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I. OVERVIEW

Modern health care institutions face a concatenation of critical challenges which threaten the stability, or even the existence, of all but the most firmly managed and fiscally sound. Many of these challenges are of national, if not international, dimensions. There is little an individual hospital can do to affect challenges and pressures of this size.

A discrete group of lesser and possibly more manageable challenges also commands the attention of hospital management and medical staff leadership. This group is characterized by the dilemmas caused by the increasingly active intervention of the legal system. Conflicting interests are clearly reflected in these challenges, however, it is not at all obvious which interest is "right" and which is "wrong." Indeed, a significant characteristic of this phenomenon is the fact that decision-makers cannot decide on the basis of the usual differential equations of "good" and "bad" or "best case" and "worst case." In this context, the competing interests are often equally compelling and have comparable equities.

One need only think of current controversial confusion raised by the "right to life" versus the "right to abortion" dispute. Similarly troubling moral, philosophical, and legal issues are inherent in questions regarding the initiation or withdrawal of extraordinary medical measures for terminally ill or comatose patients.

The relatively recent invasion of law into what was a rather calm and quiet, if not altogether untroubled house of healing, has brought about something close to the dissonance usually associated with the Tower of Babel. Indeed, reference to Bedlam may be more apt if one reflects on the crazy cacophony which results when the subjects of law and medicine are discussed—even by serious students of either, or both.

I mean not to gainsay the effect of exploding technology on this subject. However, if not for the law, the "science" of medicine could and would move inexorably onward at a pace medicine dictated. The intrusion of the law complicates the decision-makers' efforts. The recog-

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nition of new types and levels of legal rights has created conflicts for all. Even the most astute and sensitive individuals in this field are stymied by the hard choices presented in day-to-day medical practice. Technological advance, moreover, further compounds the dilemma. It is an article of national faith that science means progress and that progress is always good. However, in health matters, progress often leads to tough questions for which there are no acceptable answers. The faith in science and the scientific method leads to beliefs as metaphysical and mystical as those of our forefathers.

The broad perspective of this article will disclose great dissonance, if not madness, in the medical world. The law has always been involved with health in one way or another. From earliest times to now, the law, taking that to mean the vague, disparate miscellany of statutes, judicial decisions, regulations, pronouncements, and doctrines we all hold dear, has encouraged, inhibited, and been indifferent to health concerns. Moreover, the law displays this same range of contrariety to both health care providers and their patients. Throughout the centuries the law has been unable to come to a practical working definition of health, medicine, or indeed, the scopes of practice of the variety of practitioners who enhance or purvey it, whichever the case may be. Definitions have been based, in part at least, upon metaphysics, mysticism, magic, and no small amount of self-serving protectionist sentimentality.

With expanding technology and the increasing numbers of natural and legal "persons" who have obtained authorization to practice a health profession, the problem of definition becomes even more complex. This too creates major tensions, conflicts, confusions, and dilemmas. Who can do what, with which, to whom? That remains the question as the "who" is expanding, the "what" is much more complex, the "which" is much more than we ever dreamed, and even the "whom" is changing right before our eyes.

American laws affecting health matters are in transition. As the nation has become more aware of the vital importance of health in public and private matters and as the many definitions of health have expanded, there is an increasing legal focus on the availability, appropriateness, and quality of health care services. At precisely the same time there are pressures, reaching critical mass conditions, for the reduction of health care costs. In this process new legal duties and responsibilities are articulated in an expanding and confusing calculus. There are no easy formulas with which to resolve the conflicting legal pressures. As examples of these pressures, this Article will discuss hospital relationships with health practitioners and issues involving competing pressures for disclosure or non-disclosure of health information.

Clearly, the law can raise issues aplenty. However, we must ask

whether the legal system can provide a mechanism which will rationalize, change, and assist in the orderly transition from situations we thought we could manage to those which are difficult and perhaps unmanageable. This question is difficult to answer at the present time. It is my belief that many of these issues can be managed, even if only on an ad hoc basis, when institutional leadership has the foresight, wisdom, creativity, and resolve to make a decision and to take action. However, it is not clear whether American health leadership exhibits such capability. Perhaps this pessimistic speculation is based on the nature of the peculiarly American legal process and how it has been applied to health matters.

