" constitutes a waiver.

C. What Is "Practicing Medicine," And Who Is Practicing It?

The phrase "the practice of medicine" is not explicitly defined by statute. However, the California Medical Practice Act\(^85\) describes the type of professional conduct in which a statutory physician or surgeon is authorized to engage. "The physician's and surgeon's certificate authorizes the holder to use drugs or devices in or upon human beings and to sever or penetrate the tissues of human beings and to use any and all other methods in the treatment of diseases, injuries, deformities, and other physical and mental conditions."\(^86\) Business and Professions Code section 2052 ("section 2052") penalizes conduct that violates the Medical Practice Act, such as "practicing... any system or mode of treating the sick or afflicted in this state, or... diagnosing, treating, operating for, or prescribing for any ail-

It is interesting to note that a California appellate court interpreted the statute, as it stood in 1923, to mean that the holder of a naturopathy certificate lacked the legal right or authority to engage in the "general practice of medicine and surgery."\(^88\)

Under the foregoing definitions, it would seem that certain alternative health practitioners, such as acupuncturists and herbalists, are effectively "practicing medicine" in California, though not according to the statute. An acupuncturist in effect penetrates human tissue (the skin) by inserting needles on the surface of the body. A practitioner of TCM (O.M.D.) does not prescribe drugs listed with the Food and Drug Administration, but he or she may prescribe herbs which produce drug-like responses in patients' bodies. However, most alternative health practitioners do not "sever or penetrate the tissues of human beings" in treating them for "diseases, injuries, deformities, and other physical and mental conditions," and perhaps the California Legislature and allopathic medical community have distinguished the allopathic practitioners from the holistic practitioners in this way.

83. Id.
84. Id.
86. Id. § 2051.
87. Id. § 2052.
Business and Professions Code section 2052 does not purport to bring alternative health practitioners into the elite circle occupied by physicians and surgeons. Alternative health practitioners would seem to fit the conduct described in section 2052 because they diagnose, treat, and prescribe remedies for ailments. However, section 2052 implicitly distinguishes between physicians' authorized conduct and that of other healing arts practitioners. In setting forth the penalty for the unlicensed diagnosis or treatment of ailments, section 2052 lists valid licenses as licenses obtained pursuant to Chapter 5 of the Business and Professions Code (entitled "Medicine" and cited as the "Medical Practice Act") or licenses obtained "in accordance with some other provision of law." For example, a license obtained pursuant to Chapter 12 of the Business and Professions Code (entitled "Acupuncture," not "Medicine") is, by virtue of its citation in Chapter 12, outside the class of medical licenses obtainable under the Medical Practice Act. Moreover, the licensing provisions for alternative health practitioners specifically describe types of allowable professional conduct. The licensing provisions for all healthcare providers fall under Division 2 (entitled "Healing Arts") of the Business and Professions Code, but the Chapters are divided to address specific types of healing arts. In summary, the "practice of medicine" is a term of art applied to physicians and surgeons licensed as M.D.s, or osteopaths licensed as D.O.s (doctor of osteopathy), whereas the "healing arts" is a broad category encompassing both physicians and alternative health practitioners. However, the latter group's status can be likened to a homogeneous residue in the statutory pool of healing arts practitioners.

When do the "healing arts" become "medicine" for alternative health practitioners? As the California Legislature has structured the Business and Professions Code, "medicine" is a subcategory of the "healing arts." The current trend of integrating allopathic and alternative therapies in "integrated centers" physically combines the two fields under one roof, but patients are referred to the alternative therapists only after being screened by the physicians for serious diseases. Thus, the centers retain the medical hierarchy. While the Medical

89. CAL. BUS. & PROF. CODE § 2052 (Deering 1997).
91. See id. § 4926 (listing acupuncture under Division 2 (entitled "Healing Arts").)
92. See CAL. BUS. & PROF. CODE § 2453 (according holders of M.D. degrees and D.O. degrees equal professional status and privileges as licensed physicians and surgeons).
93. This distinction between the healing arts and medicine can be seen in sections 2000 and 4295 of the California Business and Professions Code. CAL. BUS. & PROF. CODE §§ 2000, 4295 (Deering 1997) (naming title of Division as "Healing Arts;" naming Chapter 5 as "Medicine" and Chapter 12 as "Acupuncture").
94. See Thomson, Medical Revolution, supra note 26, at 99-101.
Practice Act does not purport to limit the practice or licensing of other “healing arts practitioners,” neither does the Act bring them within the ambit of “practicing medicine.” The “practice of medicine” is still an idea housed exclusively in the Medical Practice Act, which governs licensing of “physicians and surgeons.”

D. Significance of Licensing

Since 1914, the California Legislature has held the power to regulate the practice of medicine and surgery, to protect people from “quacks and charlatans, and to insure proper qualifications of those seeking to administer aid to the sick and infirm.” As early as 1888, the California Supreme Court convicted a man of “practicing medicine without having first obtained a certificate authorizing him to do so.”

Business and Professions Code section 2052 provides that it is a misdemeanor for a person to treat the sick or afflicted in California without having a valid license as either a physician or other healing arts practitioner. With respect to advertising, the Business and Professions Code further states that any person who misrepresents himself or herself as a “physician,” “surgeon,” or “doctor,” or uses the prefix “Dr.” or the initials “M.D.,” is guilty of a misdemeanor.

Those statutes underscore the California Legislature’s concern with licensing health practitioners.

Certificates in California authorizing healing arts practitioners to diagnose or treat patients within their specialty apply to acupuncturists, chiropractors, and “drugless practitioners,” all of whom

95. See CAL. BUS. & PROF. CODE § 2000 (Deering 1997).
99. See section 2052 of the California Business and Professions Code, which provides:

   Any person who practices or attempts to practice, or who advertises or holds himself or herself out as practicing, any system or mode of treating the sick or afflicted in this state, or who diagnoses, treats, operates for, or prescribes for any ailment, blemish, deformity, disease, disfigurement, disorder, injury, or other physical or mental condition of any person, without having at the time of so doing a valid, unrevoked, or unsuspended certificate as provided in this chapter, or without being authorized to perform such act pursuant to a certificate obtained in accordance with some other provision of law, is guilty of a misdemeanor.

