

The Medical Practice Computer Profile: Proof of the Doctor's Actions in a Series of Similar Cases

An increasingly large number of medical malpractice cases is litigated every year.¹ But while the incidence of such claims has been increasing, there have been few changes made in the manner in which the disputes are resolved.² This is particularly true of the methods used to determine whether a defendant doctor has, in fact, been guilty of negligence in any given action.

To a considerable extent, the determination of whether a doctor has committed malpractice is made on the basis of the presumably expert judgments of fellow practitioners, along with the image of the doctor which opposing counsel create in the minds of the jury.³

The primary purposes of this article are to call attention to the fact that liability in many malpractice cases cannot be determined satisfactorily by the traditional method of expert medical testimony and to propose a means of alleviating this problem. The author suggests the evidentiary use of a concept known as the Medical Practice Computer Profile. Surgery for acute appendicitis will be used to illustrate how this concept may provide a rational basis for assessing liability in cases where the testimony of expert witnesses would be of little probative value.

A secondary purpose of this article is to discuss problems of discovery and admissibility as they relate to the use of computer profile evidence in medical malpractice litigation. In many cases, some of the most relevant evidence of a doctor's innocence or guilt can be derived from this computerized analysis of what he has done in similar cases involving other of his patients. Yet the laws of discovery make it very difficult to obtain the records of such cases; and even if counsel were able to gain access to the data, various provisions of the

¹DEPT. OF HEALTH, EDUCATION, AND WELFARE, MEDICAL MALPRACTICE — REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 6 (1973).

²Dietz, *The Medical Malpractice Legal System* in DEPT. OF HEALTH, EDUCATION, AND WELFARE—APPENDIX, REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE 87 (1973) [hereinafter cited as Dietz].

³*Id.* at 98, 110-13.

Evidence Code greatly impede or totally prohibit their admission into evidence. The applicable laws of discovery and admissibility will be surveyed, and the policy justifications supporting them will be examined to determine whether discovery should be restricted and admissibility denied.

I. THE MEDICAL PRACTICE COMPUTER PROFILE

The Medical Practice Computer Profile is a summary of the characteristics of a doctor's practice derived by computer analysis of the records for all of his patients.⁴ The informational product of a medical consultation or treatment of any given patient is to a large extent recorded by doctors, nurses, and laboratory technicians.⁵ Current techniques of data processing permit the recording and storage of this information in computers.⁶ Examples of the type of information that can be computer processed include: patient identification, history, physical findings, laboratory tests, use of consultants, operative reports, medications, length of hospital stay, discharge diagnosis, and complications during hospitalization.⁷

The computer profile print-out outlines in a single place a com-

⁴Kuehn reports that the Commission on Professional and Hospital Activities (C.P.H.A.) is:

the world's largest resource center of computer-processed medical information. This center receives and electronically analyzes and tabulates the abstracts of the medical records of almost 40 percent of all patients discharged from non-federal short-term general and other specialty hospitals in the United States and Canada.

The Professional Activity Study (P.A.S.) is the fundamental C.P.H.A. program, and it prepares a variety of confidential statistical reports for hospitals. An extension of the P.A.S. system is the Medical Audit Program (M.A.P.) for evaluating the quality of care reflected in medical records.

Now processing an average of 55,000 abstracts a day, C.P.H.A. serves the needs of more than 1,800 hospitals for statistical information on the care they render, and is expected to add in 1973 over 14¼ million abstracts of patients' medical records to its data banks.

Kuehn, *The Commission on Professional and Hospital Activities*, 58 BULL. AM. COLL. SURG. 7 (Oct. 1973) [hereinafter cited as Kuehn].

⁵Shenkin, *Giving the Patient His Medical Record: A Proposal to Improve the System*, 289 N. ENG. J. MED. 688 (1973).

⁶Buckley, *A Computer Based Medical Records System*, 12 METHODS INF. MED. 137 (1973); Grossman, *An Automated Medical Record System*, 224 J.A.M.A. 1616 (1973).

⁷The computer-processed record requires elimination of information in the medical record that is non-informative and non-concise. Examples of such information include:

(1) An infinite litany of negatives and normals to prompt and prove what was examined and asked; (2) A lengthy self-defense against medical legal action; (3) A paper argument; (4) A self-justification or intrapersonal discursive document; (5) An unstructured mass of 'natural language' without recallability or comparability.

Hilger, *Language and Programming for Computer Input, Filing, Retrieval and Communication* in A.M.A., SYMPOSIUM ON COMPUTER SYSTEMS IN MEDICINE 107, 108 (1971).

posite of what the doctor has done in all of his other cases.⁸ Using this profile, an objective conclusion may be made as to the manner in which the doctor delivers care to the aggregate of his patients.⁹

A. DEVELOPMENT OF THE COMPUTER PROFILE

Although the Medical Practice Computer Profile is a relatively new concept, its use may be expected to increase dramatically in the near future for two reasons: (1) the trend toward peer review by hospital staff members of the performance of physicians and surgeons working in the hospital and (2) the increased concern of the Federal Government over control of Medicare and Medicaid payments.

