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Indiana's Peer Review Privilege Statute and Its Effect on a Claim of Negligent Credentialing: Analysis and Proposed Statutory Reform

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Notes

INDIANA'S PEER REVIEW PRIVILEGE STATUTE AND ITS EFFECT ON A CLAIM OF NEGLIGENT CREDENTIALING: ANALYSIS AND PROPOSED STATUTORY REFORM

I. INTRODUCTION

Indiana's peer review privilege statute creates an evidentiary privilege for information related to the professional qualifications of health care providers in Indiana, including doctors, dentists, nurses, and other health care professionals.[1] As its name implies, the information protected by the statute is acquired during the process of "peer review." Peer review of physicians is defined as "the evaluation by practicing physicians of the quality, efficiency, and effectiveness of services ordered or performed by other physicians."[2] In a hospital setting, peer review is usually carried out in committees, which are composed of members of that hospital's medical staff.[3] The responsibilities of peer review committees vary, but they typically include the task of determining which physicians are worthy of hospital staff privileges.[4] To perform this function, hospital peer review committees initially screen the professional qualifications of physicians who apply for hospital staff privileges and periodically review those qualifications.[5]

Advocates of the peer review process assert that because the medical profession is highly specialized, physicians and other health care professionals possessing medical expertise are best qualified to evaluate the performance of

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1. *See* IND. CODE ANN. § 34-4-12.6-1 to -4 (West Supp. 1992). For a partial text of the statute, see *infra* note 84.

2. WILLIAM P. ISELE, THE HOSPITAL MEDICAL STAFF: ITS LEGAL RIGHTS AND RESPONSIBILITIES 126 (1984). Although peer review is performed on many types of health care providers, the focus of this note is the application of Indiana's peer review privilege statute to the review of physicians who are independent contractors in Indiana hospitals.

3. *See* Randall E. Butler, *Records and Proceedings of Hospital Committees Privileged Against Discovery*, 28 S. TEX. L.J. 97, 100-01 (1987).

4. The peer review committee that performs this function is typically called the credentialing committee. *Id.* at 100.

5. *Id.*

other health care providers.[6] Nonetheless, as concerned as physicians should be with assuring that they are delivering quality medical care, physicians have been reluctant to participate on peer review committees.[7] Physicians have feared that negative opinions or criticisms voiced against another physician may result in resentment, loss of referrals, or litigation once those criticisms are exposed.[8]

In an effort to encourage physicians to participate candidly and openly in the peer review process, most states have enacted peer review privilege statutes. These statutes typically protect peer review documents and discussions from discovery[9] and grant the committee members immunity[10] for action taken while

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6. *See* Arthur F. Southwick & Debora A. Slee, *Quality Assurance in Health Care: Confidentiality of Information and Immunity for Participants*, 5 J. LEGAL MED. 343 (1984), *reprinted in* ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION 623 (2d ed. 1988) ("The theory is that peers are in the best position to judge each other, and self criticism has been found to be a useful educational and quality management tool."). *See also* Christopher S. Morter, Note, *The Health Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115 (1988).

7. One physician has stated:

> Since the beginning of recorded time, it has been axiomatic that professional organizations and societies have been reluctant to criticize members of their own societies or groups. . . . Physicians and health care providers are no exception to this rule, and for years there has been widespread criticism of the medical profession for an undeclared "conspiracy of silence" to protect those individuals within the ranks who are incompetent or derelict in their duties.

The Health Care Quality Improvement Act of 1986: Hearings on H.R. 5110 Before the Subcomm. on Health and the Environment of the House of Representatives Comm. on Energy and Commerce, 99th Cong., 2d Sess. 217 (1986) (statement of Wayne W. Alberts, M.D., Medical Director, Capitol Area Permanente Medical Group, P.C.).

8. For a discussion of these fears, see *infra* notes 46-52 and accompanying text.

9. *See e.g.*, ALA. CODE § 34-24-58 (1991); ALASKA STAT. §§ 18.23.030, 18.23.070 (1991); ARIZ. REV. STAT. ANN. § 36-445.01 (Supp. 1992); ARK. CODE ANN. §§ 20-9-304, 20-9-503 (Michie 1991); CAL. EVID. CODE § 1157 (West Supp. 1993); CONN. GEN. STAT. ANN. § 19a-17b (West Supp. 1993); DEL. CODE. ANN. tit. 24, § 1768 (Supp. 1992); D.C. CODE ANN. § 32-505 (Supp. 1992); FLA. STAT. ANN. § 766.101 (West Supp. 1993); GA. CODE ANN. § 31-7-133, (Michie 1991); HAW. REV. STAT. § 624-25.5 (Supp. 1992); IDAHO CODE § 39-1393 (Supp. 1993); ILL. COMP. STAT. ANN. ch. 735, para. 5/8-2101 (Smith-Hurd 1993); IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992); IOWA CODE ANN. § 147.135 (West 1989 & Supp. 1993); KAN. STAT. ANN. § 65-4915 (1992); KY. REV. STAT. ANN. § 311.377 (Baldwin Supp. 1991); LA. REV. STAT. ANN. § 13.3715.3 (West 1991 & Supp. 1993); ME. REV. STAT. ANN. tit. 32, § 3296 (West Supp. 1992); MD. HEALTH OCC. CODE ANN. § 14-503 (1991); MASS. GEN. LAWS ANN. ch. 111, §§ 204, 205 (West Supp. 1993); MICH. COMP. LAWS ANN. § 333.21515 (West 1992); MINN. STAT. ANN. § 145.64 (West Supp. 1993); MISS. CODE ANN. § 41-63-9 (Supp. 1992); MO. ANN. STAT. § 537.035 (Vernon 1988); MONT. CODE ANN. §§ 50-16-201 to -205 (1991); NEB. REV. STAT. §§ 71-2046 to -2048 (1990); NEV. REV. STAT. ANN. § 49.265 (Michie Supp. 1991); N.H. REV. STAT. ANN. § 329:29 (Supp. 1992); N.J. STAT. ANN. § 2A:84A-22.8 (West Supp. 1992); N.M. STAT. ANN. § 41-9-5 (Michie 1989); N.Y. EDUC. LAW § 6527(3) (McKinney 1985 & Supp. 1993); N.C. GEN. STAT. § 131E-95 (1992); N.D. CENT. CODE § 23-01-02.1 (1991); OHIO REV. CODE ANN. §§ 2305.24, 2305.251 (Baldwin 1990); OKLA STAT. ANN. tit. 63, § 1-1709 (West 1984); OR. REV.

on the committee. By giving the peer review committee members immunity and making all of their opinions and recommendations confidential, physicians are encouraged to participate in the peer review process in an open and candid manner. Thus, the peer review committee, acting within the protection of the privilege, is more willing to speak out against an incompetent peer. As a result, the quality of medical care is improved.[11]

Indiana's peer review privilege statute was created in 1977.[12] The statute

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STAT. § 41.675 (Supp. 1992); PA. STAT. ANN. tit. 63, §§ 425.2, 425.4 (Supp. 1992); R.I. GEN. LAWS § 5-37.3-7 (1987); S.C. CODE ANN. §§ 40-71-10, 40-71-20 (Law. Co-op. Supp. 1992); S.D. CODIFIED LAWS ANN. § 36-4-26.1 (1992); TENN. CODE ANN. §§ 63-6-219 (Supp. 1992); TEX. REV. CIV. STAT. ANN. art. 4495(b) (West Supp. 1993); UTAH CODE ANN. §§ 26-25-1, 26-25-3 (Supp. 1992); VT. STAT. ANN. tit. 26, § 1443 (Supp. 1993) VA. CODE ANN. § 8.01-581.17 (Michie 1992); WASH. REV. CODE ANN. § 4.24.240 (West 1988); W. VA. CODE § 30-3C-3 (1991); WIS. STAT. ANN § 146.38 (West 1989). For a general discussion on the peer review privilege, see Laurent B. Frantz, Annotation, *Discovery of Hospital's Internal Records or Communications as to Qualifications or Evaluations of Individual Physician*, 81 A.L.R.3d 944 (1977 & Supp. 1990).

10. *See* ALA. CODE § 6-5-333 (Supp. 1992); ARIZ. REV. STAT. ANN. § 36-445.02 (Supp. 1992); ARK. CODE ANN. § 20-9-502 (Michie 1991); COLO. REV. STAT. ANN. § 12-36.5-105 (West 1990 & Supp. 1992); CONN. GEN. STAT. ANN. § 19a-17b (West Supp. 1993); DEL. CODE ANN. tit. 24, § 1768 (Supp. 1992); FLA. STAT. ANN. § 766.101 (West Supp. 1993); GA. CODE ANN. § 31-7-132 (Michie 1991); HAW. REV. STAT. § 671D-10 (Supp. 1992); ILL. COMP. STAT. ANN. ch. 210, para 85/10.2 (Smith-Hurd 1993); IND. CODE ANN. §§ 16-10-1-6.5, 34-4-12.6-4 (West Supp. 1992); IOWA CODE ANN. § 147.135 (West 1989 & Supp. 1993); KAN. STAT. ANN. § 65-442 (1992); LA. REV. STAT. ANN. § 13:3715.3 (West 1991); MD. HEALTH OCC. CODE ANN. § 14-504 (1991); OHIO REV. CODE ANN. § 2305.25 (Baldwin 1990); OKLA. STAT. ANN. tit. 76, §§ 25-28 (West Supp. 1993); PA. CONS. STAT. ANN. tit. 63 § 425.3 (Supp. 1992); R.I. GEN. LAWS § 5-37-1.5 (1987); S.D. CODIFIED LAWS ANN. §36-4-25 (1992); TENN. CODE ANN. § 63-6-219 (Supp. 1992); UTAH CODE ANN. § 26-25-1 (Supp. 1992); VT. STAT. ANN. tit 26, §1442 (1989); VA. CODE ANN. § 8.01-581.16 (Michie 1992); WASH. REV. CODE ANN. § 4.24.250 (West 1988); W. VA. CODE § 30-3c-2 (1991); WIS. STAT. ANN. § 146-37 (West 1989).

Issues surrounding both immunity and confidentiality present themselves in the context of the peer review privilege. However, this note focuses on the confidentiality provisions. A comprehensive discussion of the immunity provisions is therefore beyond the scope of this note.

11. See the landmark decision of Bredice v. Doctors Hosp., Inc, 50 F.R.D. 249, 250 (D.D.C. 1970), *motion reargued and denied*, 51 F.R.D. 187 (D.D.C. 1970), *and aff'd mem.*, 479 F.2d 920 (D.C.Cir. 1973) (holding that "candid and conscientious evaluation of clinical practices is a sine qua non of adequate hospital care," and that a plaintiff may not discover peer review records absent exceptional circumstances). *See also* Gregory G. Gosfield, Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552 (1979). Gosfield identifies two premises that support the granting of immunity and privilege to peer review committees. First, special privileges and immunities result in increased peer review activity, and second, increased peer review results in the improvement of medical care. *Id.* at 552. Gosfield also suggests that if one of these premises is proved false, the justification for special treatment for the peer review committee is untenable. *Id.*

12. One court has explained,

> [T]he purpose of the peer review privilege is to foster an effective review of medical care. An effective review requires that all participants to a peer review proceeding communicate candidly, objectively, and conscientiously. Absent the protection of a

encourages participation in peer review by assuring confidentiality[13] and providing immunity[14] to the physicians who serve on the committee. While the peer review privilege has admirable objectives,[15] the operation of the statute has a drastic effect on a plaintiff who sues a hospital on the theory of "negligent credentialing." A plaintiff in a negligent credentialing suit alleges in effect that a hospital negligently screened or reviewed the professional qualifications of one of its staff physicians who, as a result of incompetence, injured the patient-plaintiff.[16] Because the hospital peer review committee has the primary responsibility for overseeing the credentialing process,[17] a hospital's peer review records contain all of the evidence needed to prove a negligent credentialing claim.[18] Therefore, the peer review privilege denies a plaintiff that asserts a negligent credentialing claim access to much needed evidence.

In addition to its effect on a negligent credentialing claim, Indiana's peer review privilege can be criticized in several respects. First, self-policing may result in a "conspiracy of silence" in which health care providers are reluctant to criticize their peers.[19] In addition, the courts construing the peer review

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privilege, the candor and objectivity of peer review communications and the effectiveness of the peer review process would be hindered. Thus, the peer review privilege provides protection by granting confidentiality to all communications, proceedings, and determinations connected with a peer review process.

Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306, 1311 (Ind. App. 1988).

13. *See* IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992). For a partial text of the statute, see *infra* note 84.

14. *See* IND. CODE ANN. § 34-4-12.6-3 (West Supp. 1992).

15. *See supra* note 12.

16. Suits arising from the grant or retention of hospital privileges are termed "negligent credentialing" suits. *See* Richard L. Griffith & Jordan M. Parker, *With Malice Towards None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation*, 22 TEX. TECH. L. REV. 157 (1991). For purposes of this note, negligent credentialing will refer to both negligently granting initial staff hospital privileges and negligently renewing hospital privileges once a physician has become a member of the hospital staff.

17. *See* Reed E. Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM. J.L. & MED. 245, 248-49 (1975).

18. A lack of evidence is not problematic in the typical malpractice case where a plaintiff sues an individual physician. In these malpractice cases, the plaintiffs have access to their own medical records, which will supply much of the evidence necessary to prove malpractice. *See* IND. CODE. ANN. § 34-1-14-5 (West Supp. 1992) (allowing patients to receive copies of their own medical records once they give appropriate authorization).

For a discussion of how negligent credentialing suit plaintiffs can overcome their proof problems by using alternatives to peer review records, *see generally*, Susan Ward, Comment, *Corporate Negligence Actions Against Hospitals—Can the Plaintiff Prove a Case?*, 59 WASH. L. REV. 913, 924-25 (1984).

One of the boldest challenges to the idea that the peer review privilege should be applicable to a negligent credentialing suit can be found in B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 153 (1984).

19. *See* Goldberg, *supra* note 18, at 160-61.

statutes have given a broad interpretation to the privilege in favor of confidentiality.[20] This broad interpretation allows hospitals litigating negligent credentialing cases to shield evidence that arguably should be discoverable.[21]

Indiana's statute also contains general descriptions of privileged peer review materials and does not differentiate between materials that are purely factual and materials that contain committee opinions and evaluations.[22] For example, hospitals may shield evidence unrelated to committee opinions and deliberations, such as the date of a physician's last review and the criteria used to determine if staff privileges should be granted.[23] If the purpose of creating the privilege was to protect opinions of the committee members from discovery, applying the privilege to non-opinionated material is an abuse of the privilege. Last, while malpractice plaintiffs are denied access to peer review materials, hospitals and physicians may gain access and use peer review materials to their advantage.[24] Even after a hospital has revealed peer review records to a physician under review or after peer review records have been disclosed to the public, a plaintiff still may not use the information against a hospital. Once the physician under review and the general public know the opinions of the peer review committee, the need for a continued privilege is minimal. However, Indiana's privilege statute denies the discovery and use of the records even after their widespread exposure.

This Note proposes a statutory revision that will protect the peer review process by affording physicians serving on the committee adequate assurances of confidentiality, while also allowing a plaintiff in a negligent credentialing suit to obtain necessary evidence. Part II of this Note discusses the origins of peer review, the peer review privilege, and hospital liability for negligent credentialing to provide a background against which Indiana's peer review privilege statute can be analyzed.[25] Next, Part III examines the criticisms of the peer review process in general to emphasize the acceptability and desirability of peer review privilege reform.[26] Part IV analyzes Indiana's peer review

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20. *See* Ray v. St. John's Health Care Corp., 582 N.E.2d 464, 471 (Ind. App. 1991) ("We have given a broad interpretation of the scope of the peer review privilege."); Frank v. Trustees of the Orange County Hosp., 530 N.E.2d 135, 138 (Ind. App. 1988) ("There is no subject matter limit on the privilege.").

21. *See infra* notes 155-64 and accompanying text.

22. The language defining which peer review committee materials are privileged states: "[N]o records or determinations of, or communications to a peer review committee" are discoverable or admissible. IND. CODE ANN. § 34-4-12.6-2(h) (West Supp. 1992). For a discussion of the fact/opinion distinction, see *infra* part V.A.

23. *See infra* notes 155-64 and accompanying text.

24. *See infra* parts V.B, V.E.

25. *See* discussion *infra* part II.

