Immunity of Hospital Review Commission

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November 6, 1974

Hon. Terry Gardiner
Alaska House of Representatives
P. O. Box 1092
Ketchikan, Alaska

Dear Terry:

Enclosed is material regarding the immunity of hospital review committees.

I would appreciate it very much if you would institute legislation for the purposes outlined therein.

Sincerely yours,

JERNBERG & TAYLOR

By Robin L. Taylor

RLT/mh
Enclosure

PASSED Immunity

ALASKA STATE MEDICAL ASSOCIATION

RESOLUTION No. 19-74

SUBJECT: Subpoena Immunity

SUBMITTED BY: James Wilson, M. D.

BE IT RESOLVED, to continue to ask our Legislative Committee to work towards legislation making Hospital and Medical Society Committees' reports immune from legal action to subpoena. This is essential if these committees are ever to function effectively.

ALASKA STATE
MEDICAL ASSOCIATION
1135 W. Eighth Avenue • Anchorage, Alaska 99501 • (907) 277-6891

October 29, 1974

M E M O

To: Legislative Committee Members

From: carolyn Brown, Chairperson

Subject: Subpoena Immunity

Resolution 19-74 of the 1974 ASMA House of Delegates is attached.

As a follow up to Legislative Committee activity, attached is an excellent report put out by the Joint Commission on Accredition of Hospitals which summarizes the various states' legal attitude toward liability, immunity, and discoverability of hospital and association records and committee reports. The report is quite detailed but I thought members would like to review this in some depth.

It may be that after the legislators get to Juneau, we can take this information and push very hard for similar legislation in Alaska.

Minesota appears to have the broadest legislation surrounding this matter and this may very well serve as a model for Alaska.

You may want to keep this in your files as we attempt to deal with this throughout this legislative year.

That's all. Thank you very much.

THE FOLLOWING DOCUMENT(S) MAY NOT FILM LEGIBLY BECAUSE OF POOR QUALITY OF THE ORIGINAL.

Session Laws, Ch. 295

PUBLIC HEALTH—REVIEW ORGANIZATIONS

CHAPTER 295

S.F.No.3175

[Coded in Part]

An Act relating to health; providing for limitations on liability of review organizations; providing for confidentiality of records of review organizations; amending Minnesota Statutes 1971, Sections 145.61, Subdivision 5, and by adding a subdivision; 145.63; and 145.64.

Be it enacted by the Legislature of the State of Minnesota:

Section 1. Minnesota Statutes 1971, Section 145.61, is amended by adding a subdivision to read:

Subd. 4a. "Administrative staff" means the staff of a hospital or clinic.

Sec. 2. Minnesota Statutes 1971, Section 145.61, Subdivision 5, is amended to read:

Subd. 5. "Review organization" means a committee whose membership is limited to professionals and administrative staff, except where otherwise provided for by state or federal law, and which is established by a hospital, by a clinic, by one or more state or local associations of professionals, by an organization of professionals from a particular area or medical institution, by a health maintenance organization as defined in Minnesota Statutes, Chapter 62D, by a nonprofit health service plan corporation as defined in Minnesota Statutes, Chapter 62C or by a professional standards review organization established pursuant to 42 U.S.C., Section 1320c–1 et seq. to gather and review information relating to the care and treatment of patients for the purposes of:

(a) Evaluating and improving the quality of health care rendered in the area or medical institution;

(b) Reducing morbidity or mortality;

(c) Obtaining and disseminating statistics and information relative to the treatment and prevention of diseases, illness and injuries;

(d) Developing and publishing guidelines showing the norms of health care in the area or medical institution;

(e) Developing and publishing guidelines designed to keep within reasonable bounds the cost of health care;

(f) Reviewing the quality or cost of health care services provided to enrollees of health maintenance organizations;

(g) Acting as a professional standards review organization pursuant to 42 U.S.C., Section 1320c–1 et seq.; or

(h) Reviewing, ruling on, or advising on controversies, disputes or questions between:

(1) health insurance carriers or health maintenance organizations and their insureds or enrollees;

(2) professional licensing boards acting under their powers including disciplinary, license revocation or suspension procedures and health providers licensed by them when the matter is referred to a review committee by the professional licensing board;

(3) professionals and their patients concerning diagnosis, treatment or cure, or the charges or fees therefor;

(4) professionals and health insurance carriers or health maintenance organizations concerning a charge or fee for health care services provided to an insured or enrollee; or

(5) professionals or their patients and the federal, state, or local government, or agencies thereof.

No party shall be bound by a ruling of a review organization pursuant to this clause on a controversy, dispute or question unless he agrees in advance, either specifically or generally, to be bound by the ruling.

[42 U.S.C.A.§ 1320c.

Sec. 3. Minnesota Statutes 1971, Section 145.63, is amended to read:

145.63 Limitation on liability for members of review organizations

No person who is a member or employee of, who acts in an advisory capacity to or who furnishes counsel or services to, a review organization shall be liable for damages or other relief in any action brought by a person or persons whose activities have been or are being scrutinized or reviewed by a review organization, by reason of the performance by him of any duty, function or activity of such review organization, unless the performance of such duty, function or activity was motivated by malice toward the person affected thereby. No person shall be liable for damages or other relief in any action by reason of the performance of him of any duty, function, or activity as a member of a review committee or by reason of any recommendation or action of the review committee when the person acts in the reasonable belief that his action or recommendation is warranted by facts known to him or the review organization after reasonable efforts to ascertain the facts upon which the review organization's action or recommendation is made.

Sec. 4. Minnesota Statutes 1971, Section 145.64, is amended to read:

145.64 Confidentiality of records of review organization

All data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence, shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization, and shall not be subject to subpoena or discovery. No person described in section 145.63 shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out one or more of the purposes of a review organization. The proceedings and records of a review organization shall not be subject to discovery or introduction into evidence in any civil action against a professional arising out of the matter or matters which are the subject of consideration by the review organization. Information, documents or records otherwise available from original sources shall not be immune from discovery or use in any civil action merely because they were presented during proceedings of a review organization, nor shall any person who testified before a review organization or who is a member of it be prevented from testifying as to matters within his knowledge, but a witness cannot be asked about his testimony before a review organization or opinions formed by him as a result of its hearings.

Approved March 27, 1971

SECON

DAKOTA COUNTY—

An Act relating to Dakot appointees to the Dakot

Approved March 27, 1974.

GENEI

An Act relating to the adr sota Statutes, 1973 Sup Subdivision 1; 245A.18 tion 32.

Be it enacted by the Legis

Section 1. Minnesota St vision 1, is amended to read

245A.01 Declaration of pol

Subdivision 1. The obje Sections 1 to 30 are to pr assistance programs; to n sistance purposes; to pror grated public assistance pro income or resources to m decency and health.

It is hereby declared to provide for themselves an the eligibility requirement not refuse suitable employ general assistance and su subsistence reasonably com of such assistance and ser in promoting the public hea

A principal objective is be to aid those persons w attain self-care. To achi minimum standards of n standard for cash payment 100 percent of the actual maximum established for a and old age assistance pro tary items, 50 percent, of

51. Matchett v. Petway, 115 Cal.Rptr. 317, 320-321 (Ct. App. 1974). To assist it in determining whether the staff committees fit the required purpose of "...having the responsibility of evaluation and improvement of the quality of care rendered in the hospital...," the court took judicial notice of the Joint Commission's Standards and *Guidelines* (note 13 *supra*) describing the organization and functions of the various committees involved.