Hospitals in California are now required to institute a program of peer review.¹⁰ That is, a committee of doctors must periodically meet to consider the quality of care distributed by their fellow practitioners.¹¹ A summary similar to the Medical Practice Computer Profile is often used as an efficient means of isolating continuing irregularities, questionable judgments, and other mistakes.¹² Because of the increasing use of computers in hospitals,¹³ it is reasonable to

⁸Computer profiles in use today focus on the performance of the hospital as a unit and on the performance of major clinical services, rather than on the performance of an individual doctor. Kuehn, *supra* note 4, at 12-13.

⁹Brook, *Quality of Care Assessment: Choosing A Method for Peer Review*, 288 N. ENG. J. MED. 1323 (1973); Fressel, *Assessing Quality of Care From the Medical Record*, 286 N. ENG. J. MED. 134 (1972).

¹⁰CAL. BUS. & PROF. CODE § 2392.5 (West Supp. 1974).

The regular treatment of or prescribing for patients in a licensed general or specialized hospital having five or more physicians and surgeons on the medical staff which does not have rules established by the board of directors thereof to govern the operation of the hospital, which rules include, among other provisions, all the following, constitutes unprofessional conduct within the meaning of this chapter . . .

(c) Provision that . . . the medical staff shall meet periodically and review and analyze at regular intervals their clinical experience, and that the medical records of the patients shall be the basis for such review and analysis.

(d) Provision that adequate and accurate medical records be prepared and maintained for all patients.

¹¹The Joint Commission on Accreditation of Hospitals has also recently added to its standards for accreditation a requirement that a program of peer review be instituted in all accredited hospitals. *Medical Staff Standards for Accreditation of Hospitals*, in JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS (1973).

¹²Weinert, *Effectiveness of Hospital Tissue Committee in Raising Surgical Standards*, 150 J.A.M.A. 992 (1952); Lembcke, *Medical Auditing by Scientific Methods*, 162 J.A.M.A. 646 (1956).

¹³Kernodle, *Computers in Medicine: A Look Ahead*, 220 J.A.M.A. 1489 (1972); A.M.A., CENTER FOR HEALTH SERVICES RESEARCH AND DEVELOPMENT, *COMPUTER ASSISTED MEDICAL PRACTICE — THE A.M.A.'S ROLE* (1971); Slack, *Television Tube/Keyboard in A.M.A.*, SYMPOSIUM ON COMPUTER SYSTEMS IN MEDICINE 53 (1971); Griggs, *Computerized Central Service Charges*, 50 HOSP. TOP. 100 (March 1972); Thibodaux, *Financial Management Computer Based In-*

expect that computer profiles will become a standardized means of evaluating the performance of physicians and surgeons.

Peer review will also be required by law in the administration of health care purchased with federal funds. In 1972 Congress ordered the establishment of Professional Standards Review Organizations (PSROs) pursuant to P.L. 92-603.¹⁴ If the program is implemented on schedule,¹⁵ by 1976¹⁶ each physician in the United States will be required to belong to a local PSRO unit¹⁷ in order to receive payment¹⁸ for treatment of Medicare and Medicaid patients.¹⁹ The doctors in the local PSRO will be required to develop standards of treatment for their area²⁰ and maintain and review profiles for each

formation System, 47 HOSPITALS 51 (March 1973); Charleston (W.Va.) General Hospital, *Payment Is Due: Confidential Collection Letter From Computer*, 47 HOSPITALS 59 (March 1973); Shaffer, *Computers Play An Increasing Role in Diagnosing and Recommending Treatment of Medical Problems*, Wall St. J., Jul. 9, 1973, at 22, col. 1.

¹⁴42 U.S.C. § 1320c (Supp. II 1972).

Congressional declaration of purpose. In order to promote the effective, efficient, and economical delivery of health care services of proper quality for which payment may be made (in whole or in part) under this chapter and in recognition of the interests of patients, the public, practitioners, and providers in improved health care services, it is the purpose of this part to assure, through the application of suitable procedures of professional standards review, that the services for which payment may be made under this chapter will conform to appropriate professional standards for the provision of health care and that payment for such services will be made — (1) only when, and to the extent, medically necessary, as determined in the exercise of reasonable limits of professional discretion; and (2) in the case of services provided by a hospital or other health care facility on an inpatient basis, only when and for such period as such services cannot, consistent with professionally recognized health care standards, effectively be provided on an outpatient basis or more economically in an inpatient health care facility of a different type, as determined in the exercise of reasonable limits of professional discretion.

¹⁵There is resistance by physicians to the PSRO law. Suit has been filed by three physicians and the Association of American Physicians and Surgeons challenging the PSRO law as unconstitutional. Zimmerly, *M.D.'s Fight PSRO in Court*, 1 J. LEGAL MED. 32 (Sept.-Oct. 1972). The A.M.A. feels that the best interest of the American people would be served by repealing the law. A.M.A. Grams, 227 J.A.M.A. 388 (1974). H.R. 11444, 93d Cong., 1st Sess. (1973) would repeal the PSRO law.

