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Comment

MEDICAL PEER REVIEW: THE NEED TO ORGANIZE A PROTECTIVE APPROACH

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INTRODUCTION

EFFECTIVE MEDICAL PEER review consists of monitoring, correcting and improving patient care activities, even though they may already meet existing standards. Hospital-based physicians should and presently do dominate peer review activities because they have access to pertinent information and are in a position to issue appropriate sanctions. Most physicians may not know this, though they may appreciate the significance of increasing governmental intrusion into the peer review process. Unless physicians can offer credible evidence of their own management, external organizations will usurp control, by setting standards of practice and initiating extra-medical systems for monitoring practice activities.

Physicians are concerned that effective peer review is based on the accumulation and analysis of information about their performance. They are uncomfortable about creating the very ammunition others will use against them. Several years ago, courts opened the flood gates to malpractice plaintiffs by allowing them access to peer review information.[1] Since then, most state legislatures have enacted special rules to protect both committee data and its analysis.[2]

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1. *See*, e.g. Kinney v. Super. Ct., 255 Cal. App. 2d 106, 109, 63 Cal. Rptr. 84, 87 (1967).

2. ALA CODE § 34-24-58 (1985); ALASKA STAT. § 18.23.030 (1986); ARIZ. REV. STAT. ANN. § 36-445.01 (1987); CAL. EVID. CODE § 1157 (1987); COLO. REV. STAT. § 12-43.6 (1989); CONN. GEN. STAT. ANN. § 38-19a (1987); DEL. CODE ANN. tit. 24 § 1768 (1987); D.C. CODE ANN. § 32-505 (1981); FLA. STAT. ANN. § 766.101 (1988); GA. CODE

In a civil suit, plaintiffs still have access to their own medical information, but not peer review assessments of their physician's care and management.[3] While many medical staff members do not trust the courts to uphold these statutes, others have been oversold on their effectiveness. The purpose of this article is to counsel hospitals and medical staffs that these protective statutes do work when properly enforced.

A SURVEY OF STATUTES

Forty-eight states and the District of Columbia now have statutes that impede discovery, the admissibility of documents and information developed in the hospital and medical staff peer review process in civil litigation.[4] Legislatures developed these statutes because physicians were reticent to subject peer review processes to public scrutiny.[5] For example, California physicians were rudely awakened to their state's liberal discovery rule when an appellate court held that a plaintiff in a medical malpractice suit had substantial fishing rights into a hospital's peer review system.[6] A plaintiff

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ANN. § 31-7-143 (1985); HAW. REV. STAT. § 624-25.5 (1985); IDAHO CODE § 39-1392b (1985); ILL. REV. STAT. ch. 110, para. 8-2102 (1988); IND. CODE ANN. § 34-4-12.6-2 (1986); IOWA CODE § 258A.6 (1988); KAN. STAT. ANN. § 65-4915 (1987); KY. REV. STAT. ANN. § 311.377 (Baldwin 1987); LA. REV. STAT. ANN. § 44:7(D) (West 1982); ME. REV. STAT. tit. 32, § 3296 (1988); MD HEALTH OCC. CODE ANN. § 14-1601(d) (1987); MASS. GEN. LAWS ANN. ch. 111, § 204 (a) (West 1987); MICH. STAT. ANN. § 14.57(23)(Callaghan 1988); MINN. STAT. ANN. § 145.64 (1988); MISS. CODE ANN. § 41-63-9 (1987); MO. REV. STAT. § 537.035 (1988); MONT. CODE ANN. § 50-16-203 (1987); NEB. REV. STAT. § 71-2048 (1971); NEV. REV. STAT. § 49.265 (1987); N.H. REV. STAT. ANN. § 329:29 (1987); N.M. STAT. ANN. § 41-9-5 (1989); N.Y. EDUC. LAW § 6527 (Consol. 1988); N.C. GEN. STAT. § 131E-95 (1988); N.D. CENT. CODE § 31-08-01 (1976); OHIO REV. CODE ANN. § 23051.251 (Baldwin 1990); OKLA. STAT. ANN. tit. 79, § 16-17 (1988); OR. REV. STAT. § 41.675 (1989); PA. STAT. ANN. tit. § 63-425.4 (Purdon 1978 & Supp. 1990); R.I. GEN. LAWS § 5-37.3-7 (1987); S.C. CODE ANN. § 40.71-20 (Law. Co-op. 1986); S.D. CODIFIED LAWS ANN. § 36-4-26.1 (1986); TENN. CODE ANN. § 63-6-219 (1990); TEX. REV. CIV. STAT. ANN. art. 4495b (1990); UTAH CODE ANN. § 26-25-3 (1989); VT. STAT. ANN. tit. 26, § 1443 (1989); VA. CODE ANN. § 8.01-581.17 (1984); WASH. REV. CODE ANN. § 4.24.250 (1988); W. VA. CODE § 30-3C-3 (1986); WIS. STAT. § 146.38 (1989); WYO. STAT. § 35-17-105 (1988).