26. *See* discussion *infra* part III.

privilege statute and then analyzes the case law interpreting the statute.[27] Parts V and VI examine several criticisms of Indiana's peer review privilege statute, as well as the inadequacy of alternative means for a plaintiff to acquire evidence.[28] Part VII explores unworkable alternatives to the peer review statute. Finally, this Note concludes by offering model revisions to Indiana's current peer review statute.[29] These suggestions are aimed at tipping the scales more evenly to balance the two competing interests surrounding the peer review statute: the need to encourage candid peer review and a plaintiff's right to unfettered and liberal discovery.[30]

II. IMPORTANT HISTORICAL DEVELOPMENTS

A. The Development of Peer Review

According to the American Medical Association, the use of peer review is as old as organized medicine itself.[31] Peer review was initially created to combat the poor quality of health care that existed in the early 1900s.[32] Although readily accepted by the medical community as an effective way to improve the quality of medical care, peer review was not extensively implemented until many years later.[33] The most important development in the history of peer review came in 1952, when the Joint Commission on Accreditation of Healthcare Organizations (JCAHO)[34] was formed to monitor the quality of health care being delivered in hospitals.[35] The JCAHO is a private, not-for-profit agency that voluntarily surveys and accredits various health care organizations.[36] The JCAHO manual establishes the industry standards for health care and sets forth a requirement that hospital committees

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27. *See* discussion *infra* part IV.

28. *See* discussion *infra* parts V, VI.

29. *See* discussion *infra* parts VII, VIII.

30. *See* Schafer v. Parkview Memorial Hosp., Inc., 593 F. Supp. 61 (N.D. Ind. 1984) (discussing these two competing interests).

31. Gosfield, *supra* note 11, at 463 (citing AMA 1 PEER REVIEW MANUAL foreword at 1 (1972)).

32. *See* Gosfield, *supra* note 11, at 554. For an historical overview of the development of peer review, see *id.* at nn.10-39 and accompanying text. *See also* Haines, *Hospital Peer Review Systems: An Overview*, HEALTH MATRIX, Winter 1984-85, at 30; B. Abbott Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55, 66-68 (1982).

33. Morter, *supra* note 6, at 1116.

34. The JCAHO was formerly called The Joint Commission on the Accreditation of Hospitals (JCAH). For an analysis of the JCAHO, see James S. Roberts et al., *A History of the Joint Commission on Accreditation of Hospitals*, 258 JAMA 936 (1987).

35. Beginning in the early 1970s, peer review began to be strongly promoted by the JCAHO. *See* Southwick & Slee, *supra* note 6, at 623.

36. Griffith & Parker, *supra* note 16, at 170.

perform various peer review functions.[37] Accreditation by the JCAHO is advantageous to a hospital;[38] therefore, most hospitals will perform peer review according to the JCAHO guidelines.[39]

To assure that the quality of health care remains high, some states also have enacted laws requiring hospitals to monitor the quality of both health care and health care providers.[40] Typically, these statutes give the governing board of a hospital the responsibility of carrying out peer review functions.[41] The governing board then gives responsibility for conducting reviews to peer review committees, which are composed of members of the medical staff.[42]

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37. Gosfield, *supra* note 11, at 563-64. For an overview of each committee required by JCAHO guidelines, see Butler, *supra* note 3, at 99-101 and Gosfield, *supra* note 11, at 563-64.

38. For example, JCAHO accreditation evidences that a facility provides quality services, attracts high quality medical staff, and allows a hospital to participate in the Medicare program. JCAHO accreditation may also be required for state licensure. *See* MICHAEL G. MACDONALD ET AL., HEALTH CARE LAW, § 5.03 [2] (1992).

39. Under the JCAHO guidelines, one of the responsibilities of the "credentialing committee" is to investigate the credentials of the hospital's medical staff. *See* Butler, *supra* note 3, at 99-101. The committee must investigate the physician's professional competence, judgment, technical skill, and physical and mental health. *Id.* at 101. This function assures the hospital and its patients that the incompetent doctors are denied or revoked hospital privileges, leaving only the competent physicians to practice medicine. *See also* Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 700 (1991) ("[Peer review] remains the arena within which the greatest strides toward policing the profession have occurred because [the hospital] is the locus where physicians can readily observe one another practicing medicine on a regular basis.").

40. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-445 (Supp. 1992); IND. CODE. § 16-10-1-6.5 (West 1992); MICH. COMP. LAWS ANN. § 333.21513(d) (West 1992); NEB. REV. STAT. § 71-2046 (1990); N.Y. PUB. HEALTH LAW § 2805-j (McKinney 1985); WASH. ADMIN. CODE § 248-18-030 (1980).

41. *See, e.g.*, ARIZ. REV. STAT. ANN. § 36-445 (Supp. 1992) ("The governing body of each licensed hospital . . . shall require that physicians admitted to practice in the hospital . . . organize into committees or other organizational structures to review the professional practices within the hospital . . . for the purposes of . . . improvement of the care of patients provided in the institution."); MICH. COMP. LAWS ANN. § 333.21513(a) (West 1992) ("The . . . governing body of a hospital licensed under this article are: (a) responsible for all phases of the operation of the hospital, selection of the medical staff, and quality of care rendered in the hospital.").

42. The duty to select competent staff members is a non-delegable duty, and a hospital may be held liable if one of its committees negligently retains an incompetent physician. *See* JAMES W. SMITH, HOSPITAL LIABILITY § 3.03[2][a], at 3-11 to -12 (1992). *See also*, Purcell v. Zimbleman, 500 P.2d 335, 341 (Ariz. App. 1972) (holding hospital liable for acts of surgical review committee as a matter of law); Joiner v. Mitchell County Hosp. Auth., 186 S.E.2d 307 (1971) (holding that hospitals cannot escape liability for negligently appointing staff members on the ground that the duty to perform this function lay with the independent contractor members of the staff), *aff'd*, 189 S.E.2d 412 (Ga. 1972). For a general discussion of a hospital's responsibilities for the appointment of staff physicians, see Daniel M. Mulholland III, *The Corporate Responsibility of the Community Hospital*, 17 U. TOL. L. REV. 343 (1986); ARTHUR F. SOUTHWICK, THE LAW OF HOSPITAL AND HEALTH CARE ADMINISTRATION, 583 (2d ed. 1988); James B. Cohoon, Comment, *Piercing the Doctrine of Corporate Hospital Liability*, 17 SAN DIEGO L. REV. 383, 389 (1980); SMITH, *supra* at 3.03.

The federal government has also recognized the need for effective peer review on the national level, and, in response, created Professional Standard Review Organizations.[43] In addition, the federal government recently enacted the Health Care Quality Improvement Act of 1986 (HCQIA), which established a national databank containing evidence of physician malpractice.[44] Hospital peer review committees are required to access the national databank when performing periodic peer review of physicians.[45]

As peer review began to gain acceptance, the problems involved with implementing peer review procedures grew. Ideally, physicians should be willing to police their own ranks using peer review as a means of improving the quality of medical care. Unfortunately, ethical and professional responsibility for the improvement of medical care has not successfully motivated physicians to serve on peer review committees.[46]

The peer review procedure, in which physicians review other physicians with whom they are in professional competition, presented a multitude of problems. Physicians losing hospital privileges at the hands of a competitor often struck back with civil suits. As a result, peer review committee members

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43. Congress first acted in 1972 by creating Professional Standards Review Organizations (PSRO). 42 U.S.C. § 1320c (1972). PSROs were established to improve the delivery of health care services in health care facilities that received Medicare, Medicaid, and Maternal and Child Health Program financing. 42 U.S.C. § 1320c-1 (1972).

Dissatisfaction with PSROs arose principally from their lack of cost effectiveness, and PSROs were phased out slowly beginning in 1982 when Congress established Peer Review Organizations (PRO). 42 U.S.C. § 1320c-3 (1992). The PROs develop norms of care, diagnosis and treatment typical to local and national norms. 42 U.S.C. § 1320c-3(a)(6)(A) (1992).

44. 42 U.S.C. § 11101-11152 (1992).

45. *Id.* The national databank was created to prohibit physicians from traveling from one state to another in order to leave tarnished records behind. All insurance carriers, boards of medical examiners, and health care entities must report to the databank such information as whether any judgment has been paid on behalf of a physician, whether a physician's license has been revoked or suspended, and whether a physician's hospital privileges have been revoked. 42 U.S.C. § 1131-1132 (1992). In addition, all hospitals must access the databank first when deciding whether or not to grant hospital privileges to a physician, and again every two years following a physician's grant of hospital privileges. 42 U.S.C. § 11135 (1992). Malpractice plaintiffs with suits against health care entities can discover information reported to the databank, but only after they show that a health care entity failed to request information from the databank as required by the HCQIA. 45 C.F.R. § 60.11 (1992). For a discussion on the National Practitioner Databank, see Virginia H. Hackney, *The National Practitioner Databank: A Step Toward More Effective Peer Review*, 24 J. HEALTH & HOSP. L. 201 (1991).

46. Morter, *supra* note 6, at 1119. The same fear of participating on peer review committees surfaces in other areas as well. For example, doctors have been reluctant to testify against each other in civil malpractice cases. However, recently doctors seem slightly more willing to testify against each other. *See* W. PAGE KEETON ET AL., PROSSER AND KEETON ON THE LAW OF TORTS, § 32, at 188 n.50 (5th ed. 1984).

feared unwanted participation in litigation for defamation,[47] liability for denial of due process,[48] liability for malicious interference with business relations,[49] and liability for antitrust violations.[50] Criticisms of a physician's peers also often resulted in a loss of referrals from other doctors.[51] Physicians, as human beings, also feared loss of acceptance by their peers.[52] In response to these valid concerns, the judiciary recognized a need to eliminate barriers to effective peer review, and created the peer review privilege.

B. The Development of the Peer Review Privilege

Initially, the peer review privilege was promulgated through the common

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47. *See, e.g.*, Dorn v. Mendelzon, Inc., 242 Cal. Rptr. 259 (Cal. App. 1987); Good Samaritan Hosp. Ass'n, Inc. v. Simon, 370 So. 2d 1174 (Fla. App. 1979); Matviuw v. Johnson, 388 N.E.2d 795 (Ill. App. 1979); Hayden v. Foryt, 407 So. 2d 535 (Miss. 1981).

48. *See, e.g.*, Maimon v. Sisters of Third Order, 491 N.E.2d 779 (Ill. App. 1986); Miller v. Eisenhower Medical Ctr., 614 P.2d 258 (Cal. 1980); Halberstadt v. Kissane, 273 N.Y.S.2d 601 (1966), *aff'd*, 294 N.Y.S.2d 841 (1968); Jacobs v. Martin, 90 A.2d 151 (N.J. Super. 1952); Green v. City of St. Petersburg, 17 So. 2d 517 (Fla. 1944).

49. *See, e.g.*, McMorris v. Williamsport Hosp., Inc., 597 F.Supp. 899 (M.D. Pa. 1984).

50. *See, e.g.*, Patrick v. Burget, 486 U.S. 94 (1988); Jefferson Parish Hosp. Dist. No. 2 v. Hyde, 466 U.S. 2 (1984), *reh'g denied*, 487 U.S. 1243 (1988); Tambone v. Memorial Hosp., 825 F.2d 1132 (7th Cir. 1987); Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984), *cert. denied*, 472 U.S. 1027 (1985).

For a discussion of antitrust litigation and physician credentialing, see Jennifer L. Otto, Comment, *Antitrust Liability in the Context of Medical Peer Review: The Implications of Patrick v. Burget and the Health Care Quality Improvement Act of 1986*, 28 DUQ. L. REV. 577 (1990); William Carlson, *Physician Credentialing Decisions and the Sherman Act*, 18 CUMB. L. REV. 419 (1988).

51. Physicians who are specialists depend on their colleagues for referrals; therefore, an adverse recommendation regarding another physician may result in a loss of referrals from that physician. *See* Paul L. Scibetta, Note, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1034-35 (1990). One survey revealed that 21% of physicians lost referrals or were antagonized for participating in peer review. *See* Morter, *supra* note 6, at 1119 (citing Owens, *Peer Review: Is Testifying Worth the Hassle?*, MED. ECON., Aug. 20, 1984 at 168).

52. *See* Scibetta, *supra* note 51, at 1035:

> Physicians are human. They tend to develop friendships at their places of work. Physicians who conduct the review of a colleague's practice often have close personal ties to that colleague. It is not difficult to surmise the internal conflict that must accompany the initiation of a proceeding which will be certain to engender animosity from a personal friend, and may well have serious implications for that friend's career.

See also Timothy S. Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 HOUS. L. REV. 525, 556-67 (1988) (stating that when a physician must judge other physicians that he or she works with every day, the physician must resist giving the benefit of the doubt to a colleague who has committed an error).

law.[53] However, not every jurisdiction recognized the peer review privilege; some states applied the privilege[54] while others refused.[55] As a consequence of the increased use of quality assurance programs and the uncertainty surrounding the applicability of the common law privilege, state legislatures began to enact peer review privilege statutes in the 1970s.[56]

Currently, virtually every state[57]—including Indiana—has enacted a statutory peer review privilege allowing peer review participants to be open and candid without the fear of liability or exposure. The statutes generally have two purposes.[58] First, the statute gives immunity to the individual committee members from personal liability surrounding their peer review activities.[59] Second, the privilege protects all of the proceedings, records, and determinations of the peer review process from discovery and admissibility in any judicial proceeding.[60]

With this privilege in place, physicians are assured that any criticisms,

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53. The leading case establishing the peer review privilege was Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C.Cir. 1973). In *Bredice*, the plaintiff unsuccessfully sought production of the hospital medical staff's review committee records. In denying the request, the court recognized that the purpose of the staff review committee was to improve medical care through self-analysis. *Id.* at 250. Because self-analysis can only be effective when candid and conscientious evaluation takes place, the court held that preserving the confidentiality of peer review records was necessary. *Id.* at 250. The court went so far as to say that "[c]andid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care." *Id.* at 250. Without a showing of exceptional necessity, the court refused to threaten the well-being of the review process by allowing discovery of the peer review records. *Id.* at 250.

54. *See* Dade County Medical Ass'n v. Hlis, 372 So. 2d 117 (Fla. App. 1979) (denying the discovery of a medical society's ethics committee records because the balance of the public's interest in encouraging peer review was greater than the plaintiff's grounds for discovery). *See also* Gillman v. United States, 53 F.R.D. 316 (S.D.N.Y. 1971).

55. *See* Nazareth Literary and Benevolent Inst. v. Stephenson, 503 S.W.2d 177 (Ky. Ct. App. 1973) (holding that letters and statements generated by a hospital peer review committee were discoverable in a suit alleging that the hospital should have known about a physician's incompetence). *See also* Gureghian v. Hackensack Hosp., 262 A.2d 440 (N.J. Super. 1970) (holding that perinatal mortality committee report was discoverable in negligence suit); Davison v. St. Paul Fire and Marine Ins. Co., 248 N.W.2d 433 (Wis. 1977) (holding that records of hospital medical staff's executive and tissue committee and records from the department of obstetrics and gynecology were not protected under common law privilege; decision to create a privilege should be left for the legislature).

56. *See* Southwick & Slee, *supra* note 6, at 637.

57. *See supra* notes 9-10 for a comprehensive citation to state statutes.

58. *See* Griffith & Parker, *supra* note 16, at 160; *see also* Charles D. Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 180 (1988).

59. For a comprehensive citation to statutes granting immunity to peer review participants, see *supra* note 10.

60. For a comprehensive citation to statutes granting confidentiality to peer review records, see *supra* note 9.

committee deliberations, or committee recommendations made during the peer review process will remain undiscovered by the physician under review. This assurance encourages physicians to participate in peer review and speak out against incompetence. The peer review privilege thus effectuates the elimination of incompetent physicians and the improvement in the overall quality of medical care.[61]

C. *The Development of a Negligent Credentialing Cause of Action*

During the same time that peer review privilege statutes were being enacted, some jurisdictions began to recognize a cause of action for negligent credentialing.[62] Currently, many jurisdictions recognize this cause of action.[63] Typically, the courts have held that hospitals must use reasonable care in choosing which physicians are granted staff hospital privileges, and that hospitals

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61. *See* Maynard v. United States, 133 F.R.D. 107 (D.C.N.J. 1990) (stating that a peer review privilege statute was designed to improve the quality of medical care by encouraging thorough and candid medical review process); Bundy v. Sinopoli, 580 A.2d 1101 (N.J. Super. 1990) (holding that the purpose of peer review is to improve health care, which is a public benefit; revelation of committee opinions and recommendations would inhibit candor of the peer review committee and inhibit health care improvement).