¹⁶42 U.S.C. § 1320c-1(c) (Supp. II 1972). *Cf. also*, Welch, *Professional Standards Review Organizations — Problems and Prospects*, 289 N. ENG. J. MED. 291, 292 (1973) [hereinafter cited as Welch].

¹⁷The Secretary of Health, Education, and Welfare has designated 203 local PSRO units. There will be 28 such units in California. 39 Fed. Reg. 10203 (1974).

¹⁸42 U.S.C. § 1320c-9(b)(1) (Supp. II 1972).

¹⁹"Although at present the PSRO units will supervise only Medicare, Medicaid, and some welfare patients, it is clear that a national health insurance act would lead to inclusion of all patients under [the PSRO] umbrella." Welch, *supra* note 16, at 292.

²⁰42 U.S.C. § 1320c-5(a) (Supp. II 1972).

health care practitioner.²¹

It is inevitable that the PSROs will use computers to process the large amount of medical record data and to construct profiles.²² Thus, one or more agencies in each community will soon possess computerized data of great value to prospective litigants.

B. TRUSTWORTHINESS OF THE PROFILE

The computer profile yields a trustworthy basis for evaluation of the doctor for at least two reasons: (1) the sources of data are dependable and (2) the record is regularly used for several purposes which ensure its accuracy.

The ultimate print-out should be no less trustworthy than the medical records from which data is obtained. Because the primary records themselves are used in the treatment of patients and in the review of the quality of care provided by the hospital, it is not unreasonable to expect that, in general, they will be highly accurate and reliable.²³ Doctors, nurses, and other data recorders have a reputation for precision and care, and one may expect that they will act consistently with these traits when they record information which may have a direct bearing on the life or death of the patient for whom the record is being prepared.²⁴

Further ensuring the accuracy of the Medical Practice Computer Profile is the fact that both the primary medical records and the profile itself will be widely used for a variety of purposes unconnected with malpractice litigation which invite strict review for accuracy. The computer profile will be used to some degree in billing and accounting,²⁵ in establishment of standards of care for the hospital and its doctors²⁶ and in discipline of the individual practitioners.²⁷ Those who come into contact with the profile by being billed or disciplined will have an incentive to challenge vigorously an incorrect profile, and the resulting feedback will help ensure that the records accurately reflect the events and phenomena that they are intended to document.

II. USE OF THE COMPUTER PROFILE TO DIAGNOSE MALPRACTICE

Many cases of malpractice currently 'fall between the cracks' be-

²¹ 42 U.S.C. § 1320c-4(a)(4) (Supp. II 1972).

²² Welch, *supra* note 16, at 293.

²³ For general discussion of the medical record, see D. LOISELL, *MEDICAL MALPRACTICE* §§ 7.09, 7.10 (1973) [hereinafter cited as LOISELL]; C. MCCORMICK, *EVIDENCE* 730 (2d ed. 1972) [hereinafter cited as MCCORMICK].

²⁴ "... these recorded facts are routinely used to make decisions upon which the health and life of the patient depend." MCCORMICK, *supra* note 23, at 730.

²⁵ See *supra* note 13.

²⁶ See *supra* note 20.

²⁷ See *supra* note 21.

cause plaintiff's counsel is unable to isolate clear and convincing evidence of the particular acts of negligence which the defendant-doctor has committed.²⁸ In many such cases, the negligence becomes 'visible' only when the totality of the doctor's behavior can be considered — that is, when his overall performance in the plaintiff's and all similar cases can be evaluated. A hypothetical claim of malpractice based on an allegedly unnecessary removal of a plaintiff-patient's appendix can be used to illustrate the utility of the Medical Practice Computer Profile to affix liability on a defendant-doctor in such situations.

In the hypothetical case, the doctor has made a pre-operative diagnosis of acute appendicitis on the plaintiff-patient. Surgery is performed and recovery is uneventful; however, the pathology report shows that the appendix was normal.

Given these facts, even a medical expert would be unable to conclude whether the doctor was guilty of malpractice.²⁹ On the one hand, the removal of a normal appendix implies unnecessary surgery. On the other hand, the 'unnecessary surgery' may be a sign of good surgical judgment. The early symptoms and signs in many cases of acute appendicitis may not be conclusive, and, as one authority has suggested, the preferred course is to operate: "Exploration to discover the cause of minimal symptoms is safer than waiting; observation until typical or definite symptoms appear is dangerous and ill-advised."³⁰ Even a surgeon exercising the highest standard of care may remove a normal appendix in a certain number of cases where the symptoms strongly suggest appendicitis.

At the same time, a doctor may be performing a large amount of unnecessary surgery by repeatedly electing to operate on the basis of symptoms no more substantial than a reported twinge in the side.³¹ In such a case, any individual operation yielding a normal appendix would not be cause for suspicion.

Computer analysis of the pathology reports in a series of appendectomies by that doctor, however, may uncover malpractice that would otherwise go undetected. Profiles of leading medical practitioners show that when a pre-operative diagnosis of acute appendicitis is made a normal appendix is removed in 17 per cent of the cases.³² If a profile prepared for the defendant-doctor showed that

²⁸*Gonzales v. Nork*, Civ. No. 228566, Cal. Super. Ct., Sacramento County, Memorandum of Decision 166 (Nov. 19, 1973).

