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Peer Review Committee Minutes and Memoranda: Non-Discoverable at All Costs

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COMMENT

PEER REVIEW COMMITTEE MINUTES AND MEMORANDA: NON-DISCOVERABLE AT ALL COSTS?

INTRODUCTION

Hospital peer review committees[1] have been used to review staff physician quality since the early 1900's.[2] Confidentiality of the resulting minutes and memoranda has become widely recognized as a necessary corollary to the effectiveness of these committees. Consequently, the proceedings[3] of peer review committees have generally been held to be non-discoverable to plaintiffs in malpractice actions.

Since 1975, Ohio and forty-seven other states have passed legislation carving out a new privilege, confidentiality of review committee proceedings.[4] These non-discovery laws aid in the maintenance or improvement of quality health care through efficient, periodic review of hospital

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[1] Peer review committees monitor and evaluate the quality of patient care in a given hospital.

These committees must be distinguished from Professional Standards Review Organizations (PSRO). A PSRO is an independent organization accredited by Medicare to inspect potential member hospitals. PSRO's are primarily concerned with efficient overall hospital operations and are generally of no concern to malpractice plaintiffs. *See generally* Public Citizens Health Research Group v. Department of Health, Educ., and Welfare, 449 F. Supp. 937 (D.D.C. 1978) (history of PSRO legislation, summary of provisions, and applicability of Freedom of Information Act).

[2] Ostrow, *The Historical Precedents for Quality Assurance in Health Care*, 37 AM. J. OCCUPATIONAL THERAPY 23 (1983).

[3] The term "proceedings" may be misleading since peer review committees often meet informally. Nonetheless, the term will be used throughout this article because of its common association with peer review.

[4] ALA. CODE § 22-21-8 (1984); ALASKA STAT. § 18.23.030 (1976); ARIZ. REV. STAT. ANN. § 36-445.01 (1986); ARK. STAT. ANN. § 28-934 (1979); CAL. EVID. CODE § 1157 (West 1986); COLO. REV. STAT. § 12-43.5-102 (1985); CONN. GEN. STAT. ANN. § 38-19A (West 1986); DEL. CODE ANN. tit. 24, § 1768 (1981); D.C. CODE ANN. § 32-505 (1981); FLA. STAT. ANN. § 768.40 (West 1986); GA. CODE ANN. § 31-7-133 (1985); HAWAII REV.

services.[5] Confidentiality promotes candid self-evaluation by members of the medical profession. However, the majority of the states, including Ohio, deny access to peer review records and reports even where public policy unquestionably favors granting a plaintiff's discovery request. In such a case, only exposure will lead to an equitable result.

Where an injured patient sues a hospital for negligently permitting an incompetent physician to remain on its medical staff, peer review records and reports should be released. In *Wesley Medical Center v. Clark*,[6] the plaintiffs in the underlying medical malpractice action alleged that the hospital administrators negligently allowed the defendant physician to operate on their infant son, although they were aware, or should have been aware, of the physician's incompetence.[7] The Kansas Supreme Court affirmed the trial court's determination that (1) the hospital, as an accredited and licensed medical facility, has a duty to "monitor and evaluate" its entire medical staff; and (2) the peer review committee records regarding the defendant doctor were discoverable. The court reasoned: "[W]e decline to adopt an absolute statement of public policy declaring all such records to be protected *in toto*. . . . Under the facts presented, the public interest will best be served by allowing these plaintiffs access to the materials sought. . . ."[8]

Discovery of the committee reports revealed that the hospital's peer review committee had held hearings and had found that the doctor had performed unnecessary operations, yet the committee had failed to take

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Stat. § 624-25.5 (Supp. 1984); IDAHO CODE §§ 39-1392a, b, & e (1973); ILL. ANN. STAT. ch. 110, § 8-2101 (1986); IND. CODE ANN. § 34-4-12.6-2 (1985); IOWA CODE ANN. § 135.40 (West 1963); KAN. STAT. ANN. § 65-4915 (1985); KY. REV. STAT. § 311.377 (1980); LA. REV. STAT. ANN. § 13:3715.3 (West 1983); ME. REV. STAT. ANN. tit. 24, §§ 2505, 2510 (1985); MD. HEALTH OCC. CODE ANN. § 14-601 (1984); MICH. COMP. LAWS § 331.532 (1980); MINN. STAT. ANN. § 145.64 (West 1975); MISS. CODE ANN. § 41-63-9 (1984); MONT. CODE ANN. § 50-16-203 (1984); NEB. REV. STAT. § 71-2048 (1981); NEV. REV. STAT. § 49.265 (1981); N.H. REV. STAT. ANN. § 329:29 (Supp. 1985); N.J. STAT. ANN. § 2A:84A-22.8 (West 1979); N.M. STAT. ANN. § 41-9-5 (1986); N.Y. EDUC. LAW § 6527 (McKinney 1985); N.C. GEN. STAT. § 131E-95 (1983); N.D. CENT. CODE § 23-01-02.1 (1985); OHIO REV. CODE ANN. § 2305.251 (Baldwin 1985); OKLA. STAT. ANN. tit. 63, § 1-1709 (West Supp. 1984); OR. REV. STAT. § 41.675 (1985); PA. STAT. ANN. tit. 63, § 425.4 (Purdon Supp. 1986); R.I. GEN. LAWS § 23-17-25 (1985); S.C. CODE ANN. § 40-71-10 & 20 (Law. Co-op. 1986); S.D. CODIFIED LAWS ANN. § 36-4-26.1 (1986); TENN. CODE ANN. § 63-6-219 (1982); TEX. REV. CIV. STAT. ANN. art. § 4447d (Vernon 1976); UTAH CODE ANN. § 26-25-3 (1984); VT. STAT. ANN. tit. 26, § 1443 (Supp. 1986); VA. CODE § 8.01-581.17 (1984); WASH. REV. CODE ANN. § 4.24.250 (West Supp. 1986); W. VA. CODE § 30-3C-3 (1986); WIS. STAT. ANN. § 146.38 (West 1986); WYO. STAT. § 35-2-602 (1977).

[5] *See* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249 (D.D.C. 1970).

[6] 234 Kan. 13, 669 P.2d 209 (1983).

[7] *Id.* at 15, 669 P.2d at 212. *See* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS (JCAH), ACCREDITATION MANUAL FOR HOSPITALS (1982) [hereinafter JCAH MANUAL].