62. For an explanation of the term 'negligent credentialing', see *supra* note 16 and accompanying text. The most important event in the history of hospital liability for negligent credentialing occurred when the Illinois Supreme Court decided the landmark case of Darling v. Charlston Memorial Hospital, 211 N.E.2d 253 (1965), *cert. denied,* 383 U.S. 946 (1966). The court in *Darling* held that a hospital has a duty to its patients to oversee the care given to them by the hospital's physicians who are acting as independent contractors. Although the holding in *Darling* was not extended to hospitals for either negligently hiring or retaining incompetent physicians, the cases following *Darling* expanded their holdings to include suits for the negligent hiring or retaining of physicians. *See, e.g.,* Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981).

63. *See, e.g.*, Tucson Medical Ctr., Inc. v. Misevich, 545 P.2d 958 (Ariz. 1976); Elam v. College Park Hosp., 183 Cal. Rptr. 156 (1982); Kitto v. Gilbert, 570 P.2d 544 (Colo. App. 1977); Register v. Wilmington Medical Ctr., Inc., 377 A.2d 8 (Del. 1977); Insinga v. LaBella, 543 So. 2d 209 (Fla. 1989); Joiner v. Mitchell County Hosp. Auth., 186 S.E.2d 307, *aff'd*, 189 S.E.2d 412 (Ga. 1972); Darling v. Charlston Community Memorial Hosp., 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966); Iterman v. Baker, 15 N.E.2d 365 (Ind. 1938); Ferguson v. Gonyaw, 236 N.W.2d 543 (Mich. App. 1975); Hull v. North Valley Hosp., 498 P.2d 136 (Mont. 1972); Gridley v. Johnson, 476 S.W.2d 475 (Mo. 1972); Foley v. Bishop Clarkson Memorial Hosp., 173 N.W.2d 881 (Neb. 1970); Moore v. Board of Trustees, 495 P.2d 605, *cert. denied*, 409 U.S. 879 (Nev. 1972); Corleto v. Shore Memorial Hosp., 350 A.2d 534 (N.J. Super. Ct. Law Div. 1975); Raschel v. Rish, 488 N.Y.S.2d 923 (App. Div. 1985); Blanton v. Moses H. Cone Memorial Hosp., Inc., 354 S.E.2d 455 (N.C. 1987); Benedict v. St. Luke's Hosp., 365 N.W.2d 499 (N.D. 1985); Park N. Gen. Hosp. v. Hickman, 703 S.W.2d 262 (Tex. Ct. App. 1985); Pedroza v. Bryant, 677 P.2d 166 (Wash. 1984); Utter v. United Hosp. Center, Inc., 236 S.E.2d 213 (W.Va. 1977); Johnson v. Misericordia Community Hosp., 301 N.W.2d 156 (Wis. 1981).

One commentator has been critical of the fact that while some courts have recognized a negligent credentialing cause of action, these same courts have crippled a plaintiff's ability to prove any negligence against a hospital by holding that hospitals may assert the peer review privilege in suits for negligent credentialing. *See* Ward, *supra* note 18, at 921-22.

must use care in evaluating the physicians who are currently on the hospital's staff.[64] Indiana case law also holds that hospitals have a duty to use ordinary and reasonable care in employing reasonably qualified, reputable, licensed physicians as independent contractors.[65]

To their distinct advantage, Indiana hospitals utilize peer review committees to screen the professional qualifications of their medical staffs.[66] Thus, the most relevant and pertinent evidence regarding a hospital's critical hiring decisions is contained in the peer review records. Indiana, by adopting the peer review privilege statute, has made all of the peer review records unavailable. For the plaintiff in a negligent credentialing suit, the privilege means that proving a hospital was negligent for hiring or retaining an incompetent physician will be very difficult.[67] In attempting to gather the necessary evidence to prove their claims, most plaintiffs seeking discovery of peer review materials will be confronted with objections to discovery requests based on Indiana's peer review privilege statute. Making all peer review information privileged may ultimately have the effect of denying negligent credentialing suit plaintiffs the only evidence available to prove their claims.[68]

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64. It is generally true that as long as a hospital has acted reasonably by carefully checking and monitoring its staff, it is likely that the hospital will escape liability. Paul Simonson, *Corporate Negligence: An Evolving Theory of Hospital Liability*, *in* HOSPITAL LIABILITY 1986 (Stephen H. MacKauf ed., 1986). The minimal steps required to escape liability for negligent credentialing may include conferring with other hospitals where the doctor has had privileges, investigating other malpractice claims against the physician, or investigating the doctor's reputation in the medical community. *See* SMITH, *supra* note 42, at 3.02[2].

65. *See* Iterman v. Baker, 15 N.E.2d 365, 370 (Ind. 1938). *See also* Huber v. Protestant Deaconess Hosp. Ass'n, 133 N.E.2d 864, 870 (Ind. App. 1956). Unfortunately, the case law has never elaborated on what a hospital must do to fulfill this duty. The Indiana statute that regulates the appointment of a hospital's medical staff also provides little guidance about a hospital's duty. The statute only requires that the governing board of a hospital choose physicians based on their licensure, their performance of patient care, and their standards of care that effectively use hospital resources. *See* IND. CODE ANN. § 16-10-1-6.5 (West Supp. 1991).

66. The JCAHO requires hospitals accredited by the JCAHO to use peer review committees. *See supra* notes 34-39 and accompanying text. Receipt of Federal Medicaid benefits may also depend on that hospital having a peer review system. *See* 42 U.S.C. § 1320c-7 (1988). Furthermore, Indiana law holds the governing board of a hospital responsible for the initial and subsequent grant of privileges to the hospital's physicians. *See* IND. CODE ANN. § 16-10-1-6.5 (West Supp. 1992). The board typically delegates this responsibility to a "peer review committee," which is better qualified than the board to evaluate physician competency. *See supra* notes 40-42 and accompanying text.

67. A negligent credentialing suit plaintiff must prove that the hospital, acting through its peer review committee, negligently granted hospital privileges to an incompetent physician. *See supra* notes 64-65 and accompanying text.

68. *See* Creech, *supra* note 58.

III. THE EFFICACY OF THE PEER REVIEW PROCESS

The policies supporting the peer review privilege, the need to encourage the utilization of peer review (by the medical profession and the state and federal governments), and the JCAHO all suggest that peer review is the most effective way to monitor the quality of health care being delivered. Peer review, and not the threat of litigation, has been lauded as the best way to improve the quality of medical care. However, there are justified misgivings about the efficacy of the peer review process.[69]

Testimony given at hearings before the House of Representatives on the Health Care Quality Improvement Act (HCQIA)[70] revealed that hospitals who terminate physicians for incompetence often will give those physicians good references just to be rid of them.[71] Testimony also showed that compared to the number of impaired physicians,[72] the number being identified and screened out is small.

In addition to testimony on the HCQIA, there are several well-documented cases in which, although a hospital knew of a physician's incompetence, the peer review system—along with its confidentiality and immunity provisions—failed to eliminate the physician from the hospital staff. The peer review process has not effectively dealt with physicians who have negligently performed

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69. *See* Goldberg, *supra* note 18, at 154 ("Regrettably, the widespread adoption of the privilege cannot be justified in view of its limited benefits and its adverse impact on a patient's ability to show negligence.").

70. 42 U.S.C. § 11101-111151 (1992). For a cursory discussion of the HCQIA, see *supra* notes 44-45 and accompanying text. For a thorough analysis of the HCQIA, see Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 455 (1990). *See also* Adler, *supra* note 39; Morter, *supra* note 6.

71. *The Health Care Quality Improvement Act of 1986: Hearings on H.H. 5110 Before the Subcomm. on Health and the Environment of the House of Rep. Comm. on Energy and Commerce*, 99th Cong., 2d Sess. 216 (1986) (statement of Wayne W. Alberts, M.D., Medical Director of Kaiser Foundation Health Plan of the Mid-Atlantic States). One situation presented before the House subcommittee involved a pediatrician who was a sex offender, but was still given an honorable discharge by the Army. *Id.* This same doctor was then hired by another health care facility that was never informed about the physician's past behavior. *Id.*

72. An impaired physician is one who suffers from a substance abuse problem, physical disability, psychological disorder, or professional incompetence. *See supra* note 71, at 217. Although at least 12,500 (3%) of all physicians are believed to be impaired, only 1,500 received significant disciplinary action in 1984. *Supra* note 71, at 217. These statistics indicate that the overwhelming majority of impaired physicians are not being effectively eliminated by the peer review mechanism.

surgeries,[73] sexually abused their patients during surgery,[74] or improperly handled patient deaths.[75]

Another example of the ineffectiveness of peer review is the Indiana case of *Walton v. Jennings Community Hospital, Inc.*[76] In *Walton*, a staff surgeon had sexually harassed the nursing staff and had also been indicted for Medicaid theft while on the staff of Jennings Community Hospital. After investigating the surgeon's conduct, the peer review committee recommended that his staff privileges be immediately revoked.[77] The hospital accepted a settlement in which the surgeon agreed to resign if in return the hospital would state that he had resigned and had never been under investigation by the hospital when the hospital responded to inquiries from future employers.[78]

The grant of privilege and immunity to peer review committees was

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73. In Gonzaks v. Nork, No. 228566, slip op. 228566 (Super. Ct. Cal., Sacramento County, Nov. 19, 1973) a hospital was held liable for permitting a physician to remain on the hospital staff despite a sequence of bad results in 30 cases. Judge Goldberg, who authored the *Gonzaks* opinion, attributed the hospital's continual grant of privileges, despite the physician's incompetence, to inadequate and unused peer review procedures. *See* Goldberg, *supra* note 18, at 163.

74. In Miofsky v. Super. Court, 703 F.2d 332 (9th Cir. 1983), a surgeon committed sex crimes against over 150 of his patients while they were under anesthesia. The results of a private investigation revealed that the suppression of the surgeon's conduct was motivated by the institutional tradition that one professional does not openly criticize another professional. *See* Goldberg, *supra* note 18, at 164 (citing SACRAMENTO BEE, July 4, 1979, at A20).

75. *See* Scott v. Jackson, 596 A.2d 523 (D.C. 1991). The *Scott* case began when a *Washington Post* article reported that eight years earlier, Dr. Scott's surgical privileges had been suspended from Washington Hospital Center because of several botched operations. Greg Rushford, *Hospital Hides Doctor's Record From Patients; Suit Shines Light on Secretive Peer Review*, LEGAL TIMES, Sept. 23, 1991, at 1d. Among those botched operations was the heart surgery of Willard Jackson. *Id.*

According to the *Washington Post* article, when Dr. Scott's colleagues began to express concern over his competence, the hospital cooperated with Dr. Scott's lawyers in destroying incriminating hospital records. *Id.* The hospital also agreed to remove personnel file material that was damaging to Dr. Scott in exchange for Dr. Scott's promise to leave the hospital quietly. *Id.* Furthermore, when Dr. Scott applied for privileges at another hospital, Washington Hospital refused to allow that hospital to see the peer review records accumulated on Dr. Scott. *Id.*

76. 875 F.2d 1317 (7th Cir. 1989).

77. *Id.* at 1318.

78. *Id.* at 1318-19. The court in *Walton* invalidated the contract because it was against the public policy sought to be furthered by the Indiana peer review privilege statute. *Id.* The court identified the public policy as being the goal of promoting peer review to eliminate incompetent, unqualified physicians. *Id.* at 1321-22. Specifically, the court said that the contract would have required Jennings Hospital to mislead potential employers, because they would not be given the full, complete, and up-to-date information that they needed to make an informed hiring decision. *Id.* at 1322-23. The hospital subsequently breached the agreement by revealing Dr. Walton's background to a credentialing committee member at another hospital where Dr. Walton was seeking employment.

supposed to eliminate this type of "plea bargaining" by deficient physicians.[79] Indiana specifically allows peer review committees to share information with other committees, giving hospitals notice of a physician's blemished record.[80] However, even with the privilege, hospitals and physicians have demonstrated a willingness to conceal physician incompetency—even from other hospitals—as the contract in *Walton* illustrated. Although the hospital breached the contract and eventually revealed the information, the mere fact that medical professionals entered into such a contract is an indictment against the medical profession's willingness to police itself through peer review.

When the peer review process deteriorates, other mechanisms are available to act as a check on physician incompetency. However, these mechanisms are not without flaws. The state medical boards are available, but they rely on peer review committees for most of their information.[81] In addition, evidence exposed during HCQIA hearings showed that information about practitioners with prior misconduct or malpractice never reaches the medical boards.[82] Most of the information that state medical boards receive comes not from peer review committees, but from law enforcement personnel.[83] Therefore, the possibility of a successful and legitimate suit by a negligent credentialing suit plaintiff may be an additional way to assure that hospitals are properly performing the peer review process. However, a legitimate suit against a hospital for negligent credentialing is not likely to be successful without access to the peer review committee records.

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79. Horner, *supra* note 70, at 464. The "plea bargaining" problem was also voiced at the open hearings during the developmental stages of the Health Care Quality Improvement Act. Witnesses testified that plea bargaining is attractive to both the physician and the hospital because the physician is not reported or disciplined, and neither party incurs any legal fees. As a result of the bargain, a new hospital investigating the physician's background will receive censored information from the old hospital, to the detriment of patients. *Id.*

80. IND. CODE ANN. § 34-4-12.6-2(g)-(h) (West Supp. 1992) allows the disclosure of peer review records from one peer review committee to another.

81. *The Health Care Quality Improvement Act of 1986: Hearings on H.R. 5110 Before the Subcomm. on Health and the Environment of the House of Representatives Energy and Commerce Committee*, 99th Cong., 2d Sess. 226 (1986) (statement of Richard P. Kusserow, Inspector General of Health and Human Services).

82. *Id.* Indiana requires hospital governing boards to report disciplinary action taken against physicians. *See* IND. CODE ANN. § 16-10-1-6.5 (West 1991). Therefore, the general rule of non-reporting may be less of a problem in Indiana.

83. *The Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary*, 99th Cong., 2d Sess. 40-41 (1986) (statement of Richard P. Kusserow, Inspector General of Health and Human Services).

IV. INDIANA'S PEER REVIEW PRIVILEGE STATUTE

A. *The Statute*

Indiana's peer review privilege statute grants both confidentiality to peer review materials[84] and immunity from civil action to peer review committee

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84. IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992).
The statute states:

> (a) All proceedings of a peer review committee shall be confidential. All communications to a peer review committee shall be privileged communications. Neither the personnel of a peer review committee nor any participant in a committee proceeding shall reveal any content of communication to, the records of, or the determination of a peer review committee outside the peer committee. However, the governing board of a hospital or professional health care organization may disclose the final action taken with regard to a professional health care provider without violating the provisions of this section.
>
> (b) Except as otherwise provided in this chapter, no person who attends a peer review committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of a proceeding, any opinion, recommendation, or evaluation of the committee or of any committee member.
>
> (c) Information that is otherwise discoverable or admissible from original sources shall not be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee. A member, employee, agent of a committee or other person appearing before the committee may not be prevented from testifying as to matters within the person's knowledge and in accordance with the other provisions in this chapter. However, the witness cannot be questioned about this testimony or other proceedings before the committee or about opinions formed by the witness as a result of committee hearings.
>
> (d) A professional health care provider under investigation shall be permitted at any time to see any records accumulated by a peer review committee pertaining to the provider's personal practice. The provider shall be offered the opportunity to appear before the peer review committee with adequate representation to hear all charges and findings concerning the provider's practice and to offer rebuttal information. The rebuttal information shall be a part of the record before any disclosure of the charges and findings under this chapter is made.
>
> (e) However, if charges are brought against a professional health care provider in a hospital that, if sustained by the governing board of the hospital, could result in an action against a physician required to be reported to the medical licensing board under IC 16-10-1-6.5(b) or a similar disciplinary action against any other health care provider, the professional health care provider is entitled to one (1) evidentiary hearing before a peer review committee of the medical staff and (1) additional hearing on appeal before the governing board of the hospital.
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> . . .
>
> (g) Communications to, the records of, and determinations of a peer review committee may only be disclosed to:
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> (1) the peer review committee of a hospital or other health facility;
>
> (2) the disciplinary authority of the professional organization of which the professional health care provider under question is a member; or
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> (3) The appropriate state board of registration and licensure which the committee considers necessary for recommended disciplinary action;

members.[85] Like other states' peer review privilege statutes, it was created to encourage physicians to openly and candidly participate in the peer review process.[86] The statute defines what is considered to be a peer review committee for purposes of the statute,[87] and also contains exceptions that allow peer review records to be disclosed under certain circumstances.[88] Indiana's confidentiality provision broadly applies to any form of discovery request used

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and shall otherwise be kept confidential for use only within the scope of the committee's work, unless the professional health care provider has filed a prior written waiver of confidentiality with the peer review committee.