²⁹For general reference on appendicitis, see Condon, *Appendicitis* in DAVIS-CHRISTOPHER, *TEXTBOOK OF SURGERY* 928 (10th ed. 1972) [hereinafter cited as Condon].

³⁰*Id.* at 928.

³¹L. WILLIAMS, *HOW TO AVOID UNNECESSARY SURGERY* 120-23 (1972).

³²R. MCCLEERY, *ONE LIFE — ONE PHYSICIAN* 15 (1971) [hereinafter cited as MCCLEERY].

he removed a normal appendix in 44 per cent of the cases involving a pre-operative diagnosis of acute appendicitis, it is apparent that the doctor is quite possibly guilty of at least negligence for his repeated failure to make proper diagnoses.³³ And an equally likely explanation for the statistically inconceivable result is that the doctor purposefully fabricated some of his pre-operative diagnoses of acute appendicitis in a campaign of unnecessary surgery.

As the previous section suggested, there is virtually no limit to the number of variables which may be transferred from medical records into the computer.³⁴ Aside from the obvious utility it would have in helping physicians and surgeons in their program of self-discipline, it is clear that the computer profile could be an extremely valuable piece of evidence in the hands of innovative counsel.

Assuming that the profiles can be obtained from the agencies charged with keeping them and further assuming that the profile is admissible into evidence, it could be used by attorneys for either plaintiff or defendant. In addition to using the profile to isolate incidents of malpractice that might otherwise remain undiscovered, plaintiff's counsel might use it to show that the defendant's actions in a case were not merely the result of negligence, but were part of a conscious scheme of fraud which would justify an award of punitive damages. On the other side, the attorney for the defendant might use the profile results to show that the injury to a plaintiff-patient was not caused by lack of due care but rather that the doctor's actions in the case were fully consistent with the profile results for other doctors in his community.

III. DISCOVERY

A. THE CURRENT RESTRICTIONS

As indicated above, it is not clear who will produce and store the computer profile data. The hardware (the computers) and the software (health data banks and computer expertise) are currently monopolized by three groups: the Social Security Administration, third-party health insurance carriers (such as Blue Cross-Blue Shield), and the Commission on Professional and Hospital Activities.³⁵

A major obstacle to the use of computer profile evidence in medical malpractice litigation is the fact that discovery of such information is limited. California Evidence Code sections 1157³⁶ and

³³*Id.* at 15.

³⁴The only factor limiting the number of elements to be analyzed appears to be the cost. "At present, the cost of a computer-run review of a single patient is approximately \$12.50; if more data per patient are incorporated, costs will rise" Welch, *supra* note 16, at 294.

³⁵*Id.* at 293.

³⁶CAL. EVID. CODE § 1157 (West Supp. 1974).

Neither the proceedings nor records of organized committees of

1157.5³⁷ provide in essence that proceedings or records of peer review committees shall not be subject to discovery. Although this is an untested presumption, it seems likely that the computer profile would be classified as a proceeding or record of the peer review committee and protected from discovery.

California Evidence Code section 1158 guarantees access of a patient's attorney to the medical record of his client.³⁸ However, in view of the fact that the physician-patient privilege³⁹ prevents an attorney from obtaining the medical records of other patients treated by the same doctor,⁴⁰ section 1158 cannot be invoked as authority to obtain access to computer profile results of that doctor.

Similarly, the Federally established PSROs are required to hold data in confidence and to "assure adequate protection of the rights and interests of patients, health care practitioners, or providers of

medical staffs in hospitals having the responsibility of evaluation and improvement of the quality of care rendered in the hospital or medical review committees of local medical societies shall be subject to discovery. Except as hereinafter provided, no person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery or testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting, or to any person requesting hospital staff privileges, or in any action against an insurance carrier alleging bad faith by the carrier in refusing to accept a settlement offer within the policy limits.

The prohibitions contained in this section shall not apply to medical society committees that exceed 10 percent of the membership of the society, nor to any such committee if any person serves upon the committee when his own conduct or practice is being reviewed.

³⁷CAL. EVID. CODE § 1157.5 (West Supp. 1974).

Except in actions involving a claim of a provider of health care services for payment for such services, the prohibition relating to discovery or testimony provided by Section 1157 shall be applicable to the proceedings or records of an organized committee of any non-profit medical care foundation which is a component or subsidiary of a medical society, and which is organized in a manner which makes available professional competence to review health care services with respect to medical necessity, quality of care, or economic justification of charges or level of care.

³⁸CAL. EVID. CODE § 1158 (West Supp. 1974) provides that medical records are to be made available to a patient's attorney upon written authorization prior to the filing of any action. Failure to make records available within five days may make liable the person having custody or control of the records for legal expenses incurred in any proceeding to enforce production, including attorney's fees. For mental patients receiving treatment under the Lanterman-Petris-Short Act, CAL. WELF. & INST. CODE § 5000 (West 1972), 53 CAL. OP. ATT'Y GEN. 151 (1970) held that § 1158 does not apply; the records of mental patients are to be kept confidential despite § 1158.