[8] *Wesley*, 234 Kan. at 26, 669 P.2d at 219.

action. Shortly thereafter, the parents in *Wesley* obtained a substantial settlement from the hospital.[9] In reaction to *Wesley*, the Kansas legislature enacted a peer review confidentiality statute that does not permit such discovery.[10]

The purpose of this article is to illustrate the inherent problems of blanket peer review confidentiality and to suggest a more equitable approach. Part I traces the development of reviewing hospital quality and explains the operation and justifications of peer review committees. In Part II, the arguments supporting confidentiality are compared with the public policy favoring proper disposition of corporate negligence cases in order to determine and recommend the correct level of confidentiality. In Part III, the peer review discovery statute in section 2305.251 of the Ohio Revised Code is critically evaluated for its practical value to the advancement of hospital health care. The article concludes that a liberalization and redefinition of the Ohio statute has been long overdue and therefore, provides a model statute.

This article will not address the discoverability of other hospital records,[11] such as those protected by the physician-patient privilege[12] or hospital incident reports.[13] The potential for liability of review committee participants[14] will not be covered in detail.

I. Quality Control Through Peer Review

In 1910, the *Flexner Report*[15] exposed details of inadequate hospital conditions and called attention to the need for quality assurance. The

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[9] Telephone interview with Richard Cordry, the attorney for plaintiff-respondent, who is with the law firm of Michaud, Cordry, Michaud, Hutton, & Hutton, in Wichita, Kansas (Feb. 22, 1985). The parents sued the doctor for negligence.

[10] Kan. Stat. Ann. § 65-4915 (1985).

[11] *See generally* Calloway, *Understanding Hospital Records*, 30 Prac. Law., Jan. 15, 1984, at 11; Cramer, *Discovery of Medical and Hospital Records*, 58 Fla. B.J. 148 (1984).

[12] *See generally* Ohio Rev. Code Ann. § 2317.02 (Baldwin 1985); Gellman, *Prescribing Privacy: The Uncertain Role of the Physician in the Protection of Patient Privacy*, 62 N.C.L. Rev. 255 (1984).

[13] *See generally* Spencer, *The Hospital Incident Report: Asset or Liability?*, 22 Air Force L. Rev. 148 (1980); Comment, *Hospital Accident Reports: Admissibility and Privilege*, 79 Dick. L. Rev. 493 (1975).

[14] In most states, committee members, witnesses, and other review participants are immune from civil liability. *See, e.g.*, Ohio Rev. Code Ann. § 2305.25 (Baldwin 1985). *See generally* Comment, *Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine*, 10 Am. J.L. & Med. 115 (1984); Note, *The Legal Liability for Medical Peer Group Participants for Revocation of Hospital Staff Privileges*, 28 Drake L. Rev. 692 (1978).

[15] A. Flexner, *Medical Education in the United States and Canada: A Report to the Carnegie Foundation for the Advancement of Teaching* (1910). Although the American Medical Association, which had been founded in 1847, had set up minimum professional

Third Clinical Congress of Surgeons in North America took the first step toward voluntary accreditation in 1912. This organization adopted a resolution that introduced the necessity for standardization among hospitals.[16] In the same year E. A. Codman, a Massachusetts professor of surgery, developed an early system of review which successfully revealed various sources of deficient health care within his own hospital.[17] In 1918, the American College of Surgeons (ACS)[18] initiated the first nationwide system of voluntary accreditation. The ACS established a minimum standard for hospitals seeking accreditation.[19] In a one page report entitled *Minimum Standard*, the ACS required "[t]hat the staff review and analyze at regular intervals their clinical experience in the various departments of the hospital."[20]

The Joint Commission on the Accreditation of Hospitals (JCAH) was established in 1951[21] in order to continue the work of the ACS.[22] In 1953, the JCAH published the *Standards for Hospital Accreditations*,[23] which was an expansion of the ACS *Minimum Standard*. Although accreditation is a voluntary process, the JCAH has become a widely accepted standard of quality assurance in American hospitals.[24]

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standards and some states had medical licensure regulations, Flexner believed that health care remained inadequate. *See* Gosfield, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMPLE L.Q. 552 (1979).

[16] L. DAVIS, FELLOWSHIP OF SURGEONS: A HISTORY OF THE AMERICAN COLLEGE OF SURGEONS 476 (1960); Affeldt & Walczak, *The Role of JCAH in Assuring Quality Care*, in HOSPITAL QUALITY ASSURANCE 49 (1984). The resolution recognized that such a system would provide patients with a mechanism with which they could recognize better facilities and would provide physicians with an incentive to improve the overall quality of health care services.

[17] Codman reassessed the health status of patients at least one year following hospitalization and compared that result with the actual treatment rendered. The cases with inconsistent or unsuccessful results were studied for causal connections. Codman, *The Product of a Hospital*, 18 SURGERY, GYNECOLOGY, AND OBSTETRICS 491 (1914).

[18] A more complete history of the ACS is provided in Gosfield, *supra* note 15, at 554-55.

[19] *See* Shanahan, *The Quality Assurance Standard of the JCAH: A Rational Approach to Patient Care Evaluation*, in ORGANIZATION AND CHANGE IN HEALTH CARE QUALITY ASSURANCE 21, 23 (1983).

[20] *Id.* (quoting the 1918 ACS *Minimum Standard* report).

[21] The JCAH was composed of members of the American College of Surgeons, the American Hospital Association, the American Medical Association, the American College of Physicians, and the Canadian Medical Association. Maxwell, Hardie, Rendall, Day, Lawrence, & Walton, *Seeking Quality*, THE LANCET, Jan. 1, 1983, at 45-48.

[22] JCAH, ACCREDITATION MANUAL FOR HOSPITALS, Introduction at VII (1978); Gosfield, *supra* note 15, at 555 n.36.

[23] JCAH, STANDARDS FOR HOSPITAL ACCREDITATION (1953).

[24] By 1965, 84% of the hospital beds in the United States were in hospitals accredited by the JCAH. C. EISELE, THE MEDICAL STAFF IN THE MODERN HOSPITAL (1967); Dunn & Holbrook, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance*, 16 WASHBURN L.J. 54, 58 (1976).

There are two sources from which quality review committees may arise. First, the JCAH requires that accredited institutions establish mechanisms to review qualifications and performance of their medical staffs.[25] Second, in some jurisdictions the law has imposed a duty on hospital governing bodies to maintain a system of continuing review.[26] It is noteworthy that state courts and legislatures have merely affirmed the position of the JCAH that a hospital must establish quality review committees in order to fulfill the duty of its governing body to protect the public from incompetent physicians.[27] Hospitals have responded by establishing some form of quality review.

