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The Medical Peer Review Privilege after Virmani

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The Medical Peer Review Privilege After *Virmani*

In *Virmani v. Novant Health, Inc.*,[1] the United States Court of Appeals for the Fourth Circuit handed down a decision that limited the application of a long-standing privilege integral to North Carolina's health care systems: the Medical Review Committee Privilege.[2] The court refused to recognize the privilege, holding that the plaintiff's interest in obtaining evidence to support his discrimination claim outweighed the public health interest in recognizing the Medical Review Committee Privilege.[3] While the ruling in *Virmani* is consistent with other federal courts' decisions,[4] the Fourth Circuit's superficial treatment of the policy underlying the privilege failed to achieve the depth of analysis found in other court opinions. The Fourth Circuit did not examine the policies fundamental to North Carolina's Medical Review Committee statute as enunciated by the North Carolina courts. Moreover, it mischaracterized the policies underlying the enactment of peer-review statutes in other states.

This Recent Development examines the Court of Appeals's inadequate analysis of the critical conflict between Dr. Virmani's

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1. 259 F.3d 284 (4th Cir. 2001).

2. *Id.* The statutory privilege provides that a participant in a medical review proceeding cannot be compelled to testify in any civil action regarding matters discussed during the proceeding. N.C. GEN. STAT. § 131E-95 (1999). Furthermore, the statute grants to a member of a medical review committee immunity from any civil action arising from any "act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee." *Id.* § 131E-95(a). Finally, the proceedings of the medical review committee and the information and documents it produces are considered confidential and not subject to discovery or introduction into evidence in any civil action against a provider of professional health services. *Id.* § 131E-95(b); *see also* Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 227 (1988) (surveying the peer-review privilege in other states and discussing North Carolina's approach).

3. *Virmani*, 259 F.3d at 293.

4. In addition, other federal courts also have declined to recognize the privilege. *See* Marshall v. Spectrum Med. Group, 198 F.R.D. 1, 5 (D. Me. 2000) (declining to recognize Maine's peer-review privilege in an anesthesiologist's action under the Americans with Disabilities Act (ADA)); Holland v. Muscatine Gen. Hosp., 971 F. Supp. 385, 389–90 (S.D. Iowa 1997) (declining to recognize a privilege in a Title VII action); Robertson v. Neuromedical Ctr., 169 F.R.D. 80, 83–84 (M.D. La. 1996) (declining to recognize a privilege in an ADA case); Johnson v. Nyack Hosp., 169 F.R.D. 550, 559–61 (S.D.N.Y. 1996) (declining to recognize application of New York and New Jersey statutes in a federal discrimination claim); LeMasters v. Christ Hosp., 791 F. Supp. 188, 190–92 (S.D. Ohio 1991) (declining to recognize a privilege in an alleged sex discrimination claim).

fundamental right to access evidence for his discrimination claim and the state's interest in ensuring quality health care.[5] The interest in "ferreting out invidious discrimination"[6] is extremely important in today's society where "racism and discrimination are . . . no strangers to us in the United States."[7] Thus, the court's decision to uphold the privilege was warranted in light of the policy interest of preventing discrimination. However, by not giving the public policy underlying the peer-review privilege its full effect, the Fourth Circuit has limited the applicability of North Carolina's Medical Peer Review Privilege in federal courts and may have affected adversely the application of the privilege in North Carolina courts.

In addition to examining the Fourth Circuit's decision, this Recent Development explores the alternative approaches available to the court to protect the confidentiality concerns of the party seeking to uphold the privilege, while still providing plaintiffs with access to relevant evidence in federal claims.[8]

Medical peer review is one of the primary means of ensuring quality patient care[9] within the medical profession.[10] A self-

5. *See infra* notes 35–102 and accompanying text.

6. Univ. of Pa. v. EEOC, 493 U.S. 182, 193 (1990).

7. *Testimony of the National Coalition of Hispanic Health and Human Services Organizations on H.R. 5540: Hearings Before the Subcommittee on Civil and Constitutional Rights of the House Committee on Judiciary*, 99th Cong. 70 (1986) (statement of William A. Bogan, Vice-President of COSSMHO).

8. *See infra* notes 103–11 and accompanying text (discussing possible procedural protections such as an in camera review and less intrusive discovery order).