II. THE HOLMESIAN CONCEPT OF FELT NEEDS

Oliver Wendell Holmes, Jr., sat for some thirty years on the United States Supreme Court. Prior to that, he sat for seventeen years on the Supreme Judicial Court of the Commonwealth of Massachusetts completing his term as Chief Justice. Early in his life, Justice Holmes was a lecturer on common law at the Lowell Institute in Boston. The lectures he gave there were converted into a book called *The Common Law*,[1] a work of high erudition and importance. In his book, Justice Holmes put forth a definition of law that is most appropriate to this discussion:

> The life of the law has not been logic: it has been experience. The felt necessities of the time, the prevalent moral and political theories, intuitions of public policy, avowed or unconscious, even the prejudices which judges share with their fellow-men, have had a good deal more to do than the syllogism in determining the rules by which men should be governed. . . . The substance of the law at any given time pretty nearly corresponds, so far as it goes, with what is then understood to be convenient; but its form and machinery, and the degree to which it is able to work out desired results, depend very much upon its past.[2]

To a very large extent, the life of the American health care system has had the same experience. Medicine has grown, diversified, and expanded in response to the expressed desires of some part of society to solve what it perceived to be mysteries of illness and disease. Over the years, specific kinds of health concerns have received special attention. Great exertions of time and energy have been made, and large infusions of public and private dollars have been allocated and expended. The fact that technological change may have created those illnesses and diseases which captured our attention is irrelevant for the purpose of this discussion. Likewise, the fact that there was (and will be) some

1. O.W. HOLMES, THE COMMON LAW (1881).
2. *Id.* at 1-2.

element of favoritism, special pleading, and fadism is irrelevant. There were felt needs, and some part of the legal or health care process responded.

For every reponse to a felt need there will eventually be an equal and opposite reaction. Lawyers and physicians alike have learned from past experiences and have attempted to apply that knowledge to some currently articulated felt necessity. Both law and medicine have long standing traditions, both professions are challenged today as never before. It is noteworthy that this challenge occurs because more is expected of the two professions and because neither lawyers nor physicians control their systems as they did before. The public demands that these two professions especially respond to its newly noted needs. But the lawyers and physicians cannot.

Medicine specifically faces a social and legal confrontation today that it has never faced before in its long history. Its practitioners and specialists are for many reasons completely ill prepared to deal with these assaults. At the same time the public has grown more sophisticated and now demands much more from physicians without giving in return what has been for a century at least a reverence almost akin to that which the laity formerly extended to the clergy. Today, however, the public views medicine in a totally different light. Attitudes of awe and respectful hope have changed across the nation. The general population now has high expectations and little patience with explanations that attempt to show why health care of the highest quality and in the most advanced state of the art cannot be delivered right now to everyone at the very lowest costs.

Meanwhile the legal system, pressured by increasing demands for the infinitely changing and illusive thing called quality (and the similarly troubling notion of equality) creates new kinds of duties and responsibilities and imposes them not only on the practitioners but also the institutions where the practitioners perform. This phenomenon of institutional or corporate responsibility has been the subject of a number of thoughtful articles and will not be pursued at this point.

So-called corporate or institutional liability is vicarious responsibility in a new garb. Demands for institutional liability impose on hospitals and other health care facilities duties which can only be carried out by specifically licensed practitioners. Hospitals face the overriding pressure imposed by the legal system to correct, modify, or structure the behavior of the private practitioners who have permission to perform professionally in the institution. Accordingly, hospitals have the difficult job of balancing the competing scopes of practice between "traditional" practitioners and recently recognized health care professionals. Another logical battleground of emerging legal significance is

that involving healthcare information. We shall have more to say on these issues presently.

Once again we are in crisis. This time, the writers and editorialists inform us, it is a health care crisis. It seems that every generation or so America rediscovers a "crisis." All the forces of society bewail the newly found old problem. Think, if you will, of the recurrent racial, economic, environmental, or educational crises. They and the crisis in health care are all similar. We have heard it all before. These recurrent crises symbolize the inability of the American political, social, economic, and legal systems to deal lastingly and finally with human problems. It is perhaps true that no such systems can deal lastingly and finally with human problems.