Peer review committees seek to monitor and evaluate the quality of patient care. This is accomplished by reviewing patient records that in-

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One major reason for the acceptance of the JCAH standards is that the federal government grants all hospitals accredited by JCAH a presumption of compliance with the Medicare-Medicaid *Conditions of Participation.* 42 U.S.C. § 1395(bb)(a)(1) (1976). The *Conditions of Participation* under 42 C.F.R. § 405.1020 are binding upon hospitals seeking government reimbursement. 42 U.S.C. § 1395x(e)(9). In 1983, the U.S. Department of Health and Human Services published proposed new *Conditions of Participation* [48 Fed. Reg. 299 (Jan. 4, 1983) (to be codified at 45 C.F.R. Parts 405, 480, and 482 through 488)] in order to simplify, combine, and relax the old *Conditions of Participation.* ASPEN SYSTEMS CORP. HEALTH LAW CENTER, HOSPITAL LAW MANUAL, ADMINISTRATOR'S VOLUME 1A, 10 (1959, updated 1984) [hereinafter ASPEN SYSTEMS].

Second, other state and federal programs may recommend or even require JCAH accreditation. *Id.* at 11 n.24 and accompanying text. Further, the prestige associated with accreditation has been a motivating force for hospitals to comply with the JCAH. *Id.*

[25] The JCAH duty to review is set forth in JCAH, ACCREDITATION MANUAL FOR HOSPITALS (1985), *Medical Staff Standards,* Standard VI (effective for survey purposes July 1, 1984, and for accreditation purposes, Jan. 1, 1985); ASPEN SYSTEMS, *supra* note 24, at 11. The Aspen Systems Manual states: "As a part of the hospital's quality assurance program, the medical staff strives to assure the provision of high-quality patient care through the monitoring and evaluation of the quality and appropriateness of patient care." JCAH accreditation is based on conformity with these standards, and noncompliance could result in the loss of accredited status.

Also, the *Conditions of Participation* explicitly require such review. 42 C.F.R. § 405.1020. *See also* ASPEN SYSTEMS, *supra* note 24, at 10.

[26] Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966); *See* Ludlam, *The Impact of the Darling Decision upon the Practice of Medicine and Hospitals,* 11 FORUM 756 (1976).

[27] For a complete discussion of the duty of hospitals to maintain a competent medical staff, *see infra* notes 60-88 and accompanying text.

Medical Staff Standard I of the JCAH, *supra* note 25, requires that:

> There is a single organized medical staff that has overall responsibility for the quality of the professional services provided by individuals with clinical privileges, as well as the responsibility of accounting therefore to the governing body. There is a mechanism to assure that all individuals with clinical privileges provide services within the scope of individual clinical privileges granted.

See also JCAH, HOSPITAL ACCREDITATION REFERENCES 13 (1964), stating: "The governing body must assume the legal and moral responsibility for the conduct of the hospital as an institution. It is responsible to the patient, the community, and the sponsoring organization."

dicate serious or unexpected complications[28] and by reviewing randomly selected medical records.[29] The committee may simply choose one of these review methods, depending upon the scope of the individual committee.[30] Generally, a case will not be reviewed unless the patient has developed complications during hospitalization.[31] Peer review committees are composed exclusively of the hospital's staff physicians.[32]

Peer review proceedings are likely to contain evidence material to a malpractice claim. The JCAH encourages several types of quality review[33] that may be desired by an injured patient,[34] but most states have enacted legislation making the minutes and memoranda of these committees immune from discovery.[35] Understandably, peer review committee participants would be reluctant to testify candidly when confronted with the possibility of malpractice claims against the physician whose prac-

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[28] For example, tissue committees which essentially are surgical peer review committees, review surgical records in which the pre-operative and post-operative diagnosis evidence a major discrepancy. Butler, *Hospital Peer Review Committees: Privileges of Confidentiality and Immunity*, 23 S. TEX. L.J. 45, 48 (1982); Dunn & Holbrook, *supra* note 24, at 61-62.

Medical audit committees examine records of patients that die under peculiar circumstances, *e.g.*, within twenty-four hours after admission or as a result of cerebral hemorrhage. Dunn & Holbrook, *supra* note 24, at 60-61. These records are analyzed to discover whether the physician acted in a professionally competent manner. *Id.*

[29] *See* Fifer, *Integrating Quality Assurance Mechanisms*, in ORGANIZATION AND CHANGE IN HEALTH CARE QUALITY ASSURANCE 217, 221 (1983).

[30] The scope of each hospital review committee is defined in the bylaws of that hospital. The JCAH requires these bylaws. *See* JCAH MANUAL, *supra* note 7, at 106.

[31] Bower, *Discovery of Peer Committee Review Reports in Medical Malpractice*, 1983 TRIAL LAW. Q., at 55, 57.

[32] Physicians are in the best position to organize and maintain peer review committees. ASPEN SYSTEMS, *supra* note 24; Fifer, *supra* note 29, at 220; Hetherington, *Quality Assurance and Organization Effectiveness in Hospitals*, in ORGANIZATION AND CHANGE IN HEALTH CARE QUALITY ASSURANCE 75 (1983). Consequently, staff physicians are minimally controlled. In fact, they are given a great deal of power and independence. ASPEN SYSTEMS, *supra* note 24; Hetherington, *supra* note 32 at 76.

[33] JCAH encourages hospitals to maintain the following quality review committees: tissue review, pharmacy and therapy review, medical record review, review of the clinical use of antibiotics, and review of "other patient-related professional activities." JCAH, *supra* note 30, at 106-08.

[34] For example, credentials committees are quality review committees which often may be of interest to malpractice plaintiffs. Butler, *supra* note 28, at 48. In corporate negligence cases, *see infra* notes 60-68, the information compiled by a credentials committee may be quite helpful.

[35] *See supra* note 4. Also, legislatures in a number of states have enacted statutes that limit the liability of those engaged in medical review activities. These statutes are designed to assure peer review participants that they are protected from suits brought by disgruntled physicians alleging libel, defamation, and interference with professional relationships. *See supra* note 14.

tice is the subject of review.[36] Shields from peer review discovery effectively side-step such confrontations, but in so doing, the committees function as a form of unchecked self-review.[37] As such, committee physicians tend to explain away behavior of their peers.[38] Therefore, plaintiffs suing hospitals for negligent review often espouse weighty public policy arguments in favor of discovery.