> ...[A] court must have before it facts which allow it to match the staff committee's mission and functions against the specifications of the statute....*The burden of establishing entitlement to nondisclosure rested with the party resisting discovery, not the party seeking it*....(Emphasis added.)

52. Gillman v. United States, note 36 *supra*.

53. Banks v. Lockheed-Georgia Company, 53 F.R.D. 283, 285 (N.D.Ga. 1971).

54. *See e.g.*, N.Y. Education Law Sec. 6900 *et seq.* (McKinney Supp. 1973); Pa. Session Laws of 1974, Act No. 151; Rev. Code of Wash. Ann. Sec. 18.88.010 *et. seq.* (Supp. 1973). Nursing and other professional evaluation activities may be brought within the ambit of nondiscovery statutes whose language cannot be stretched to cover nonphysician review by combining all professional quality review activities into a joint activity under the aegis of a medical staff committee. Indeed, the Joint Commission already endorses the integration of nursing service audit and medical audit into a total plan of patient care audit. On this latter point, see J. D. Porterfield, *Accreditation Clinic*, The Hospital Medical Staff, Sept. 1974, at 33.

Revised 10/7/74

THE LIABILITY MYTH EXPOSED:
HOSPITAL REVIEW ACTIVITIES POSE NO RISK

by

Charles M. Jacobs, J.D. and Susan Weagly

I. INTRODUCTION

There are important reasons why a hospital must be able to demonstrate that it takes all reasonable steps to assure that the professional care rendered to its patients is of optimal achievable quality: namely, to gain accreditation, to obtain third-party reimbursement, to assure the community's continued support and confidence in its operations, and to use as a defense in malpractice actions.

To make this demonstration requires that the hospital have ongoing programs of performance review and medical staff credentialling.[1] Although by law ultimate responsibility for quality care rests with the hospital corporate board,[2] direct review of the efficacy and economy of health care services by its nature must be a peer activity. Hence, authority to conduct it must be delegated to the professionals who render the services.

The JCAH Standards, and more recently state licensure and federal reimbursement provisions, require that the physicians and dentists who provide professional care in a hospital must be constituted as an organized medical staff. It is to this hospital medical staff organization that the quality review authority is delegated.

By itself, this delegation to the medical staff of specific quality review functions does not relieve the hospital corporation of its ultimate legal and moral responsibility to the patients and community served for the appropriateness of care provided in the hospital. Indeed, the modern view is that such review involves administrative, not clinical, activities, and that in performing them, the medical staff organization acts as the agent of the hospital.

Three recent cases are illustrative. Two of them hold that the bare assertion by the hospital that it has delegated quality assurance functions to its medical staff does not relieve the institution of liability if, in fact, the medical staff fails to perform these functions or performs them negligently.[3] A third holds the hospital liable when it could and should have detected the incompetence of a staff physician but did not because the review procedures followed by the medical staff were inadequate.[4]

The holding in a fourth case is not so clear, but it can be interpreted as saying that when reliance on the review activities and recommendations of its staff is reasonable under the circumstances, the hospital will be relieved of liability.[5]

Thus, not only accreditation but legal requirements as well mandate well-defined and effective hospital procedures to assure proper adherence to and accountability for maintenance of quality and economy.

The chief review responsibilities that a hospital *delegates to* its medical staff and holds the staff *accountable for* performing properly are:

- *First,* reviewing the quality (through performance evaluation or "audit") and economy (through utilization review) of the patient care rendered at the hospital; and
- *Second,* evaluating the credentials and competence of professional peers in connection with staff appointment, reappointment, and the delineation of clinical privileges.

Documentation is essential to any system requiring accountability. Therefore, the medical staff's credentials recommendations and reports of medical care evaluation reviews must be supported by documentation of sufficient detail to permit the hospital board to make decisions and policies in reliance on them.

In turn, the board's decisions and policies must be supported by documentation sufficient to demonstrate to the public and to the Joint Commission that it is meeting its corporate duty to its patients.

II. PHYSICIAN PARTICIPATION

Hospital systems for evaluating health provider performance and for internal medical staff credentialling must rely on the active involvement of the current medical staff. Unfortunately, such involvement is often inhibited and even foreclosed by deeply rooted concerns about the potential professional and legal sanctions thought to flow from participation in such activities.

The actual fears are probably socioeconomic: loss of referrals and of friends, ostracism, and other peer retaliation.

However, the fears most often expressed are of a legal nature, especially liability arising from claims of conspiracy or defamation and potential malpractice exposure through use, in litigation, of the records and results of the review process.

These liability fears, although based almost entirely on myth, are commonly advanced as reasons for physician unwillingness to conduct or to submit to effective review. Therefore, it is critical that the myth be exposed.

III. CONSPIRACY

When a hospital, by action of its medical staff and board, excludes a practitioner from staff membership or restricts or reduces his clinical privileges, the hospital and the responsible board or staff members may have to defend against a claim that they conspired to violate the practitioner's civil rights, to restrict competition, to interfere with advantageous professional or economic relations, or to further some other unlawful end.

Allegations of conspiracy are easily made but very difficult to prove. When there are legitimate grounds for exclusion or restriction and these are explicitly demonstrated, the possibility of monetary liability based on a charge of conspiracy is farfetched and fanciful, especially if some basic precautions are observed:[6]

- Avoid even the appearance of conspiracy by faithfully following bylaw credentialling, review, and corrective action provisions;
- Provide notice, hearing, and other elements of procedural due process; and
- Restrict all deliberations to formal proceedings.

The cases demonstrate two lessons: that failure to afford due process is perhaps more indicative of conspiratorial action than any other nonspecific factor, and that a case based primarily on a conspiracy allegation is a sign of desperation in seeking a cause of action.

IV. DEFAMATION AND IMMUNITY

When a physician's medical staff membership status or competence to exercise clinical privileges is being investigated,

evaluated, and decided at a hospital, the physician's qualifications, competence, ethics or character may, of necessity, be discussed orally and in writing. Accordingly, lawsuits asserting slander (oral defamation) or libel (written defamation) may result.

Proportionate to the number of credentials determinations made, however, very few such lawsuits actually are initiated; and even when initiated, they rarely, if ever, establish liability. The reasons for this are:

- Statements of medical staff members participating in quality review activities are protected at common law by a "qualified privilege." When the quality activity is deemed quasi-judicial, the statements of participants are covered by an "absolute privilege" that provides total immunity from liability.

- Properly drafted medical staff bylaws and application forms for medical staff appointment, reappointment, and the delineation of clinical privileges are effective protective measures against liability.

- Many states provide medical staff members and others with statutory immunity from liability arising from hospital quality review activities conducted in good faith.

- Insurance protection against this liability risk is available to hospital board and administrative personnel and to members of the medical staff.

A. QUALIFIED OR ABSOLUTE PRIVILEGE

A well-established common law rule, called "qualified privilege," provides protection from liability to those involved in reviewing a practitioner's competence, qualifications, and conduct for purposes of hospital appointment, reappointment, delineation of clinical privileges, or disciplinary action. Thus, medical staff committee members and those who communicate information to them are protected from liability for defamation in what they say or write if these conditions are met:

- The communication is made in good faith and without malice.

- Reasonable care is exercised to ascertain the truth of the matter communicated.

- The information is reported accurately and fairly.

- The communication is made only to others with legitimate interest in the quality or economy of patient care.