(h) Except in cases of required disclosure to the professional health care provider under investigation, no records or determinations of, or communications to a peer review committee shall be:

(1) subject to subpoena or discovery; or

(2) admissible in evidence;

in any judicial or administrative proceeding, including a proceeding under IC 16-9.5-10, without a prior written waiver executed by the committee.

(i) Except in cases as authorized under this chapter, the evidentiary privileges created by this section shall be invoked by all witnesses and organizations in all judicial and administrative proceedings unless the witness or organization first has a waiver of the privilege, by its chairman, vice chairman, or secretary. . . .

85. IND. CODE ANN. § 34-4-12.6-3 (West Supp. 1992).

86. Although Indiana does not record any legislative history, the courts have recited the purpose behind Indiana's peer review privilege statute. *See* Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306, 1311 (Ind. App. 1988). "[T]he purpose of the peer review privilege is to foster an effective review of medical care. An effective review requires that all participants to a peer review proceeding communicate candidly, objectively, and conscientiously. Absent the protection of a privilege, the candor and objectivity of peer review communications and the effectiveness of the peer review process would be hindered." *See also* Marrese v. Interqual, Inc., 748 F.2d 373, 392 (7th Cir. 1984): "[P]eer review is essential to the very lifeblood and heartbeat of medical competency and quality medical care in the State of Indiana and throughout the nation. [The peer review privilege] encourages competent and qualified physicians to participate in the medical peer review process, thus assuring the citizens of Indiana that hospital medical staffs are competent, qualified, and practicing in accord with approved medical standards."; Doe v. St. Joseph's Hosp., 113 F.R.D 677, 678 (N.D. Ind. 1987): "To enable the health care professionals to properly police their own ranks the Indiana General Assembly enacted [the peer review privilege]. . . ."

87. *See* IND. CODE ANN. § 34-4-12.6-1(c) (West Supp. 1992).

88. The exceptions to the peer review privilege include information that becomes part of the peer review record but is otherwise discoverable. IND. CODE ANN. § 34-4-12.6-2(c) (West Supp. 1992). This exception avoids the possibility that public information, such as pending malpractice claims, would be privileged simply because the information was used by the committee and became a part of its record. Another exception allows the governing board of a hospital to disclose any final action taken with regard to a health care provider, such as whether a physician's privileges have been revoked. IND. CODE ANN. § 34-4-12.6-2(a) (West Supp. 1992). The committee may also execute a waiver in writing to lift the privilege, IND. CODE ANN. § 34-4-12.6(h), (i) (West Supp. 1992), and may use information obtained in the committee for legitimate internal business purposes, such as the hospital's own defense. IND. CODE ANN. § 34-4-12.6-4 (West Supp. 1992). Another exception allows disclosure of peer review materials to other hospital peer review committees, the disciplinary board of a professional organization, and several state agencies. IND. CODE ANN. § 34-4-12.6-2(g) (West Supp. 1992). Disclosure to the state attorney general is also permitted. IND. CODE ANN. § 34-4-12.6-2(k) (West Supp. 1992).

to discover what transpired during the committee meetings. Therefore, the privilege can be asserted in reply to requests for production of documents,[89] deposition questions,[90] interrogatory questions,[91] and trial testimony[92] related to committee proceedings. Unfortunately, the portion of the statute delineating which peer review committee records are privileged only states that "no records or determinations of, or communications to a peer review committee" are admissible or discoverable.[93] This language is very broad because it encompasses committee "records," a term that possibly includes anything pertaining to the review process.[94] However, the Indiana courts have provided litigants with some guidance as to how to apply the privilege.[95]

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89. *See, e.g.*, Community Hosps. v. Medtronic, Inc., 594 N.E.2d 448 (Ind. App. 1992); Ray v. St. John's Health Care Corp., 582 N.E.2d 464 (Ind. App. 1991); Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306, 1308-09 (Ind. App. 1988).

90. *See, e.g*, Frank v. Trustees of Orange County Hosp., 530 N.E.2d 135 (Ind. App. 1988); *Terre Haute Regional Hosp., Inc.*, 524 N.E.2d at 1308-09.

91. *See, e.g., Terre Haute Regional Hosp., Inc.*, 524 N.E.2d at 1308-09.

92. Members serving on the committee may not testify during any judicial proceeding about anything that transpired during the committee meetings. IND. CODE ANN. § 34-4-12.6-4 (West Supp. 1992).

93. IND. CODE ANN. § 34-4-12.6-2(h) (West Supp. 1992).

94. Ray v. St. John's Health Care Corp., 582 N.E.2d 464, 472-73 (Ind. App. 1991), limited the scope of the privilege to matters involving the review of patient care, the review of a physician's credentials, and the review of the validity of claims against a physician. The holding, however, did not make any distinction between factual data, opinions, or evaluations in the committee records.

95. Cases where federal jurisdiction is premised on federal questions present unique issues when applying Indiana's peer review privilege statute. Because most negligent credentialing cases are based on state law, it is beyond the scope of this note to extensively discuss the impact of the peer review privilege on federal question litigation. However, a brief discussion of the federal case law will be given.

Under Rule 501 of the Federal Rules of Evidence, privileges in federal courts are determined by the common law as interpreted by the courts of the United States. FED. R. EVID. 501. In applying Rule 501, the federal courts have utilized a four-part balancing test that weighs the plaintiff's need to ascertain the truth against the defendant's need to protect confidentiality. *See, e.g.*, Doe v. St. Joseph's Hosp., 113 F.R.D. 677 (N.D. Ind. 1987) (announcing the four-part test).

First, because privileges are not favored in the law, the court should narrowly construe them. *Id.* at 679. Second, the court should weigh the need for truth against the policy sought to be furthered by the privilege and consider whether recognition of the privilege would further that policy. *Id.* Third, the court should evaluate whether the communication originated in confidence that it would not be disclosed. *Id.* Last, the court must consider whether the relation sought to be protected by the privilege is one that the community sedulously fosters. In the context of the peer review privilege statute as applied to employment discrimination claims, the *Doe* court held that, although the peer review privilege was very important to unbridled candor in the peer review process, the need for the truth in cases where discrimination is alleged outweighs the policy supporting the privilege. *Id.* at 679-80. In Schafer v. Parkview Memorial Hospital, Inc., 593 F. Supp. 61 (N.D. Ind. 1984), the court applied a similar test in the context of the Age Discrimination in Employment Act. *Id.* at 64.

Like the state courts, the federal courts have placed great emphasis on the policy supporting the peer review privilege and on Indiana's decision to codify the privilege. *See Doe*, 113 F.R.D. 677 (N.D. Ind. 1987); *see also Schafer*, 593 F. Supp. 61 (N.D. Ind. 1984). Therefore, the federal

B. The Case Law

In *Parkview Memorial Hospital, Inc. v. Pepple*,[96] the court of appeals held that the privilege is not limited in application to medical malpractice claims, but that it applies to all judicial or administrative proceedings.[97] Later case law following the *Pepple* holding applied the statute in wrongful discharge claims,[98] negligent credentialing claims,[99] antitrust actions,[100] discrimination claims,[101] and products liability claims.[102]

Older case law also held that there was no subject matter limitation on the privilege, and that *all* proceedings, communications, and determinations occurring during the peer review were privileged under the statute.[103] However, the more recent case of *Ray v. St. John's Health Care Corporation*[104] limited the application of the privilege's confidentiality element to three situations.[105] The *Ray* court held that only communications involving

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decisions have usually been in accord with the rationale in the state law decisions. However, the Indiana Court of Appeals has explicitly rejected the federal balancing test, reasoning that a balancing test would "strip away" the protection afforded to the peer review committee and thwart the privilege. *See* Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306, 1311 (Ind. App. 1988).

96. 483 N.E.2d 469 (Ind. App. 1985), *aff'd*, 511 N.E.2d 467 (Ind. App. 1987).

97. *Id.* at 470. In *Pepple*, Dr. Pepple sought judicial review of Parkview's adverse decision regarding his recredentialing. Parkview filed a motion *in limine* seeking to prohibit any witness, party, or counsel from giving any testimony regarding any proceedings of, records of, or determinations of the peer review committee. *Id.* at 469-70. In response, Dr. Pepple argued that IND. CODE 34-4-12.6-2, which grants privilege and confidentiality to peer review records, only applied to medical malpractice claims. *Id.* at 470. The court of appeals held that the statute unambiguously applied to all judicial or administrative proceedings, and that if the legislature had intended to limit the statute's application to medical malpractice cases, it could have done so. *Id.* at 470.

98. *See id.*; Frank v. Trustees of Orange County Hosp., Inc., 530 N.E.2d 135 (Ind. App. 1988); Ray v. St. John's Health Care Corp., 582 N.E.2d 464 (Ind. App. 1991).

99. *See* Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306, 1310, 1312 (Ind. App. 1988) (noting that the plaintiff alleged that Terre Haute Regional Hospital intentionally and fraudulently retained a physician, despite the fact that he was unqualified and was performing unnecessary surgeries).

100. *See* Marrese v. Interqual, Inc., 748 F.2d 373 (7th Cir. 1984).

101. *See* Doe v. St. Joseph's Hosp., 113 F.R.D. 677 (N.D. Ind. 1987) (holding that the peer review privilege applied to a case of alleged violation of Title VII of the Civil Rights Act of 1964 and Section 1981 of Title 42 of the United States Code).

102. *See* Community Hosp. v. Medtronic, Inc., 594 N.E.2d 448 (Ind. App. 1992) (holding that the peer review privilege statute is applicable to an incident report needed to support a defense to a products liability suit against the manufacturer of a neuromuscular stimulator).

103. *See* Frank v. Trustees of Orange County Hosp., Inc., 530 N.E.2d 135, 138 (Ind. App. 1988). The court of appeals gave the statute broad application by stating that it had no subject matter limitation. *Id.*

104. 582 N.E.2d 464 (Ind. App. 1991).

105. *Id.* at 472.

statements made pursuant to the review of patient care, the qualifications of a staff physician, and the merits of a claim against a physician are privileged under Indiana's statute.[106] The *Ray* court also held that the party asserting the privilege must submit all of the requested documents to the trial judge for an in camera inspection.[107] The holdings of *Ray* marked a significant departure from past cases that tended to give overbroad application to the peer review privilege statute. Unfortunately, *Ray's* holdings did not provide much guidance to trial court judges and future parties about what specific items are considered privileged under the three-part test.[108]

In *Community Hospitals v. Medtronic, Inc.*,[109] the court of appeals held that an incident report, which was submitted to a quality assurance committee, was protected from discovery by the peer review privilege statute.[110] The court reasoned that because the quality assurance committee was responsible for the evaluation of patient care, any document submitted to it for that purpose would be privileged.[111] Allowing the discovery of an incident report would not require the disclosure of any committee member's opinions or evaluations;[112] yet, the court was still willing to protect the report.

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106. *Id.* *See also* Keskin v. Munster Medical Research Found., 580 N.E.2d 354 (Ind. App. 1991) (limiting the scope of the privilege by holding that the peer review privilege statute does not apply to contractual arrangements made by a hospital's board of directors).

107. *Ray* at 473-74. The party submitting the document for in camera inspection is required to itemize each document, provide a factual summary of each document, and state why the document should be considered privileged. *Id.* (citing Burr v. United Farm Bureau Mut. Ins. Co., 560 N.E.2d 1250, 1255 (Ind. App. 1990)).

For another state that utilizes in camera inspection regarding peer review documents, see State ex rel. Grandview Hospital & Medical Center v. Gorman, 554 N.E.2d 1297 (Ohio 1990) (holding that where the plaintiff asserted that documents fell under an exception to the peer review privilege, the trial court had clear authority to inspect the documents in camera to determine if the documents were excepted).

108. For example, the *Ray* court made no attempt to distinguish between fact-sensitive and opinion-sensitive materials. Ray v. St. John's Health Care Corp., 582 N.E.2d 464 (Ind. App. 1991).

109. 594 N.E.2d 448 (Ind. App. 1992).

110. *Id.* at 452. In *Medtronic*, a patient was "overstimulated" by a neuromuscular stimulator while he was an outpatient at Community Hospitals. *Id.* at 449-50. The complaint named the manufacturer of the stimulator, Medtronic, and alleged a products liability claim. *Id.* at 450. As a defense, Medtronic argued that Community Hospital was responsible for the injury. *Id.* at 450. In the context of trying to prove its defense, Medtronic sought the incident report that was generated by an employee of Community after the "overstimulation" occurred. *Id.* at 450.

111. *Id.* at 452.

112. Incident reports are generated in the course of *concurrent* as opposed to *retrospective* review of medical care. *See* Southwick & Slee, *supra* note 6, at 652. They therefore do not contain opinions as to the quality and care delivered in the past. *See* Davidson v. Light, 79 F.R.D. 137, 139-40 (D. Colo. 1978) (holding that even when opinions were contained in an incident report, the purpose of the report was particular to one patient, not to formulate general hospital policies; thus no privilege attaches).

Another example of the broad interpretation that the courts give to the peer review privilege statute is *Frank v. Trustees of Orange County Hospital, Inc.*[113] The *Frank* court held that informal conversations of the peer review committee members conducted outside the formal peer review process were privileged.[114] The *Frank* court reasoned that what transpired in the formal committee process likely shaped the content of informal conversations.[115] *Frank's* holding and reasoning likely mean that a party may not even depose committee members regarding their opinions formed independently of the peer review process.[116] A court relying on *Frank* could reason that discovery of informal conversations would allow a party to discover peer review information indirectly, which could not be discovered directly.[117]

Unlike some evidentiary privileges that may be waived without a written waiver,[118] the peer review privilege may only be waived where the peer review committee has executed a written waiver.[119] The court of appeals, in *Terre Haute Regional Hospital, Inc. v. Basden*,[120] held that a written waiver is necessary before peer review information may be used by a negligent credentialing suit plaintiff despite the fact that some of the peer review communications may have been viewed outside the committee process.[121] Other Indiana cases have required a written waiver even where the peer review committee records have been disclosed to the individual under investigation and have become a matter of public record.[122] Where such widespread disclosure

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113. 530 N.E.2d 135 (Ind. App. 1988).

114. *See id.* at 137. *See also* Ray v. St. John's Health Care Corp., 582 N.E.2d 464 (Ind. App. 1991). Although *Ray* narrowed the peer review privilege statute's application, it affirmed the holding in *Frank* that private, informal conversations between committee members are still privileged. *Ray*, 582 N.E.2d at 472.

115. *Frank*, 530 N.E.2d at 137.

116. IND. CODE ANN. § 34-4-12.6-2(c) (West Supp. 1992) permits the members of the peer review committee to testify to matters within their personal knowledge, as long as they do not disclose opinions that were formed as a result of the peer review process or any other proceedings before the committee. Given the difficulty for an individual to separate opinions formed inside versus outside the committee process, a court relying on *Frank* could hold that *any* opinions a committee member had are privileged.

117. *See Frank*, 530 N.E.2d at 135.

118. For example, the attorney-client privilege may be waived when the client carelessly speaks to the attorney within the hearing range of third parties. *See* GRAHAM C. LILLY, AN INTRODUCTION TO THE LAW OF EVIDENCE 384-85 (2d ed. 1987). Also, the physician-patient privilege may be waived when the patient puts his or her physical or mental state at issue when bringing suit against another individual. *See* Collins v. Bair, 268 N.E.2d 95 (Ind. 1971).

119. IND. CODE ANN. § 34-4-12.6-2(h)-(i) (West Supp. 1992).

120. 524 N.E.2d 1306 (Ind. App. 1988).

121. *Id.* at 1312.

122. For example, in Stiller v. LaPorte Hospital, Inc., 570 N.E.2d 99 (Ind. App. 1991), prior to the filing of the suit, LaPorte's peer review committee's opinions, evaluations, and findings had been revealed to Dr. Stiller on numerous occasions. After the case was filed in state court and was

has already occurred, a waiver seems unnecessary. However, the language of the peer review privilege statute requires a written waiver in all circumstances before the records may be used by anyone, including a plaintiff in a negligent credentialing suit.[123]

Terre Haute Regional Hospital, Inc. v. Basden[124] is the only Indiana case that has analyzed a claim of negligent credentialing in the context of the Indiana peer review privilege statute. When decided, the holding in *Basden* gave new guidance on the applicability of the privilege. First, the *Basden* court held that application of the confidentiality portion of the peer review statute—unlike the immunity provisions[125]—was not dependant on good faith review by the committee members.[126] Also, the court held that in cases where a prima facie showing of fraud has been made, the peer review materials would lose their protected status.[127]

Basden also illustrates the broad interpretation that will be given to the inclusiveness of the peer review statute. In denying the plaintiff's discovery requests, the court refused discovery of information that in no way required disclosure of peer review committee opinions or evaluations. The court protected the discovery of hospital committee reports, which were available to any member of the hospital staff.[128] It further protected the identities of the

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later appealed, the findings of the committee became public knowledge and part of a published judicial opinion. However, when a negligent credentialing suit plaintiff, who was litigating against Starke Memorial Hospital, tried to discover LaPorte's committee reports, Starke Memorial successfully argued that the records were privileged because no written waiver had been executed by LaPorte Hospital's peer review committee. *See* Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991).