II. CONFIDENTIALITY AND THE HOSPITAL'S DUTY

State statutes that prevent discovery of peer review committee proceedings are, for the most part, a product of the medical malpractice crisis.[39] The American Hospital Association and other medical societies that are represented by the JCAH continue to provide influential support for such statutory discovery bars.[40] These statutes create a qualified[41] legal privilege of confidentiality. Although most jurisdictions have already enacted some form of this legislation, further developments regarding the scope of the privilege in each state are inevitable.[42]

The public policy supporting confidentiality of peer review committee proceedings was stated in *Bredice v. Doctors Hospital, Inc.*[43] There, the District of Columbia district court denied the plaintiff's motion for the production of minutes and reports of any Board or Committee of the hospital or its staff concerning the death of a patient. The *Bredice*

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[36] This argument was judicially accepted in *Bredice*, 50 F.R.D. at 250.

[37] Some authorities contend that physicians are in the best position to review the staff. Hetherington, *supra* note 32, at 75.

[38] *See infra* notes 33 and 68 and accompanying text.

[39] For a discussion of the "medical malpractice crisis" of the 1970's, see Aitken, *Medical Malpractice: The Alleged "Crisis" in Perspective*, 1976 INS. L.J. 90 (1976); Berger, *The Medical Malpractice Crisis: How One State Reacted*, 11 FORUM 64 (1975); Sheehan, *Medical Malpractice Crisis in Insurance: How It Happened and Some Proposed Solutions*, 11 FORUM 80 (1975).

In most jurisdictions, statutes protecting peer review proceedings from discovery were passed during this time period. *See, e.g.*, OHIO REV. CODE ANN. § 2305.251 (Baldwin 1985).

[40] Confidentiality is critical to an effective quality assurance program. AHA POLICY AND STATEMENT, QUALITY ASSURANCE IN HEALTH CARE INSTITUTIONS (1978) (Available at the American Hospital Ass'n, Chicago, Ill.).

[41] In most jurisdictions, there are statutory exceptions to the peer review committee discovery protection. Also, courts vary in their interpretations of the statutes. *See infra* notes 52-58.

[42] *See* Springer, *The Conflicting Legal Pressures on the Modern Hospital*, 14 N.C. CENT. L.J. 82, 92 (1983). The body of law creating statutory peer review protective statutes "is still in its infancy and is undeveloped and often unpredictable." *Id.* According to Springer, the discoverability controversy will endure because "the pressure for disclosure will continue and even mount." *Id.* at 94.

[43] 50 F.R.D. 249 (D.D.C. 1970).

court held that (1) the plaintiff had not shown "good cause"[44] for the discovery of committee records[45] and (2) that the plaintiff's motion was against public policy. The court expounded:

> Confidentiality is essential to effective functioning of these staff meetings; and these staff meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. 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.[46]

A few courts have specifically rejected the *Bredice* rationale in favor of more liberal discovery rules[47] and/or the desire to provide the judicial system with the best evidence.[48] In response to decisions declaring peer review proceeding minutes or memoranda subject to discovery, many state legislatures have drafted statutes protecting peer review records.[49]

The language of peer review protection legislation varies from state to state.[50] The intent of the legislature is frequently unclear.[51] State courts

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[44] *Id.* at 251.

[45] The court stated:

> 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. . . . These committee meetings, being retrospective with the purpose of self-improvement, are entitled to a qualified privilege on the basis of this overwhelming public interest.

Id.

[46] *Id.* at 250.

[47] *See, e.g.*, Kenney v. Superior Court, 255 Cal. App. 2d 106, 63 Cal. Rptr. 84 (1967) (information sought should be disclosed if it will assist the plaintiff's preparation for trial).

[48] *See, e.g.*, Nazareth Literary and Benevolent Institution v. Stephenson, 503 S.W.2d 177 (Ky. 1973) (finding public policy favors disclosure as long as the information sought is relevant to the subject matter of the action).

[49] *See, e.g.*, KAN. STAT. ANN. § 65-4915 (1985), which was adopted after the court's decision in Wesley Medical Center v. Clark, 234 Kan. 13, 669 P.2d 209 (1983).

[50] N.H. REV. STAT. ANN. § 329:29 (Supp. 1985) provides a broad privilege. *See infra* note 56 and accompanying text.

On the other hand, some peer review protection statutes have an extremely limited scope. N.J. STAT. ANN. § 2A:84A-22.8 (West 1979) only exempts "utilization review committees." Hence, the privilege has been narrowly construed so that discovery of several types of peer review committees, including tissue committees, has been permitted. Young v. King, 136 N.J. Super. 127, 344 A.2d 792 (1975).

[51] For example, no legislative history is available for OHIO REV. CODE ANN. § 2305.251 (Baldwin 1985).

interpreting peer review shield statutes have found several exceptions to the general rule of non-discovery.[52] Some state legislation expressly provides for such exceptions.[53] Generally, the exceptions focus on either the character of the material sought[54] or the status of the proponent of the material sought in the discovery.[55] Some statutes simply forbid the discovery of all quality review committee reports. For example, New Hampshire's non-discovery legislation states:

> All proceedings, records, findings and deliberations of medical review committees . . . are confidential and privileged and shall not be used or available for use or subject to process in any other proceeding. The manner in which a medical review committee and each member thereof deliberates, decides or votes on any matter submitted to it is likewise confidential and privileged and shall not be the subject of inquiry in any other proceeding.[56]

State legislatures rarely include clauses that permit discovery upon a showing of exceptional need.[57] The inequity of omitting this type of provision[58] is apparent in the area of corporate negligence.[59] Under this

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[52] *See, e.g.*, Kalish v. Mount Sinai Hosp., 270 N.W.2d 783 (Minn. 1978).

[53] *See, e.g.*, NEV. REV. STAT. § 49.265 (1981).

[54] *See, e.g.*, Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976).

[55] *See, e.g.*, NEV. REV. STAT. § 49.265 (1981).

[56] N.H. REV. STAT. ANN. § 329:29 (Supp. 1985).

[57] However, a few jurisdictions do provide such a clause. For example, the Nebraska statute states:

> The proceedings, minutes, records, and reports of any medical staff committee . . . together with all communications originating in such committees are privileged communications which may not be disclosed or obtained by legal discovery proceedings *unless* . . . a court of record, after a hearing and *for good cause arising from extraordinary circumstances being shown*, orders the disclosure. . . .

NEB. REV. STAT. § 71-2408 (1981) (emphasis added).

For other examples refer to D.C. CODE ANN. § 32-505 (1981); ME. REV. STAT. ANN. tit. 32, § 3296 (1978); VA. CODE § 8.01-581.17 (1984).