The qualified privilege doctrine was an effective barrier to liability in three of the four known, reported cases in which it was asserted.[7] The unusual factual situation in the fourth case--an action against a hospital trustee whose alleged defamatory statements were communicated to other trustees to effect denial of a surgeon's reappointment--warranted a trial to allow a jury to decide whether the trustee was maliciously motivated by a belief that his mother was overcharged for an operation performed by the surgeon.[8]

The moral: When credentials and audit activities are used for improper purposes--to satisfy personal rather than institutional and patient care needs--the subterfuge is easily recognized by the courts and the qualified privilege is lost. But when the motives of participants in these activities are proper, the qualified privilege is an effective barrier to liability.[9]

When "absolute" privilege applies, total protection is provided, because the presence of malice or of any of the other limitations to qualified privilege is immaterial. Absolute privilege attaches in judicial and legislative proceedings, in administrative hearings, and in other quasi-judicial or quasi-legislative activities.

The courts in California have ruled that hearings by the board of a public hospital and by a medical staff committee of a private hospital are quasi-judicial proceedings and that communications made in connection with them, even if malicious or unfair, are absolutely privileged.[10] A similar ruling was recently obtained in New Mexico when a committee of osteopathic and medical association officers, established to review allegations of incompetence and unethical conduct, was held to be a quasi-judicial body, thus clothing alleged defamatory statements made to it with an absolute privilege.[11]

On the other hand, a private hospital's medical staff

executive committee is not a quasi-judicial body, according to a Wisconsin court; so absolute privilege did not apply to the charges made to the committee by one staff physician against another. Probably because of the factual circumstances, no claim of qualified privilege was asserted, and the plaintiff was held entitled to a jury determination on the issues of maliciousness and unfair reporting of the true facts.[12]

In balance, reliance on the availability of absolute privilege as a defense is probably somewhat wishful. Instead, observance of the common law requirements for qualified privilege should provide the necessary immunity against liability in medical staff defamation actions.

B. BYLAW RELEASE PROVISIONS

Medical staff applicants and staff members should be required to specifically release committee members and other hospital personnel from civil liability for alleged harm resulting from the performance of official quality maintenance duties. The Joint Commission's *Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations --1971* suggests the following language for incorporation in medical staff bylaws and in membership and clinical privileges application forms:

> By applying for appointment to the medical staff, each applicant...authorizes the hospital to consult with members of medical staffs of other hospitals with which the applicant has been associated..., consents to the hospital's inspection of all records and documents that may be material to an evaluation of his professional qualifications and competence...[and] of his moral and ethical qualifications..., releases from any liability all representatives of the hospital and its medical staff for their acts performed in good faith and without malice in connection with evaluating the applicant and his credentials, and releases from any liability all individuals and organizations who provide information to the hospital in good faith and without malice concerning the applicant's competence, ethics, character and other qualifications for staff appointment and clinical privileges, including otherwise privileged or confidential information.[13]

Article XIV of the *Guidelines* incorporates additional authorization, consent, and release provisions and makes them applicable to all hospital quality activities.

Although there has been no definitive test by litigation on the legal effectiveness of such bylaw provisions, they should be helpful in the defense of defamation charges arising from nonmalicious hospital quality maintenance activities.[14] It is true, however, that lawyers are concerned about what is known as the "adhesion contract" issue.

An adhesion contract is one that is forced upon one party by another party in a superior position and is usually invalid by law. A hospital with release and immunity provisions in its application forms and bylaws possibly could be considered a superior party. Local counsel will be able to say whether or not this may be a problem in the various jurisdictions.[15]

C. PROCEDURAL PROTECTION

Protection against potential liability for defamation is also offered by incorporating a provision into medical staff bylaws requiring that the physician seeking a hearing on an adverse credentials decision must first request in writing a specification of the charges. For example, where defamation was claimed in connection with a reduction in privileges, the court held that the physician, by such written request, consented to disclosure of potentially derogatory but relevant information.[16] The Joint Commission's *Guidelines* includes this procedural device by providing that grounds for denial, reduction, or other adverse committee actions are disclosed only after a hearing is specifically requested.[17]

D. IMMUNITY STATUTES

Laws that offer varying degrees of protection against liability to those engaged in hospital quality maintenance activities are now in force in 36 states.[18] Statutory immunity is provided in 32 of these states, although six limit their coverage only to "utilization review" activities.[19] A seventh state has two immunity

statutes: one protecting physicians who serve on, and individuals who provide information to, [illegible] committees; the other providing immunity to those who supply information *to any* in-hospital staff committee whose purpose is the evaluation and improvement of the quality of care.[20]

Since the states that enacted these limited statutes (in response to the utilization review requirements of the federal Medicare/Medicaid legislation) have already demonstrated a willingness to limit hospital reviewer's liability, it is reasonable to suppose that they will now be willing, if asked, to clothe with immunity review activities concerned with quality as well as economy.

The immunity offered by the remaining 25 of these 36 statutes is relatively more inclusive, but even these laws vary with regard to the specific persons and activities covered. In some, coverage is directed specifically to "members" of "medical staff" review committees;[21] while others include members of the hospital's board as well.[22]

Several statutes specifically extend immunity to third parties providing information to medical review committees,[23] and others also protect committee agents, employees, consultants, and advisors.[24] A few contain provisions broad enough in scope to cover nursing and other health professional evaluation committees.[25]

In addition, the language in most of the statutes is broad enough to include any quality maintenance activity. They speak in terms of "evaluation and improvement of the quality of care" or "evaluation of credentials and qualifications of physicians for performance of their duties."

But a few are more restrictive; one, for example, mentions only "retrospective" medical reviews.[26] Another has been construed to cover only "actions taken by a medical committee (i.e., refusing, suspending or revoking hospital privileges to any doctor) and [not] possible defamatory publications made by such a committee."[27]

* The desirability of relieving the fears of liability of persons engaged in quality maintenance activities has also been recognized by Congress. The Professional Standards Review Organization (PSRO) section of Public Law 92-603 contains a provision limiting the liability of members and employees of a PSRO and of those providing professional

consultation and services or other information to a PSRO.[23]

And the *Report of the Secretary's Commission on Medical Malpractice* supports the principle of immunity with this recommendation:

> The Commission RECOMMENDS that the states enact legislation to authorize, with due process, the appropriate committee of a hospital medical staff to suspend, revoke or curtail the privileges of a physician for good cause shown. The committee members and the hospital should have qualified immunity from suit for their acts.[25]

In the end, however, an immunity statute will not enhance a hospital's internal review programs if the medical staff is unaware of its existence and coverage. One way of disseminating this essential information to all staff members and applicants is to attach to the medical staff bylaws an analysis detailing the persons and activities protected by applicable state and federal law. Where there is no statute or where the coverage is too limited, lobbying activities through state hospital and medical associations are appropriate and needed.

These statutes may add little or nothing to the protection already available through common law, but they do serve to lower medical staff anxiety, thus increasing meaningful participation in quality maintenance activities. (For an analysis of the state immunity and nondiscovery statutes, see the chart on page MYTH/21).

E. INSURANCE COVERAGE

Every physician knows that people seek medical treatment for relief of problems which have no medical cure. The same is true of legal "treatment." Despite the very substantial barriers to obtaining legal relief, on occasion a staff member or applicant who feels aggrieved by the application to him of hospital quality programs may nevertheless start a lawsuit. Assuring staff members of their freedom from liability for participation in hospital review may not be convincing: the burden of defending a lawsuit is potentially as onerous as is the question of ultimate liability. Therefore, this issue must also be addressed.

The essence of the defamation lawsuit is "personal harm," as distinct from the notion of "bodily harm" which underlies

the malpractice action. Both are insurable risks, but unless the ordinary malpractice policy bears a specific endorsement, it will not cover personal harm. In some parts of the country, this personal harm coverage is now included in physician malpractice insurance policies through prior negotiation with the insurance carrier. Where physicians are not so covered, the hospital, by rider to its own insurance, can cover its medical staff members against this liability risk.