CAL. BUS. & PROF. CODE § 2052 (Deering 1997).
100. See CAL. BUS. & PROF. CODE § 2054 (Deering 1997) (defining penalty for misrepresentation as physician and surgeon).
101. See California Business and Professions Code section 4927(d), which defines an “acupuncturist” as an individual to whom a valid, unrevoked license has been issued to practice acupuncture. The statute further defines “acupuncture” to mean:
are considered alternative health practitioners by mainstream medicine.

The California Legislature expressly stated in the Acupuncture Licensure Act\(^{104}\) that it is concerned with “the need to treat the whole person” and to “encourage the more effective utilization of the skills of acupuncturists by California citizens desiring a holistic approach to health.”\(^{105}\) The Acupuncture Licensure Act confers upon licensed acupuncturists a legal status as healthcare providers,\(^{106}\) so long as these individuals are licensed with the state Acupuncture Examining Committee.\(^{107}\) Thus, patients can reasonably expect to divulge certain confidences to such practitioners in the course of treatment for mental or physical ailments.

Notwithstanding the California Legislature’s validation of licensed acupuncturists as healthcare providers, the California Attorney General has distinguished acupuncturists from licensed physicians and surgeons in the area of advertising and solicitation.\(^{108}\) A certified acupuncturist who is not also licensed as a physician and surgeon under the Medical Practice Act\(^{109}\) may not use the initials “O.M.D.” and the title “Oriental Medical Doctor,”\(^{110}\) without more, in advertising an acupuncture practice.

The rationale for this distinction is grounded in the historical use of initials and professional titles in connection with the healing arts. Such titles serve to inform the public with whom it is dealing, telling the public in exactly which “school” (e.g., allopathic, osteopathic, na-

\[\text{[T]he stimulation of certain point or points on or near the surface of the body by the insertion of needles to prevent or modify the perception of pain or to normalize physiological functions, including pain control, for the treatment of certain diseases or dysfunctions of the body and includes the techniques of electroacupuncture, cupping, and moxibustion.}\]

\citeauthor{calbusprofcode1997} \citeyear{calbusprofcode1997}.

102. \cite{calbusprofcode1997} § 1000-1057.

103. \cite{calbusprofcode1997} § 2500 (Deering 1997) (drugless practitioner’s certificate authorizing holder “to treat diseases, injuries, deformities, or other physical or mental conditions without the use of drugs”).

104. \cite{calbusprofcode1997} §§ 4925-4969.

105. \cite{calbusprofcode1997} § 4926.

106. \cite{calbusprofcode1997} (legislative intent to subject acupuncturists to regulation and control as “primary healthcare profession”). \cite{calbusprofcode1997} § 4937(b) (authorizing the holder of a license “[t]o perform or prescribe the use of oriental massage, acupressure, breathing techniques, exercises or nutrition, including the incorporation of drugless substances and herbs as dietary supplements to promote health”).

107. \cite{calbusprofcode1997} § 4935(c)(2) (Deering 1997).

108. \cite{opcalatygencal1988} (Deering 1997).


110. Some acupuncturists practicing in California receive degrees in the field of oriental medicine, either from schools in California or abroad. The degree is called a “doctorate” in oriental medicine and is designated by the initials “O.M.D.” for “Oriental Medical Doctor.” \cite{opcalatygencal1988}.
turopathic) the practitioner has trained. The public can be expected to rely on such designations when selecting a healthcare provider. Graduates and practitioners of the allopathic school of medicine are designated by the initials “M.D.” and the title “medical doctor” or “doctor of medicine.” Graduates and practitioners of the other “schools” (e.g., D.O. (doctor of osteopathy), D.C. (doctor of chiropractic), D.N. (doctor of naturopathy)) receive non-M.D. titles.

The Acupuncture Certification Committee permits certified acupuncturists to use the designation “doctor” or the abbreviation “Dr.” if (1) they hold a doctorate in acupuncture from an approved institution, and (2) they also further indicate the type of doctorate they hold. However, despite this variety of medical options available to the public, the California Attorney General has ruled that the designation “M.D.” has been exclusively reserved to individuals who have both received an M.D. degree and obtained a license under the Medical Practice Act. Thus, a licensed acupuncturist who properly qualifies her “Dr.” designation still is not considered a statutory physician without the M.D. degree and the medical license. As for other types of healing arts practitioners, Business and Professions Code section 2278 likewise states that a person not licensed as a physician or surgeon must further indicate the type of certificate held if that person uses the title “doctor” or the prefix “Dr.”

This system of titles bears upon the application of the physician-patient privilege. Case law has established that the Evidence Code’s definition of “physician,” for purposes of the physician-patient privilege, is limited to medical doctors (M.D.s). Therefore, a healthcare provider’s certification under state law does not automatically bring that individual under the coverage of the physician-patient privilege.

112. See id. at 58 (citing Brandwein v. California Bd. of Osteopathic Examiners, 708 F.2d 1466, 1473 (9th Cir. 1983)).
113. See id. at 57.
114. See id. at 58.
116. See 71 Op. Cal. Att’y Gen. 54, 58 (1988) (referring to Cal. Bus. & Prof. Code § 2054). The Attorney General found that from the “plain wording” of section 2054, the use of the initials “M.D.” or the title “Medical Doctor,” without more, by one who is not a licensed physician, violates both parts of section 2054 by indicating or implying the person was licensed as a physician to practice medicine under the Medical Practice Act, thus constituting a representation of that status to the public. See id. at 59.
119. See id.
III. Alternative Legal Schemes for Preserving Confidentiality

A. Confidentiality of Medical Information Act

It is useful to examine whether other legal schemes exist in California to protect a patient's confidences entrusted to alternative healthcare providers, and whether these schemes may realistically achieve the same result as the testimonial physician-patient privilege.