123. *See* IND. CODE ANN. § 34-4-12.6-2(h)-(i) (West Supp. 1992).

124. 524 N.E.2d 1306 (Ind. App. 1988).

125. *See* IND. CODE ANN. § 34-4-12.6-3 (West Supp. 1992).

126. *Basden*, 524 N.E.2d at 1310.

127. *Id.* *Basden's* holding represents a way for a negligent credentialing suit plaintiff to circumvent the privilege by alleging fraud. Nevertheless, the plaintiff who attempts to prove fraud will have difficulty establishing the prima facie elements of fraud. To sustain an action for fraud, the plaintiff must prove by a preponderance of the evidence that a material representation of a past or existing fact was made that was untrue and known to be untrue by the party making it, or else recklessly made, and that another party did in fact rely on the representation and was induced thereby to his detriment. *Basden*, 524 N.E.2d at 1310 (citing Plymale v. Upright, 419 N.E.2d 756, 760 (Ind. App. 1981)).

In a negligent credentialing case, a successful allegation of fraud would require a showing that the peer review committee represented to the plaintiff that a physician was competent by granting him or her hospital privileges when the hospital knew or should have known it was untrue, and that the plaintiff relied on this fact and was induced to rely on the physician's competence, only to be injured as a result of the physician's incompetence.

128. Appellee's Brief at 6, Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1306 (Ind. App. 1988) (No. 61A01-8802-CV-43).

people with whom the committee spoke when investigating the physician,[129] whether action was taken against the physician as a result of the peer review investigation,[130] and what factors were considered in the peer review process.[131] None of these discovery requests required the disclosure of any committee member's opinions or evaluations, yet the *Basden* court found the above items to be privileged. If the purpose of the peer review privilege is to protect opinions and evaluations, *Basden's* holding—which allows for the protection of other information—is unnecessarily broad.

To summarize, the Indiana courts have clarified that the peer review privilege statute applies to cases of negligent credentialing.[132] In addition, the courts have given broad interpretation to the language in the statute.[133] Furthermore, no case has ever specified in particular what types of evidence are privileged, other than those records relating to the qualifications of a physician.[134] For a negligent credentialing suit plaintiff, these holdings mean that the most relevant discovery requests that can be served on a hospital will be challenged as privileged until the legislature clarifies the extent of the privilege.[135]

V. CRITICISMS OF INDIANA'S PEER REVIEW PRIVILEGE STATUTE

In addition to the hardship the peer review privilege statute poses for the plaintiff in a negligent credentialing suit, Indiana's peer review privilege can be criticized in several other respects. In general, the statute could be construed as an indication that the law protects hospitals and physicians from liability, but sacrifices the improvement of the quality of patient care that would occur through the exposure of incompetency.[136]

The peer review privilege statute has several specific areas of concern. First, the statute does not differentiate between materials that are purely factual

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129. *Id.* at 7.

130. *Id.* at 7-8.

131. *Id.* at 8.

132. *See Basden*, 524 N.E.2d 1306.

133. *See* Frank v. Trustees of Orange County Hosp., Inc., 530 N.E.2d 135 (Ind. App. 1988) (holding that private, informal conversations are privileged).

134. *See* Ray v. St. John's Health Care Corp., 582 N.E.2d 464 (Ind. App. 1991).

135. In Terre Haute Regional Hospital, Inc. v. Basden, 524 N.E.2d 1306, 1309 n.1 (Ind. App. 1988), the court asserted that the amendment and revision of statutes is within the power of the legislature such that the court would not rewrite the peer review privilege statute.

136. For an expression of the same view, see Goldberg, *supra* note 18, at 158. "If the peer review privilege will allow institutional protection to become more important than the improvement in the quality of patient care through the disclosure of unsafe practices, the law is indeed 'a ass-a idiot'." *Id.* (citing CHARLES DICKENS, THE ADVENTURES OF OLIVER TWIST ch. 51 (1837-1838)).

and materials that contain committee opinions and evaluations.[137] Second, physicians under investigation by a peer review committee can see committee records and hear all charges and findings against them,[138] while a negligent credentialing suit plaintiff is still denied access to the records. Third, even after peer review information becomes public record, a plaintiff still needs a written waiver from the committee before discovery and use of the records are permitted.[139] Fourth, persons appearing before the peer review committee are prohibited from voluntarily testifying about their own opinions.[140] Fifth, a hospital can use select peer review records for its own defense while denying the plaintiff access to other peer review information.[141] Last, the peer review statute potentially violates the Indiana Constitution.[142]

A. Absence of a Distinction Between Fact and Opinion

Indiana's peer review privilege gives a general grant of privilege to all proceedings, records, determinations of, and communications to a peer review committee.[143] The statute does not distinguish between different types of information, although peer review records usually contain information of many types and from many different sources.[144] Peer review records generally can be classified as input, deliberations, output, and procedures.[145] 'Input' describes information that enters the peer review records from outside sources, and includes anything not generated by the committee itself. It may include patient medical records, malpractice claims, applications for staff privileges, utilization data, incident reports, reference letters, or verbal testimony.[146] Input information is generated by outside sources and contains no committee member opinions or evaluations.[147] Therefore, the need to keep input privileged is minimal.

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137. The language defining which peer review committee materials are privileged states: "[N]o records or determinations of, or communications to a peer review committee" are discoverable or admissible. IND. CODE ANN. § 34-4-12.6-2(h) (West Supp. 1992).

138. IND. CODE ANN. § 34-4-12.6-2(d) (West Supp. 1992).

139. IND. CODE ANN. § 34-4-12.6-2(i) (West Supp. 1992). *See also* discussion *infra* part V.C.

140. IND. CODE ANN. § 34-4-12.6-2(c) (West Supp. 1992). *See also* discussion *infra* part V.D.

141. IND. CODE ANN. § 34-4-12.6-4 (West Supp. 1992). *See also* discussion *infra* part V.E.

142. See discussion *infra* part V.F.

143. *See* IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992).

144. The records of the peer review committee typically include statistical data from in-house investigations, incident reports, investigations of complaints, patient charts, references and communications from other hospital peer review committees, applications for the granting or renewal of hospital privileges, minutes of the committee meetings, memoranda to physicians or other hospital boards, and written opinions and evaluations produced in the course of review. *See* Ward, *supra* note 18, at 919.

145. *See* Southwick & Slee, *supra* note 6, at 626-28.

146. *Id.* at 626.

147. One exception to this assertion is where the input is from another peer review committee.

The term 'deliberations' describes information generated during the peer review process. Deliberations include minutes of the committee meetings, verbal discussions during the meetings, memoranda to other hospital boards, and written recommendations and opinions produced in the course of peer review.[148] This type of information is "opinion sensitive" because it is comprised of the committee members' criticisms of their fellow physicians' professional competency. Disclosure of these records would likely discourage physicians from participating in the peer review process; therefore, deliberations are legitimately in need of the privilege.[149]

'Output' refers to the final product of the peer review process. It may include written recommendations, minutes, or reports.[150] Output represents the final product of a peer review committee, which was derived from committee member opinions and criticisms. Because committee members are very interested in having their opinions protected, the output privilege is critical in encouraging peer review participation.

Another type of peer review information is 'documentation', or evidence of the procedures that a peer review committee follows when conducting peer review.[151] Documentation includes the frequency and dates of evaluation of a particular physician, the type of documents examined during peer review, the types and names of outside sources the committee consulted, and any other information related to peer review committee procedures.[152] Procedural information predominantly involves who, what, where, and when information and is devoid of any opinion-sensitive information. Therefore, the need to keep evidence related to peer review procedures privileged is limited.[153]

Based on the above analysis, the only peer review information legitimately in need of a privilege is material containing opinions or evaluations that were generated by individual committee members or the committee as a whole.[154]

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148. *See* Southwick & Slee, *supra* note 6, at 626.

149. Information from other peer review committees does originate from an outside source, but is more akin to deliberations-type information. It is generated by a peer review committee, albeit a different committee, so the need to keep it privileged still exists.

150. *See* Southwick & Slee, *supra* note 6, at 626.

151. *Id.*

152. *Id.*

153. Southwick and Slee suggest that a hospital should be eager to disclose the procedures undertaken by its peer review committee, especially when showing proof of JCAHO requirements, state licensing requirements, and in defending against suits alleging negligence, antitrust, or wrongful denial of staff privileges. *Id.* at 626-27.

154. See also Butler, *supra* note 3, at 107, for the proposition that minutes of the committee meetings, correspondence between committee members relating to the review process, and final committee product meet the general rule that the peer review privilege should only include documents that have been "generated by a hospital committee for a hospital purpose."

Therefore, because they contain opinions and evaluations, only deliberations and output are in need of a privilege. Input and procedural information have no legitimate need to be privileged because they contain only factual data, not opinions. Thus, hospitals cannot argue that the sanctity of the peer review committee would be threatened if a negligent credentialing suit plaintiff could discover purely factual input and procedural information.

However, hospitals can assert the privilege for all materials in good faith because the statutory language granting the privilege is so broad. Hospitals also have the assurance that the courts will routinely rule in their favor for non-discoverability. For a negligent credentialing suit plaintiff, broad protection means that any discovery request that implicates anything remotely connected to peer review will be objected to on the basis of the peer review privilege.

As an example of the broad objections hospitals have asserted, hospitals have refused to answer discovery requests asking for the identities of the other health care providers or entities who were consulted regarding an investigation of a physician.[155] They have also refused to reveal what criteria were used in the evaluations process.[156] In addition, hospitals have objected to discovery inquiries asking whether the hospital was aware of or had investigated pending malpractice claims against the physician,[157] inquiries about what procedures were followed during a given peer review session,[158] and inquiries into the mechanisms that a hospital utilizes to monitor the outcome of surgeries performed at that hospital.[159] Furthermore, hospitals have asserted the privilege to questions asking whether the hospital had determined if a physician was board certified,[160] and have refused to divulge the type of hospital privileges the physician had been granted.[161] Lastly, hospitals have refused

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In some cases, disclosure of a particular piece of information may necessarily implicate the source, and thus would be a disclosure of someone's opinion. The likelihood of this occurring is minimal, but where it does, the party asserting the privilege should have the burden of showing that disclosure would reveal the source.

155. Appellee's Brief at 7, Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1307 (Ind. App. 1988) (No. 61A01-8802-CV-43) (asking whether the committee spoke with other physicians outside the hospital).

156. *Id.* at 6 (asking what factors other than past peer review findings were considered in deciding whether or not reappointment of staff privileges was desirable).

157. Miller v. Stiller, No. 64DO2-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991).

158. Appellee's Brief at 7, Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 1307 (asking what the committee did to investigate unnecessary surgeries).

159. Miller v. Stiller, No. 64DO2-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991).

160. *Id.* (asking whether the hospital learned whether physician was board certified in orthopedic surgery).

161. *Id.*

to disclose whether a hospital ever performed periodic peer review on a physician,[162] if the hospital ever requested a curriculum vitae from the physician,[163] or at what other hospitals the physician has or had hospital privileges.[164]

A negligent credentialing suit plaintiff who is facing objections to this "factual" information is forced to go through the unnecessary time and expense of filing a motion to compel discovery, with little hope of success. A judge considering a motion to compel on specific discovery requests has limited guidance from either Indiana's statute or case law. Discovery rulings are piecemeal, making results across the state inconsistent and unpredictable to the litigants.[165]

B. Unequal Access to Peer Review Records

Indiana's statute also allows a physician who has been reviewed by a peer review committee to see the committee records.[166] This exception to the peer review privilege allows a health care provider under investigation to see, at any time, the records accumulated by a peer review committee.[167] The health care provider is afforded the opportunity to appear before the committee with representation, to hear all of the charges, and to offer rebuttal information.[168] Further, if disciplinary action could result from the investigation, the physician is entitled to an evidentiary hearing before the peer review committee and an appeal before the hospital governing board.[169]

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162. Deposition of Ernest W. Stiller, page 141 (December 11, 1991) (on file with Donald W. Rice, Portage, Indiana).

163. *Id.* at 165 (asking whether the hospital, prior to or after grant of hospital privilege, requested a curriculum vitae from physician).

164. *Id.* at 157. Some additional examples include whether action was taken against the physician as a result of the peer review investigation, Appellee's Brief at 7-8, Terre Haute Regional Hosp., Inc. v. Basden, 524 N.E.2d 130, and whether the physician was ever suspended or terminated from a hospital. *Id.*; Deposition of Ernest W. Stiller, pages 135-36 (December 11, 1991) (on file with Donald W. Rice, Portage, Indiana). Lastly, hospitals have objected to discovery of whether, during the peer review process, a hospital asked the physician about any previous suspensions from other hospitals, and whether any complaints about a physician had ever been made by the hospital staff. Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991).

165. For an analysis of how the peer review statutes in Illinois, Florida, Pennsylvania, Colorado, and California have been applied unpredictably by the courts, see generally James T. Hicks, *Uncertainty and Unpredictability in Application of Peer Review Privilege Statutes*, 24 J. HEALTH & HOSP. L. 137 (1991).

166. IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992).

167. IND. CODE ANN. § 34-4-12.6-2(d) (West Supp. 1992).

168. *Id.*

169. IND. CODE ANN. § 34-4-12.6-2(e) (West Supp. 1992).

If a physician chooses to exercise this right under the statute, the opinions, evaluations, and determinations of the peer review committee will be revealed to that physician. The committee members are thus forced to confront their peer with their opinions. At this juncture, the need for the privilege is virtually eliminated; yet, the peer review privilege still prevents the discovery and use of the disclosed information by anyone other than the peer review committee.[170] For a negligent credentialing suit plaintiff, this exception may mean that relevant evidence in the plaintiff's hands is inadmissable, even if a physician has already had access to the information.[171]

C. *Questionable Waiver Provisions*

Under the current statute, a plaintiff can only discover or admit peer review materials into evidence when the peer review committee holding the information executes a written waiver.[172] A written waiver is required even after committee records have been revealed in other proceedings, court records, or

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170. *See* Perrignon v. Bergen Corp., 77 F.R.D. 455 (N.D. Cal. 1978) (holding that after confidentiality is broken, the purpose of the privilege is defeated).

171. The following case serves as an example. In 1985, LaPorte Hospital began investigating the professional competency of Dr. Ernest Stiller, a staff orthopedic surgeon. The proceedings of the investigation and the findings against Dr. Stiller were published in the judicial opinion of Stiller v. LaPorte Hospital, Inc., 570 N.E.2d 99 (Ind. App. 1991). The appellate briefs of both Stiller and LaPorte Hospital make it apparent that Dr. Stiller exercised his right to all evidentiary hearings and that he was confronted by his peers, who were very critical of his professional competency. *Id.* at 101-02. Dr. Stiller was given copies of all the evidence the committee had collected against him, including committee recommendations and opinions. Appellee's Brief at appendix, Stiller v. LaPorte Hosp., Inc., 570 N.E.2d 99 (Ind. App. 1991). Thus, after all of the evidentiary hearings were completed, the peer review opinions and evaluations were known by Dr. Stiller, eliminating the need for the privilege. Furthermore, the findings against Dr. Stiller became public when the case went to trial and was later appealed. *See generally* Stiller v. LaPorte Hosp., Inc., No. 86-513 (Stark Cir. Ct. 1990) (trial court proceeding); *Stiller*, 570 N.E.2d at 99 (Ind. App. 1991) (appellate court proceeding).

In a later negligent credentialing case, Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991), the negligent credentialing suit plaintiff sought to use the information from *Stiller v. LaPorte Hospital* as evidence that Starke Memorial negligently retained Dr. Stiller despite his incompetency. In response, Starke Memorial asserted that the information was privileged under the peer review privilege statute, and that because no waiver had been executed by LaPorte Hospital, the information remained privileged. *Id.* Ultimately, the privilege was successfully asserted by Starke Memorial against the plaintiff. *See* Miller v. Stiller, No. 64D02-9105-CT-1384 V (Porter Super. Ct. filed April 5, 1991).