³⁹CAL. EVID. CODE § 994 (West Supp. 1974).

⁴⁰Marcus v. Superior Court, 18 Cal. App. 3d 22, 95 Cal. Rptr. 545 (1971); cf. also, Unick v. Kessler Memorial Hosp., 107 N.J. Super. 121, 257 A.2d 134 (1969); New York City Council v. Goldwater, 133 N.Y. 420, 31 N.E.2d 31 (1940); Note, *Privileged Communications*, 16 IND. L.J. 592 (1941).

health care."⁴¹ The public will be provided with lists of practitioners excluded from eligibility for reimbursement;⁴² however, there is no indication that the public will be allowed to see the computer profile of that or any other doctor.⁴³

Attorneys attempting to obtain information from private computer companies will likely encounter similar obstacles. To ensure the privacy of such records, the New York Legislature recently passed a statute declaring that the records of a computer company containing information concerning psychiatric patients are private corporate records and not subject to public inspection.⁴⁴ Private computer companies processing medical information in other states have maintained strict confidentiality even without statutory restrictions.⁴⁵ Administrators for government information computer facilities generally leave information dissemination decisions in the hands of the user agency, and the usual decision has been to prohibit access by the public.⁴⁶

B. THE PEER REVIEW PRIVILEGE

As noted, the peer review privilege conferred by the PSRO law⁴⁷ and California Evidence Code sections 1157⁴⁸ and 1157.5⁴⁹ prevents the discovery of proceedings and records of committees concerned with evaluating the performance of medical practitioners. There is no case law dealing with this privilege in the context of computer profile evidence. The two major justifications for the privilege seem to be the physician-patient privilege⁵⁰ and a quasi-judicial work-product

⁴¹ 42 U.S.C. § 1320c-15(a) (Supp. II 1972).

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

⁴² 42 U.S.C. § 1320c-9(b)(2) (Supp. II 1972).

⁴³ See also 42 U.S.C. § 1320c-8 (Supp. II 1972); *Shively v. Stewart*, 65 Cal. 2d 475, 55 Cal. Rptr. 217, 421 P.2d 65 (1966) (physician can discover from disciplinary board the basis for accusatory action); Annot., *Pre-trial discovery in disciplinary proceedings against physician*, 28 A.L.R.3d 1440 (1969).

⁴⁴ N.Y. CIVIL RIGHTS LAW § 79-j (8 McKinney Supp. 1973); cf. also, Curran, *Protection of Privacy and Confidentiality*, 182 SCIENCE 797 (1973).

⁴⁵ See *supra* note 4. The C.P.H.A. does publish some data in its P.A.S. Reporter. There is no identification of individual hospitals, however.

⁴⁶ Comment, *Public Access to Government-Held Computerized Information*, 68 NW. U.L. REV. 433, 448 (1973).

⁴⁷ See *supra* note 41.

⁴⁸ See *supra* note 36.

⁴⁹ See *supra* note 37.

⁵⁰ CAL. EVID. CODE § 994 (West Supp. 1974).

privilege.⁵¹

The policies justifying the physician-patient privilege have been widely criticized,⁵² and there are so many exceptions⁵³ to the privilege that McCormick has observed: "Not much except for the smile is left for the doctor."⁵⁴ In view of the potential usefulness of profile evidence in malpractice litigation, the policies justifying the physician-patient privilege do not seem sufficient to warrant prevention of discovery of such evidence.

A more persuasive five-step argument may be constructed for the quasi-judicial work-product privilege.⁵⁵

(1) The peer review body has an important quasi-judicial administrative function.

(2) The peer review body provides a mechanism for efficient discipline of doctors and control of malpractice.

(3) Voluntary participation of all physicians in the peer review process needs to be encouraged.

(4) Peer review such as that planned under the PSRO system raises implications of 'Big Brother and 1984' that many physicians abhor. A no-discovery policy encourages doctors to participate in peer review on a voluntary basis with minimal outside supervision or control.

(5) Taking into consideration all the above factors, a quasi-judicial work-product privilege for peer review bodies is the best way to accomplish what should be the paramount goal of higher quality health care.

There are at least three legitimate counter-arguments to a quasi-judicial work-product privilege. In the first place, the computer profile evidence is produced independently of any input by the peer review body, and the fact that a peer review committee will be a potential user does not justify limiting its use to such groups. The greater the number of uses to which the profile is put, the greater the opportunity to discover and eliminate unrecognized shortcomings in medical care.

⁵¹Goodley v. Sullivant, 32 Cal. App. 3d 619, 108 Cal. Rptr. 451 (1973); Ascherman v. Natanson, 23 Cal. App. 3d 861, 866, 100 Cal. Rptr. 656, 659 (1972). *Cf also*, Brown v. Superior Court of Butte County, 219 Cal. App. 2d 430, 443, 32 Cal. Rptr. 527, 535 (1963); Annot., *Scope of Defendant's Duty of Pre-Trial Discovery in Medical Malpractice Action*, 15 A.L.R.3d 1446 (1967).