The California Confidentiality of Medical Information Act ("Act")\(^{120}\) provides: "No provider of healthcare shall disclose medical information regarding a patient of the provider without first obtaining an authorization, except as provided in subdivision (b) or (c)."\(^{121}\) The Act requires healthcare providers to establish procedures to ensure the confidentiality of patient medical information,\(^{122}\) and also prohibits third party administrators of health plans from disclosing medical information processed in connection with performing administrative services.\(^{123}\) Considered together, the statutory provisions require a healthcare provider to hold confidential a patient's medical information unless the information falls under one of several exceptions\(^{124}\) to the Act.

Because the Act provides for disclosure "[w]hen otherwise specifically required by law,"\(^{125}\) this exception to the Act impliedly overlaps with exceptions to the Evidence Code's physician-patient privilege, including the patient-litigant exception.\(^{126}\) Thus, where the law bars the application of the physician-patient privilege for relevancy reasons in a personal injury action, the Act also would presumably fail to protect against the unauthorized disclosure of confidential medical information. While it would seem under both statutes that protection of a

---

120. **CAL. CIV. CODE** § 56 (West 1997).
121. **CAL. CIV. CODE** § 56.10(a) (West 1997).
122. **Id.** § 56.20.
123. **See CAL. CIV. CODE** § 56.26(a) (West 1997).
124. **See CAL. CIV. CODE** § 56.10. The exceptions to the Confidentiality of Medical Information Act include the following situations:
   (1) Pursuant to court order;
   (2) In a proceeding before a court or administrative agency pursuant to a subpoena or subpoena duces tecum;
   (3) To an arbitrator or arbitration panel, when arbitration is lawfully recognized by either party, pursuant to provisions authorizing discovery in arbitration;
   (4) For purposes of diagnosis and treatment of the patient;
   (5) As necessary to an insurer, employer, healthcare service plan, governmental authority, or other entity responsible for determination of payment;
   (6) In connection with peer review and quality assurance activities;
   (7) In connection with licensure or accreditation of the provider;
   (8) When otherwise specifically required by law.

See **id.**
125. **Id.** § 56.10(b)(7).
126. **See CAL. EVID. CODE** § 996 (Deering 1997) (patient-litigant exception).
patient’s communications may be limited in similar ways for similar situations, such as when a patient puts his or her own health in issue, the fact remains that the physician-patient privilege governs testimony at a legal proceeding, whether those communications are of a “medical” or personal nature, so long as they are revealed during the course of treatment. The Act, by contrast, governs disclosure of “medical” information, generally in settings outside of court, and establishes procedures for ensuring confidentiality of such information.

The Act defines a “provider of healthcare” as any person licensed under the “healing arts” of the Business and Professions Code. For example, acupuncturists, physicians (licensed under the Medical Practice Act), osteopaths, chiropractors, emergency medical care personnel, health clinics, or healthcare service plans must follow procedures for ensuring confidentiality of medical information. However, Ayurvedic practitioners, Oriental Medical Doctors (O.M.D.s), and other types of unlicensed alternative healers may make unauthorized, unexcused disclosure of a patient’s medical information both inside and outside of court without incurring liability. Because the physician-patient privilege cannot protect patients’ confidential communications even to licensed non-physician healers, the Act should attempt to fill this gap by covering unlicensed “healing arts” practi-

127. Cal. Civ. Code § 56.05(d) (West 1997) (providing that any person licensed pursuant to Division 2 (“healing arts”) of the Business and Professions Code is a “provider of healthcare”).


131. Ayurvedic medicine (meaning “science of life”) has been practiced in India for the past 5000 years. See Alternative Medicine, supra note 2, at 63. This comprehensive system of medicine combines natural therapies with a personalized approach founded on the concept of metabolic body types, or “doshas.” See id. Once the ayurvedic practitioner identifies the patient’s metabolic body type, the practitioner designs a specific treatment plan which may include herbal tonics, yoga, meditation, massage, and medicated inhalations. See id. In ayurvedic medicine, health is defined as a soundness and balance between body, mind, and soul, and an equilibrium between the doshas; pathology is defined as a disruption of this state of balance due to genetic, congenital, internal, or external trauma; seasonal, natural tendencies or habits; and magnetic and electrical influences. See id. at 66.

Ayurvedic practitioners are not licensed in any state, although possibly thousands are at least minimally qualified. Thomson, Looking for Dr. Right, supra note 4, at 84.

132. Remedies for violation of the Confidentiality of Medical Information Act, which applies to medical doctors, include compensatory damages, punitive damages not to exceed $3000, attorney fees not to exceed $1000, and costs of suit. See Cal. Civ. Code § 56.35 (West 1997). A violation is a misdemeanor if the patient suffers economic loss or personal injury. See id.
tioners in order to give patients a safety net, however marginal, against having their medical information disclosed.

B. State Constitutional Right to Privacy

In the event that an alternative healthcare provider discloses a patient’s confidential communications, the patient may be able to seek damages for violation of the state constitutional right to privacy under article I, section 1 of the California Constitution. Article I, section 1 provides that “[a]ll people are by nature free and independent and have inalienable rights,” among which is pursuing and obtaining privacy. This constitutional right to privacy “has been held to operate even though a statutory privilege does not protect the matter in question.” One court treated the privacy right as independent of a related statutory privilege. Thus, the physician-patient privilege is but one aspect of privacy, and privacy as a whole is subject to constitutional standards.

To date, this cause of action has not yet been applied to alternative healthcare providers. However, the California Supreme Court has examined the privacy interest in malpractice actions with respect to health insurers and physicians. California appellate courts view the constitutional provision as self-executing, requiring no legislation to create a legal and enforceable right of privacy for Californians.