This situation has also surfaced in other jurisdictions. *See, e.g.*, Henry Mayo Newhall Memorial Hosp., Inc. v. Superior Court, 146 Cal. Rptr. 542 (Cal. App. 1978) (noting that despite the fact that the transcript of the hospital proceedings against a physician had become public record, the hospital successfully asserted the peer review privilege).

172. *See* IND. CODE ANN. § 34-4-12.6-2(h), (i) (West Supp. 1992).

judicial opinions.[173]

Pursuant to the statute[174] and the case law,[175] the waiver provision works a hardship on a negligent credentialing suit plaintiff. Once the peer review committee records are disclosed to the physician under investigation and after they have become a matter of public record, a negligent credentialing suit plaintiff's use of the same evidence would not result in any of the harms that the statute was designed to prevent.[176]

In some instances, the peer review committee must disclose the information involuntarily. For example, if a physician challenges a loss of hospital privileges in a civil lawsuit, committee records necessarily will be introduced into evidence by the physician and the hospital in proving the validity of the loss of privileges. In this scenario, the committee can seek protective and restraining orders to prevent a third party from using the disclosed information. However, where a peer review committee fails to keep the information confidential, a court should consider the privilege waived.[177] In addition, where a peer review committee is careless and discloses information to a third party, the privilege should be considered waived.[178]

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173. Again, the case of Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991) serves as an illustration. Before the *Miller* case was initiated, Dr. Stiller was engaged in litigation regarding the revocation of his privileges from LaPorte hospital. In the trial court stage, and later in the appellate court decision of *Stiller v. LaPorte Hospital*, LaPorte Hospital used information contained in the peer review records to support its claim that Dr. Stiller's discharge was justified. *See* Stiller v. LaPorte Hosp., Inc., No. 86-513 (Stark Cir. Ct. 1990); Stiller v. LaPorte Hosp., Inc., 570 N.E.2d 99 (Ind. App. 1991). Thus, all of the evidence presented in court became a matter of public record both in the lower court record and in the published appellate court decision. However, although the information contained in *Stiller* became a matter of public record, Starke Memorial Hospital successfully asserted that because LaPorte Hospital's peer review committee did not execute a written waiver, the evidence contained in the prior court decision was inadmissible. The negligent credentialing suit plaintiff who was suing Starke Memorial Hospital was thus unable to use any of the evidence used in *Stiller v. LaPorte Hospital* to support her claim.

174. IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992).

175. In Terre Haute Regional Hospital, Inc. v. Basden, 524 N.E.2d 1306 (Ind. App. 1988), the court denied discovery of peer review documents where there had been no written waiver by the hospital, even though peer review communications had been viewed outside the review process. *Id.* at 1312.

176. *See* Goldberg, *supra* note 18, at 157-58 (stating that once a physician is confronted by the peer review committee, the need for confidentiality is dissipated, because both the physician and the committee members have already been harmed by the disclosure).

177. *See* Salmonsen v. Brown, 309 N.Y.2d 535 (1970) (holding that a hospital's right to object to production of peer review report was waived by failure to obtain a protective order or furnish an excuse for not doing so).

178. This is the same rule that is applied to the attorney-client privilege. See *supra* note 118.

D. The Prohibition of Voluntary Testimony of Peer Review Committee Participants

Under Indiana's peer review privilege statute, those attending a committee proceeding may not testify about what they said to the committee.[179] Moreover, a witness before a committee cannot testify about any opinion formed as a result of the committee process.[180] However, the testimony or opinion of an individual witness or a committee member can be characterized as input to the committee, containing no opinions of any other committee members.[181] Therefore, prohibiting individuals from voluntarily repeating their own opinions does not promote the policy of keeping peer review committee members' opinions confidential.

Contrary to the current statute, peer review committee members or those providing the committee with information should be able to voluntarily testify about their opinions of a physician that the committee has reviewed.[182] Voluntary testimony should be permitted as long as the opinions of the other committee members are not revealed. Although the entire committee has the responsibility for working, communicating, and interacting together, the privilege is not for the benefit of the committee as an entity, but for each individual.[183] Peer review committee members or other individuals may want the opinions they gave to the peer review committee to be known to others, especially if they feel strongly about a physician's incompetence. However, the current statute prohibits voluntary testimony.

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179. *See* IND. CODE. ANN. § 34-4-12.6-2(b), (c) (West Supp. 1992). For a partial text of the statute, see *supra* note 84.

180. *See id.*

181. For a discussion of input, *see supra* notes 146-47 and accompanying text.

182. *See* West Covina Hosp., Inc. v. Superior Court, 718 P.2d 119 (Cal. 1986). In *West Covina*, the plaintiff brought suit against West Covina Hospital, alleging that the hospital had negligently granted surgical privileges and retained an incompetent physician. *Id.* at 120. The plaintiff sought the voluntary testimony of a physician who was a member of the hospital's peer review committee. *Id.* The Supreme Court of California held that a peer review committee member could waive the committee privilege and testify about the peer review committee proceedings. *Id.* at 124. The court reasoned that although prohibiting compelled testimony is necessary to promote candor and frankness in the peer review process, prohibiting voluntary testimony is not. *Id.*

183. For a discussion of how allowing voluntary testimony of individual committee members threatens the sanctity of the peer review process, see generally Sosni N. Biricik, Note, *Reconciling Section 1157, Elam, and West Covina Hospital: Is the Sanctity of the Hospital Peer Review Committee Salvageable?*, 61 S. CAL. L. REV. 183 (1987) (analyzing California's peer review privilege statute in light of West Covina Hospital, Inc. v. Superior Court, 718 P.2d 119 (Cal. 1986)).

E. Unfair Use of Peer Review Committee Records

Under the current statute, a health care provider, a hospital, or the hospital's governing board may use peer review information for its own legal defense.[184] This exception has the possibility of creating a puzzling legal situation. A plaintiff[185] may not discover any peer review information in any pretrial procedures or at trial, but a hospital may use selected materials for its own defense.[186] Thus, a hospital can invoke the privilege to conceal information and can utilize the exception to the privilege for its own advantage.[187] In the context of a negligent credentialing suit, a hospital could reveal selected peer review materials to refute a negligent credentialing suit plaintiff's allegations, while using the privilege to hide information that shows its own negligence.[188]

F. Potential State Constitutional Violations

While allowing aggrieved physicians to see committee records seriously undermines the confidentiality of the peer review proceedings, such an allowance is necessary to guard against federal and state due process claims brought by physicians who allege that they were unfairly excluded from a hospital.[189] Discrimination in favor of allowing physicians to see committee records while denying a negligent credentialing suit plaintiff access may violate

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184. IND. CODE. ANN § 34-4-12.6.4(7) (West Supp. 1992). Although the statute allows hospitals to use peer review records for *internal* business purposes, several appellate courts have had available to them peer review committee records, suggesting that hospitals may use the records in judicial proceedings. *See, e.g.*, Stiller v. LaPorte Hosp., Inc., 570 N.E.2d 99 (Ind. App. 1991) (noting that hospital used committee records to show that its decision to revoke physician's hospital privilege complied with hospital procedural and substantive by-laws). *See also* Pepple v. Parkview Memorial Hosp., Inc., 511 N.E.2d 467 (Ind. App. 1987) (holding that the statute only allows peer review committees to use peer review records for internal purposes, but recognizing that other courts have had access to privileged communications).

185. The plaintiff may be either a patient alleging malpractice or negligent credentialing, or a physician alleging wrongful discharge.

186. See Southwick & Slee, *supra* note 6, at 626-27 for other ways in which a hospital may want to use peer review materials.

187. *See* Stiller v. LaPorte Hospital, 570 N.E.2d 99 (Ind. App. 1991) (noting that hospital presented peer review evidence in its defense for revoking a physician's privileges).

188. *See* Ward, *supra* note 18, at 924; *see generally* Hall, *supra* note 17.

189. Due process is a special concern, especially when state run hospitals are involved. *See* Goldberg, *supra* note 18, at 155. *See also* Frank v. Trustees of Orange County Hospital, Inc., 530 N.E.2d 135 (Ind. App. 1988) ("[The physician's right to see peer review documents] insure[s] against arbitrary, discriminatory, or unreasonable state action by a hospital . . . . Therefore the granting of absolute privilege covering all communications during the peer review process does not violate Frank's due process rights."). *Id.* at 138; Jenkins v. Wu, 468 N.E.2d 1162, 1167 (Ill. 1984) (holding that peer review privilege statute's validity would be questionable under the Due Process Clause if the statutory exception that allows physicians to see peer review records did not exist).

the equal protection clause of Indiana's constitution.[190] However, actual challenges to the peer review statute based on violations of equal protection generally have been unsuccessful in other states.[191]

First, physicians and negligent credentialing suit plaintiffs are not "similarly situated." While a plaintiff has other evidence available to prove a negligent credentialing claim, a physician who is challenging a discharge has as evidence only the peer review records.[192] Second, there may be a "compelling interest" in treating even similarly situated persons differently.[193] Improvement of the level of medical care would likely be characterized by any court as a legitimate goal of public policy in which Indiana would have a compelling interest.[194] Because the peer review privilege is necessary to encourage effective quality control, a court would likely find the peer review privilege necessary for the improvement of medical care.[195] Therefore, although an actual state equal protection problem may exist, state constitutional challenges to the peer review privilege based on denial of equal protection will likely be unsuccessful.

A plaintiff whose claim is effectively barred by the peer review privilege may also be able to allege a denial of access to the courts in violation of the Indiana Constitution.[196] If a plaintiff is not able to discover any evidence

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190. "The General Assembly shall not grant to any citizen, or class of citizens, privileges or immunities, which, upon the same terms, shall not equally belong to all citizens." IND. CONST. art. I, § 23.

191. *See* Jenkins v. Wu, 468 N.E.2d 1162 (Ill. 1984).

192. In *Jenkins*, the Illinois Supreme Court held that a physician alleging a due process claim and a plaintiff alleging malpractice are not similarly situated. *Id.* at 1167. The court reasoned that the discovery of peer review records is essential to prove a physician's due process claim, while a malpractice plaintiff's claim can be proved without peer review records by using that plaintiff's own medical records. *Id.*

However, if need for the peer review information determines whether parties are similarly situated, a negligent credentialing suit plaintiff is very similarly situated to a physician who alleges a violation of due process. Just as a physician needs to have the peer review records to show that unfair procedures were used, a negligent credentialing suit plaintiff needs the records to show that the peer review committee acted negligently.

193. *See In re* Terry, 329 N.E.2d 38 (Ind. 1975), *cert. denied*, 423 U.S. 867. *See also Jenkins*, 468 N.E.2d at 1166-67 (citing Massachusetts Bd. of Retirement v. Murgia, 427 U.S. 307, 312 (1976)); People *ex rel.* Difanis v. Barr, 414 N.E.2d 731 (Ill. 1980); Kujawinski v. Kujawinski, 376 N.E.2d 1382 (Ill. 1978).

194. *See* Southwick & Slee, *supra* note 6, at 637.

195. *Id.*

196. IND. CONST. art. I, § 12, states that "[a]ll courts shall be open; and every person, for injury done to him in his person, property, or reputation, shall have remedy by due course of law. Justice shall be administered freely, and without purchase; completely, and without denial; speedily, and without delay."

For a discussion on the constitutionality of peer review privilege statutes, see generally Creech, *supra* note 58, at 209-10.

relating to a physician's credentialing, the effect may be a complete bar to a plaintiff's remedy.[197] However, other courts interpreting constitutional provisions similar to those of Indiana have opined that because the plaintiff can acquire proof of negligence from other sources, no denial of access exists.[198] The courts have held that the peer review privilege statute merely regulates a negligent credentialing claim or have held that it has no effect at all on the claim.[199] While the peer review privilege statute may not rise to the level of a constitutional denial of access, its limitations on discovery ultimately have such an effect.[200]

VI. Reasons Why Other Avenues of Discovery are Inadequate

Critics of peer review privilege reform have argued that other sources of information are available to the plaintiff on which to base a claim of negligent credentialing.[201] Therefore, the best way to alleviate negligent credentialing suit plaintiffs' proof problems may be to force them to use circumstantial evidence to prove their claims. By showing a court that ample evidence of a physician's incompetence existed, a hospital could be proven negligent for not thoroughly investigating the physician's professional competency.

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197. The plaintiff in *Miller v. Stiller*, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991), lost to the defendant, Starke Memorial Hospital, on a motion for summary judgment. Despite many discovery attempts, the plaintiff's expert witness did not have enough information on which to render an opinion that would have effectively responded to the hospital's summary judgment motion. In addition, the plaintiff sought an interlocutory appeal on the issue of the peer review privilege, which the court of appeals declined to accept.

198. *See* Humana Hospital, Inc. v. Superior Court, 742 P.2d 1382, 1386 (Ariz. 1987) (stating that the peer review privilege statute did not abrogate the plaintiff's claim, but merely regulated it because other evidence, such as what the hospital credentialing procedures were, testimony whether or not they were followed, and other expert testimony, could be utilized by plaintiff to prove her claim). *See also* Palm Beach Gardens Community Hosp. v. Shaw 446 So. 2d 1090 (Fla. Dist. Ct. App. 1984); Jenkins v. Wu, 468 N.E.2d 1162, 1167-68 (Ill. 1984) (holding that denial of peer review information should have little impact on plaintiffs' ability to maintain their causes of action); Snell v. Marshall Hosp., 204 Cal. Rptr. 200, 201-02 (Cal. App. 1984) (holding that, despite the fact that the state of California recognized a cause of action for negligent credentialing, discovery of privileged applications for hospital submitted to peer review committee would be valuable proof to the plaintiff, and that denial of this request might require the plaintiff to abandon her remedy, denial of discovery was proper because the peer review committee was a privileged group under California law).

199. *See supra* note 198.

200. *See* Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991). After repeated discovery attempts that were denied based on the peer review privilege statute, the plaintiff lost the defendant hospital on a motion for summary judgment. *Id.*

201. *See* Ward, *supra* note 18, at 199.

A. Evidence of a Physician's Current Professional Status

A plaintiff could discover dismissals from other hospitals.[202] However, under the peer review privilege statute, Indiana hospitals are not required to disclose whether they have revoked a physician's staff privileges.[203] When faced with a discovery request, based on the peer review privilege, a hospital may refuse to answer whether it dismissed a physician.[204]

Additionally, inadequate board certification[205] may provide some evidence of a hospital's negligence in granting a physician hospital privileges. In response to whether a hospital learned of a physician's board certifications, a negative answer may be evidence that the hospital is not screening carefully enough, and an affirmative answer may show that the hospital negligently granted staff privileges in the absence of board certification. However, a hospital—by asserting the peer review privilege—may refuse to divulge whether it learned of the physician's board certifications.[206] This impairs the plaintiff's ability to prove either lack of screening or a negligent grant of staff privileges.

B. Evidence of Other Allegations of Malpractice or Wrongdoing Against a Physician

A negligent credentialing suit plaintiff's discovery of other malpractice actions[207] would show a physician's pattern of negligence. A plaintiff could contact the Indiana Department of Insurance for a certified record of all of the malpractice claims that have been filed against the physician in Indiana.[208] However, unless a hospital will admit knowledge of malpractice actions or can be charged with constructive notice, this evidence will be of minimal help to a plaintiff. Furthermore, malpractice claims may only be pending, and—given our

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202. *See, e.g.*, Johnson v. Misericordia Community Hosp., 301 N.W.2d 156, 174 (Wisc. 1981) (noting that plaintiff inquired into whether surgical privileges at other hospitals had been limited or revoked).

203. The statute says: "[T]he governing board of a hospital . . . *may* disclose the final action taken with regard to a professional health care provider." IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992) (emphasis added).

204. *See* Appellee's Brief at 7-8, Terre Haute Regional Hosp. v. Basden, 524 N.E.2d 1307 (Ind. App. 1988) (No 61A01-8802-CV-43).

205. *See* Miller v. Stiller, No. 64D02-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991) (noting that the plaintiff asked the hospital whether the physician was board certified).

206. *See* Miller v. Stiller, No. 64DO2-9105-CT-1384V (Porter Super. Ct. filed April 5, 1991).

207. *See, e.g.*, Purcell v. Zimbelman, 500 P.2d 335, 343-45 (Ariz. App. 1972) (holding that malpractice claims are admissible to show a hospital's notice of physician incompetence).