3. *See supra* note 1.

4. *See supra* note 2. Neither Arkansas nor New Jersey protects peer review committee documents. The former has a protective statute, applying only to proceedings and records of committees of the state or local professional association, not to hospitals and medical staffs. *See* ARK. STAT. ANN. § 20-9-503 (1990). The latter statute applies to in-hospital committees dealing with utilization review and not to the broader scope of patient care evaluation. *See* N.J. REV. STAT. § 2A: 84A-22.8 (1976); Young v. King, 136 N.J. Super. 127, 344 A.2d 792 (1975).

5. *See supra* note 2.

6. Kinney, 255 Cal. App. 2d at 109, 63 Cal. Rptr. at 87.

could discover other physicians' comments regarding the competency of the defendant physician.[7] Moreover, a plaintiff could identify the critical physicians involved and subject them to pretrial discovery proceedings to obtain further information.[8] Although much of this information was inadmissible at trial, the plaintiff's ability to access such a data base clearly facilitates his development of relevant, admissible evidence. California Evidence Code § 1157,[9] enacted in apparent response to this court's decision, prompted a majority of states to enact similar legislation during the malpractice insurance crisis in the 1970's.[10] Legislation of this type has withstood judicial scrutiny. For example, a California court noted that where medical staff committees are responsible for the competence of staff practitioners, the quality of in-hospital medical care depends on the committee members' candor in evaluating their associates' medical skills and in regulating their staff privileges.[11] Section 1157 was enacted on the theory that external access to committee peer review investigations stifled candor and inhibited objectivity.[12] Unavailability of recorded evidence of a physician's incompetence may jeopardize or prevent a plaintiff's recovery in a medical malpractice suit.[13] Section 1157, therefore, represents a legislative choice between competing public concerns by embracing the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence.[14]

WHOSE RECORDS ARE PROTECTED?

An important element of a number of state statutes which limit discoverability of peer review documents is that only documents generated by these committees are protected.[15] These states, how-

7. *Id.* at 114, 63 Cal. Rptr. at 90.

8. *Id.* at 109, 63 Cal. Rptr. at 87.

9. CAL. EVID. CODE § 1157 (West 1990).

10. *See supra* note 2.

11. Machett V. Super. Ct., 40 Cal. App. 3d 623, 628-29, 115 Cal. Rptr. 317, 320 (1974).

12. *Id.* § 1157 states that documents of a hospital medical staff committee dealing with patient care evaluation are not discoverable. *See supra* note 9. Section 1157 does not, however, protect one who surreptitiously, or even negligently makes such public statements. Such statements pose security problems for medical staffs, but there is a difference between security and non-discoverability. The former is a data management problem which requires hospitals to protect against unauthorized disclosures; the latter is a procedural issue that has already been decided by the legislatures in favor of hospital's and their medical staffs.

13. *See* Machett, 40 Cal. App. 3d. at 628-29, 115 Cal. Rptr. at 320.

14. *Id.*

15. Thirty-nine states and the District of Columbia have such limitations. Nine other states limit their protections to documents of other specifically identical review organizations. *See supra* note 2.

ever, do not protect documents which are generated by other hospital entities even though such documents may have been created by an organized medical staff and may deal with patient care evaluation.[16] Since these statutes contravene the concept of liberal discovery, the burden of establishing entitlement to non-disclosure rests with the party resisting discovery, not the party seeking it.[17] It is imperative, therefore, for hospitals to create peer review systems and organizations to fit the precise language of their protective statute. Hospitals often conduct peer review under the auspices of committees, even when the activity is carried out by departments or sections of a hospital as required by the Joint Commissions on Accreditation of Health Care Organizations (JCAHO).[18] Peer review activities, therefore, should be conducted by a committee of the respective department or section in order to protect the non-discoverability of their documents. Washington and Texas require these committees to be "regularly constituted."[19] Therefore, hospitals in other states should clearly identify how their committees will be constituted in their Medical Staff Bylaws, Quality Assurance Plan, and if the committee is intra-departmental or intersectional, in their Department or Sectional Rules and Regulations.