[58] Sissella Bok notes that "[s]ecrecy preserves liberty, yet this very liberty allows the invasion of that of others." S. BOK, SECRETS 28 (1983). Confidentiality has thus "become a means for covering up a multitude of questionable and often dangerous practices." *Id.* at 133.

Most peer review shield laws are not drafted in keeping with traditional legal standards for creating a privilege. *See* Dunn & Holbrook, *supra* note 24, at 66. According to Professor Wigmore, four conditions are necessary to justify the creation of a privilege:

> (1) The communications must originate in a *confidence* that they will not be disclosed;
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> (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.

theory, a hospital may be held liable for negligently retaining an incompetent physician on the hospital medical staff.

The doctrine of corporate negligence is a relatively new development.[60] Its growth can be attributed to the increasingly active role that hospitals play in monitoring and controlling the quality level of patient medical care. The duty to review physician treatment arises from the common law,[61] JCAH,[62] hospital bylaws,[63] and state statutes.[64] Prior to this cause of action, plaintiffs who brought malpractice suits could only successfully sue hospitals under the doctrine of respondeat superior or the theory of negligent hiring of a physician. In many jurisdictions, injured patients were totally barred from recovery against hospitals by charitable or governmental immunity statutes. The ability to sue hospitals provides plaintiffs with several advantages,[65] the most important of which is access to the hospital's "deep pocket."

Only if these four conditions are present should a privilege be recognized. 8 WIGMORE, EVIDENCE § 2285 (McNaughton rev. ed. 1961).

Arguably, the application of peer review shield statutes does not comply with the fourth condition. In the context of the physician-patient privilege, the majority opinion in Tarasoff v. Regents of University of California, 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976) (holding psychiatrist liable for acts of insane patient), stated "the privilege ends where the public peril begins." *Id.* at 441, 551 P.2d at 347, 131 Cal. Rptr. at 27.

[59] Corporate negligence is also referred to as "institutional liability." *See* Springer, *supra* note 42, at 90.

[60] Hollowell, *Does Hospital Corporate Liability Extend to Medical Staff Supervision?*, 32 DEFENSE L.J. 203, 204-05 (1983).

[61] The courts of thirteen states have expressly recognized corporate negligence. Tucson Medical Center, Inc. v. Misevch, 113 Ariz. 34, 545 P.2d 958 (1976); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); Kitto v. Gilbert, 39 Colo. App. 374, 570 P.2d 544 (1977); Mitchell County Hosp. Auth. v. Joiner, 229 Ga. 140, 189 S.E.2d 412 (1972); Darling v. Charleston Community Memorial Hosp., 33 Ill. 2d 326, 211 N.E.2d 253 (1965); Johnson v. St. Bernard Hosp., 79 Ill. App. 3d 709, 35 Ill. Dec. 364, 399 N.E.2d 198 (1979); Ferguson v. Gonyaw, 64 Mich. App. 685, 236 N.W.2d 543 (1975); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Bost v. Riley, 44 N.C. App. 638, 262 S.E.2d 391 (1980); Corleto v. Short Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975); Hannola v. City of Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980); Johnson V. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

[62] Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

[63] Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).

[64] Wesley Medical Center v. Clark, 234 Kan. 13, 669 P.2d 209 (1983).

[65] By suing the hospital, an injured patient may avoid the necessity of expert testimony by another physician as to the professional standard of care. Some states only subject hospitals to the standard of a reasonable man as opposed to the professional standard used for doctors. As such, the plaintiff can avoid the so called "conspiracy of silence." Second, jurors may not be as reluctant to find against a hospital as they might be for a physician. Third, the statute of limitations may be longer for hospitals. Annotation, *Hospital's Liability for negligence in Failing to Review or Supervise Treatment Given by Doctor, or to Require Consultation*, 12 A.L.R. 4th 57, 63 (1982).

Corporate negligence liability serves an exceptionally important public need. According to one commentator, "[ten] percent of health care practitioners are so marginal in their performance as to be (to use Nader's catchy phrase) unsafe at any speed."[66] Although state statutes providing immunity from committee member liability and record discovery stimulate candor, few hospitals successfully maintain truly efficient peer review committees.[67] When physicians are faced with reviewing their fellow professionals, the tendency is to explain away behavior.[68] As a result, patients are seriously, and sometimes fatally injured by incompetent physicians. Potential institutional liability will stimulate more effective physician self-review.

Generally, a hospital breaches its institutional duty if its peer review committee (1) fails to review[69] a physician who should have been reviewed, or (2) fails to report inadequate treatment to the proper hospital authorities.[70] In short, the hospital is held accountable if its mechanisms for review are negligent. Recently, a Wisconsin court reasoned:

> The complex manner of operation of the modern day medical institution clearly demonstrates that they furnish far more than

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[66] Fifer, *supra* note 29, at 220.

[67] Dr. Springer notes:

> It has been my experience in my practice to work with a good number of dedicated medical staff leaders who were firm, fair and effective in enforcing medical staff disciplinary procedures. However, most hospitals are often unable to obtain or retain quality leadership over long periods of time. Presently there is no system in any hospital which ensures the consistency of quality medical staff leadership.

Springer, *supra* note 42, at 89.

[68] *See* Hetherington, *supra* note 32, at 77 ("Too often . . . the members of organized medical staffs see themselves as defenders of the medical profession."); Springer, *supra* note 42, at 89. *See also* Fifer, *supra* note 29, at 221 stating:

> [M]any physicians decry the need to evaluate the quality of professional performance, saying "we all know that 10 percent of the doctors in this hospital (this society, this city, this state) could not take care of your cat, and, further, we all know who they are . . .!" Lacking objective criteria or even some consensus among various reviewers, the judgment of "goodness" hinges on "whether I would have done it that way."

Other motivating factors to explaining away behavior include: the tendency to avoid "red tape," Hetherington, *supra* note 32, at 74; and the fear of disgruntled physicians retaliating against committee action by suing under theories of lack of procedural due process, Springer, *supra* note 42, at 89-90; or discrimination, Annotation, *Hospital's Liability for Negligence in Selection or Appointment of Staff Physician or Surgeon*, 37 A.L.R.3d 645 (1971).

[69] State supreme courts which have dealt with the subject unanimously hold that this duty to review does not include the duty to supervise actual physician treatment. *See generally* Hollowell, *supra* note 60. However, one California lower court found a hospital duty to supervise actual physician treatment. Gonzalez v. Nork and Mercy Hospital, No. 228566 (Cal. Super., Nov. 19, 1973), *rev'd on other grounds*, 60 Cal. App. 3d 770, 131 Cal. Rptr. 717 (1976), *aff'd and transferred*, 20 Cal. 3d 437, 573 P.2d 458, 143 Cal. Rptr. 240 (1978).