208. Indiana law requires that every medical malpractice complaint be filed with the Indiana Insurance Commissioner. IND. CODE ANN. § 16-9.5-9-1 (West 1992). Certified copies of the complaints may be requested from the Commissioner, and are to be taken as prima facie evidence of the facts therein in all courts. IND. CODE ANN. § 27-1-3-5 (West 1993).

litigious society—may provide no evidence at all of physician misconduct.[209]

In addition, where a physician has only had privileges at one hospital, where no injured patients have ever filed lawsuits against the physician, or where physician misconduct is not well known, evidence surrounding prior acts of misconduct may be unavailable. Often, the only way a plaintiff may be successful in using circumstantial evidence is when the number of incidents of prior misconduct is enormous and well documented by others.[210] Requiring many prior acts of misconduct before a hospital can be held liable is an extension of the notion that every dog is entitled to one bite; such a rule has never been applied to dogs and certainly should not apply to physicians.[211]

C. Testimony of Other Individuals

A plaintiff could also use as evidence the testimony of other patients injured by the physician's negligence,[212] or the testimony of other hospital staff members. However, staff members may be unwilling to testify or cooperate, and the testimony of other patients may be unavailable.[213] Procuring other physicians on the hospital staff to testify against the physician may be impossible, and peer review committee members are prohibited from testifying regarding anything related to the peer review process.[214] Asking peer review committee members about their individual opinions formed independent of peer review proceedings may also be prohibited.[215]

D. Evidence in Other Patients' Medical Charts

Another approach to a negligent credentialing suit plaintiff's proof problems may be to gain access to the medical records of the physician's other patients. By showing that a physician had a pattern of negligently treating other patients, a negligent credentialing suit plaintiff can show that a hospital knew or should have known the physician was incompetent.[216] The Indiana Supreme Court

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209. *See* SMITH, *supra* note 42, § 3.03[2] at 3-19 (stating that the practicality of an approach that finds a hospital liable for failing to investigate a single lawsuit is questionable given our litigious society).

210. *See* Goldberg, *supra* note 18, at 165-66.

211. *Id.* at 166.

212. *See* Purcell v. Zimbelman, 500 P.2d 335, 344 (Ariz. App. 1972) (noting that previous patients were called as witnesses).

213. *See* Ward, *supra* note 18, at 924-25.

214. *See* IND. CODE ANN. § 34-4-12.6-2 (West Supp. 1992).

215. *See* Frank v. Trustees of Orange County Hosp., Inc., 530 N.E.2d 135 (Ind. App. 1988) (holding that informal conversations occurring outside the peer review process were not discoverable because these conversations were likely shaped by what occurred during the peer review process).

216. *See* Ward, *supra* note 18, at 925.

followed this approach in *Terre Haute Regional Hospital, Inc. v. Trueblood*.[217] Despite claims that allowing discovery of non-party medical records would violate the physician-patient privilege,[218] the *Trueblood* court sanctioned the discovery of the non-party records where all information disclosing the identity of the non-party was redacted from the records.[219]

Other patients' records may seem useful to a negligent credentialing suit plaintiff, but they do little to diminish a plaintiff's proof problems.[220] First, the non-party medical records themselves are not evidence of prior acts of malpractice, and without the testimony of the non-parties or without all of these non-parties' other medical records, charging a hospital with notice of these uncharged acts of malpractice would be difficult. Second, persons with first hand knowledge about the non-party records, such as the patient and the treating physician, will not be witnesses. Thus, a "battle of experts" will ensue with each side's expert giving testimony about redacted medical records on patients the experts have never seen nor treated.[221] While this type of expert testimony may allow a negligent credentialing suit plaintiff to survive a motion for summary judgment, it will probably not be enough to carry the burden of proof at trial.

E. Information Accumulated Pursuant to the Health Care Quality Improvement Act

The Health Care Quality Improvement Act of 1986,[222] which creates a national databank charged with tracking the professional competency of physicians, also provides a possible means for a negligent credentialing suit

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217. 600 N.E.2d 1358 (Ind. 1992). In *Trueblood*, the plaintiff claimed that the hospital was negligent in reappointing an orthopedic surgeon, and was negligent in failing to supervise and monitor him. *Id.* at 1359. The plaintiff also alleged that the hospital knew the physician was performing unnecessary surgeries for financial gain. *Id.* To assist her in proving her claim, the plaintiff sought to discover some of the medical records of the physician's former surgery patients.

218. *See* IND. CODE ANN. § 34-1-14-5 (West 1983).

219. *Id.* at 1362. Similar approaches have been adopted by a few other jurisdictions. *See, e.g.*, Ziegler v. Superior Court, 656 P.2d 1251 (Ariz. App. 1982) (holding that plaintiff was entitled to see records of former pacemaker patients); Community Hosp. Ass'n v. District Court, 570 P.2d 243 (Colo. 1977) (holding that medical records of neurosurgeon patients were discoverable); Louisville General Hosp., Inc. v. Hellmann, 500 S.W.2d 790 (Ky. App. 1973) (noting that emergency room records of former patients were ordered produced). *See also* Application of American Tobacco Co., 880 F.2d 1520 (2d Cir. 1989); Rudnick v. Superior Court, 523 P.2d 643 (Cal. App. 1974); Amisub, Inc., v. Kemper, 543 So. 2d 470 (Fla. App. 1989); Ventimiglia v. Moffitt, 502 So. 2d 14 (Fla. App. 1986); State *ex. rel.* Benoit v. Randall, 431 S.W.2d 107 (Mo. 1968); Osterman v. Ehrenworth, 256 A.2d 123 (N.J. Super. Ct. App. Div. 1969).

220. *See Trueblood*, 600 N.E.2d at 1362-63 (Shepard, C. J., dissenting).

221. *See Trueblood*, 600 N.E.2d at 1363 (Shepard, C. J., dissenting).

222. 42 U.S.C. §§ 11101-11152 (1992).

plaintiff to discover evidence of hospital negligence. Because the HCQIA requires hospitals to access the databank when performing peer review, it assumes that a hospital is presumed to know the information in the databank.[223] A plaintiff litigating a malpractice action against a hospital can discover databank information, if evidence is submitted to the databank that a hospital failed to request databank information as required by the HCQIA.[224] The evidence necessary to show hospital noncompliance is not specified in the statute,[225] but may include depositions, interrogatories, or admissions of noncompliance.[226] However, a negligent credentialing suit plaintiff may be unable to ascertain whether a hospital inquired into the databank, because the peer review committee may claim that disclosing whether an inquiry was made is privileged under Indiana's peer review statute.[227]

Even if a plaintiff can gain access to databank information, the information may provide minimal help for a plaintiff in showing that a hospital was negligent in granting a physician privileges at that hospital. One discharge from a hospital or several malpractice judgments may not prove negligence on the part of a hospital in granting privileges to a physician.[228] In fact, the HCQIA regulations specifically state that evidence of payment or settlement of a malpractice claim is not to be taken as conclusive evidence that malpractice has occurred.[229]

In summary, under the current discovery avenues available, a negligent credentialing suit plaintiff has a difficult time discovering any information with which to prove his or her claim. Information related to the peer review process is strictly privileged, and information from other sources is either unavailable or of little use in proving a hospital's negligence. A hospital accused of failing

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223. 42 U.S.C. § 11135(b) (1992). For an overview of the information contained in the databank, see *supra* note 45.

224. 45 C.F.R. § 60.11 (1992). The code states in part:

> Information in the databank will be available . . . to . . . an attorney, or individual representing himself or herself, who has filed a medical malpractice action or claim in a State or Federal court or other adjudicative body against a hospital, and who requests information regarding a specific physician, dentist, or other health care practitioner who is also named in the action or claim. Provided, that this information will be disclosed only upon the submission of evidence that the hospital failed to request information from the Data Bank as required by [the HCQIA], and may be used solely with respect to litigation resulting from the action or claim against the hospital.

225. Stephen P. Nash et al., *The National Practitioner Data Bank: Legal Issues and Practical Guidance on Compliance*, *in* 1991 HEALTH LAW HANDBOOK 49, 64 (Alice G. Gosfield ed., 1991).

226. *Id.*

227. *See supra* notes 151-53 and accompanying text.

228. *See* Horner, *supra* note 70, at 485 (noting that proven malpractice claims are not evidence of actual malpractice, only that a plaintiff was successful in persuading a sympathetic jury).

229. 45 C.F.R. 60.7(d) (1992).

to carry out its duty to accredit only competent physicians should be eager to exculpate itself by revealing its peer review records.[230] However, the plaintiff carries the burden of proof, and hospitals will continue successfully to oppose discovery requests under the broad umbrella of the peer review privilege statute until the privilege is strictly defined.

VII. POSSIBLE SOLUTIONS THAT ARE UNDESIRABLE

A. Elimination of the Peer Review Privilege

The easiest way to remedy the problems that a negligent credentialing suit plaintiff encounters by the application of the peer review privilege is to eliminate the privilege. A plaintiff could be given access to all of the committee records and discover the committee members' opinions, the opinions of other peer review committees, the minutes of the committee meetings, and everything else that the committee used in its evaluation process. Abrogation would force peer review committees to perform their functions very carefully, because the privilege shielding their conduct would be eliminated. Committees that perform their functions effectively would not be threatened because they would have nothing to hide from a negligent credentialing suit plaintiff. Total abrogation of the privilege may not even have any effect on physicians choosing to participate in peer review. For example, one Indiana physician chose to participate in peer review even though he did not know that the peer review privilege existed.[231]

However, the peer review privilege is still needed to encourage the day-to-day operations of peer review committees. Without some guarantee of

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230. The plaintiff in Basden v. Terre Haute Regional Hospital, Inc., 524 N.E.2d 1306 (Ind. App. 1988), was of the opinion that the more a hospital opposes discovery requests, the more it is admitting negligence.

> Basden has alleged that [Terre Haute Regional Hospital] did not protect her from a doctor who THRH knew was performing unnecessary surgeries . . . THRH professes to have fulfilled its duty in extending privileges only to qualified, reputable physicians. Given this assertion, one can only wonder why THRH does not request a waiver of the peer review privilege and allow Basden access to the information which would exculpate THRH. Apparently, THRH fears that release of the information will instead support Basden's allegations. The peer review statute was *not* designed to protect hospitals from fraudulent conduct in employing unqualified physicians and surgeons for their own financial gain. If THRH is allowed to shield itself from liability by hiding behind the peer review statute, THRH may continue conducting fraudulent peer review of its physicians and surgeons. The price citizens of this State would pay for such deplorable conduct is far too great.

Appellee's Brief, at 34-35.

231. Appellant's Brief at 29, Frank v. Orange County Hosp., Inc., 530 N.E.2d 135 (Ind. App. 1988) (No. 88A01-8805-CV-149) (noting that the doctor was unaware of the privilege until shortly before his deposition was taken by the malpractice plaintiff).

privilege, no opinions or criticisms of incompetent physicians would ever be expressed during the committee proceedings, making the peer review process a complete nullity. Furthermore, because legislatures, the judiciary, and the medical profession have seen peer review as a positive mechanism for policing physician-owned health care entities,[232] elimination of the privilege would prove an insurmountable task.

B. Use of a Balancing Test

Another possible alternative would be the implementation of a balancing test similar to the one used in the federal courts under Federal Rule of Evidence Rule 501.[233] A balancing approach would probably be the most flexible because the nature of the discovery requests and the level of need the plaintiff can demonstrate will be different in each case.[234] As Rule 501 has been interpreted by the case law, the applicability of the peer review privilege would depend on the outcome of a four part test: the privilege should be construed narrowly, should be applied only to further the privilege's policy, should be applied only to information that originated with the assurance of non-disclosure, and should be applied where the community sedulously fosters the relationship that the privilege intended to encourage.[235]

First, the court would interpret the peer review privilege statute narrowly, because evidentiary privileges are not favored, and, where applicable, they

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232. *See* Southwick & Slee, *supra* note 6, at 625. Southwick and Slee note that the JCAHO guidelines, state law regulating the licensure of hospitals and physicians, federal law requiring peer review to review the appropriateness of Medicare services, and judicial decisions imposing liability on hospitals for corporate negligence all are evidence that peer review is unavoidable. *Id.*

233. FED. R. EVID. 501. For a discussion of how the federal courts have applied the privilege to federal question litigation, see *supra* note 95. Some states have used a balancing test to determine the applicability of the peer review privilege. *See, e.g.*, Bundy v. Sinopoli, 580 A.2d 1101 (N.J.L. 1990) (holding that the trial court must conduct an in camera inspection to determine the need for hospital peer review committee records, balancing the extent that other information is available from other sources, the degree of harm the plaintiff would suffer if denied discovery, and the possible prejudice to the peer review committee). *See also* D.C. CODE ANN. § 32-505 (1981). The statute allows the discovery of peer review records when a showing of extraordinary necessity for them is made. *Id.* Extraordinary necessity was shown in Scott v. Jackson, 596 A.2d 523, 525-26 (D.C. 1991) (finding an extraordinary showing of necessity in the case of malpractice where the act of negligence took place over 10 years earlier, the hospital had destroyed records relating to negligent act, the hospital had destroyed the personnel file of the physician who was responsible for the negligent act, a witness had died, and memories of the incident had faded).

234. For a case that identifies the flexibility in the context of FED. R. EVID. 501, see Trammel v. United States. 445 U.S. 40, 47 (1980) (the purpose of Rule 501 is to permit flexibility in developing the rules of privilege on a case-by-case basis, leaving the door open to change).

235. *See* Doe v. St. Joseph's Hosp., Inc., 113 F.R.D. 677, 679-80 (N.D. Ind. 1987); Schafer v. Parkview Memorial Hosp., Inc., 593 F.Supp. 61 (N.D. Ind. 1984).

should be construed narrowly.[236] For a negligent credentialing suit plaintiff, this part of the test would favor freer access to the peer review records. A court would allow discovery of anything unrelated to committee members' opinions, and would allow discovery of peer review materials that had already been disclosed.

Second, the court would weigh the need for truth against the policy sought to be promoted by the privilege, and the likelihood that recognition of the privilege would further that policy.[237] This analysis of the balancing test would help the negligent credentialing suit plaintiff in several ways. First, the need for truth would always be great where a plaintiff alleges that a peer review committee—with the responsibility of carefully screening physicians—has performed its duties negligently. Second, the balancing approach could be tailored to the individual circumstances surrounding the objects of discovery. Again, where a physician under review has seen the committee records or the materials have become a matter of public record, the continued recognition of the privilege would further no policy and the privilege would be inapplicable.

Third, the court would consider whether the communications originated in a confidence warranting that they would not be disclosed.[238] If Indiana were to adopt a balancing test, confidentiality would not be guaranteed except in unforeseeable situations where the test would balance in favor of confidentiality. Therefore, the application of part three of the balancing test would weigh in favor of discoverability.

Fourth, the court would consider whether the peer review privilege is sedulously fostered by the community.[239] This part of the test would probably weigh against a negligent credentialing suit plaintiff. Legislatures, the judiciary, and the medical profession have recognized the need for a peer review privilege.[240] Based on peer review's wide acceptance, a court would likely find that the community sedulously fosters the privilege.

While a balancing test is a feasible approach, it is undesirable. First, it would lead to judicial uncertainty regarding the applicability of the privilege. Discovery rulings would not be uniform or predictable[241] and would thus result

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236. United States v. Nixon, 418 U.S. 683 (1974).

237. Ryan v. Commissioner, 568 F.2d 531, 543 (7th Cir. 1977), *cert. denied*, 429 U.S. 820 (1978).

238. Schafer v. Parkview Memorial Hosp., Inc., 593 F.Supp. 61 (N.D. Ind. 1984).

239. *Id.*

240. *See supra* note 9.

241. *See* Southwick & Slee, *supra* note 6, at 639 (noting that uncertainties of judicial application have surfaced in applying both legislative and common law peer review privileges, resulting in unpredictable and surprising results).

in surprise and uncertainty to the litigants. Also, because the courts have routinely given deference to the sanctity of the peer review process by making all proceedings, records, and communications confidential, there would be little likelihood that the courts would find the balance to be in favor of a negligent credentialing suit plaintiff.

The best approach to reforming the peer review privilege is a legislative statutory change. While reform by courts would chip away at the privilege in a piecemeal fashion,[242] a comprehensive statute would provide for predictability. The judiciary would have better guidance in applying the privilege, and the litigants would have a better understanding of how to shape their requests and objections to discovery.