Documents created by individuals may not be protected from discovery if those people were not acting on behalf of committees with respect to patient care evaluation.[20] For example, a Chief of Staff who summarily dismisses another physician from the staff as a function of his own office and not as a function of the peer review committee, creates discoverable information.[21] The actions of hospital departmental and service chiefs, who restrict the privileges of subordinates, are also discoverable.[22] Persons acting for a committee, however, create non-discoverable documents when they involve investigations ultimately considered by the committee. For example, a nurse epidemiologist's investigation of an infection written prior to consideration by the Infection Control Committee was held

16. *Id.* A committee is a legally definable term and most courts tend to limit the protection of non-discovery statutes to that organization.

17. Santa Rosa Memorial Hosp. v. Super. Ct., 174 Cal App. 3d 711,727, 220 Cal. Rptr. 236, 247. (1985).

18. JOINT COMMISSION ON ACCREDIATION OF HEALTH CARE ORGANIZATIONS MANUAL FOR HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1991).

19. Coburn v. Seda, 101 Wash.2d. 270, 677 P.2d. 173 (1984); Gulf Coast Req. Blood Center Relator v. Houston, 745 S.W.2d. 557 (Tex. Ct. App. 1988).

20. *See, e.g.*, Marchand v. Henry Ford Hosp., 398 Mich. 163, 167, 247 N.W.2d. 280, 282 (1976).

21. Doe v. St. Joseph's, 113 F.R.D. 677 (N.D. Ind. 1987).

22. Machand, *supra* note 20 at 167, 247 N.W.2d at 282.

to be a committee document because her duty to the committee included performance of this function.[23]

States which protect medical staff committee documents from discovery may not protect administrative files in offices of CEO's or in governing board offices.[24] In these states, communication between protected committees may occur,[25] but documentation of those communications should reside in the original committee files. Governing boards can and should be given specific information concerning patient care evaluation by the Quality Assurance Committee or by the Medical Executive Committee, but documents retained by the governing board should be general in context. All specific information should be returned to the protected committee files.

WHOSE COMMITTEES ARE INVOLVED?

Each state defines by statute the structure of a protected committee or organization; however, states vary as to the jurisdiction under which these organizations exist. In some states, the committee or review organization must be under the aegis of the medical staff,[26] while in the majority of states, the committee may be either administrative, medical staff or both.[27] In either case, the hospital or medical staff bears the burden of demonstrating that the particular committee complies with the specific language of the protective statute.[28]

Some states require that protection be limited to documents and information of medical staff committees which deal with patient

23. In re "K", 132 N.H. 4, 561 A.2d 1063 (1989). *See also*, Jorday v. Ct. App. for Fourth Sup. Jud. Dist., 701 S.W.2d 644 (Tex 1985).

24. Matchett v. Super. Ct. for County of Tuba, 40 Cal. App. 3d. 623, 115 Cal. Rptr. 347 (Cal. Ct. App. 1974); Shelton v. Moorehead Memorial Hosp., 318 N.C. 76, 347 S.E.2d 824 (1986); Anderson v. Breda, 103 Wash.2d. 901, 700 P.2d 737 (1985); State, Good Samaritan Medical Center v. Maroney, 123 Wis.2d 89, 365 N.W.2d 887 (Wis. Ct. App. 1985).

25. Harris Hosp. v. Schattman, 734 S.W.2d 759 (Tex. 1987).

26. Ala., Cal., Colo., Conn., D.C., Fla., Haw., Ind., Iowa, Mass., Miss., Mont., Nev., N.C., Or., S.C. *See supra* note 2.

27. Ark., Ariz., Del., Ga., Idaho, Ill., Kan., Ky., La., Me., Md., Mich., Minn., Mo., Nev., N.H., N.M., N.Y., N.D., Ohio, Okla., Pa., R.I., S.D., Tenn., Tex., Utah, Vt., Va., Wash., W.Va., Wis., Wyo. *See supra* note 2.