⁵²The physician-patient privilege was not recognized at common law. Both Wigmore and McCormick denounce it. MCCORMICK, *supra* note 23, at 223-28. The 1971 draft of the Proposed Federal Rules of Evidence omits the physician-patient privilege, but does include a psychotherapist-patient privilege. The reasons are explained in the Advisory Committee's Note to COMMITTEE ON RULES OF PRACTICE AND PROCEDURE OF THE JUDICIAL CONFERENCE OF U.S., PROPOSED FED. R. EVID. 504 (Rev. Draft March 1971).

⁵³CAL. EVID. CODE (West 1966) includes 12 exceptions (§§ 996-1007).

⁵⁴MCCORMICK, *supra* note 23, at 227.

⁵⁵*See supra* note 51.

Secondly, PSROs have not yet shown themselves to be capable of providing an effective system for discipline of the medical profession. As one authority has observed:⁵⁶

The laws governing medicine are extremely weak, and state licensing boards generally fail to police the profession. Because of fragmentation and inertia within the medical community, medicine's much-vaunted system of self-discipline is largely a myth.

Thus, before granting such groups the quasi-judicial work-product privilege, it might be prudent to wait and see if the privilege is deserved.

Finally, there are equitable considerations raised by Evidence Code section 1157.5.⁵⁷ Although section 1157.5 prevents a patient from obtaining the records of other patients for use in a malpractice action, it seems that doctors would have free access to the data in actions for payment for services. Insofar as private litigation is concerned, there is no legitimate basis to permit one party to have access to the profiles while denying them to his adversary.

The conclusion, then, is that the PSRO law, the physician-patient privilege, and Evidence Code sections 1157 and 1157.5 should be amended to permit free discovery of profiles by both plaintiff's and defendant's counsel. Although it is conceded that such free disclosure is not without its disadvantages, it would seem that the overall interest of the public would be better served by ensuring at least limited access to the profiles for the purpose of preparing for civil litigation.

IV. ADMISSIBILITY OF THE COMPUTER PROFILE

A. THE CURRENT RESTRICTIONS

In view of the fact that the computer profile is a relatively new development, it is not surprising that there are no provisions of the California Evidence Code which deal expressly with its admissibility. Nor has there been any litigation in any jurisdiction involving the admissibility of such evidence.

Nevertheless, it is clear that various provisions of the Evidence Code operate to restrict or totally prohibit the admission of evidence such as the computer profile.

The hypothetical surgery for acute appendicitis can be used profitably to examine problems of admissibility of computer profile evidence. It may be assumed that the defense attorney has profile data showing that leading medical practitioners in the area remove a normal appendix in 17 per cent of their cases.⁵⁸ The appendectomy

⁵⁶H. LEWIS, *THE MEDICAL OFFENDERS* 19 (1970).

⁵⁷See *supra* note 37.

⁵⁸MCCLEERY, *supra* note 32, at 15.

profile of the defendant-doctor shows that he removed a normal appendix in 15 per cent of his prior cases. The defense attorney wants to introduce the profile results to prove the good performance record of the doctor and to show that the removal of the plaintiff's appendix in the case at bar was probably consistent with due care.

1. THE HEARSAY RULE (CALIFORNIA EVIDENCE CODE SECTION 1200)

The computer print-out of the doctor's profile of performance is clearly hearsay when offered to prove the truth of the matter stated therein.⁵⁹ It is a veritable totem pole of out-of-court statements: the computer says that the abstractor said that the medical record said (1) that the doctor wrote "the diagnosis is appendicitis" and (2) that the pathologist wrote that "the appendix is normal."

Because the agencies involved in the preparation of computer profiles⁶⁰ clearly fall within the California Evidence Code definition of a "business,"⁶¹ the appendectomy profile evidence qualifies for consideration under the business record exception to the hearsay rule.⁶² The profiles easily satisfy three of the four trustworthiness requirements of the business records exception to the hearsay rule. These are: (1) the computer profile print-out is made in the regular course of business,⁶³ (2) the source of information and method of preparation are trustworthy, and (3) a custodian or other qualified witness will be able to testify as to its identity and the mode of preparation.

In a literal sense, the appendectomy profile fails to satisfy the fourth requirement for trustworthiness, that the business writing be made at or near the time of the occurrence of the act, condition, or event that the writing is offered to prove. It is true that there may be a long delay between the occurrence of the act and the time that someone instructs the computer to print out that information. However, the crucial period would seem to be that where fallible human memory is involved, that is, the time between the observation of the phenomenon and the entry in the medical record. Since the medical record itself qualifies as an admissible business record⁶⁴ and since there is little likelihood that the information stored in the computer will change or be forgotten regardless of when the print-out is

⁵⁹CAL. EVID. CODE § 1200 (West 1966).

⁶⁰See *supra* note 35.

⁶¹CAL. EVID. CODE § 1270 (West 1966).

⁶²CAL. EVID. CODE § 1271 (West 1966).

⁶³A malpractice attorney might want to use a tailor-made program to discover information from the computer relevant to the case at issue. Such a 'one-shot' computer profile 'prepared for litigation purposes' most likely would have difficulty satisfying the 'regular course of business' trustworthiness requirement.