This is similar to the insurance protection that hospitals often afford their trustees. Premiums are generally not costly. That many hospitals already provide this protection to medical staffs is all too often unknown to the physicians covered.

V. MALPRACTICE

The fear that the proceedings or reports of hospital review committees or that statements made by committee members in the course of deliberations can find their way into malpractice actions has an even greater negative effect on physician participation in these activities than does fear of defamation actions. However, the malpractice fears have no better foundation than the defamation worries; not only is this fear largely speculative, but the clear direction of both reported case law and state legislation is to the contrary.

Confusion between quality documents and patient medical records, and between the "discoverability" and "admissibility" of documentary evidence, is probably responsible for the fear. However, these two types of documents are markedly dissimilar, as are the rules relating to the discovery and admission in evidence of each.

Discovery is intended to aid a litigant in preparing for trial. It provides him with advance access to witnesses or documents, thus helping him to learn facts in support of his complaint or defense. The information obtained is then used to determine what witnesses to subpoena, what other records to look for, what line of questioning to pursue, and so forth. And even if the discovered materials are not admissible as evidence, they can sometimes be used in cross examination at trial to cast doubt on, that is, to "impeach," a witness' testimony.

Generally, liberal discovery is favored; when both sides know all of the material facts, the time required to

complete the trial is shortened and the results are likely to be more equitable. Thus, the law provides every litigant with wide latitude in establishing his complaint or defense through the use of subpoenas and other pretrial procedures.

Accordingly, patient medical records are generally discoverable. And one would suspect that these same policy considerations would subject the proceedings and reports of hospital review committees to discovery. However, that has not been the case; an overriding public interest in quality medical care forces this contrary result.

A. DISCOVERY CASES

Attempts to subpoena hospital quality documents fail more often than they succeed. As Bernstein states, "Hospital records and reports that reflect upon the quality of a physician's professional performance are tempting morsels for opposition attorneys. Few have succeeded in seeing this confidential material."[30]

Prior to passage of their respective nondiscovery statutes, a New York court refused discovery of medical staff committee records for use in a malpractice action, whereas a California court permitted discovery of the records of hospital disciplinary proceedings relating to a physician's removal from the staff.[31]

In 1970, a New Jersey trial court allowed discovery of a hospital's perinatal mortality committee minutes, but that same year, a federal district court denied discovery of "minutes and reports of any Board or Committee of Doctors Hospital or its staff concerning the death" of the plaintiff's husband.[32]

This federal court decision, which was recently affirmed by the United States Court of Appeals for the District of Columbia, fully articulates the public policy considerations against discovery:

> The minutes and reports of the boards or committees of the Hospital are records of medical staff reviews by committees of doctors acting pursuant to the requirements of the Joint Commission on Accreditation of Hospitals.

* * *

> Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients....To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.
>
> * * *
>
> There is an overwhelming public interest in having those staff meetings held on a confidential basis so that the flow of ideas and advice can continue unimpeded. Absent evidence of extraordinary circumstances, there is no good cause shown requiring disclosure of the minutes of these meetings....[They] are entitled to a qualified privilege on the basis of this overwhelming public interest.[33]

In a second ruling on the plaintiff's renewed request for the same discovery before a different judge, the court stated that the earlier decision

> ...analyzed the considerations of public policy supporting the extension of qualified privilege of confidentiality concerning the subject matter of the meetings of the hospital staff review committees, and this Court now adheres to [the] ruling that the proceedings at such meetings are entitled to a qualified privilege on the basis of the overwhelming public interest found to exist....[34]

Here the resolution of two conflicting public interests is involved: promoting equitable results for the plaintiff in a malpractice suit through liberal discovery rules, and promoting the improvement and maintenance of quality in hospitals through the nondiscovery of documents and testimony arising from the review activity. It is clear why the "overwhelming public interest" in controls to assure quality medical care is held to take precedence over the individual malpractice plaintiff's interest.

While the plaintiff permitted such discovery may be in an improved litigating position, denying discovery usually does

not worsen his position: he can still prove his case by the traditional route--the patient medical record, the factual testimony of those present at the care transaction that allegedly caused the harm, and the opinion testimony of expert witnesses. The alternative, allowing discovery, would destroy the effective conduct of the very activity in which the public has an overwhelming interest.

Perhaps when the quality material for which discovery is sought is the only avenue open to the plaintiff because of truly exceptional circumstances, such as the death of all witnesses or the loss or destruction of relevant medical records, limited discovery may be justified. And even the District of Columbia decision recognizes this possibility. But "absent evidence of [such] extraordinary circumstances," nondiscovery is equitable and is required by the public interest.

The "public interest" impetus for nondiscovery is reflected in statutory law as well as in court decisions. As of September, 1974, 21 states provided some degree of protection from discovery of the information and data generated or received by hospital evaluation committees.

This nondiscovery principle, as a common law doctrine rather than a statutory provision, has also been considered in two other hospital cases. In one, the widow of a patient who committed suicide in a federally-operated institution attempted to discover the report of a board of inquiry specially convened pursuant to federal regulations to investigate the suicide. A federal court in New York held that both the report of the board of inquiry and the hospital director's review of the board's findings were not subject to discovery. The *only* portion of the report to which the plaintiff acquired access was *factual testimony* by hospital employees describing the actual circumstances surrounding the suicide.[36] In other words, the evaluative portions were deemed nondiscoverable.

A Kentucky hospital's liability to a patient for permitting an allegedly incompetent physician to continue at the hospital was at issue in the second case. There, the court permitted discovery of written statements by members of the medical staff who had personally observed this physician's performance and were critical of his professional ability. These statements had been solicited by the hospital in anticipation that a hearing might be requested when the hospital notified the physician of its intent to deny him permanent staff status.[37]

The Kentucky court rejected the public policy consideration underlying the nondiscovery case law precedents

and legislative enactments in other states. But, the court's argument that the New York suicide case undermines the nondiscovery doctrine is most unpersuasive. And its decision is further compromised by almost sole reliance on an earlier California case[38] which was *subsequently overturned* by enactment of the California "nondiscovery" statute the very next year.[39]

The court did, however, suggest the availability of some measure of protection in future cases alluding to the possibility that portions of this subpoenaed material might have been legitimately withheld or deleted through the use of a "protective order," if one had been sought.

B. NONDISCOVERY STATUTES

Of the 21 states that protect hospital review activities from discovery, 17 specifically provide for nondiscoverability of the review committee's proceedings and reports: 13 declare them generally not subject to subpoena, discovery or disclosure,[40] and four speak in terms of confidentiality and/or privilege.[41] (Four other states have laws that are substantially less protective.)[42]

Some statutes also provide, probably gratuitously, that committee members may not be required to testify as to what transpired during committee deliberations[43] or that the results of committee activities may not be admitted into evidence.[44]

* The California statute is typical:

> Neither the proceedings nor the records of organized committees of medical staffs in hospitals having the responsibility of evaluation and improvement of the quality of care rendered in the hospital...shall be subject to discovery ...[and] no person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat.[45]

* * The Minnesota statute is one of the broadest in coverage:

> All data and information acquired by a review organization, in the exercise of its duties and functions, shall...not be subject to subpoena or discovery. No person...shall disclose what transpired at a meeting of a review organization except to the extent necessary to carry out...[its] purposes. The proceedings and records of a review organization shall not be

> subject to discovery or introduction into evidence in any civil action against a professional arising out of the...matters which are the subject of consideration...."[5]

In this provision, a "review organization" is defined as:

> ...a committee whose membership is limited to professionals and administrative staff...and which is established by a hospital, by a clinic, by...state or local associations of professionals, by an organization of professionals from a particular area or medical institution, by a health maintenance organization ..., by a nonprofit health service plan corporation...or by a professional standards review organization...to gather and review information relating to the care and treatment of patients....