28. Santa Rosa Memorial Hosp. v. Super. Ct., 255 Cal. App. 2d at 109, 63 Cal Rptr. at 87. No court has overturned these protective non-discovery statutes. Kentucky, however, may be an exception since its highest court overruled legislation aimed at protecting from discovery documented committee communications. See Sweasy v. King's Daughters Memorial Hosp., 771 S.W.2d. 812 (Ky. 1989). The legislation was struck down because it conflicted with a restriction in Kentucky's constitution which requires that laws relate to no more than one subject and the subject must be expressed in the title.

care evaluation. Such committees may be multi-disciplinary.[29] Therefore, the documents of the medical staff committee may be protected even if a majority of the members are non-physicians.[30]

DOES NON-DISCOVERABILITY LIMIT TESTIMONY?

Many states' statutes provide that no individual in attendance at a protective committee meeting is required to testify as to what transpired at the meeting.[31] Such provisions, however, do not explicitly prohibit voluntary testimony by individuals in attendance. Thus, a California court concluded that where a physician volunteered committee information and testimony, neither the defendant physician nor the hospital could preclude him from disclosing the otherwise non-discoverable information.[32] The court strictly construed the statute, which, on its face, prohibited any requirement to testify, but allowed the voluntary release of information.[33] When California physicians opposed this decision, hospital medical staffs responded by adopting specific bylaws which precluded any disclosure of information acquired through the committee process.[34] Physicians who violate this bylaw are subject to disciplinary proceedings. In numerous states, the relevant statutes address both re-

29. Santa Rosa Memorial Hosp. v. Super. Ct. 255 Cal. App. 2d. at 109, 63 Cal Rptr. at 87.

30. For example, infection control committees which are structured according to the JCAHO requirements are still considered medical staff committees, despite their inter-disciplinary makeup. *See supra*, note 18.

31. Alaska, Ariz., Cal., Conn., Del., Fla., Ga., Haw., Idaho, Ind., Kan., Ky., Minn., Miss., Mo., Nev., N.Y., N.C., Ohio, Pa., Tenn., Vt., W.Va., Wyo. *See supra* note 2.

32. West Corina Hosp. v. Super. Ct., 41 Cal. 3d. 846, 718 P. 2d. 119, 226 Cal. Rptr. 132 (1986).

33. *Id.* at 855, 718 P.2d at 122, 226 Cal. Rptr. at 136.

34. MEDICAL STAFF PEER REVIEW ACTIVITY CONFIDENTIALITY AGREEMENT. As a member of a Medical Staff Committee involved in the evaluation and improvement of the quality of care rendered in the hospital, I recognize that confidentiality is vital to the free and candid discussions necessary to effective medical staff peer review activities. Therefore, I agree to respect and maintain the confidentiality of all discussions, deliberations, records, and other information generated in connection with these activities, and to make no voluntary disclosures of such information except to persons authorized to receive it in the conduct of medical staff affairs.

Furthermore, my participation in peer review and quality assurance activities is in reliance on my belief that the confidentiality of these activities will be similarly preserved by every other member of the medical staff or other individual involved. I understand the hospitals and the medical staff are entitled to undertake such action as is deemed appropriate to ensure that this confidentiality is maintained, including action necessitated by any breach or threatened breach of this agreement.

Dated: _____ Signed: _____

quired and voluntary releases of information.[35] The hospital medical staffs in these states do not need to adopt bylaws similar to those found in California.

THE ULTIMATE CONFLICT: THE NON-DISCOVERY STATUTE v. HOSPITAL CORPORATE LIABILITY

Long before the landmark case of *Darling v. Charleston Community Memorial Hospital*,[36] hospitals had the responsibility of directing their medical staffs to select appropriate physicians for medical staff appointments and to conduct appropriate disciplinary proceedings. The *Darling* case expanded the hospital's responsibility by requiring it to ensure that its medical staff's conduct adequate on-going peer review.[37] Under this theory of hospital corporate liability, the hospital's duty to screen and monitor the medical staff committees stems directly from its responsibility to patients and not from any paternalistic position it may have towards physicians on its medical staff. Decisions in other states have extended the corporate liability theory to cases where the hospital and its medical staff failed to investigate existing evidence in determining whether a physician is competent to be on the medical staff and whether the physician should lose his medical credentials.[38] For example, a California court held a hospital, with notice of prior lawsuits against the defendant physician, potentially liable for failing to investigate those civil actions to determine whether medical staff privileges should continue.[39] The court found that the hospital not only had a duty to ensure that its medical staff evaluate such cases, but also to determine whether it conducted periodic reviews of the defendant physician in an appropriate manner.[40] Query: if peer review had been carefully and properly conducted, would the committee have recommended revocation or suspension of the defendant physician's staff privileges?