Social change is occurring every day; physical change goes on. Felt needs today are different, and these changes have an impact on the demand for medical care. Indeed, the changing values of Americans have much to do with the demand for higher quality health care, and consequently the manner in which the law may be employed to achieve that end. This change in values is fundamental, and yet our responses to the demand may be the same as those employing the frame of reference which we formerly used when dealing with problems of this nature. That is, the attempt to meet this felt need may be made in the context of the notions implicit in the doctrine of *laissez faire*, or in terms of true socialism.

The system of values developed during the early phase of industrialization in United States history no longer seems applicable to emerging institutional, group, and individual patterns. A great many forces are working to hasten these shifts in values. They intermesh at different speeds and tempos for different people, and they work differently from one place to another. Among these contrasting forces are growing national affluence and poverty, increasing societal complexity as life becomes simpler, and increasing national insecurity about and confidence in the future. Other forces at work are heightened rates of change, exploding technology, upheavals in theology, changing notions of morality, the ascendancy of "youth values," strong demands from so-called minorities, new roles for business and government, wider accessibility of the mass media of communication, innovative use of collective action and confrontation, and a conviction among many Americans that the nation has not lived up to its promises and ideals, explicit or implicit.

Under the circumstances, standards of what is important — what should have priority in a hierarchy of priorities — are changing. Even the upper-middle class American finds that the attainment of status and material goals is so relatively easy that the quest for them no

longer offers a challenge. Rather than face a lifetime of futility and senseless pursuit of material objects, some people, at almost every level of life, are seeking different goals based on different ("higher") values. Taken together these forces, events, and trends indicate a time of rapid and fundamental shifts in the core of values by which most Americans live. Moreover, in all areas of life these shifts augur new assaults on the established way of doing things, such as providing services and redressing grievances. The law as Justice Holmes described it is intimately involved in providing supportive mechanisms for the implementation and realization of the felt needs of society as they come to be expressed. Thus the law is grappling with bringing about change. At the same time, it is a most effective instrument against change.

National affluence, coupled with the accessibility and influence of the mass media, has an important additional impact; it facilitates the expression, dissemination, and acceptance of personal, community, and national values. Values tend to be generated by the basic needs that people have. Simply stated, needs dictate values by defining what is most important. The United States has departed from what might be called the frontier frame of reference, by which I mean not only the conquest of land but also the control of the economy under the concept of free enterprise and the notion of "survival of the fittest" as it applies to human relations. We have evolved into a society that is more socially oriented, more organized, and more institutionalized. As this has happened and as affluence has reached larger portions of the population, the felt needs of the people have changed from that of basic survival in a competitive setting to sophisticated concerns for self-growth and self-actualization. This would seem to indicate that the individual in this day and in the years to come will be more concerned with personal well-being and perhaps the well-being of society as well. He will express as deep a concern for the "quality of life" as for life itself. He will seek and demand good health care. If it cannot be found within the present social and legal frameworks, he will develop approaches to make sure that it will evolve. But at the same time, technological growth and its social, economic, and moral dislocation creates precisely contrary values. Sometimes we seem to care less about the plight of the individual who may become more and more equated with his computerized identification code. We spend more time in the quest for satisfaction of nerve ends than in the quest of social good.

The law, it is suggested, has been and will be a vehicle to bring about change. It will reflect the current felt necessities of these times and it will bend to meet the current desires. But, as Justice Holmes further described, the prevalent moral and political theories, intuitions of public policy, and even the prejudices that judges and other lawmakers

share with their fellow beings will have considerable impact. Moreover, the changes that are effected by the law will still depend very much upon the way things were done in the past.

From earliest times the law has had an interest in the community's health. From the times of Moses (and even before) to the latest pronouncement of the United States Supreme Court, a major concern of the law-giver was the public health. Indeed, the primary power of the state is the police power. Pursuant to the police power, it is the responsibility of government to provide for and protect the health, safety, welfare, and morals of the community. It is through the police power that state government is active in the field of public health. The police power extends to the person and the property of every individual and corporation in the state. It also extends to the conduct of private matters as well as to business affairs.

It is my thesis that the law inhibits, enhances, and ignores health care issues all at the same time. In doing so it creates for the institutional decision-maker the conflicting pressures which lead to the dilemmas noted above. In altogether too many situations, the law presents itself in such a manner as to confound the average health practitioner or health care manager. Only the most able can consistently operate effectively in this atmosphere. This Article will discuss two examples of conflicting legal pressures as they currently affect health care institutional managers.