Congress included a nondisclosure provision in the Professional Standards Review Organization legislation covering the data and reports that health care providers and professionals submit to PSRO organizations.

Of course, if a participant in a medical staff review activity has personal knowledge of the underlying facts of a case, then merely because he discussed those facts at a hospital meeting will not grant him immunity from testifying as to these facts either during discovery proceedings or at trial. While he cannot be asked what he or others said, saw, or heard at the committee meeting, he can be asked about his independent personal knowledge of the underlying transaction. If the rule were otherwise, hospital-based review activities could be used as a subterfuge for withholding material evidence.

Similarly, if a participant in a hospital review activity, as a witness or a member of a committee, is himself later sued for malpractice for the same incident that was the subject of the hospital review, he can be made to testify as to what he knows about the incident but not about what transpired during the review activity.

These commonsense exceptions are stated as follows:

- In the California statute:

  > The prohibition relating to discovery or testimony shall not apply to the statements made

to any person in attendance at such a meeting who is later a party to an action or proceeding the subject matter of which was reviewed at such meeting....

- In the Minnesota statute:

  [A]ny person who testified before a review organization or who is a member of it [shall not] be prevented from testifying as to matters within his knowledge, but a witness cannot be asked about his testimony before a review organization or opinions formed by him as a result of its hearings.

C. APPLICATION OF NONDISCOVERY STATUTES

At least four of these nondiscovery statutes have been tested in litigation. In Hawaii, application of the statute prevented discovery of medical association investigatory records relating to a physician.[48]

Nebraska's statute proved an effective barrier to a malpractice plaintiff's attempted use of a medical staff committee's records concerning suspension of a physician's privileges. The court explained the rationale behind the legislative action in this way:

> The basis for the privilege...is the public interest in the improvement of the care and treatment of patients. The Joint Commission...requires there be constant analysis and review of the clinical work done in the hospital. The importance of communication of information to...and full and open discussion in the committees during the review of clinical work can be easily seen.[49]

In New York, the nondisclosure statute did not prohibit discovery *from the defendant physician* of facts underlying the action merely because he had disclosed these facts in a presentation and report at a joint meeting of the local medical society and hospital staff. This result is in accord with an express provision in the New York statute, similar to the California and Minnesota provisions, that statements of the underlying facts made by a person who is a party to an action involving the same subject matter are not protected from discovery merely because the statements were made at the meeting.[50]

In the fourth case, a malpractice plaintiff requested the hospital's "personnel and/or staff files" as well as the files of various medical staff committees concerning a physician's staff membership. In holding that California Evidence Code section 1157 (see page MTH/14) barred access to the medical staff files, the court underscored the public policy issues that the nondiscovery statute seeks to resolve:

> ...[T]he quality of in-hospital medical care depends heavily upon the committee members' frankness in evaluating their associates' medical skills and their objectivity in regulating staff privileges....
>
> Section 1157 was enacted upon the theory that external access to peer investigations conducted by staff committees stifles candor and inhibits objectivity. It evinces a legislative judgment that the quality of in-hospital medical practice will be elevated by armoring staff inquiries with a measure of confidentiality.
>
> This confidentiality exacts a social cost, because it impairs malpractice plaintiffs' access to evidence...[and] might seriously jeopardize or even prevent the plaintiff's recovery. Section 1157 represents a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence.[51]

And, although section 1157 speaks only to "organized committees of medical staffs," this court held that insofar as hospital administration files reflect "the proceedings of staff committees...conforming to the statute," such administration files are also nondiscoverable.

But does this distinction mean that the records and proceedings of nursing, pharmacy and other professional audit activities will be considered "administration" files and hence discoverable? The courts have not adhered to such a rigid line in the past.

For example, without the benefit of statutory nondiscovery, a federal court in New York refused discovery of the report of a board of inquiry convened to investigate a suicide in a government hospital.[52] Similarly, another federal court in Georgia denied discovery of an aircraft manufacturer's

internal study of compliance with equal opportunity laws, because "...it would be contrary to [public] policy to discourage frank self-criticism and evaluation in the development of affirmative action programs of this kind."[53]

These decisions both demonstrate that the determinative factor is not who conducts the review but is rather the intrinsic nature of the documentation and activity sought to be protected and encouraged.

Since nonphysician quality review serves the same purposes as the medical review function--namely, the assurance of optimal quality patient care, the competent performance of the health practitioner, and professional self-discipline, it is clear that nonphysician quality review should receive equal protection. Today, the public has no less an interest in candid, objective nursing care evaluation than in medical care evaluation, especially since states are beginning to liberalize the nurses' role in health care by permitting them to perform acts heretofore exclusively limited to physicians.[54]

VI. ADMISSIBILITY

The nonadmissibility of hospital quality program documents is more easily demonstrated and would present no problem if it weren't for the confusion of this documentation with patient medical records. When courts consider the admissibility of documentary evidence, they want to make certain that the proffered documents contain reliable and valid information and were not prepared especially for the purposes of trial.

Among their other disabilities, documents cannot be subjected to cross-examination. Accordingly, the hearsay rule has severely limited the extent to which written materials may be admitted into evidence. It is only through a specific exception to the hearsay rule that patient medical records are introduced into evidence. This exception, from commercial law, originally related to "business" records.

For admission into evidence under the business record exception, a record must (1) be made in the ordinary course of business where it is integral to the business to maintain such a record, (2) be made at the time of or close enough in time to the transaction that is the subject of the lawsuit to provide reasonable assurance that the transaction is accurately reported, (3) be made by a party to

the transaction, and (4) be made to record an act, condition, or event, as distinguished from conclusions, judgments, and opinions. Of course, the exact formulation of the hearsay rule and of its exceptions varies in different jurisdictions, but this statement is generally accurate.

Patients' medical records are usually admissible under the business records exception when the hospital medical record administrator or other "custodian" of the records testifies that they were made in the regular course of the hospital's business, that it is the business of the hospital to keep such records, and that they were made at or close to the time of the patient care events they document. Even so, those portions of the medical record reflecting conclusions, judgments, or opinions, rather than facts, may not be admissible except under special circumstances.

Although made in the course of the hospital's business, the proceedings and reports of review committees cannot meet the other conditions of the business record test for admissibility:

- They are prospective (credentials) or retrospective (audit) and are not made at the right time.
- They are second-hand evidence of the patient care acts, conditions, or events described in the actual patient medical record.
- They are made by persons who were not present at the events they purport to review and describe.
- They are made for purposes only indirectly related to the medical treatment of any particular patient.
- They contain opinions, professional judgments, and conclusions.
- They are not "integral" to the hospital's business of providing patient care (except, perhaps, where required by law).

For these reasons, no known attempt to admit hospital quality assurance documents into evidence as proof of malpractice has succeeded.

VII. CONCLUSION

The hospital has a professional, legal and social obligation to make every reasonable effort towards assuring that care rendered to its patients meets the highest achievable standards of economy and quality. To satisfy the public mandate for accountability, the hospital must be able always to demonstrate that this obligation is indeed being met by viable, effective internal review programs.

That such programs can be effective only through the active participation of the professionals who provide the patient care services, and that the professionals have based their nonparticipation in part on fears of potential legal liability, are obvious statements of fact.