[70] Annotation, *supra* note 65, at 62.

> mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons . . . and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid. Certainly, the person who avails himself of our modern "hospital facilities". . . does not anticipate that its . . . doctors . . . will be acting solely on their own responsibility.[71]

The landmark corporate negligence case is *Darling v. Charleston Community Memorial Hospital*[72] In *Darling*, a physician seriously injured a child's leg while removing a cast. The injury resulted in a later partial amputation of the child's limb. The *Darling* court rejected the argument that the hospital could not control physician care and was the first high court to recognize the principle that the hospital governing body "is an apex from which authority flows and to which responsibility returns."[73] The result of the decision was that hospitals were charged with the duty to exercise reasonable care in the selection, review, and supervision of their staffs.[74] The *Darling* decision stopped short of defining corporate negligence in detail. Since the court found that the defendant physician was a hospital employee, the opinion did not address the issue of whether the hospital's liability was also dependent upon that employment status.[75] Second, the court failed to define the point at which a hospital's duty ends.[76] Therefore, although the impact of the decision was significant, *Darling* has been given limited precedential weight.[77]

Purcell v. Zimbelman[78] clarifies those areas of corporate negligence left untouched in *Darling*. In *Purcell*, the plaintiff alleged that the defendant physician negligently performed rectal surgery. There had been several other suits filed against the same doctor with similar allegations. The *Purcell* court held that (1) a finding of corporate negligence liability is not dependent upon a hospital-physician employment relationship and

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[71] Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156, 164 (1981).

[72] 33 Ill. 2d 326, 211 N.E.2d 253 (1965).

[73] ASPEN SYSTEMS, *supra* note 24.

[74] Hollowell, *supra* note 60, at 204.

[75] Comment, *Patient Recovery A Poor Prognosis for Hospitals? The Expanding Scope of Hospital Liability*, 10 OHIO N.U.L. REV. 519, 534 (1983).

[76] Hollowell, *supra* note 60, at 204.

[77] Illinois cases decided since *Darling* have limited the scope of corporate negligence. *See, e.g.*, Stogsdill v. Manor Convalescent Home, Inc., 35 Ill. App. 3d 634, 343 N.E.2d 589 (1976) (duty of hospital arises only where an employment relationship is found). *See infra* note 82.

[78] 18 Ariz. App. 75, 500 P.2d 335 (1972).

that (2) a hospital has the "duty of supervising the competence" of staff physicians,[79] as opposed to the duty of supervising actual treatment by those doctors. The *Purcell* limitations represent the purest form of corporate negligence.[80] Although several state courts have adopted "pure corporate negligence,"[81] other jurisdictions recognize some variety of the doctrine.[82]

Standards published by the JCAH or medical staff bylaws promulgated by the hospital may be used by malpractice plaintiffs to establish corporate liability. The JCAH requires that accredited hospitals conform to its standards and establish minimum hospital bylaws.[83] These standards and hospital bylaws have been used to establish the hospital's standard of care in selecting or retaining members of the medical staff.[84] Proof of noncompliance with either the JCAH standards or the hospital's bylaws may be damaging evidence of a breach of the hospital's standard of care.[85]

State statutes and administrative agency regulations may be used to establish corporate negligence liability. Some hospital licensure statutes simply place the overall responsibility for hospital patient care upon the hospital's governing body.[86] Others expressly provide that the hospital's governing entity is solely responsible for the actual selection and review of staff physicians.[87] Regulations promulgated pursuant to state legislation often detail the hospital's duty to hire, limit, and review its medical staff.[88] These state regulations have been used to define the hospital's standard of care.

Peer review minutes and memoranda can be crucial to a finding of institutional liability. In cases where a hospital's alleged misconduct involves an omission the hospital will not be held liable unless it can be estalished that the actions taken by it against a staff physician, whether in the form of suspension, remonstration, restrictions, or other means, were insufficient under the circumstances of the case. It is difficult for a malpractice plaintiff to show that a defendant hospital has breached

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[79] *Id.* at 81, 500 P. 2d at 341.

[80] Hollwell, *supra* note 60, at 210; Comment, *supra* note 75, at 537-38.

[81] *See, e.g.*, Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.W.2d 156 (1981).

[82] For example, the Illinois courts have reduced hospital corporate negligence to no more than respondeat superior. Comment, *supra* note 75, at 538 n.123.

[83] JCAH, MANUAL *supra* note 7, *Medical Staff*, Standard IV Interpretation at 106.

[84] Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975); Pederson v. Dumouchel, 72 Wash. 2d 73, 431 P.2d 973 (1967).

[85] In addition, the loss of accreditation could occur.

[86] *See, e.g.*, WIS. STAT. ANN. § 50.36 (West Supp. 1986).

[87] *See, e.g.*, MICH. COMP. LAWS § 33.21513 (1978).

[88] *See, e.g.*, FLA. ADMIN. CODE § 10D-28.58, implementing FLA. STAT. § 395.11 (1947); OKLA. HOSPITAL LICENSURE REGS., Part Two, A, 3, State Department of Health, Licensure and Certification Div. (April 17, 1976); ASPEN SYSTEMS, *supra* note 24, *Medical Staff* at 8-9.

its duty to review physician staff privileges unless the plaintiff first obtains records of that review. Most states do not provide a discovery exception for an injured patient who sues a hospital, even when he can show an exceptional need for such discovery.[89] The presence of an "extraordinary necessity" exception would trigger in camera proceedings[90] to decide whether the need for disclosure was justifiable.[91]

When a discovery exception for a showing of extraordinary need is absent from state peer review shield legislation, unfair legal results are inevitable. For example, until recently, Arizona's peer review confidentiality statute[92] reserved trial court power to order hospital disclosure of peer review committee records. It is clear that the drafters intended to permit discovery of some peer review documents in some situations, but the statutory description of protected committee records was unclear. The statute read, in part: "the information considered by the (peer review) committees is subject to subpeona but shall be delivered by the custodian only to the judge in a judicial proceeding, who shall review such information. . . ."[93]

This legislation was interpreted by the Supreme Court of Arizona in the context of a corporate negligence action. In *Tucson Medical Center, Inc. v. Misevch*,[94] plaintiff alleged that the defendant physician was intoxicated and falling asleep while he was operating on plaintiff's wife. Subsequently, she suffered from brain damage and cardiac arrest, and

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[89] *See supra* note 42 and accompanying text. In the four jurisdictions (District of Columbia, Maine, Nebraska, and Virginia) that do have such a clause, there is no reported case law allowing discovery of peer review committee records. *See supra* note 57. Further, none of the four jurisdictions recognize corporate negligence as a cause of action. It is likely that a court would allow discovery if faced with a corporate negligence case in a state with a statutory clause which allows discovery after a showing of exceptional necessity. Wesley Medical Center v. Clark, 234 Kan. 13, 669 P.2d 209 (1983). *See supra* note 11 and accompanying text.