To state a cause of action for invasion of privacy in violation of the state constitution, a plaintiff-patient must establish each of the following: “(1) a legally protected privacy interest; (2) a reasonable expectation of privacy in the circumstances; and (3) conduct by defendant constituting a serious invasion of privacy.” The information may be of the type that eventually would have been discovered in litigation. Thus, this privacy protection afforded by the state constitution conceivably may be broader than the physician-patient privilege, as in the case where the patient puts his or her own mental or

133. CAL. CONST. art. I, § 1.
134. Id.
137. See Davis v. Superior Court, 9 Cal. Rptr. 2d at 334.
139. See Davis v. Superior Court, 9 Cal. Rptr. 2d at 334-35; see also Cutter v. Brownbridge, 228 Cal. Rptr. 545, 549 (Cal. Ct. App. 1986).
For example, a court might rule that even where the patient-litigant exception to the physician-patient privilege could require the disclosure in court of patient's communications to his or her physician, the nature of the information may be such that it gives the patient a cognizable privacy interest entitled to protection under the state constitution.\textsuperscript{144}

In \textit{Hill v. National Collegiate Athletic Association},\textsuperscript{145} the California Supreme Court explained that a "reasonable" expectation of privacy is "an objective entitlement founded on broadly based and widely accepted community norms... relative to the customs of the time and place, to the occupation of the plaintiff and to the habits of his neighbors and fellow citizens."\textsuperscript{147} In the context of alternative healthcare, the issue becomes what constitutes a "reasonable" expectation of privacy for one's disclosures to an alternative health practitioner. It is unclear whether courts would analogize a patient's visit to an alternative health practitioner to a formal visit to a physician, or whether courts would treat communications to alternative health practitioners as casual conversation similar to conversation made with an ordinary consumer service provider selected from the Yellow Pages. The significance of the patient's reasonable expectations in this context lies in the public interest in encouraging confidential commu-

\textsuperscript{142} However, when a patient places his or her physical condition in issue, the patient's expectation of privacy regarding that condition is substantially lowered by the very nature of the action. \textit{See id.} at 1006.

\textsuperscript{143} The patient-litigant exception typically has been applied to personal injury cases in which the plaintiff tenders his or her physical or emotional condition as an issue by seeking damages for what he or she contends are physical or emotional injuries. \textit{Cal. Evid. Code} § 996 (Deering 1997).

\textsuperscript{144} For example, in a case where plaintiff alleged intentional infliction of emotional distress and invasion of privacy under article I, section 1 of the California Constitution, due to the dissemination of a medical report which disclosed that he had tested positive for the HIV virus, the court held that the patient's reasonable expectation of privacy outweighed the policies underlying defendant-insurer's defense that a judicial proceedings privilege under California Civil Procedure Code section 47(2) allowed disclosure. \textit{See Urbaniak v. Newton}, 277 Cal. Rptr. 354, 358-61 (Cal. Ct. App. 1991). The court reasoned that a public interest in a patient's disclosure of HIV positive status for the purpose of alerting a healthcare worker to the need for safety precautions. \textit{See id.} at 360. The court explained that "[i]n the field of healthcare, disclosure of information about a patient constitutes 'improper use' when it will subvert a public interest favoring communication of confidential information by violating the patient's reasonable expectations of privacy." \textit{Id.} at 360. Although the physician-patient privilege per se was not at issue in the case, it is conceivable that the privilege could have been waived when plaintiff put his health in issue. The court might have used a similar balancing test and concluded that the patient-litigant exception did not apply to disclosure of the plaintiff's HIV status where the information was unrelated to the injuries at bar.

\textsuperscript{145} \textit{Hill v. National Collegiate Athletic Ass'n}, 865 P.2d 633 (Cal. 1994).

\textsuperscript{146} \textit{Id.} at 655.

\textsuperscript{147} \textit{Id.} (quoting Restatement (Second) of Torts § 652(d), cmt. c).
communications within a proper professional framework. By enforcing a patient’s reasonable expectations of privacy, courts will both encourage free communication needed for an effective professional relationship and protect the relationship from abuse.\textsuperscript{148}

The \textit{Hill} court emphasized that the “extent” of a legally protected privacy interest is dependent on the circumstances:\textsuperscript{149} “Even when a legally cognizable privacy interest is present, other factors may affect a person’s reasonable expectation of privacy. For example, advance notice of an impending action may serve to ‘limit [an] intrusion upon personal dignity and security’ that would otherwise be regarded as serious.”\textsuperscript{150}

The California Court of Appeal in \textit{Board of Medical Quality Assurance v. Gherardini}\textsuperscript{151} relied on similar considerations of reasonable privacy expectations in holding that article I, section 1 of the California Constitution protects the confidentiality of medical records.\textsuperscript{152} The court observed that under California statutes, the physician-patient privilege creates a “zone of privacy whose purposes are (1) to preclude humiliation of the patient that might follow disclosure of his ailments [citations] and (2) to encourage the patient’s full disclosure to the physician of all information necessary for effective diagnosis and treatment of the patient.”\textsuperscript{153} Holding that this “zone of privacy” was entitled to constitutional protection under article I, section 1, the court reasoned:

The patient should be able to rest assured with the knowledge that ‘the law recognizes the communications as confidential, and guards against the possibility of his feelings being shocked or his reputation tarnished by their subsequent disclosure.’ . . . The reasonable expectation that such personal matters will remain with the physician are no less in a patient-physician relationship than between the patient and psychotherapist.\textsuperscript{154}

When courts decide that the narrowly-drawn physician-patient privilege does not apply to a given situation and that the patient’s expectation of privacy merits further exploration, courts will be free to look at ethical justifications for privacy protection. The analysis should include an examination of potential harms created by un-