Upon analysis, however, the fears allegedly deterring such participation--defamation and malpractice liability resulting from adverse use of hospital review findings--are seen to be almost wholly unfounded. The public has recognized these concerns, and, based on its overriding interest in quality medical care, has provided for the professionals who participate in and document these activities both legislative and judicial safeguards.

The excuse of liability being no longer tenable, the public and the Joint Commission are entitled to demand that hospital medical and professional staffs, and hospital boards and administrative officers, will vigorously pursue and faithfully discharge these review responsibilities.

ANALYSIS OF STATE IMMUNITY AND NONDISCOVERY STATUTES

STATUTORY COVERAGE / STATE	UTILIZATION REVIEW ONLY	IMMUNITY	Any Member of Med. Committee	Physician/Dentist Members Only	Hospital Board	Nursing and Other Prof. Committee	Third Parties Who Provide Data	Advisor/Employee Agent/Consultant	NONDISCOVERY	Committee's Own Work Product	Only Data Made Available To	Nursing and Other Prof. Eval. Doc.		TESTIMONY SPECIFICALLY COVERED		NONADMISSIBLE
Alabama				✓						✓						
Arizona				✓			✓	✓		✓				✓		
Arkansas																
California			✓							✓				✓		
Connecticut	✓															
Delaware				✓												
Florida			✓							✓				✓		✓
Hawaii			✓							✓				✓		
Idaho			✓			✓	✓			✓		✓		✓		✓
Illinois				✓												
Indiana			✓													
Kansas			✓		✓											
Kentucky				✓												
Louisiana			✓			✓	✓			✓		✓				
Massachusetts			✓													
Michigan							✓			✓						
Minnesota			✓			✓		✓		✓		✓		✓		✓
Missouri				✓	✓											
Montana										✓						✓
Nebraska										✓						✓
Nevada										✓				✓		
N. Hampshire			✓													
New Jersey	✓										✓					
New Mexico			✓			✓										
New York				✓						✓				✓		
N. Carolina			✓													
N. Dakota	✓										✓					
Ohio	✓										✓					
Oregon										✓						✓
Pennsylvania			✓			✓	✓	✓			✓					
S. Dakota			✓													
Tennessee	✓															
Texas			✓			✓	✓			✓		✓				
Utah	Two provisions--see discussion on pages MYTH/7-8.															
Washington				✓						✓						
Wyoming			✓		✓			✓		✓						

NOTES

1. The most explicit statement of the requirement appears in the Quality of Professional Services Standard, *Accreditation Manual for Hospitals* (Chicago: Joint Commission on Accreditation of Hospitals, 1974):

> ...[T]he Board of Commissioners of the Joint Commission has formally announced this policy: That hospital accreditation shall depend...in particular, on evidence that the hospital medical staff is effectively implementing objective measures leading to assurance of the quality of patient care; that other professional staffs are doing the same in the services they provide; and that the governing body and management support and assist in the implementation thereof. *** The hospital shall demonstrate that the quality of patient care provided is constantly optimal by continuously evaluating it through reliable and valid measures.

2. *See e.g.*, Darling v. Charleston Community Memorial Hospital, 211 N.E.2d 253 (Ill. 1965), *cert. denied* 383 U.S. 946 (1966); Foley v. Bishop Clarkson Memorial Hospital, 173 N.W.2d 881 (Neb. 1970); Fiorentino v. Wenger, 227 N.E.2d 296 (N.Y. 1967); cases cited and discussed notes 3, 4, and 5 *infra*. *Cf.* Moore v. Board of Trustees of Carson-Tahoe Hospital, 495 P.2d 605 (Nev. 1972). The principle has also been enacted into statutory law in several jurisdictions. *See e.g.*, Ind. Ann. Stat. Sec. 42-1605a (Supp. 1972); Mich. Stat. Ann. Sec. 14.1179(2) (Supp. 1974).

3. In *Mitchell County Hospital Authority v. Joiner*, 189 S.E.2d 412, 414 (Ga. 1972), *aff'g* 186 S.E.2d 307 (Ga. App. 1971), the court held that "the delegation of authority to screen applicants for staff membership on the medical staff does not relieve the Authority of its responsibility since the members of such staff [when performing such administrative acts on behalf of the hospital] act as agents for the Authority...."

In *Purcell v. Zimbelman*, 500 P.2d 335, 341 (Ariz. App. 1972), the court held that the fact that the surgery department had considered the surgeon's competence and had failed to recommend corrective action was no defense. "The Department of Surgery was acting for and on behalf of the hospital in fulfilling this duty and if the department was negligent in not taking action against [the surgeon] or recommending to the board of trustees that action be taken, then the hospital would also be negligent."

4. Gonzales v. Nork, No. 225866, at 164, 194 (Super. Ct. Cal., Sacramento County, November 19, 1973). In his Memorandum of Decision, Judge Goldberg approved and expressly adopted the line of authority that establishes hospital corporate responsibility for the quality of patient care. (Cases cited note 2 *supra*.) He distilled from the prior decisions the following rule regarding the hospital's duty and held the hospital liable for its failure to meet this standard:

> The hospital has a duty to protect its patients from malpractice by members of its medical staff when it knows or should have known that malpractice was likely to be committed upon them. Mercy Hospital had no actual knowledge of Dr. Nork's propensity to commit malpractice, but it was negligent in not knowing...because it did not have a system for acquiring knowledge; it did not use the knowledge available to it properly; it failed to investigate... [a] case, which would have given it knowledge; and it cannot excuse itself on the ground that its medical staff did not inform it.

Directly on the agency issue, Judge Goldberg said:

> ...[T]he hospital is required to have a medical staff...[that is] "self-governing" or independent....But this does not immunize it from liability, because the medical staff acts for the hospital in the discharge of the hospital's responsibilities to protect its patients.

Although the hospital settled the claim against it prior to entry of the judgment,

the surgeon has appealed the judgment against him. Since he claimed at the trial that the hospital should bear the entire burden, the corporate liability issue may be ruled on by the California appellate court.

5. In *Hull v. North Valley Hospital*, 498 P.2d 136, 144 (Mont. 1972), the court's opinion states that, "the record insofar as the Hospital is concerned, demonstrates an effort to supervise the quality of medical practice within the Hospital," and holds the hospital not liable where, notwithstanding such supervision, a patient suffered harm. However, this opinion can also be interpreted as opposed to the *Joiner-Purcell-Nork* theories on two critical points: first, that the medical staff acts on behalf of the hospital in conducting staff review and evaluation; and second, that "knowledge within [staff] doctors' minds, uncommunicated to the Board, is not a demonstration of knowledge of the Board as a matter of law...."

   The *Nork* court expressly refused to follow this line of reasoning, observing that:

   > Restricting hospital liability to cases of actual knowledge would promote carelessness. If it were so restricted, "the less a hospital knows...the safer it is against charges of negligence." (Citations omitted.) *** [I]t does not seem likely that the higher courts of [California] would follow Hull and put the risk of harm resulting from medical staff inactivity on the patient rather than on the hospital. Gonzales v. Nork, No. 225866, at 153, 164 (Super. Ct. Cal., Sacramento County, November 19, 1973).

   See A. Southwick, *The Hospital As An Institution--Expanding Responsibilities Change Its Relationship With the Staff Physician*, 9 Calif. Western L. Rev. 429 (1973), for a critique of *Hull*.