⁶⁴*People v. Moore*, 85 Cal. Rptr. 194, 5 Cal. App. 3d 486 (1970); *Springer v. Reimers*, 84 Cal. Rptr. 486, 4 Cal. App. 3d 325 (1970); *People v. Utter*, 101 Cal. Rptr. 214, 24 Cal. App. 3d 535 (1972).

made,⁶⁵ it should not be difficult to convince a court that the computer profile hearsay is admissible under the business records exception, or alternatively, to encourage the court to create a modified business record exception.⁶⁶

In the few states in which the question has been litigated, the courts have concluded that computer-assembled data qualify for admission as business records.⁶⁷ Two other states have recently amended their hearsay rules to permit the admission of electronically stored records.⁶⁸ Although there has been no litigation at the appellate level in California, it seems safe to conclude that the California courts will reach similar conclusions when the question is raised.

2. EVIDENCE OF CHARACTER (CALIFORNIA EVIDENCE CODE SECTIONS 1101, 1104)

Although the hearsay objection can probably be circumvented, it is much more difficult to avoid the section 1101 objection that the profile should be excluded because it is an attempt to use evidence of a person's character to prove circumstantially the nature of his conduct on a specified occasion.⁶⁹ This exclusionary rule is reinforced by section 1104:⁷⁰

... evidence of a trait of a person's character with respect to care or skill is inadmissible to prove the quality of his conduct on a specified occasion.

Returning to the appendectomy example, it would appear that the defendant-doctor is attempting to use evidence of his prior specific acts to prove that he acted with due care on the occasion which is before the court. To the extent that this constitutes evidence of character, sections 1101 and 1104 would seem to exclude expressly the use of the appendectomy statistics. Thus, the Evidence Code sections result in the denial of a valuable argument to the defendant-doctor who has favorable profile experience, and conferral of a privi-

⁶⁵Note, *Admissibility of Computer Kept Business Records*, 55 CORNELL L. REV. 1033, 1041 (1970).

⁶⁶CAL. EVID. CODE § 160 (West 1966).

⁶⁷*Transport Indemnity Co. v. Seiv*, 178 Neb. 253, 132 N.W.2d 871 (1965); *Merrick v. United States Rubber Co.*, 7 Ariz. App. 433, 440 P.2d 314 (1968); *Olympic Insurance Co. v. H.D. Harrison, Inc.*, 418 F.2d 669 (5th Cir. 1969); and *King v. State ex rel. Murdock Acceptance Corp.*, 222 So. 2d 293 (Miss. 1969). For general reference, see: LOUISELL, *supra* note 23, § 7.10, n. 48 (Supp. 1973); Annot., *Proof of Business Records Kept or Stored on Electronic Computing Equipment*, 11 A.L.R.3d 1377 (1967); Note, *Admissibility of Computer Kept Business Records*, 55 CORNELL L. REV. 1033 (1970); Note, *The Admissibility of Computer Print-Outs of Business Records*, 41 MISS. L.J. 604 (1970).

⁶⁸FLA. STAT. ANN. § 92.36 (2) (Supp. 1973); IOWA CODE ANN. § 622.28 (Supp. 1973).

⁶⁹CAL. EVID. CODE § 1101 (West 1966).

⁷⁰CAL. EVID. CODE § 1104 (West 1966).

lege to conceal it on the defendant-doctor who has an unfavorable profile.

It must be recognized, however, that sections 1101 and 1104 do not exclude all computer profile evidence. Section 1101(b) permits the introduction of evidence relevant to prove motive, opportunity, intent, preparation, plan, knowledge, identity, or absence of mistake or accident.⁷¹ Thus, if the profile of the defendant-doctor shows that he removed a normal appendix in 44 per cent of his prior cases,⁷² and if the plaintiff's attorney wished to introduce such evidence as part of his proof that the doctor was engaged in a scheme of fraud, the computer profile should be admissible under section 1101(b).⁷³ One may presume that defense attorneys will spend long hours trying to find ways to fit favorable profile evidence into one of the exceptions of 1101(b) and, thus, expose the jury to data casting a favorable reflection on their clients.

B. ADMISSION OF EVIDENCE OF CHARACTER TO PROVE CONDUCT: POLICY CONSIDERATIONS

It is apparent from the above discussion that sections 1101 and 1104 represent the primary obstacle to admission of profile evidence, and it seems worthwhile to examine the policy considerations on which those sections rest to determine if profile evidence should, in fact, be excluded.

The California Law Revision Comment for Evidence Code section 1101 explains why it is generally desirable to exclude evidence of character to prove conduct in a civil case:⁷⁴

First, character evidence is of slight probative value and may be very prejudicial. Second, character evidence tends to distract the trier of fact from the main question of what actually happened on the particular occasion and permits the trier of fact to reward the good man and to punish the bad man because of their respective characters.