\textsuperscript{148} See \textit{In re Lifschutz}, 467 P.2d 557, 567 (Cal. 1970) (holding that patient’s interest in preserving confidentiality of private communications to psychiatrist “draws sustenance from our constitutional heritage”).
\textsuperscript{149} See \textit{Hill}, 865 P.2d at 655.
\textsuperscript{150} \textit{Id.} (quoting \textit{Ingersoll v. Palmer}, 743 P.2d 1299, 1316 (Cal. 1987) (internal citation omitted)).
\textsuperscript{152} \textit{See id.} at 61.
\textsuperscript{153} \textit{Id.}
\textsuperscript{154} \textit{Id.} (quoting \textit{In re Flint}, 34 P. 863, 864 (Cal. 1893)).
wanted disclosure of personal medical or health status information. Scholars of healthcare reform classify such harms as "intrinsic" and "consequential" moral harms.\textsuperscript{155}

Intrinsic moral harms occur when personal information is unwantedly or unjustifiably disclosed. Consequential harms result from a loss of privacy, and they matter morally regardless of whether the loss of privacy results from an intentional, negligent, or perfectly innocent action of another. The moral significance of such losses of privacy lies in the actual harm caused.\textsuperscript{156}

Consequential harms affect a patient's economic interests.\textsuperscript{157} Unauthorized disclosure of personal or medical information may result in loss of employment or employability, loss of insurance or insurability, and loss of housing opportunities, especially for individuals having stigmatizing conditions such as HIV, tuberculosis, mental illness, or a history of drug or alcohol abuse.\textsuperscript{158} Disclosure of some conditions can cause the patient embarrassment, social isolation, and the loss of self-esteem, particularly when the "perceived causes of the medical condition or illness include the use of illegal drugs, socially disfavored forms of sexual expression, or other behavior not widely socially approved."\textsuperscript{159} However, while it may seem that patients can fall back on the constitutional privacy right to protect the confidentiality of their communications to alternative health practitioners, the process of demonstrating such necessity or of bringing an action for damages can be burdensome.

C. Voluntary Ethical Codes of Confidentiality

Physicians have a fundamental ethical obligation to protect the confidentiality of information obtained from patients during the course of treatment or diagnosis. This ethical obligation finds its earliest expression in the Hippocratic Oath, which states in part: "What I may see or hear in the course of the treatment or even outside of the treatment in regard to the life of man, which on no account one must spread abroad, I will keep to myself holding such things shameful to be spoken about."\textsuperscript{160}

The American Medical Association Principles of Medical Ethics provide that:

\textsuperscript{155} See Gostin et al., \textit{supra} note 19, at 23.
\textsuperscript{156} See \textit{id}.
\textsuperscript{157} See \textit{id}.
\textsuperscript{158} See \textit{id}.
\textsuperscript{159} \textit{Id.} at 24.
\textsuperscript{160} Wade, \textit{supra} note 41, at 1167 n.148 (citing L. Edelstein, \textit{The Hippocratic Oath: Text, Translation and Interpretation} 3 (1945)). The Hippocratic Oath is believed to date from around 400 B.C. \textit{Id.} See also Weil, \textit{supra} note 9, at 90-92 (discussing Hippocratic medicine's origins).
Information disclosed to a physician during the course of the relationship between physician and patient is confidential to the greatest possible degree. The patient should feel free to make a full disclosure of information to the physician in order that the physician may most effectively provide needed services. . . . The physician should not reveal confidential communications or information without the express consent of the patient, unless required to do so by law.161

Both the Hippocratic Oath and the American Medical Association Principles of Medical Ethics stand as ethical codes which licensed physicians are encouraged to adopt in dealing with patients. It is useful to note that the latter code provides for disclosure of confidential information if the law so requires.162 Thus, a patient cannot look to these codes of professional conduct for protection if legal issues arise.

Alternative health practitioners may establish their own codes of conduct. For example, the California Yoga Teachers Association Code of Professional Standards provides for treating “all communications from students with professional confidence,” not disclosing such confidences to anyone except: “as mandated by law; to prevent a clear and immediate danger to someone; in the course of a civil, criminal, or disciplinary action arising from the instruction where the teacher is a defendant; . . . or by previously obtained written permission.”163 Such codes, like the physicians’ ethical codes of confidentiality, limit the disclosure of a patient or client’s private communications, but are subject to mandates by law and other circumstances involving legal action. Therefore, the existence of a “healer-patient” relationship would appear useful to fill the gaps left by such voluntary ethical codes.

IV. “Practicing Medicine” Should Confer Physician-Patient Privilege

The resurgence of alternative forms of healthcare, many of them older than the allopathic medical system, indicates that alternative therapies should share naturally, along with conventional therapies, the umbrella of the physician-patient privilege. However, a distinction should be made between alternative health practitioners considered outside of mainstream medicine and those whose healing arts have become accepted as conventional medicine. For those practitioners who have worked their way into the mainstream, the statutory

161. Wade, supra note 41, at 1167 n.154 (citing CURRENT OPINIONS OF THE JUDICIAL COUNSEL OF THE AMERICAN MEDICAL ASSOCIATION Canon 5.05 (1984)) (emphasis added).
162. Id.
privilege should be defined broadly enough to include those individuals as "physicians" or "healing arts practitioners." Thus, three avenues exist with respect to the privilege: (1) limiting the privilege to ordinary physicians and surgeons (i.e., M.D.s); (2) redefining the term "physician" altogether to include alternative health practitioners; or (3) adding qualifying types of alternative health practitioners to the statute (e.g., acupuncturists) as persons who "practice medicine" in accordance with a standard defined by the medical community or state licensing boards.

Before examining this Note's proposal for a model revision to the physician-patient privilege, it is necessary to understand the desirability of protecting patient confidentiality in alternative healthcare settings. This Part examines three hypothetical situations involving a patient who visits different types of alternative health practitioners and the merits of applying the physician-patient privilege in each case.