A hospital's duty to ensure that physicians properly conduct peer review conflicts with the protective nature of discovery statutes such that a plaintiff is denied access to information necessary to

35. Alaska, Conn., Fla., Ga., Idaho, Ind., Ky., Mass., Minn., Miss., Mo., N.M., Ohio, Or., Pa., R.I., Vt., W.Va., Wyo. *See supra* note 2.

36. Darling v. Charleston Community Memorial Hosp., 33 Ill.2d. 326, 211 N.E.2d. 253 (1965).

37. *Id.* at 332, 211 N.E.2d at 257.

38. *See infra* note 39.

39. Elam v. College Park Hosp., 132 Cal. App. 3d. 332, 183 Cal. Rptr. 156 (Ct. App. 1982). *See also* Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P.2d. 335 (Ct. App. 1972).

40. Elam, 132 Cal. App. 3d. at 346, 183 Cal. Rptr. at 165.

bring a cause of action against the hospital to enforce that duty. This conflict may not have been considered by those legislating the confidentiality statutes. When such a conflict has arisen, courts have upheld the purpose of the non-discovery statutes: to encourage physicians to exercise candor and frankness in their self-evaluation for the benefit of community health.[41]

Despite the non-discovery statutes, some information is available to a plaintiff in a malpractice action against a medical staff member and that member's hospital. A few states allow a plaintiff to determine not only the status of a defendant physician's privileges at a hospital,[42] but also whether a physician's patient management was evaluated by a peer review committee.[43] A plaintiff may obtain from a board of governors administrative documents and records regarding the defendant physician, including a physician's educational transcripts.[44] Beyond such limited access, however, non-discovery statutes bar a plaintiff from obtaining further information.[45] Thus, a plaintiff should be able to procure all available public information against a defendant physician and the hospital and should be able to solicit protected expert opinions regarding the plaintiff's care and management while in the hospital. At trial, a jury may function as a credentials committee to determine whether a medical staff and its hospital negligently allowed the defendant physician to remain on the staff or to perform procedures which were beyond his capacity. Physicians should know that while non-discovery statutes are effective, any public information available to a plaintiff may be considered by a jury. A hospital and its medical staff should see that its credentials committee operates effectively in order to prevent a jury from retrospectively reviewing such public information.

THE INCIDENT REPORT: AN ENIGMA OR SOLUTION?

Most hospitals have created incident reporting systems to docu-

41. Humana Hosp. Desert Valley v. Super. Ct., 54 Ariz. App. 396, 742 P.2d 1382 (1987); W. Covina Hosp. v. Super. Ct., 153 Cal. App. 3d 136, 200 Cal. Rptr. 162 (1984); Snell v. Super. Ct., 158 Cal. App. 3d 44, 204 Cal. Rptr. 200 (1984); Brown v. Super. Ct., 168 Cal. App. 3d 489, 214 Cal. Rptr. 267 (1985); Willing v. St. Joseph Hosp., 176 Ill. App. 3d, 531 N.E. 2d 824 (1988); Shelton v. Morehead Memorial Hosp., 318 N.C. 76, 347 S.E.2d 824 (1986).

42. Richter v. Diamond, 108 Ill. 2d. 265, 483 N.E.2d. 1256 (1985); Anderson v. Breda, 103 Wash.2d. 901, 700 P.2d. 737 (1985).