6. *See e.g.*, Willis v. Santa Ana Community Hospital Association, 26 Cal.Rptr. 640 (1962); Visalli v. Mary's Help Hospital, No. 151707 (Super. Ct. Cal., San Mateo County, March 15, 1974); Hagan v. Osteopathic General Hospital of Rhode Island, 232 A.2d 596 (R.I. 1967). *See also* Ascherman v. San Francisco Medical Society, 114 Cal.Rptr. 691 (Ct. App. 1974); Goodley v. Sullivant, 108 Cal.Rptr. 451 (Ct. App. 1973); Silver v. Castle Memorial Hospital, 497 P.2d 564 (Hawaii 1972), *cert. denied* 409 U.S. 1048 (1972).

7. Schechet v. Kesten, 141 N.W.2d 641 (Mich. 1966); Shapiro v. Health Insurance Plan of Greater New York, 7 N.Y.2d 56 (1959); Mayfield v. Gleichert, 484 S.W.2d 856 (Tex. 1969).

8. Raymond v. Cregar, 185 A.2d 856 (N.J. 1962).

9. *Cf.* Sussman v. Overlook Hospital Association, 222 A.2d 530 (N.J. Super. 1966), for a well-reasoned dictum supportive of the privilege.

10. Ascherman v. Natanson, 100 Cal.Rptr. 656 (Ct. App. 1972); Goodley v. Sullivant, 103 Cal.Rptr. 451 (Ct. App. 1973). The absolute privilege is based on California Civil Code section 47.2, a defamation-privilege statute that protects, in general, all communications made in legislative, judicial, or quasi-judicial proceedings. By the opinions in these cases, absolute privilege is also extended to statements made while preparing for a hearing, as in interviewing prospective witnesses or during committee meetings leading to a hearing.

    Goodley is noteworthy on a third issue. The plaintiff argued that absolute privilege was not available to medical staff committees. California Civil Code section 43.7 provides a "particular" qualified privilege covering "any act or proceeding undertaken or performed" by members of a medical staff committee; whereas, section 47.2 "is a general defamation-privilege that is directed to all executive, legislative, and judicial proceedings." Therefore, said the plaintiff, because "particular statutes control over general statutes," 47.2 was inapplicable and the test of the qualified privilege in 43.7 should have controlled.

    In rejecting this argument, the opinion construes 43.7 narrowly:

> Section 43.7 is concerned with actions taken by a medical committee...and is not concerned with possible defamatory publications made by such a committee. Since...43.7 is not applicable to defamations [it is] not inconsistent with section [47.2]....

This narrow construction should not cause undue concern in other jurisdictions with similarly worded qualified immunity statutes. The more reasonable view seems to be that these qualified immunity statutes protect committee communications as well as actions. D. Rubsaman, ed., Professional Liability Newsletter, note 4 (May, 1974). And if the *Gooley* interpretation is adopted in other states, committee utterances remain protected by the common law qualified privilege. (See the discussion at page MTM/4.)

11. Franklin v. Blank, ___ P.2d ___ (N. Mex. 1974). The court reasoned that:

> ...appropriate professional societies, by exercising peer review, can and do perform a great public service by exercising control over those persons placed in a position of public trust....It is hardly open to dispute that communications initiating such proceedings are an indispensable part thereof and are to be protected by the privilege.

12. DiMiceli v. Klieger, 206 N.W.2d 184 (Wis. 1973).

13. Guidelines for the Formulation of Medical Staff Bylaws, Rules and Regulations--1971 (Chicago: Joint Commission on Accreditation of Hospitals), Art. V, Sec. 1d [hereinafter cited as Guidelines].

14. In *Cypress v. Newport News General and Non-Sectarian Hospital Association*, 251 F.Supp. 667 (E.D.Va. 1966), the court suggested that such medical staff release provisions should be employed and would be effective.

15. But the purposes served by such medical staff bylaw release provisions--maintenance of quality health care--are so much in the public interest that this may be an overriding consideration if the adhesion concept is ever asserted in litigation. Also, an applicant or staff member who is fully informed of the presence and import of release and immunity provisions and who does not object to them at the outset may be barred from later pleading invalidity because of adhesion.

16. Schechet v. Kesten, 141 N.W.2d 641 (Mich. 1966).

17. Guidelines, note 13 *supra*, Art. VIII, Sec. 2, 3.

18. For convenience, the statutes are grouped in accordance with the protection they offer. Those in the first group provide immunity from defamation liability to committee members and also protection against discovery of committee reports. The statutes in the second group provide immunity but are silent on discovery. The third group lists statutes that are limited to nondiscoverability.

Seventeen states provide both immunity and nondiscovery protection.

Code of Ala. Tit. 46, Sec. 297(a3) (Supp. 1973).
Ariz. Rev. Stat. Sec. 36-441, -445 to -445.03 (Supp. 1973).
Cal. Civil Code Sec. 43.7 (West Supp. 1974), 47.2 (West 1954); Cal. Evid. Code Sec. 1157, 1157.5 (West Supp. 1974).
Fla. Session Laws 1973, Ch. 73-50.
Hawaii Rev. Stat. Sec. 624.25.5, 663-1.7 (Supp. 1973).
Idaho Code Sec. 39-1392 to -1392e (Supp. 1973).
La. Regular Session Laws--1974, Act No. 315.
Mich. Stat. Ann. Sec. 14.57(21-23), 14.1179 (12) (Supp. 1974).
Minn. 68th Legislature--Second Regular Session Laws, 1974, Ch. 295.
N.J. Stat. Ann. Sec. 2A:84A-22.8, -22.9 (Supp. 1974).
N.Y. Education Law Sec. 6527(3) (McKinney Supp. 1973).
N.D. Century Code Sec. 23-01-02.1 (1970).

Ohio Rev. Code Sec. 2305.24, .25 (1971).
Pa. Stat. Tit. 62, Sec. 444.2 (Supp. 1974); Session Laws of 1974, Act No. 193.
Tex. Ann. Civ. Stat. Art. 4447d, Sec. 3 (Supp. 1973).
Rev. Code of Wash. Ann. Sec. 4.24.240, .250, .260 (1973).
Wyo. Stat. Sec. 35-140.1 to -140.4, 35-528 to -530 (Supp. 1973).

Immunity but not nondiscovery protection is provided in 15 states.

Ark. Stat. Sec. 82-357 to -359 (Supp. 1973).
Gen. Stat. of Conn. Sec. 52-557e (1973).
Del. Code Ann. Tit. 24, Sec. 1768 (Supp. 1970).
Ill. Stat. Ch. 91, Sec. 2a (1973).
Ind. Code Sec. 16-10-1-6.5 (1971).
Kan. Stat. Ann. Sec. 65-442 (Supp. 1973).
Ky. Rev. Stat. Ch. 311-377 (Supp. 1972).
Ann. Laws of Mass. Ch. 231, Sec. 85N (Supp. 1973).
Vernon Ann. Mo. Stat. Sec. 537.035 (Supp. 1973).
N.H. Rev. Stat. Ann. Sec. 329:27, :28 (Supp. 1973).
N. Mex. Stat. Ann. Sec. 12-5-16 (Supp. 1973).
N.C. 1973 General Assembly--Second Session Laws, 1974, Ch. 1111.
S.D. Compiled Laws Sec. 36-4-25, -26 (1967).
Tenn. Code Ann. Vol. 11, Sec. 63-623 (Supp. 1974).
Utah Code Ann. Vol. 3, Sec. 26-18-1 (Supp. 1973); Vol. 6A, Sec. 58-12-25 (1974).

Four states have provisions which relate only to nondiscovery of committee minutes and reports.

Rev. Codes of Mont. Sec. 59-6301 to -6304 (1970).
Rev. Stat. of Neb. Sec. 71-2046 to -2048 (1971).
Nev. Rev. Stat. Sec. 49.265 (1973).
Ore. Stat. Sec. 41.675 (1973).