[90] In camera proceedings provide a trial judge with discretionary power to allow portions of otherwise protected material to be discoverable.

[91] The right to disclose a portion of otherwise privileged information has developed over centuries. Catholic theologians allowed doctors to reveal only "so much of the secret as (was) necessary to avert the harm, and only to the person threatened, who (had) a right to this information, rather than to . . . the curious or the gossip-hungry at large." BOK, *supra* note 58, at 130.

[92] ARIZ. REV. STAT. § 36-445.01 (1986). In 1982, the Arizona legislature amended the statute to read:

> All proceedings, records, and materials prepared in connection with . . . peer review . . . and the records of such reviews . . . shall be confidential and shall not be subject to discovery. . . . In any legal action brought against a hospital licensed pursuant to this chapter claiming negligence for failure to adequately do peer review, representatives of the hospital are permitted to testify as to whether there was peer review as to the subject matter being litigated.

[93] ARIZ. REV. STAT. § 36-445.01 (1986).

[94] 113 Ariz. 34, 545 P.2d 958 (1976).

later died. The Arizona court held that Tucson Medical Center and its governing body could be held liable for injuries resulting from that physician's negligent administration of anesthesia.[95] The high court established (1) a duty to supervise the competence of staff doctors and, (2) a duty to act by limiting or terminating staff privileges[96] if the physician could pose an unreasonable risk to patients.

Even though the *Misevch* court established corporate negligence in Arizona, the supreme court's holding placed the plaintiff at a tremendous disadvantage on remand. The court interpreted the state peer review discovery statute to limit the scope of documents available to the plaintiff by distinguishing between factual findings of the committee and information considered by the committee. The court remanded the case to the trial court with instructions that: "[T]he proper demarcation is between purely factual, investigative matters and materials which are the product of reflective deliberation. . . . Statements and information considered by the committee are subject to subpeona for the determinations of the trial judge, but the reports and minutes of the medical review committees are not."[97]

The Arizona statute provides for automatic in camera proceedings, but the court's approach is unreliable. Evidence gathered by a peer review committee and findings of that committee are equally important. A committee finding is just as likely to contain evidence of corporate negligence liability as are facts presented to the peer review committee. The statute erroneously implies that disclosure of committee findings is much more injurious to effective and candid peer review than is discovery of committee evidence. As a result trial courts will concentrate exclusively upon an input-output distinction in order to make a discovery decision. They will favor defendants because the evidence of a hospital staff's duty to report committee findings will be insufficient. The *Misevch* discovery holding is a result of the vague wording and rationale behind the Arizona statute.

In 1970, when *Bredice v. Doctors Hospital, Inc.*[98] espoused the public policy rationale in favor of peer review committee record confidentiality, the opinion still carefully noted that in certain situations the public

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[95] *Id.* at 36, 545 P.2d at 960.

[96] The court relied on Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d 335 (1972), and concluded:

> If the medical staff was negligent in the exercise of its duty of supervising its members or in failing to recommend action by the hospital's governing body prior to the case in issue, then the hospital would be negligent. . . . When the hospital's alleged negligence is predicated on an ommission to act, the hospital will not be held responsible unless it had reason to know that it should have acted within its duty to the patient to see to it that only professionally competent persons were on its staff.

Tucson Med. Center, 113 Ariz. at 36, 545 P.2d at 960.

[97] 113 Ariz. 34, 545 P.2d at 961.

[98] 50 F.R.D. 249 (D.D.C. 1970).

interest would best be served by allowing discovery. The *Bredice* court held that peer review committee minutes and reports concerning a malpractice plaintiff were not discoverable, but the information was entitled to a "qualified" privilege that could be overridden by a showing of "exceptional necessity" or "extraordinary circumstances."[99] Clearly, current state review confidentiality legislation has not been responsive to the fundamental scope of the privilege as espoused in *Bredice*.

The language of a state peer review confidentiality statute should compel a two step trial court process. First, it should mandate in camera proceedings upon a showing of just cause. To determine whether "just cause" exists, a trial judge should consider the importance of the information to the plaintiff's case as well as the difficulty that the proponent will encounter in acquiring equivalent information.[100] Second, the statute should guide in camera consideration so that an exception to non-discovery is granted only where the value to the litigation outweighs the value of confidentiality.[101] A discovery request should be granted when the need for peer review information is so important that public policy favors disclosure in light of the widely recognized importance of peer review committee confidentiality. Except in corporate negligence cases, a malpractice plaintiff will rarely be able to exhibit the requisite need to justify disclosure. Therefore, information should be disclosed only after a showing of "exceptional necessity."[102] A corporate negligence plaintiff's need would pass the "exceptional necessity" test when the defendant physician has a recurrent history of professional negligence complaints. As a result, peer review committee candor would only be sacrificed in exceptional cases.

The trial judge should disclose only those records relating to whether the peer review committee knew or should have known that the physician was (1) incompetent to practice medicine, or (2) unfit to operate, diagnose or treat patients in the specific area that the plaintiff was injured. Again, the need for discovery should be weighed against the need for confidentiality before any information is revealed.

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[99] *Id.* at 250-51.

[100] Professor Moore recommends these two considerations to aid in determining whether "just cause" exists in the context of FED. R. CIV. P. 26(B)(3), which relates to the discovery of attorney work product information. MILLIGAN, OHIO FORMS OF PRACTICE & PLEADING at 26-74 (1984). Like an attorney's work product, the product of a peer review committee is sensitive material that should not be freely disclosed.

[101] *See* WIGMORE, *supra* note 58.

[102] By using the phrase "exceptional necessity," only worthy proponents will have access to peer review committee information. Here, a mere showing of "just cause" might lead some courts to require little more than relevance for the production or discovery of peer review information.