43. Brown v. Super. Ct., 168 Cal. App. 3d., 214 Cal. Rptr. 266 (1985).

44. Willing v. St. Joseph Hosp., 176 Ill. App. 3d. 737, 531 N.E.2d 824 (1988).

45. *See supra* note 2.

ment problematic events. These systems may serve several purposes such as informing the hospital attorney (or insurance carrier, if any) of the events that may produce litigation and gathering data indicating trends that would lead to quality of care improvement programs. In California, for example, if the goal of an incident report is solely to communicate information from the hospital to the attorney, the document is non-discoverable because of the protection of the attorney-client privilege.[46] The privilege, however, may be waived if nurses or physicians use the document for quality of care purposes.[47] Utilizing a document solely for these purposes, however, does not invoke the non-discovery protection unless the peer review system is under the jurisdiction of the appropriate peer review organization. In California, therefore, it is important for hospitals to consider the purpose of their incident reports and to structure a proper organization governing them to ensure that either the attorney/client privilege or the peer review non-discovery protection applies. If the primary purpose of the incident reporting system is to improve quality of care rather than to communicate with an attorney, it is necessary to structure a medical staff committee that has jurisdiction over both the creation and the evaluation of these reports.[48] A risk management committee will suffice. Also, a hospital's incident reporting system should be altered to fit the applicable protective statute. To accomplish this, a medical staff risk management committee could assume control over the creation

46. Sierra Vista Hosp. v. Super. Ct., 248 Cal. App. 2d. 359, 56 Cal. Rptr. 387 (Ct. App. 1967).

47. This result was achieved in Colorado when copies of the incident report were sent to the Director of Nursing as well as the CEO. Bernardi v. Community Hosp. Ass'n, 166 Colo. 280, 443 P.2d 708 (1968).

48. There have been few court decisions governing incident reports. In North Carolina, for example, an incident report is not protected by the attorney/client privilege and is discoverable from the CEO of the hospital. *See*, e.g. Shelton v. Morehead Memorial Hosp., 318 N.C. 76, 347 S.E.2d 824 (1986). Furthermore, in Missouri, an incident report is protected by the attorney/client privilege if the primary purpose is communication, although the document may also be used for patient care evaluation. *See*, e.g. Enhe v. Anderson, 733 S.W.2d 462 (Mo. Ct. App. 1987). In Massachusetts, incident reporting systems are both required and protected, regardless of their purpose. *See*, e.g. Beth Israel Hosp. Ass'n v. Board of Registration in Medicine, 401 Mass. 172, 515 N.E.2d 574 (1987). In Michigan, incident reports are protected from discoverability if an individual or committee is assigned a review function. *See*, e.g. Gallagher v. Detroit - Macomb Hosp. Ass'n., 171 Mich. App. 761, 431 N.W.2d 90 (1988). In Kansas, Pennsylvania, Arizona, New York and North Carolina, incident reports would not be discoverable if the reporting systems were organized as peer review patient care evaluation processes. *See*, e.g. Porter v. Snyder, 115 F.R.D. 77 (D. Kan. 1987); Wood v. Geriatrics Medical Center, Inc., No. 85-6447 (E.D. Pa., filed July 11, 1986); Lincoln Hosp. Health Center v. Super. Ct., 159 Ariz. 456, 768 P.2d. 188 (Ariz. Ct. App. 1989); Shelton v. Morehead Memorial Hosp., *supra* note 41.

and review of these documents, acting as a patient care evaluation committee.

In 1979, the California Hospital Association developed a model incident reporting system, the Notification System, to be placed under the control of a medical staff committee. Neither the reports nor their evaluations would be discoverable. Each committee would develop its own rules for providing information to its hospital's insurance carrier or risk management service. That information could alert the insurance carrier, its attorney, or the risk management service to potential problems for purposes of investigation. Therefore, information generated from a well fashioned hospital reporting system should be protected from discovery. This would increase the importance of risk management by encouraging greater involvement by the medical staff in assessing and managing risk. One study has shown that medical staff involvement substantially improves a hospital's position in litigation.[49] Both the administration and the medical staff of a hospital should participate in the risk management committee to decide how to report incidents, who should report them, and how that data should be used.

CONCLUSION

Physicians need not be unduly concerned about the discovery of hospital peer review data, as long as that data is generated and evaluated in strict compliance with protective statutes. In turn, hospitals could protect against discovery of their incident reports by placing them under the control of a peer review committee or hospital organization with comparable functions. As a result, this would encourage greater involvement and cooperation by the medical staff and the administration in conducting peer review activities.

49. MORLOCK & MALITZ, *Do Hospital Risk Management Programs Make a Difference?* in FINAL REPORT TO THE NATIONAL CENTER FOR HEALTH SERVICES RESEARCH AND HEALTH CARE TECHNOLOGY ASSESSMENT (1988).