See discussion of the nondiscovery issue beginning at page MYTH/10.

For an earlier compilation of statutes see B. J. Anderson, *Peer Review Manual* (Chicago: American Medical Association, 1971), Vol. II, 1973 Update for Appendix H--Immunity Statutes.

19. The six states whose provisions are limited in coverage to utilization review activities are Arkansas, Connecticut, New Jersey, North Dakota, Ohio and Tennessee.

20. Utah, note 18 *supra*.

21. These statutes, in turn, fall into two classes: (1) those protecting any members of staff committees and (2) those limited by their terms to physician or dentist members of such committees. In class 1 are: California, Florida, Hawaii, Indiana, Kansas, Massachusetts, New Hampshire, North Carolina, South Dakota, Wyoming, note 18 *supra*; and in class 2 are: Alabama, Arizona, Delaware, Illinois, Kentucky, Missouri, New York, Washington, note 18 *supra*.

22. Kansas, Missouri, Wyoming, note 18 *supra*.

23. Arizona, Idaho, Louisiana, Michigan, Pennsylvania, Texas, Utah, note 18 *supra*.

24. Arizona, Minnesota, Pennsylvania, Wyoming, note 18 *supra*.

25. Idaho, Louisiana, Minnesota, New Mexico, Pennsylvania, Texas, note 18 *supra*.

26. Indiana, note 18 *supra*.

27. Goodley v. Sullivant, 108 Cal.Rptr. 451 (Ct. App. 1973), interpreting Cal. Civil Code section 43.7 (West Supp. 1974). See discussion, note 10 *supra*.

28. 42 U.S.C. 1320c-16 (Supp. 1972).

> 1320c-16. (a)...[N]o person providing information to any [PSRO] shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law...unless--
>
> (1) such information is unrelated to the performance of the duties and functions of the [PSRO], or
>
> (2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.
>
> (b)(1) No individual who, as a member or employee of any [PSRO] or who furnishes professional counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of a [PSRO]...to have violated any criminal law, or to be civilly liable under any law...provided he has exercised due care.
>
> (2) The provisions of paragraph (1) shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

29. Medical Malpractice: Report of the Secretary's Commission on Medical Malpractice (Washington, D.C.: Department of Health, Education, and Welfare, 1973), p. 57.

30. A. H. Bernstein, *Access to physicians' hospital records*, Hospitals, J.A.H.A., 45:148, Sept. 1, 1971.

31. Judd v. Park Avenue Hospital, 235 N.Y.S.2d 843, *aff'd* 235 N.Y.S.2d 1023 (1962); Kenney v. Superior Court, 63 Cal.Rptr. 84 (Ct. App. 1967).

32. Goreghian v. Hackensack Hospital, 262 A.2d 440 (N.J. 1970); Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.C.D.C. 1970), 51 F.R.D. 187 (D.C.D.C. 1970), *aff'd without opinion* 479 F.2d 920 (D.C.Cir. 1973).

33. Bredice, 50 F.R.D. 249, 250-251

34. Bredice, 51 F.R.D. 187, 188.

35. Notes 40-42 *infra*.

36. Gillman v. United States, 53 F.R.D. 316 (S.D.N.Y. 1971).

37. Nazareth Literary and Benevolent Institution v. Stephenson, 503 S.W.2d 177 (Ky. 1973).

38. Kenney v. Superior Court, note 31 *supra*.

39. In *Matchett v. Petway*, 115 Cal.Rptr. 317, 320 (Ct. App. 1974), the same court that allowed the earlier discovery construed California's nondiscovery statute--Evidence Code section 1157:

> Evidence Code section 1157 expresses a legislative judgment that the public interest in medical staff candor...requires a degree of confidentiality. It was enacted in 1965 in apparent response to this court's decision in Kenney....

40. Arizona, California, Florida, Hawaii, Idaho, Louisiana, Michigan, Minnesota, Nebraska, Nevada, New York, Texas, Washington, note 18 *supra*. Of these thirteen, four--Idaho, Louisiana, Minnesota, Texas--are broad enough in scope to protect the records of nursing and other health professional evaluation committees.

41. Alabama, Montana, Oregon, Wyoming, note 18 *supra*.

42. New Jersey, North Dakota, Ohio, Pennsylvania, note 18 *supra*. By express terms, each of these statutes limits nondiscovery protection to the information and data made

available to a committee. Interpreted literally, they would not protect a committee's own records and proceedings; as a practical matter, however, a committee's work product will be covered because it will consist either of the privileged data submitted to it or its own evaluative, judgmental conclusions concerning that data. More important is that three of these statutes--New Jersey, North Dakota, Ohio--relate only to "utilization review" committees.

43. Arizona, California, Florida, Hawaii, Idaho, Minnesota, Nevada, New York, note 18 *supra*.

44. Florida, Idaho, Minnesota, Montana, Nebraska, Oregon, note 18 *supra*.

45. Cal. Evid. Code Sec. 1157 (West Supp. 1974).

46. Minn. 68th Legislature--Second Regular Session Laws, 1974, Ch. 295.

47. 42 U.S.C. 1320c-15 (Supp. 1970).

PROHIBITION AGAINST DISCLOSURE OF INFORMATION

1320c-15. (a) Any data or information acquired by any [PSRO] in the exercise of its duties and functions, shall be held in confidence and shall not be disclosed to any person except (1) to the extent that may be necessary to carry out the purposes of this part or (2) in such cases and under such circumstances as the Secretary shall by regulations provide to assure adequate protection of the rights and interests of patients, health care practitioners, or providers of health care.

The following section of the law--42 U.S.C. 1320c-14--also raises some confidentiality issues.

CORRELATION OF FUNCTIONS BETWEEN [PSROs] AND ADMINISTRATIVE INSTRUMENTALITIES

1320c-14. The Secretary shall by regulations provide for...such interchange of data and information, and such other cooperation...between and among--

(a)(1) agencies and organizations which are parties to agreements entered into pursuant to section 1816, (2) carriers which are parties to contracts entered into pursuant to section 1842, and (3) any other public or private agency [other than a PSRO] having review or control functions, or proved relevant data-gathering procedures and experience, and

(b) [PSROs], as may be necessary or appropriate for the effective administration of title XVIII, or State plans....

Several commentators have reviewed the possible legal implications of these and other sections of the PSRO legislation. *See e.g.*, E. J. Anderson, *Professional Standards Review Organizations*, Chicago Medicine, 77:745 (Sept. 7, 1974); C. E. Welch, *PSRO's --Pros and Cons*, New England Journal of Medicine, 290:1319 (June 6, 1974); D. E. Willett, *Malpractice claims--will they increase or decrease with PSROs?*, Bulletin of the American College of Surgeons, 59:7 (May 1974).

48. Silver v. Gordon (Cir. Ct., Honolulu, Hawaii, September 21, 1971), interpreting Hawaii Rev. Stat. Sec. 624-25.5 (Supp. 1973), reported in The Citation, 24:59 (Dec. 1971).

49. Oviatt v. Archbishop Bergan Mercy Hospital, 214 N.W.2d 490, 492 (Neb. 1974), interpreting Rev. Stat. of Neb. Sec. 71-2048 (1971).

50. Pindar v. Parke Davis and Company, 337 N.Y.S.2d 452, 453 (Sup. Ct. 1972), interpreting N.Y. Education Law Sec. 6527(3) (McKinney Supp. 1973). It can be inferred that the defendant was resisting discovery of his own testimony about the underlying patient care events, prompting the court to comment that "the facts giving rise to the causes of action are particularly within the knowledge of [this] individual defendant...."