III. Examples of Conflicting Legal Pressures

Almost any issue which comes to mind when one thinks of the modern health care institution will include a litany of responsibilities which give rise to conflicting legal pressures. The list is seemingly inexhaustible. The pressures which come about because of increasing the potential for malpractice liability against both the practitioner and the institution give rise to the need for stringent internal controls on health care delivery by each and every practitioner. These controls, which are generally institutional, in turn create conflict centers within the institution as the hospital attempts to modify and manage the behavior of physicians in areas such as medication ordering, medical record managing, decisions regarding the length of a patient's hospital stay, decisions regarding the amount of time that the physician must or should spend with the patient, and in the application of technological advances. The use of equipment, new machines, and new modalities of treatment gives rise to the clash of competing interests. There is no question that recent drastic modification in the manner in which third-party payors reimburse health care providers will open a latter day Pandora's box of conflict between hospitals and practitioners.

A. *Hospital Relationships With Practitioners*

Putting aside problems which are foreseeable because of new reimbursement schemes, there are many existing examples of conflicts inherent in the often tense relationship between hospital management and individual practitioner.

1. Liability for Credentialing Versus Due Process

In the matter of credentialing, the competing interests are clear. Today the hospital is responsible for what happens within it. This includes having a credentialing system applicable to individuals on the medical staff. On the other hand, many a practitioner still believes that he is *sui juris*, so to speak, once he is licensed and certified in a specialty. Hospitals are liable for negligence in the initial appointment process as well as in the reappointment process.[3] Hospitals have a clear legal duty to exercise reasonable care in the selection and retention of members of the medical staff and in the periodic granting of specialized clinical privileges. The process through which this is done involves the so-called organized medical staff. Too often, even at this stage of hospital evolution, the members of organized medical staffs see themselves as defenders of the private practitioner and see the private practice of medicine in the context of absolute autonomy — the *sui juris* notion. It is unimportant from the perspective of this writing whether that attitude is correct or incorrect. What is noteworthy is the obvious clash that does occur and will continue to occur when hospital management (often including the medical staff leadership) attempts to initiate an effective peer review plan or attempts to apply the provisions of such a plan to practitioners who have been found deficient.

Of course, this paints too broad a picture. 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. Moreover, even when the leadership perceives its mission clearly and operates efficiently, the law nevertheless provides an aggrieved practitioner with important guarantees of fairness which approximate the bundle of rights associated with notions of due process. I do not mean to criticize the application of due process to hospital-medical staff relationships. My point is that often the hospital's legally-imposed duty to review the individuals on its medical staff

3 Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); Johnson v. Misericordia Hosp., 99 Wis. 2d 708, 301 N.W 2d 156 (1981); Purcell v. Zimbelman, 18 Ariz. App. 75, 500 P 2d 335 (1972)

clashes directly with its equally compelling duty to act fairly toward the aggrieved practitioner.[4]

The complex political, social, economic, and professional environment in the modern hospital further weakens the ability of hospital management to be effective. Little is foreseeable in the immediate future which will provide mitigation of this situation. However, both the courts and legislatures are active. The courts are becoming more receptive to novel suits alleging institutional liability for the failure to properly evaluate, reevaluate, monitor, or control the actions of the independent practitioner in the hospital. This, of course, should act as a stimulus to more effective peer review procedures. At the same time the courts are quite liberal in granting judicial scrutiny of hospital disciplinary actions. One can make strong arguments for both judicial approaches. But from the institutional perspective, competing pressures (to get tough with possible malpractitioners while carefully providing due process at each stage of the activity) are often puzzling and unworkable. Moreover, several legislatures have moved to center stage by imposing stringent reporting requirements on hospitals which take disciplinary actions.[5] This legislation often inhibits institutional action because the consequence to the miscreant practitioner, who is after all still a peer and perhaps a colleague, is more severe than any one wishes to impose. The net effect of these conflicting pressures is that appropriate action does not take place, patients are harmed unnecessarily, practitioners are not properly guided by their peers, and hospitals are exposed to greater risk. Recent actions at the state and federal levels are likely to exacerbate this problem.