III. Peer Review Discovery In Ohio

In 1975, the Ohio legislature adopted Ohio Revised Code Section 2305.251 which is a typical peer review confidentiality statute which provides that

> Proceedings and records of all peer review committees . . . shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care professional or institution arising out of matters which are the subject of evaluation and review by such committee. No person within attendance at a meeting of such committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings or such committee, or as to any finding, recommendation, evaluation, opinion, or other action of such committee or member thereof. Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented during proceedings of such committee nor should any person testifying before such committee or who is any member of such committee be prevented from testifying as to matters within his knowledge, but the witness cannot be asked about his testimony before such committee or opinion formed by him as a result of any such committee hearing.[103]

Ohio courts have upheld the statute's constitutionality,[104] and have held that even physicians may not discover peer review information.[105] In 1981, the Ohio Court of Appeals held that where a party opposes the introduction of peer review evidence, "it is incumbent upon the trial court to hold an in camera inspection of the information, documents, or records in question and to question the witness as to the nature of his testimony,"[106] but discovery of all peer review information was prohibited by the statute. Therefore, Ohio common law provides for in camera proceedings, but the trial judge has little power to release any peer review information.

Ohio's recognition of hospital corporate negligence stems from Ohio common law, Ohio legislation, and accepted hospital standards. In *Hannola v. City of Lakewood*,[107] the plaintiff sued Lakewood Hospital alleging

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[103] Ohio Rev. Code Ann. § 2305.251 (Baldwin 1985). Section 2305.251 applies to the following committees: utilization review, tissue review, peer review, and committees reviewing professional qualifications, activities of its medical staff, and applicants for admission.

[104] *See* Gates v. Brewer, 2 Ohio App. 3d 347, 442 N.E.2d 72 (1981); Young v. Gersten, 56 Ohio Misc. 1 (1978).

[105] *See* Atkins v. Walker, 65 Ohio App. 2d 136, 416 N.E.2d 651 (1979).

[106] *Gates*, 2 Ohio App. 3d at 351, 442 N.E.2d at 77.

[107] 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

that her husband died as a result of the negligence of a staff physician in the hospital's emergency room. The Ohio Court of Appeals cited traditional corporate negligence cases and recognized an independant hospital duty to protect hospital patients from staff physicians' negligence.[108]

Ohio legislation and the JCAH may also be used to establish hospital corporate negligence liability. The Ohio Revised Code requires every hospital governing body to maintain standards that define staff physician competence.[109] This statute has been interpreted to establish a hospital duty to adopt standards that measure professional staff skill and competence.[110] Also, JCAH accredited Ohio hospitals must utilize peer review committees to monitor and evaluate the quality of patient care provided by their staff physicians.[111] The JCAH requirements have become a national standard for accredited hospitals. At least, the Ohio legislation and the JCAH standards are useful to establish the hospital's duty of care.[112] Proof of a breach by the hospital will result in hospital corporate liability.

Although the Ohio peer review statutory shield has been interpreted to trigger in camera proceedings,[113] the scope of the trial judge's power of disclosure is limited. Ohio, like most states,[114] provides no exception for discovery even when the circumstances are such that public policy would favor discovery. Since Ohio courts have already defined the scope of the statute, the state legislature has the sole authority to initiate such an exception.

The most logical approach for the Ohio legislature to follow is to amend section 2305.251. The legislative changes should be minimal so as to avoid legislative overruling of Ohio precedent interpreting the old statute.[115] Ohio courts will continue to interpret the legislation, such as determining when an "extraordinary necessity" exists. The legislature should aid Ohio courts by providing some legislative history. The phrase "absent a showing of extraordinary necessity exhibited in a hearing held for good cause"[116] should be inserted as follows:

> *Absent a showing of extraordinary necessity exhibited in a hearing held for good cause,* proceedings and records of all peer review

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[108] *Id.* at 69, 426 N.E.2d at 1192. The court stated: "A hospital clearly does have a duty to prevent a physician's malpractice at least to the extent that it establishes procedures for the granting of staff privileges and for the review of those privileges." *Id.*

[109] OHIO REV. CODE ANN. § 3701.351 (Baldwin 1985).

[110] *See* Dooley v. Barberton Citizens Hosp., 11 Ohio St. 3d 216, 465 N.E.2d 58 (1984).

[111] *See supra* note 25 and accompanying text.

[112] Shilkret v. Annapolis Emergency Hosp. Ass'n, 276 Md. 187, 349 A.2d 245 (1975).

[113] *See supra* note 106.

[114] Only four jurisdictions provide the exception. *See supra* note 57.

[115] *See supra* notes 104-05, 107 and accompany text.

[116] For the reasoning behind this wording choice, see *supra* notes 100-02 and accompanying text.

> committees . . . shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care professional or institution arising out of matters which are the subject of evaluation and review by such committee. No person within attendance at a meeting of such committee shall be permitted or required to testify in any civil action as to any evidence or other matters produced or presented during the proceedings of such committee, or as to any finding recommendation, evaluation, opinion, or other action of such committee or member thereof *absent a showing of extraordinary necessity exhibited in a hearing held for good cause.* Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented during proceedings of such committee nor should any person testifying before such committee or who is any member of such committee be prevented from testifying as to matters within his knowledge, but the witness cannot be asked about his testimony before such committee or opinion formed by him as a result of any such committee hearing *absent a showing of extraordinary necessity exhibited in a hearing held for good cause.*[117]

Plaintiffs suing under a hospital corporate negligence theory are the most likely discovery proponents to display a need so important that public policy favors disclosure in light of the well recognized importance of peer review committee confidentiality. Therefore, adoption of the suggested discovery exception would promote Ohio hospital corporate liability.

IV. Conclusion

In summary, the confidentiality of peer review committee minutes and memoranda has been instrumental in the growth of peer review which has, in turn, lead to improved hospital care. It is clear that there is a strong public interest in promoting proper limitations on hospital staff privileges for incompetent physicians. Where a hospital governing body maintains strict review mechanisms for the granting, limiting, and terminating of staff privileges, corporate negligence liability is unlikely.

The threat to hospitals of potential liability will result in improved health care. Corporate negligence liability will generally occur where hospital review and reporting is ineffective. In this respect, hospital corporate negligence is an effective tool to curb malpractice. The financial threat of the imposition of civil liability upon a hospital provides an incentive for hospitals to adopt policies ensuring tougher qualification and

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[117] Ohio Rev. Code Ann. § 2305.251 (Baldwin 1985) (insertions emphasized).

review standards. However, the privilege of confidentiality should not hinder a plaintiff's cause of action for inadequate review. Most state peer review committee shield laws can create evidentiary barriers to corporate negligence liability. Although the need for peer review confidentiality is well accepted, the public is better served by disclosure in cases where extraordinary need for peer review information exists.

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