⁷¹In a recent case, Sacramento Superior Court Judge Abbott Goldberg relied on § 1101(b) as authority to allow admission of the "similar fact evidence" of 38 patients and 50 operations to show (1) the intent of the defendant-doctor to commit fraud and (2) the knowledge of the hospital authorities of that fraud. Computer profile evidence was not used. However, statistical analysis of what the defendant-doctor had done in a series of similar cases was used, and similar principles are involved in computer profile evidence. *Gonzalez v. Nork*, Civ. No. 228566, Cal. Super. Ct., Sacramento County, Memorandum of Decision 8-9 (Nov. 19, 1973).

⁷²MCCLEERY, *supra* note 32, at 15.

⁷³*People v. Beamon*, 8 Cal. 3d 625, 632-33, 105 Cal. Rptr. 681, 685-86, 504 P.2d 905, 909-11 (1973) (codifies the prior law); *Janisse v. Winston Investment Co.*, 154 Cal. App. 2d 580, 588, 317 P.2d 48, 54 (1957) (same in civil or criminal case); *Atkins Corp. v. Tourny*, 6 Cal. 2d 206, 215, 57 P.2d 480, 485 (1936) (evidence of other frauds admissible to prove intent); *People v. Morani*, 196 Cal. 154, 158-59, 236 P. 135, 136-38 (1925) (evidence of prior operations admissible to prove knowledge of probable results).

⁷⁴CAL. EVID. CODE § 1101 (West 1966).

Third, introduction of character evidence may result in confusion of issues and require extended collateral inquiry.

Ideally, liability in medical malpractice litigation should be based on the merits of the medical issues in the case before the court and not on what the doctor has done in other cases. For example, the exclusion of evidence of character from medical malpractice litigation certainly seems appropriate when it is in the form of opinion of satisfied patients. Such evidence is generally not probative,⁷⁵ is easily manufactured, and necessitates an undue consumption of time.

The reasons for excluding evidence of character seem less convincing, however, when applied to exclude profile results. The computer profile accurately tabulates the prior experience of the doctor. There should be no distraction of the trier of fact from what actually happened on the particular occasion. The computer profile summarizes the quality of care given in the aggregate, and the focus is not on any single prior case.

Moreover, to again return to the hypothetical, the nature of acute appendicitis may be such that even medical experts cannot ascertain malpractice on the basis of evidence in an isolated case.⁷⁶ In such circumstances, expert testimony will be of very little help to the jury, and it would seem that the improprieties of the defendant-doctor can be revealed only with the introduction of some evidence of what he has done to other patients in the same situation.

The fact remains that the appendectomy profile results are highly prejudicial, and they do not provide the ultimate answer of whether the removal of the appendix in a particular case was consistent with due care. The exact manner in which the jury reaches its determination in such a case is open to speculation,⁷⁷ though it seems reasonable to presume that less distortion of the truth would probably occur if the jury were allowed to reach its judgment on malpractice with the doctor's medical practice profile in mind. Where a doctor's profile shows that a normal appendix was removed in 17 per cent of prior cases,⁷⁸ the doctor has provided valuable service to society in his medical practice, and should be allowed to invoke good general character to rebut suspicious circumstances. On the other hand, if the doctor's profile shows that a normal appendix was removed in 44 per cent of his cases,⁷⁹ it seems appropriate to use this data as evidence tending to show the likelihood of negligence or fraud in the case at issue.

⁷⁵ "Three-quarters of those whose care was considered less than optimal felt they had received the best of care." McCLEERY, *supra* note 32, at 34.

⁷⁶ Condon, *supra* note 29, at 928.

⁷⁷ Dietz, *supra* note 2, at 98, 110-13.

⁷⁸ McCLEERY, *supra* note 32, at 15.

⁷⁹ *Id.*

V. CONCLUSION

With the growth of peer review programs and the increasing concern expressed by Federal officials over control of Medicare payments, it seems inevitable that large amounts of computerized data will be accumulated as various agencies attempt to evaluate the quality of health care services. It is apparent that, as this data becomes more sophisticated and more plentiful, it would be desirable for attorneys to study it carefully to determine its possible utility in malpractice litigation. As suggested above, it is reasonable to conclude that the profiles will be found to contain much evidence of probative value, and attempts should be made by attorneys to use it to their clients' advantage.

It has been the principal thesis of this article that profile evidence is highly trustworthy and deserves to be admitted in many cases, particularly in those in which malpractice can be proved only by considering the totality of the particular defendant's behavior. To facilitate such use, it seems clear that statutory revision is necessary, first to enable counsel to gain access to the information and, second, to permit the admission of such evidence.

With regard to admissibility, it has been conceded that evidence of a person's character or his actions on a previous occasion may be prejudicial when used as proof of the nature of his conduct in the instance at issue. But, in view of the considerable probative value the profile evidence may have, it would seem that this danger does not warrant an absolute prohibition on the use of profile data. Judges have always had wide discretion to exclude prejudicial evidence,⁸⁰ and it would seem the most prudent course would be to permit broad use of the evidence while permitting the court to consider in each case (1) the relevance of the evidence, (2) the possibility of finding alternative methods to prove the same contention, and (3) the possible prejudice which may result if the evidence is admitted.

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⁸⁰CAL. EVID. CODE § 352 (West 1966).