2. Limitations of Staff Versus Anti-trust Threats

Recently, one of the most dramatic intrusions of law into the health field which may have long-term implications is the application of anti-trust law to hospital operations. Most hospital organizations and many hospital counsel are ill-prepared to deal effectively with anti-trust liti-

4 *Compare Elam*, 132 Cal. App. 3d 332, 183 Cal. Rptr. 156, *with* Miller v. Eisenhower Medical Center, 27 Cal. 3d 614, 614 P.2d 258, 166 Cal. Rptr. 826 (1980) (holding defendant hospital must either accept plaintiff's application for medical staff membership or conduct proceedings to properly apply a hospital bylaws standard which permitted denial of staff membership upon a showing of applicant's inability to work with others, when hospital had failed to find that plaintiff applicant's inability to work with others posed a threat to the quality of the hospital's medical care).

5 *E.g.*, N.C. GEN. STAT. § 90-14.13 (1981). Under this provision the chief administrative officer of every licensed hospital is required (after consultation with the chief of staff) to report to the State Board of Medical Examiners revocations, suspensions, or limitation of a physician's privileges to practice in the hospital. Resignations from practice in the institution must also be reported to the State Board. Failures to report must be reported by the State Board to the hospital hearing agency. Partial immunity is provided to the administrator.

gation. More often than not the mere threat of a suit is sufficient to inhibit a proposed management action. Importantly, the application of anti-trust law has come at precisely the same time that many hospitals have been forced to make critical and far-reaching management decisions regarding revision of the corporate structure, allocation of limited physical and human resources, reorganization of hospital services, realignment of professional staffing patterns, development of strategies to maximize competitive advantage, and other business decisions which may adversely affect heretofore sacrosanct practitioner prerogatives.

The pressures which will result from changes in the reimbursement strategies of public and private payors will alone cause disruption of many traditional relationships within the hospital and among varieties of health care providers. The point to be made once again is that this disruption will create tensions and conflicts which involve legitimate competing interests. It will not be possible to identify the "good guys" or the "bad guys." In this setting, even though the hospital may successfully defend an anti-trust suit which attacked, for example, a moratorium on appointments in certain over-populated medical specialties, there will be no winner. The cost of defense in terms of time, money, and emotional expense will always be exorbitant. It will be the fate of hospitals around the country to have to choose between the Scylla of scrapping or deferring necessary plans because of the anti-trust threat and the Charybdis of choosing to proceed in the certain knowledge that at least four years will be spent in litigation.

B. Disclosure of Information

One of the clearest examples of the clash of competing interests can be seen in laws dealing with disclosure of health information. Pressures abound for increased access to medical information while, at the same time, pressures grow for the expansion of protection from disclosure. The controversy over public access to the meetings of even private hospitals, the increasing expansion of sunshine laws to cover even "executive sessions" of the meetings of public hospitals, and the pressures from the communication mass media to get into the records and documents of hospitals and health care facilities are current common examples. Perhaps the most troubling to the practitioner and institution are those questions which arise within the area of defining confidentiality and access. Two examples will be discussed here: peer review protection statutes and the so-called duty to warn.

1. Liberal Discovery versus Peer Review Protection Statutes

The activities of hospital or medical staff review committees have been the center of a continuing legal controversy. The requirement

that such committees be established and put into operation comes from the government as well as accrediting bodies such as the Joint Commission on Accreditation of Hospitals. The role of review committees in improving hospital care has certainly been recognized by legislatures and courts which have responded by creating protective legal shields to encourage these committees. However, this body of law is still in its infancy and is undeveloped and often unpredictable. As the work of these committees grows in importance their reports are increasingly relevant to the courts, attorneys, and others who present an equally compelling need to have access to the information.

Confidentiality is crucial to every review committee in a hospital. The committee needs confidentiality in order to be able to discuss and evaluate a colleague's credentials or clinical performance while maintaining an atmosphere of scientific objectivity and professional cordiality within the hospital. Candor is always important. Evaluators should not operate in an atmosphere of fear that what they say will be immediately disclosed to the public in general or to attorneys for plaintiffs in particular. Obviously most members of review committees would be hesitant to investigate incidents fully if their reports and recommendations could be used willy-nilly as evidence in lawsuits against them, their hospital, or colleagues. Certainly there is validity in the desire of an aggrieved patient to discover relevant evidence and in the need of the judicial system to seek out the best evidence. However, these interests must be counterbalanced with the equally compelling public interest in protecting and encouraging the peer review process within the hospital. State legislatures have responded differently to these competing interests. The result is that hospitals in each state must have their counsel carefully analyze the particular state statutes and relevent case law in order to determine how they and their committee members are protected. Obviously committees and their review processes should be structured to provide maximum protection of their functions.