A. Hypothetical A: Visit to Physician Trained in Acupuncture

For two years, Patient, in her early twenties, has noticed the gradual appearance of dime-sized, brownish-red splotches on her legs which leave semi-permanent subcutaneous scars. Patient has already undergone two biopsies and consulted with primary-care physicians and specialists, all of whom have diagnosed her with a vascular autoimmune disease. At a dermatologist's suggestion, Patient tried two anti-inflammatory drugs, but their potential side effects of addiction and ulcers were unpalatable, causing her to stop taking the drugs. At the first meeting with a licensed physician (M.D.) who also is trained to perform acupuncture, Patient reveals that she first noticed the spots at about the time of her traumatic termination of a long-term relationship, and that the spots continued to manifest with severity during a subsequent, emotionally-abusive relationship in the two-year period preceding Patient's visit to this physician.

Patient's communications to the physician may receive protection under four theories: physician-patient privilege, the Confidentiality of Medical Information Act, state constitutional privacy provisions, and the Hippocratic Oath. However, only the physician-patient privilege precludes testimony regarding her condition and the other personal information disclosed during the course of treatment.

Absent circumstances which would waive the physician-patient privilege, Patient's communications about her disease and personal life to the physician who is licensed to perform acupuncture would fall under the privilege because that physician is covered by the Evidence Code as a statutory "physician," regardless of the acupuncture activi-

164. See supra Part II.C.
ties, and because he is providing treatment. The physician's ethical obligation under the Hippocratic Oath arises primarily from a moral duty to preserve confidentiality and does not entail a legal duty to preserve such confidentiality in court. Nor would the Confidentiality of Medical Information Act prevent disclosure in court, as that statute regulates general dissemination of health information. Whether Patient can demonstrate a reasonable expectation of privacy to satisfy the state constitutional privacy right is largely a question of fact, which variations extend beyond the scope of this hypothetical.

B. Hypothetical B: Visit to Yoga Instructor

Patient consults a yoga instructor at the end of class one day about ways to eradicate the spots on her legs. The yoga instructor recommends certain postures, called asanas, to improve circulation in and remove toxins from those areas. In the ensuing seven-month period in which Patient continues to receive yoga instruction, Patient divulges medically-relevant, personal information regarding the stressful conditions of her life which accompanied the appearance of the spots.

Because the yoga instructor is not a physician or surgeon, Patient's communications to the yoga instructor do not fall within the physician-patient privilege. Nor does the yoga instructor's voluntary code of confidentiality—as set forth in the California Yoga Teachers Association Code of Professional Standards—preserve confidentiality in court. Patient could expect protection under the physician-patient privilege only if a physician had referred Patient to the yoga instructor, and if the yoga instructor were deemed a third party reasonably necessary for accomplishing the purpose for which the physician was consulted. Such an arrangement would be conceivable in a situation where Patient visits an integrated health center employing both physicians and yoga instructors. Coordinating treatment among physicians and alternative practitioners would be quite standard at these centers, and the physician-patient privilege could arguably extend to the relationship between Patient and the center as a whole.

166. For a description of the types and physical benefits of yoga, see The Complete Family Guide to Alternative Medicine: An Illustrated Encyclopedia of Natural Healing 61-65 (Richard Thomas & C. Norman Shealy eds., 1996) (describing forms of yoga and treatable conditions as including stress, high blood pressure, back and neck pain, asthma, arthritis, digestive disorders, depression).
168. See Cal. Evid. Code § 994 (Deering 1997) (extending physician-patient privilege to relationship between patient and medical corporation). If the integrated center could be considered a medical corporation, this section would apply.
C. Hypothetical C: Visit to Licensed Acupuncturist/O.M.D.

After consulting the telephone book, Patient finds a practitioner of TCM (O.M.D.) who is also a certified acupuncturist. An O.M.D. typically makes a diagnosis by questioning, observing, and listening to a patient, and by feeling the patient's pulse at the radial arteries of both wrists. The answers to questions about symptoms and any findings of abnormalities in breath sounds, skin color and texture, or general bodily appearance and odor may provide clues to the location of problems in one or more of the "organ systems" that form the basis of traditional Chinese medical theory. This acupuncturist/O.M.D. reaches the same diagnosis of Patient's physical condition as that reached by Patient's dermatologist (i.e., that Patient is suffering from an inflammation of the arteries which can be characterized as an autoimmune disorder). However, the acupuncturist/O.M.D. asks Patient more personal, detailed questions about her lifestyle, personality, and environment in order to tailor an herbal prescription to her mind/body type and to determine which acupunctural nerve points to stimulate.

The visit to the acupuncturist/O.M.D. may entail at least the same level of disclosure of personal aspects of Patient's life and physical condition as the level of disclosure given during the visit to the physician. Perhaps the acupuncturist/O.M.D.'s inquiries may be more detailed than those of an M.D. Moreover, a patient may be more willing to communicate openly with an alternative health practitioner than with a medical doctor, especially if the patient has already tried home remedies. A patient may be embarrassed to tell his or her medical doctors what remedies he or she has already tried before seeking formal medical treatment. Developing patient confidence in the healer serves the utilitarian goal of the physician-patient privilege.

The most salient similarity between the unconventional treatment and the orthodox treatment is the patient's intent to seek diagnosis and treatment. When this statutory requirement is met, although the acupuncturist is not a statutory physician, the fact that both the dermatologist and acupuncturist hold licenses in the state of California to treat and diagnose patients should entitle both types of "doctors" to invoke the physician-patient privilege. This entitlement also should apply to a standard O.M.D. (a TCM practitioner not trained in acu-

169. See ALTERNATIVE MEDICINE, supra note 2, at 453-56 (describing methods of diagnosis in TCM); Weil, supra note 9, at 143-55 (explaining TCM).

170. In China, O.M.D.s go to traditional Chinese medical school for five years. In the United States, TCM is taught at two dozen accredited colleges, but the highest degree offered at this time is a Master's degree. Rattenbury, supra note 1, at 62. See also ALTERNATIVE MEDICINE, supra note 2, at 454 (summarizing the status of TCM in the 20th century).