VIII. MODEL REVISIONS TO INDIANA'S PEER REVIEW PRIVILEGE STATUTE

The following revisions to the Indiana peer review privilege statute provide a functional approach to the peer review privilege. Persons supplying input to the peer review committee would be assured that their opinions would remain confidential when such a confidence is necessary. Furthermore, negligent credentialing suit plaintiffs would be able to obtain and use evidence to enable their experts to form an opinion about a hospital's negligence.

Model Statute[243]
Immunity and Privileged Communications: Health Care
Provider Peer Review Committees

34-4-12.6-6-1 Definitions

. . .

(h) As used in this chapter, "work product" of a peer review committee refers to any committee product produced by the committee itself that contains an individual's opinion or any peer review committee's opinion related to the qualifications of a health care provider, related to patient care rendered by a professional health provider, or related to the merits of a complaint against a health care provider, including:

(1) Any oral or written committee product obtained by a peer review

242. Other jurisdictions have taken a piecemeal approach, with mixed results. *See supra* note 165.

243. This model statute must be read in conjunction with the full text of the current peer review statute. *See* IND. CODE ANN. § 34-4-12.6-1-4 (West Supp. 1992). The model statute adds provisions to the current statute and amends existing portions of the current statute.

committee from another peer review committee as defined in IC 34-4-12.6-1(c) that was produced by that committee itself, and that contains any individual's opinion or any peer review committee opinion related to a health care provider's professional competency, related to patient care rendered by a professional health provider, or related to the merits of a complaint against a health care provider; and

(2) Any oral or written information submitted from third parties, other than peer review committees, that contains opinions related to the qualifications of a health care provider, related to patient care rendered by a professional health provider, or related to the merits of a complaint against a health care provider.

As used in this chapter, "work product" specifically excludes:

(1) The names and professional qualifications of those serving on the peer review committee, past or present;

(2) The application for initial and renewal of hospital privileges submitted by a health care provider;

(3) Written and oral statements made to a peer review committee by a health care provider related to that health care provider's professional competency;

(4) The written and unwritten procedures and policies that a peer review committee follows in evaluating the professional competency of a health care provider, in evaluating the patient care rendered by a professional health care provider, or in evaluating the merits of a complaint against a professional health care provider;

(5) Incident reports prepared in the routine course of the hospital's business;

(6) Written or oral statements presented to a committee that contain no opinions about the professional competency of a health care provider, as to patient care rendered against a professional health care provider, or as to the merits of a complaint against a professional health care provider;

(7) The nature and extent of the hospital privileges that a health care provider enjoys or has enjoyed at a health care facility;

(8) The dates, nature, and extent that a health care provider's

privileges at a health care facility were ever granted, denied, suspended, revoked or limited;

(9) Information relating to the procedures that a peer review committee followed with respect to conducting any peer review procedure upon a health care provider, such as:

(A) the dates on which any peer review of a health care provider was performed;

(B) the identities of the persons or organizations with whom the peer review communicated concerning the professional competency of a health care provider, concerning patient care rendered by a professional heath care provider, or concerning the merits of a complaint against a health care provider, such as the Indiana Department of Insurance, other hospitals, or other health care providers; or

(C) any other information relating to the steps a peer review committee took in evaluating the professional competency of a health care provider, in evaluating patient care rendered by a health care provider, or in evaluating the merits of a complaint against a health care provider; and

(10) Any other oral or written peer review information that contains no opinions about the professional qualifications of a health care provider, opinions about patient care rendered by a health care provider, or opinions about the merit of a complaint against a health care provider.

As used in this chapter, the definition of "opinion" does not include the nature and extent that a health care provider's hospital privileges were ever granted, denied, suspended, revoked or limited.

Commentary: This section is an addition to the definitional section of Indiana's current peer review privilege statute. This addition codifies the distinction between peer review information containing opinions, information that is purely factual, information that is merely input, and information that reveals what procedural steps a peer review committee followed.[244] By listing specific

244. *See supra* part V.A. For additional jurisdictions that have recognized these distinctions, see D.C. CODE ANN. § 32-505 (1981) (stating that written or oral statements presented to peer review committee were not privileged); Hill v. Sandu, 129 F.R.D. 548 (D. Kan. 1990) (holding that documents submitted to peer review committee relating to the physician's award of staff privileges

examples of items that are clearly not committee "work product," both the parties to litigation and the judiciary will have a concrete understanding about what constitutes privileged "work product."

Furthermore, by including "catch-all" provisions,[245] the statute allows the judiciary some flexibility when handling unanticipated circumstances. Those "catch-all" provisions also indicate to the litigants and the judiciary that the examples given in the statute are not exhaustive.

The model scheme also assures peer review committee members and other individuals that any opinions expressed during the peer review process will remain completely confidential.[246] At the same time, it allows for the discovery of non-opinion sensitive information, giving negligent credentialing suit plaintiffs the evidence they need.[247]

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were not privileged under statute); Porter v. Snyder, 115 F.R.D. 77 (D. Kan. 1987) (holding that incident reports containing factual data were not privileged); John C. Lincoln Hosp. and Health Center v. Superior Court, 768 P.2d 188 (Ariz. Ct. App. 1989) (holding that incident reports were not privileged); Hinson v. Clairemont Community Hosp., 267 Cal. Rptr. 503 (Cal. Ct. App. 1990) (holding that an otolaryngologist's application for staff privileges was not privileged because the document was prepared by a physician, not by a peer review committee); Brown v. Superior Court, 200 Cal. Rptr. 541 (Cal. Ct. App. 1984) (holding that discovery of the fact of whether a hospital evaluated a physician was not a demand for contents of "proceedings or records" of peer review evaluations and thus was not privileged under the peer review statute); Richter v. Diamond, 483 N.E.2d 1256 (Ill. 1985) (holding that whether a physician's privileges have been restricted and the specific restrictions were not privileged information); Ekstrom v. Temple, 553 N.E.2d 424 (Ill. Ct. App. 1990) (holding that the identity of hospital infection control committee members and the physician's application for hospital privileges were not privileged under the Medical Studies Act); Willing v. St. Joseph Hosp. 531 N.E.2d 824 (Ill. Ct. App. 1988) (holding that records relating to a physician's application for hospital privileges were not privileged); Byork v. Carmer, 487 N.Y.S.2d 226 (N.Y. App. Div. 1985) (holding that information as to whether a hospital knew of physician's prior negligent acts was not privileged); Fowler v. Pirris, 34 Pa. D. & C. 3d. 530, 536-38 (1981) (holding that a physician's application for hospital privilege and documents reflecting committees review of the physician's qualification were not privileged under Pennsylvania's peer review privilege act, construing PA. STAT. ANN. tit. 63 § 425.4 (West Supp. 1992)); Barnes v. Whittington, 751 S.W.2d 493 (Tex. 1988) (holding that documents gratuitously submitted to peer review committee were not privileged); Santa Rosa Medical Center v. Spears, 709 S.W.2d 720 (Tex. Ct. App. 1986) (holding that names and addresses of committee members were not privileged under the privilege statute). *But see* Parker v. St. Claire's Hosp., 553 N.Y.S.2d 533 (N.Y. App. Div. 1990) (holding that a physician's initial application for privileges and subsequent application for renewal of privileges were privileged under a statute prohibiting disclosure of "records relating to performance of a medical or quality assurance review function").

245. *See* text of model statute 34-4-12.6-2(h)(9)(C) and (10).

246. *See supra* notes 46-52 and accompanying text.

247. *See supra* part V.A. and notes 132-35 and accompanying text.

34-4-12.6-2 Confidentiality and privilege[248]

(a) All work product, as defined in IC 34-4-12.6-1(h), of a peer review committee shall be confidential. Neither the personnel of a peer review committee nor any participant in a committee proceeding, except a health care provider making oral or written statements to the peer review committee regarding that health care provider's professional competency, shall reveal any work product of a peer review committee outside the peer committee.

(b) Information that is otherwise discoverable or admissible from original sources shall not be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee.

(c) Except as otherwise provided in this chapter, no person who attends a peer review committee proceeding shall be required to disclose any knowledge of work product acquired in connection with a peer review proceeding. If a person in attendance at a peer review proceeding chooses to voluntarily disclose committee work product, that person may disclose his or her input that was given to the peer review committee and any opinions formed as a result of the committee proceedings. However, voluntary disclosure may not include disclosing the opinions of the other committee members. Also, any person that attends a peer review committee may not be prevented from testifying regarding matters within the person's knowledge and in accordance with the other provisions in the chapter.

Commentary: This section revises the current statute by eliminating the prohibition on voluntary testimony by persons who attended a peer review committee meeting.[249] Committee members that feel strongly about expressing their own opinions and about expressing their personal reactions to committee findings may testify.[250] Furthermore, prohibiting the volunteers from disclosing other peer review committee members' opinions assures those members choosing not to disclose that their opinions will still be protected from disclosure.[251] While it is an improvement on the current statute, some disadvantages may still exist with this proposed revision.

Hospital peer review committees act under the authority of the hospital, and the committee's members will likely look out for that hospital's best interests.

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248. This section replaces IND. CODE ANN. § 34-4-12.6-2(a)-(c) (West Supp. 1992). For a comparison of this revision with the current code sections, *see supra* note 84.

249. *See supra* part V.D.

250. *See supra* notes 182-83 and accompanying text.

251. *See supra* notes 182-83 and accompanying text.

Thus, it is possible that only committee members with testimony favorable to the hospital will be willing to testify voluntarily.[252] However, at the same time, a peer review committee member may be sympathetic to a plaintiff's case and voluntarily testify, even to the hospital's detriment.[253]

34-4-12.6-2 Confidentiality and privilege

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(n) Notwithstanding any other provision of this chapter, a plaintiff may discover oral or written peer review committee work product where:

(1) The plaintiff is bringing suit against a health care provider alleging that the health care provider failed to exercise reasonable care in initially granting a health care provider privileges at that health care facility or in subsequently renewing that health care provider's privileges; and

(2) The plaintiff is seeking committee work product relating to the committee's investigation of a health care provider's professional competency; and

(3) The health care provider has exercised his or her statutory rights under IC 34-4-12.6-2(d)-(f).

(o) The work product discoverable in section (n) will only include oral or written work product that was disclosed to a health care provider in an evidentiary or other hearing pursuant to IC 34-4-12.6-2(d)-(f). In addition, the plaintiff may only use the work product obtained under paragraph (n) for purposes of the immediate suit against a health care provider that alleges that the health care provider failed to exercise reasonable care in initially granting hospital privileges to a health care provider or failed to exercise reasonable care in subsequently renewing that health care provider's privileges.

Commentary: This addition to Indiana's statute would allow a negligent credentialing suit plaintiff the same access to peer review records that a health care provider possesses.[254] The addition avoids continued application of the privilege where a physician has already seen the peer review records,[255] and

252. *See* Morter, *supra* note 6, at 1135.
253. *Id.*
254. *See supra* part V.B.
255. *See supra* notes 166-71 and accompanying text.

thus effectively eliminates potential equal protection violations.[256] By limiting the plaintiff's use of the work product to cases of negligent credentialing, it also assures physicians on the peer review committee that what they contribute during the peer review process will not be beneficial to a plaintiff alleging malpractice against an individual physician.[257]

Where a plaintiff is suing both a hospital for negligent credentialing and a physician for malpractice, the above approach may require that separate or bifurcated trials be conducted.[258] However, the extra burden that may be imposed on the litigants is preferable to total elimination of a valid claim of negligent credentialing.

34-4-12.6-2 Confidentiality and privilege

. . .

(i) Except in such cases as are authorized in this chapter, the evidentiary privileges created by this section shall be invoked by all witnesses and organizations in all judicial and administrative proceedings unless the peer review committee has executed a waiver. A waiver may occur:

(1) By execution of a written waiver on behalf of the committee holding the privilege; or

(2) By intentional or negligent disclosure of peer review work product to parties other than those entities listed in IC 34-4-12.6-(g).

In cases where anyone other than the members of a peer review committee, their agents, or employees has submitted opinions about the professional competency of a health care provider, about patient care rendered by a professional health provider, or about the merits of a complaint against a health care provider, waiver of the opinions submitted to the peer review committee may occur only when that other person exercises a written waiver.

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256. *See supra* notes 189-95 and accompanying text.

257. This approach is similar to the HCQIA requirements imposed on a malpractice plaintiff who seeks information from the national databank. 42 U.S.C. § 11112 - 11157 (1992). Under the HCQIA regulations, a plaintiff may discover information contained in the national databank if three conditions are met. First, the plaintiff must be bringing suit against both a hospital and a physician. Second, the plaintiff must show that the hospital did not comply with the HCQIA requirements that the hospital must request information from the databank. Third, the plaintiff may only use the information obtained against the hospital. 45 C.F.R. § 60.11 (1992).

258. A jury would have a difficult time using the peer review records against the hospital while disregarding the records in determining the liability of the physician.

Commentary: This amendment and addition to the Indiana statute allows a plaintiff under certain conditions to use the peer review information without an execution of a written waiver.[259] This section also has a special provision that addresses information received by one peer review committee from another peer review committee or another individual. In these cases, once third parties have given information to a peer review committee, these third parties lose control over the information that they have submitted. If the peer review committee receiving the information is careless in disclosing the third-party information, waiver should not be imputed to third parties. However, this special provision will not prevent a waiver from occurring where an individual or other peer review committee negligently discloses their own information.[260]

Collectively, the proposed statutory revisions and amendments address two other problems associated with Indiana's current peer review privilege statute: The unfair use of peer review information by hospitals[261] and the potential constitutional equal access violations.[262] Disparity in the use of peer review information by hospitals, compared to the use by negligent credentialing suit plaintiffs, is remedied by giving negligent credentialing suit plaintiffs greater access to peer review information. Greater access places a negligent credentialing suit plaintiff on a more equal footing with a hospital regarding the evidence available to each side.[263] However, a hospital may still have a slight evidentiary advantage in its ability to use committee "work product" for its legal defense, as permitted by the statute.[264] Even with this possible shortcoming, however, the proposed revisions are a solution to the current statute's deficiencies and their practical effects.

By allowing a negligent credentialing suit plaintiff greater access to peer review records, the statute also gives a plaintiff with a negligent credentialing claim greater access to the courts.[265] Discovery of peer review facts and opinions in compliance with the statutory revisions assures plaintiffs that they will have enough evidence to prove their claims. Thus, a negligent credentialing claim is less likely to be effectively blocked in violation of the Indiana Constitution's "right of access to the courts" guarantee.[266]

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259. *See supra* part V.C.

260. In other words, where an individual who submits information to a peer review committee then negligently discloses this information to a third party, the fact that the same information was presented before a peer review committee does not make waiver of the information dependant upon the peer review committee's execution of a written waiver.

261. *See supra* part V.E.

262. *See supra* notes 196-200 and accompanying text.

263. *See supra* notes 196-200 and accompanying text.

264. *See supra* part V.E.

265. *See supra* notes 196-200 and accompanying text.

266. IND. CONST. art. I, § 12. See *supra* notes 196-200 and accompanying text.

In addition, the collective revisions also have the effect of improving the effectiveness of peer review.[267] By allowing a plaintiff with a negligent credentialing claim greater access to peer review related materials, the chances for a successful suit is greatly increased. The possibility of a provable case of negligent credentialing will give hospitals more incentive to assure that their peer review committees are operating effectively to eliminate incompetent physicians. Where peer review committees are failing to fulfill their purposes, negligent credentialing suit plaintiffs can act as an effective check on these committees.[268]

IX. CONCLUSION

Indiana's peer review privilege statute was enacted with the noble purpose of improving the quality of health care in Indiana. In many instances the privilege may be furthering this purpose. However, the broad interpretation given to the privilege by the courts has expanded the privilege beyond its necessary scope.

Revisions in Indiana's peer review privilege statute are needed to prevent the peer review privilege from defeating the purpose for which it was enacted. By protecting the "work product" of a peer review committee only where absolutely necessary, peer review can still be carried out effectively and the quality of medical care can still be improved. Moreover, the threat of a provable negligent credentialing case will act as an additional incentive for hospitals to make sure that their peer review committees are conscientiously performing their review functions. Lastly, plaintiffs injured by physicians who never should have had hospital privileges will have an effective remedy to address their wrongs. Making a negligent credentialing suit plaintiff's case easier to prove may indeed result in an increase in malpractice litigation. However, the most logical way to cut down on the amount of malpractice litigation is to cut down on the amount of malpractice.[269]

Jennifer J. Kalas

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267. *See supra* part III.

268. *See supra* part III.

269. Adapted from *Malpractice--With or Without Insurance*, SAT. REVIEW, March 20, 1976, at 4.