Within this area, there is a sub-area which involves immunity against liability which some statutes provide for members of the committee or persons who participate with the committee. There is also the sub-area of access to the materials for the purposes of discovery or admissibility. Both of these have been the subject of intense judicial activity.

Some courts have created a common law rule of absolute immunity in the area of peer review.[6] Others have imposed a qualified immunity.[7] Of course the statutory immunity provides an important aid to

6 Franklin v. Blank, 86 N.M. 585, 525 P.2d 945 (1974); Goodley v. Sullivant, 32 Cal. App. 3d 619, 108 Cal. Rptr. 451 (1973); Schechet v. Kesten, 3 Mich. App. 126, 141 N.W.2d 641 (1966).

7 Mayfield v. Gleichert, 484 S.W.2d 619 (Tex. Civ. App. 1972). *See also* J. HORTY, HOSPITAL LAW, chs. 2, 5, 68 (1982).

the members of the committee. While the protections vary from state to state, these statutes generally provide an immunity unless there is evidence that the member acted with malice. For example, in *Duby v. Baron*,[8] the court considered the Massachusetts Peer Review Statute which provides in part:

> No member of a professional society or of a duly appointed committee thereof, or a duly appointed member of a committee of a medical staff of a licensed hospital shall be liable in a suit for damages as a result of his acts, omissions or proceedings undertaken or performed within the scope of his duties as such committee member, provided that he acts in good faith and in the reasonable belief that based on all of the facts the action or inaction on his part was warranted.[9]

In *Duby* a surgeon brought suit against a peer review committee and a hospital after his clinical privileges at the hospital were terminated. The facts which prompted the determination were that following a therapeutic abortion the patient's condition deteriorated. The surgeon took no action in response to the patient's condition until after he had received repeated telephone messages from the nursing staff and a severe warning by the chief of obstetrics at the hospital. The surgeon performed an operation after the warning but made no notation of either operation on the hospital records. The chief of surgery was informed of this situation and was aware of previous incidents involving this surgeon. In response, the chief of surgery suspended the surgeon's surgical privileges even though he knew that the surgeon had another abortion scheduled two days later.

The chief of surgery then sent letters to the Executive Committee and Credentials Committee of the hospital reporting the situation to date and recommending that the surgeon be deprived of surgical privileges. The Executive Committee and Credentials Committee voted to suspend the surgeon temporarily. After various hearings and votes, the aggrieved surgeon was stripped of hospital privileges indefinitely. He brought suit against certain hospital administrators, Credentials Committee members, and the entire Executive Committee. The trial court found that the Executive Committee had acted within the scope of its duties concerning the surgeon, that the facts supported the finding that each defendant had acted in good faith, and that based on all the facts, the action or inaction was warranted. These findings were affirmed on appeal.

The fact that courts have almost uniformly decided in favor of protecting the activities of members of peer review committees with respect

8 369 Mass. 614, 341 N.E.2d 870 (1976). *See also* J. HORTY, *supra* note 7, at chs. 2, 6, 46.

9 MASS. ANN. LAWS ch. 231, § 85N (Michie/Law. Co-op 1974).

to their deliberations should not give anyone the notion that these committees are absolutely protected. The protection is qualified. The committees and their individual members must act without malice. However, statutes clearly provide a rationale for committees to act with candor and forthrightness because they are protected in their deliberations.

Regarding the question of discovery and admissibility, there is much more judicial activity and much more uncertainty. While the rationale for protection against discovery and admissibility can be as clearly articulated as it was in *Bredice v. Doctors' Hospital, Inc.*,[10] there is, nevertheless, great controversy. The courts have varied widely in their interpretations of the scope of the statute while, at the same time, they have attempted to come to some rough approximation of justice.

Courts have reached conflicting results in cases involving plaintiffs who were former patients and who sought to obtain information from the reports of the deliberations of the peer review committees in order to make the case of negligence. In *Bredice v. Doctors' Hospital, Inc.*, the District Court for the District of Columbia invoked a common law privilege for peer review records.[11] However, in *Davison v. St. Paul Fire & Marine Insurance Co.*,[12] the Supreme Court of Wisconsin refused to recognize the *Bredice* privilege. There an injured patient brought a tort action against a hospital and its insurer to recover damages for alleged negligence and medical malpractice in his care and treatment. The Wisconsin court refused to recognize the privilege and refused to prevent the deposition of the members of the committee. The court dismissed the hospital's argument that committee minutes and reports were privileged by saying there was no specific statute which protected them.