171. See supra Part II.A.
puncture) because the consultation retains a treatment element. However, O.M.D.s are not permitted to practice in California unless they are already licensed as acupuncturists.\textsuperscript{172} A similar restriction applies to homeopaths: only persons already licensed as M.D.s or D.O.s may become certified as homeopaths.\textsuperscript{173}

As the Evidence Code now stands, the confidentiality of Patient's communications to a licensed acupuncturist/O.M.D. is not protected by the physician-patient privilege. Therefore, even if a voluntary code of confidentiality exists among such healthcare providers, a court can still compel the acupuncturist/O.M.D. to testify as to the communication. Patient may be able to seek protection and damages on grounds of the constitutional right to privacy, but the process of obtaining this protection requires Patient to establish a prima facie case of a reasonable expectation of privacy\textsuperscript{174}—a burdensome process in itself.

The critical point these hypotheticals illustrate is that a patient, to obtain accurate diagnosis and treatment of his or her ailment, is inclined to reveal similar types of information to different types of healthcare providers, but receives protection under the current statutory scheme only when the communications are made to a statutory physician (M.D.). On the one hand, patients probably do not select a healthcare provider on the basis of the availability of the testimonial privilege;\textsuperscript{175} on the other hand, artificially limiting the privilege to statutory physicians may deny patients the full and intended benefit of a medical confidence if the alternative healthcare practitioner is called to testify in court. Moreover, where, as in the preceding hypotheticals, a patient visits an alternative healthcare practitioner (acupuncturist/O.M.D.) as a last resort after undergoing a long line of orthodox treatment within a period of years, fairness dictates that the law should not cut off the chain of medical confidences at this point in the search for a cure.

\textsuperscript{172} See Cal. Bus. & Prof. Code § 4935 (Deering 1997) (person who engages in the practice of “oriental medicine” or “Chinese medicine” must possess acupuncturist’s license).

\textsuperscript{173} Certification of M.D.s or D.O.s as homeopaths occurs through the American Board of Homeotherapeutics or the Council for Homeopathic Certification. There is no national certification for laypersons. Rattenbury, supra note 1, at 62.

\textsuperscript{174} See infra Part III.B.

\textsuperscript{175} Opponents of the physician-patient privilege claim that patients neither know about privilege laws nor would avoid treatment in the absence of a privilege. However, no empirical evidence has been presented by either the proponents or opponents of the physician-patient privilege concerning either the utilitarian or deontological views. See Shuman, supra note 16, at 664-65.
V. Proposal

The Evidence Code and the Business and Professions Code do not consider alternative health practitioners, whether licensed or not, to be practicing the same type of “medicine” as that practiced by physicians and surgeons. Instead, these statutes indiscriminately imply that all alternative health practitioners (except osteopaths) belong in the residue of “healing arts.” Given the current status of alternative health practitioners, two alternatives exist for bringing these individuals within the coverage of the physician-patient privilege.

One option is to redefine the meaning of “practicing medicine” to include alternative health practitioners. The burgeoning supply of information related to alternative therapies, the promise of reducing healthcare costs through preventive medicine, and federal deregulation of the herbal and vitamin industries are helping alternative therapies gain momentum. At the same time, there likely will be vehement opposition to expanding the definition of “medicine,” as there has been since the early part of this century, by the American Medical Association and similar physicians’ groups.

A second option is to redefine “physician” to include alternative health practitioners. This idea, too, would seem repugnant to the allopathic medical community. The current definition of “physician” might cease to evoke the standard noble images of an individual who endures four years of medical school and three or more years of residency work in a hospital. Instead, the public would confront a cloud of images upon hearing the word “physician,” having to choose from among M.D.s, N.D.s, O.M.D.s, and D.O.s. In addition to the confusion that may result from allowing the public to choose from an array of “physicians,” there is no urgency to overturn the definition of a longstanding professional designation (M.D.) when such designation

176. This phenomenon can be seen in the structure of the Business and Professions Code. Division 2 (“Healing Arts”) generally organizes specific healing arts into specific “Chapters.” However, “Medicine” is explicitly set off and set forth in Chapter 5. See CAL. BUS. & PROF. CODE § 2050-2056.

177. Congress virtually deregulated herbal products and vitamins when it passed the Dietary Supplement and Health Education Act in 1994. Now, the FDA must prove that herbal supplements such as melatonin are unsafe before requesting their recall. Philp, Vision of Future, supra note 27, at All.

178. See BEINFIELD & KORNGOLD, supra note 12, at 22-23 (discussing the narrowing of the Western institution of medicine and corresponding disenfranchisement of naturopathy, homeopathy, and herbology as forms of mainstream medicine in the early 20th century); Robbins, supra note 10, at 89-105, 182-202 (describing how patriarchal historical influences and the AMA’s “monopoly” on medicine have led to the suppression of alternative forms of healthcare in the United States). There may be hope for an integration of conventional and alternative medicine. In light of the rising popularity of alternative medicine, the AMA is suggesting that physicians learn more about alternative therapies. See Thomson, Looking for Dr. Right, supra note 4, at 103.
serves to govern specific activities in medicine. Likewise, an alternative health practitioner such as a naturopath would scoff at the idea of being called an M.D., because an M.D. certification represents the very institution the naturopath seeks to counter.