California has a string of cases interpreting the California peer review protection statute.[13] California's statute protects the comments of committee members and the written committee records from discovery or admissibility in a malpractice case. However, the statute also provides that there shall be no privilege in a lawsuit brought by a physician who has been investigated by a committee when the suit is based on that investigation. But even in that setting the California courts, and indeed many courts, will strictly construe the statute in its specific

10. 50 F.R.D. 249 (D.D.C. 1970). "Confidentiality is essential to effective functioning of these [peer review] staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients." *Id.* at 250.

11 *Id.* at 251

12 75 Wis. 2d 190, 248 N.W.2d 433 (1977).

13 *See* Matchett v. Superior Court, 40 Cal. App. 3d 623, 115 Cal. Rptr. 317 (1974) (holding statute protecting applicant for hospital staff privileges does not permit discovery of proceedings and records by patient who brings suit against doctor and against hospital for negligently allowing staff privileges)

terms.[14]

There is no question that this conflict will go on. The peer review committees, to the extent that they are effective, will produce valuable information which will be helpful to a variety of disparate interests. The reports will clarify facts; they will consist of salient facts. This is precisely the information that is needed by any person engaged in litigation. So the pressure for disclosure will continue and even mount. Interestingly enough, the ineffectiveness of peer review process is also a fact which may bear on allegations of institutional negligence. A plaintiff will seek such records in any event. The courts will continue to be called upon in an attempt to resolve these issues. Courts will not only apply the particular language of the statute but also strong equity considerations.

2. Physician-Patient Privilege versus Duty to Warn

The final area to be discussed in this Article is the problem presented by a line of cases which impose upon physicians, and inferentially hospitals, a duty to disclose information which arises in the physician-patient relationship. The definitive articulation of this notion came in *Tarasoff v. The Regents of the University of California*.[15] In *Tarasoff* suit was brought against the Regents of the University, psychotherapists employed by the University Hospital, and campus police to recover for the murder of plaintiff's daughter by a psychiatric patient. In October of 1969 a man named Prosenjit Poddar killed Tatiana Tarasoff. The plaintiffs in the case, Tatiana's parents, alleged that two months earlier Poddar had confided his intention to kill Tatiana to Dr.

14 *E.g.*, Smith v. State, 298 N.C. 115, 257 S.E.2d 399 (1979). Plaintiff doctor was dismissed as a superintendent of a state hospital for mentally disordered patients after refusing to turn over to his immediate superior tapes of a Credential Committee's meeting requested to investigate two deaths within the hospital, and containing information as to a staff doctor's conduct in refusing to verify the deaths. Plaintiff relied on N.C. GEN. STAT. § 122-8.1 (1974), which was then applicable to physicians in state hospitals:

> No physician, psychiatrist or any other officer, agent or employee of any of the institutions or hospitals under the management, control and supervision of the Department of Human Resources shall be required to disclose any information, record, report, case history or memorandum which may have been acquired, made or compiled in attending or treating an inmate or patient of said institutions or hospitals in a professional character, and which information, records, reports, case histories and memorandums were *necessary in order to prescribe for or to treat said inmate or patient or to do any act for him in a professional capacity* unless a court of competent jurisdiction shall issue an order compelling such disclosure. (emphasis added).

The court held that the information on the tapes was not protected under N.C. GEN. STAT. § 122-8.1 (1974) because it was not necessarily within the language of the statute emphasized above. The court further construed the statute as inapplicable to the refusal of a state hospital superintendent to turn over information to the State Department of Human Resources, charged with the duty of overseeing state hospital administration, when it investigates complaints of medical staff neglect. The court upheld the superintendent's dismissal finding that he had withheld the tapes to prevent embarrassing disclosure and not to protect a doctor-patient relationship.

15. 17 Cal. 3d 425, 551 P.2d 334, 131 Cal. Rptr. 14 (1976).

Lawrence Moore, a psychologist employed by the Cowell Memorial Hospital at the University of California, Berkeley. The parents alleged that on Moore's request campus police briefly detained Poddar but released him when he appeared rational. Further, the plaintiff claimed that a physician, Dr. Moore's superior, then directed that no further action be taken to detain Poddar. No one warned plaintiffs of Tatiana's peril. At trial the superior court sustained defendant's demurrer without leave to amend. The Supreme Court of California held that when a psychotherapist determines or should determine pursuant to the standards of his profession that his patient presents a serious danger of violence to another, he incurs an obligation to use reasonable care to protect the intended victim against such danger. The discharge of such duty, the court went on, may require the therapist to take one or more of various steps depending on the nature of the case. The court stated, "Thus it may call for him to warn the intended victim or others likely to apprise the victim of the danger, to notify the police, or to take whatever other steps are reasonably necessary under the circumstances."[16]

There is no question that this so-called duty to warn directly clashes with the privilege that exists between psychiatrist and patient or psychologist and patient. In fact, the decision has created no small amount of confusion in the minds of physicians generally and psychiatrists in particular. There is no guideline, no real criterion, to aid the physician in making the decision as to when a threat or utterance of peril is in fact a clear and present danger and should trigger the responses articulated by the Supreme Court of California.

In a similar case the Superior Court of New Jersey followed the *Tarasoff* rule and applied it to a case in which a wrongful death action was brought against a psychiatrist because one of the psychiatrist's patients murdered the plaintiff's daughter.[17] The court held that the psychiatrist could be liable on the *Tarasoff* principle. Moreover, the New Jersey Court found another rationale for the ruling. The court analogized the duty to warn in the same context as other legally imposed duties to warn. The court noted the general rule that a person who negligently exposes another to a contagious disease is liable in damages when the other contracts the disease. Specifically, the court stated a physician has a duty to warn third persons against possible exposure to contagious or infectious diseases. Physicians must also report observed tuberculosis, venereal disease, and various other contagious diseases as well as certain other conditions. Thus, it used the public health duty to warn the general population to justify a duty to warn a specific person.

16. *Id.* at 43, 551 P.2d at 340, 131 Cal. Rptr. at 20.
17. McIntosh v. Milano, 168 N.J. Super. 466, 403 A.2d 500 (1979).

The New Jersey Court also addressed the confidentiality issue. It indicated that the defendant asserted the need for confidentiality in therapy and also alleged socially undesirable ramifications, particularly to patients and potential patients arising out of a *Tarasoff*-type duty when therapists may not be able to predict dangerousness accurately. The court opined that although confidentiality is important, the need for confidentiality cannot be considered either absolute or decisive.[18] Employing the public health analogy once again, the court noted that a patient is entitled to disclose his symptoms and condition to his physician in confidence, except where the public interest or the private interest of a patient so demands. Therefore, a patient possesses a limited right to confidentiality in extrajudicial disclosures subject to exceptions prompted by the supervening interests of society.

Of course there are limits to the scope of this rule.[19] In *Cole v. Taylor*,[20] the Iowa Supreme Court properly rejected a suit by a patient against her psychiatrist on the claim that in his professional capacity he negligently failed to prevent her from killing her husband. The court held that there was no duty to warn in this case nor was there a duty to "prevent."[21]

IV. Summary and Conclusions

Of the myriad challenges facing the modern health care institution and the professionals who are called upon to participate in its management there are no more difficult ones than those which involve competing, equally compelling interests. Often the conflicts and dilemmas they present cannot be resolved by the application of usual strategies or conventional wisdom. Strangely, these conflicts arise due to the manner in which the law intrudes into health care matters. By responding to differing felt needs, the law often creates the dilemmas which it has no mechanism to resolve.

It is this writer's opinion that the law will continue to encourage, inhibit, and be indifferent to health concerns. Moreover, the challenges which accompany that state of affairs will severely test the health professional. Only the most resourceful, wise, creative, and resolute will be able to manage successfully in the days to come.

18 *Id.* at 478, 403 A.2d at 512

19 *In re* Votteler, 327 N.W.2d 759 (Iowa 1982) (psychiatrist not liable for failure to warn his patient's husband when, after acting so as to put the victim on notice as to the patient's dangerousness, the patient ran over the victim with a car).

20 301 N.W.2d 766 (Iowa 1981).

21 *Id.* at 767-68