This Note proposes adoption of the first option—a modification to the California Evidence Code to extend the physician-patient privilege to include various licensed alternative healthcare practitioners as “persons authorized . . . to practice medicine.” This change would continue the statutory tradition of granting the privilege to persons who “practice medicine”—which is loosely described by the Business and Professions Code\(^\text{179}\)—without altering the meaning of that phrase because the statute has never explicitly defined “practicing medicine.” Currently, the Medical Practice Act merely describes types of conduct permitted of physicians and surgeons (e.g., diagnosing, using drugs, severing human tissues).\(^\text{180}\) In a practical sense, licensed alternative healthcare practitioners are already persons “authorized” to “practice medicine” because they perform many of the same primary-care functions performed by statutory physicians. For example, a patient might want to seek an herbal remedy for the flu from an O.M.D. rather than seeking antibiotics from a physician. The California Legislature needs only to describe the conduct permitted by the holder of an acupuncture, naturopathy, or homeopathy certificate, and those descriptions should qualify as descriptions of “practicing medicine” in the same way that descriptions of conduct under the Medical Practice Act adequately characterize the “practice of medicine.”\(^\text{181}\)

Since 1888, the California Legislature has required physicians to be licensed as a safeguard to the public.\(^\text{182}\) Although the physician-patient privilege is a rule of evidence concerning the admissibility of evidence in court and is not a substantive rule regulating the conduct of physicians,\(^\text{183}\) the fact that the Evidence Code grants the privilege to “physicians”\(^\text{184}\)—who, by that designation, are licensed—implies certification as a precondition for the privilege to apply. The

179. The Business and Professions Code does not define the term “practicing medicine” per se, but merely describes conduct permitted under the Code by licensed physicians and surgeons. See supra Part II.C and D.
180. See CAL. BUS. & PROF. CODE § 2051 (Deering 1997).
181. The framework for allowing licensed alternative health practitioners to share in the expansive category of “practicing medicine” already exists in Division 2 (“Healing Arts”) of the Business and Professions Code. In Business and Professions Code section 851, the California Legislature has delegated healing arts licensing standards to a “healing arts licensure board or examining committee,” which may require applicants for licensure or certification to meet standards set by private voluntary associations or professional societies. See CAL. BUS. & PROF. CODE § 851 (Deering 1997).
183. See CAL. BUS. & PROF. CODE § 2397 (Deering 1997).
public has a clearer understanding of what constitutes safe, confidential, and legal "medicine" when physicians are licensed. No less should be required of alternative health practitioners who undertake to "practice medicine" by treating and diagnosing patients according to the principles of their healing arts. Allowing licensed alternative health practitioners to share in the physician-patient privilege would still be consistent with the policies underlying the regulation of medicine as set forth in the growing number of healing arts practitioners licensing acts.  

As modified, section 990 of the California Evidence Code would read (with modifications in boldface):

§ 990. "Physician" OR "HEALING ARTS PRACTITIONER"

As used in this article, "physician" OR "HEALING ARTS PRACTITIONER" means a person authorized, or reasonably believed by the patient to be authorized, to practice medicine in any state or nation.

Section 991 would then read:

§ 991. "Patient"

As used in this article, "patient" means a person who consults a physician OR HEALING ARTS PRACTITIONER or submits to an examination by a physician OR HEALING ARTS PRACTITIONER for the purpose of securing a diagnosis or preventive, palliative, or curative treatment of his [OR HER] physical or mental or emotional condition.

Finally, section 992 would integrate the two definitions to read:

§ 992. "Confidential communication between patient and physician OR HEALING ARTS PRACTITIONER"

As used in this article, "confidential communication between patient and physician OR HEALING ARTS PRACTITIONER" means information, including information obtained by an examination of the patient, transmitted between and patient and his [OR HER] physician OR HEALING ARTS PRACTITIONER 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 OR HEALING ARTS PRACTITIONER is consulted, and includes a diagnosis made and the advice given by the physician OR HEALING ARTS PRACTITIONER in the course of that relationship.

The Medical Practice Act would retain its exclusive definition of a “physician,” while the appropriate state licensing acts, such as the Acupuncture Licensure Act, would define or describe how such “healing arts practitioners” may “practice medicine.” The lack of a formal definition for the term “practicing medicine” would allow the legislature to expand the set of individuals whose conduct amounts to “practicing medicine,” which, in turn, would allow these alternative healers to come within the physician-patient privilege, thus converting such privilege into a “healer-patient” privilege. The composite of the Medical Practice Act and other healing arts practitioners licensing acts would govern the community of professionals “practicing medicine” within the meaning of the Evidence Code.

Unless a statutory scheme for licensure already exists, as in the case of acupuncturists and chiropractors, practitioners’ groups and organizations should make a concerted effort to establish licensure and accreditation standards. Such legalization of their qualifications would elevate their status in the eyes of the business community and encourage employers to adopt health plans for their employees which include alternative therapies. Employers may view such licensure and registration with the state as a safeguard for their health plans. At the consumer level, grassroots movements advocating alternative therapies may encourage HMOs and insurance companies to cover or incorporate alternative therapies into their plans.

**Conclusion**

Americans are coming to regard freedom of medical choice as a fundamental right in their search for health. Although alternative health practitioners are now assuming greater responsibility for the medical treatment of patients, the legal status of the physician-patient privilege has not been modified to reflect the changing nature of this healer-patient relationship. The confidential nature of communications to alternative health practitioners warrants such an extension of the statutory physician-patient privilege to licensed alternative health practitioners. Licensure or certification of these healing arts practitioners under state law would ensure the practitioners’ qualifications to treat or diagnose ailments in the manner prescribed by state guide-

187. It should be noted that any healing arts licensing provision which intends to allow the alternative health practitioner to invoke the physician-patient privilege should carefully set forth the activities that constitute the “practice of medicine” so that not all persons who fall under Division 2 (“Healing Arts”) of the Business and Professions Code are automatically entitled to “practice medicine.”
188. For example, Ben & Jerry’s Homemade, Inc. in Vermont views registration and licensure of alternative healthcare providers as a safeguard and has provided an alternative care benefit for its 550 employees since 1989. Firshein, *supra* note 24, at 31.
lines. If the inclusion of alternative health practitioners within the mainstream medical community and within the attendant physician-patient privilege ultimately meets with widespread resistance, then at a minimum, patient confidences should be accorded common-law or constitutional protection where disclosure of such information results in the invasion of a patient's right to privacy.