9. State licensing board disciplinary actions, as well as medical malpractice suits, regulate the quality of health care. Medical peer review, however, has become the most widely accepted method of identifying and correcting substandard health care. *See* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?* 25 AM. J.L. & MED. 7, 15 (1999) (noting that despite the existence of other alternatives to monitor physician quality, "peer review has become widely accepted as the primary means to weed out low quality physicians"); *see also* Christopher S. Morter, Comment, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1118 (1988) (discussing the advantages of having medical professionals as opposed to lay persons determine who are inadequate hospital personnel).

10. *See* Morter, *supra* note 9, at 1120 (discussing peer review and the Health Care Quality Improvement Act of 1986). Peer review originated with the establishment of the American College of Surgeons ("ACS") in 1913 in an effort to improve the substandard quality of care that existed in the early twentieth century. Not until 1952, however, did the Joint Commission on Accreditation of Health Care Organizations ("JCAHO") adopt an official procedure. *See id.* at 1116. Today, the JCAHO Accreditation Manual provides the guidelines for peer review. Furthermore, maintaining a medical peer-review system is a condition for JCAHO accreditation. *See* COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS, Medical Staff, § 3.1.6 (Joint Comm'n Accreditation of Healthcare Orgs. 2001) [hereinafter COMPREHENSIVE ACCREDITATION MANUAL].

regulatory mechanism, the peer-review process enlists doctors to evaluate and critique the competency of their peers.[11] Peer review involves examining the credentials of physicians applying for staff privileges within a hospital, as well as monitoring the quality of patient care given by physicians who already possess staff privileges.[12]

Confidentiality is essential to meaningful and effective peer review.[13] Without the protections of immunity and confidentiality that peer-review statutes afford, physicians may be reluctant to serve on peer-review committees or to conduct meaningful peer reviews.[14] Peer-review statutes enable physicians to identify problems in their peers' performance and to take appropriate remedial steps without the fear of retributive lawsuits or other negative consequences.[15]

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11. *See* Morter, *supra* note 9, at 1116–20; *see also* Scheutzow, *supra* note 9, at 8 (positing that medical professionals think that privileged information and insulation from liability are the keys to effective peer review).

12. *See* George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 725 (2001) (noting that in the credentialing process, the peer-review committee reviews a physician's training, competence, and certifications); *see also* Morter, *supra* note 9, at 1116–17 (noting the various peer-review functions promulgated by the JCAHO).

13. *See* Bredice v. Doctor's Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970) ("Confidentiality is essential to effective functioning of these staff meetings; and these meetings are essential to the continued improvement in the care and treatment of patients."), *aff'd mem.*, 479 F.2d 920 (D.C. Cir. 1973).

14. The confidentiality and immunity provisions of the medical peer-review statutes shield physicians from several adverse consequences resulting from their participation in the peer-review process. These can include retaliatory measures taken by the physicians who have received an unfavorable review, such as claims for defamation, discrimination, or antitrust. *See, e.g.*, Patrick v. Burget, 486 U.S. 94, 105 (1988) (upholding an antitrust action against defendant physicians); Holly v. Auld, 450 So. 2d 217, 221 (Fla. 1984) (holding that Florida's medical review statute protected the credentials committee's action from introduction in a plaintiff's defamation action); Brandwein v. Gustman, 367 So. 2d 725, 726 (Fla. Dist. Ct. App. 1979) (affirming the dismissal of a physician's defamation suit against a fellow doctor). In addition, physicians conducting peer review also face potential non-legal retribution in the form of lost referrals and admissions from the doctor under review. Peer-review statutes that provide for confidentiality of the peer-review process and immunity from liability are a direct effort to circumvent these concerns. *See generally* Newton, *supra* note 12, at 727 (indicating that Congress and many state legislatures passed peer-review statutes to protect the integrity of the peer-review process and to allay participants' fears of personal liability); Creech, *supra* note 2, at 179–80 (noting that at least forty-six states have statutes to protect the medical peer-review process because of these concerns); Morter, *supra* note 9, at 1119 (stating that quieting the fear of participating physicians has been the goal of most federal and state peer-review legislation).

15. Morter, *supra* note 9, at 1118–20 (noting that defamation suits brought by reviewed physicians as well as loss of referrals from reviewed physicians discourage physicians from participating in peer review); *see also* Newton, *supra* note 12, at 727 (finding that a reluctance to criticize one's peers and a fear of lawsuits against participating

Candid peer review ensures that incompetent or impaired doctors are held accountable.[16] The goals of peer review are to prevent malpractice and ultimately improve the condition of health care. Doctors participating in peer review can recommend that the hospital board terminate or reduce the scope of the reviewed physician's privileges to practice at the health care facility. In addition, peer-review committees can recommend training, education, or monitoring to improve the reviewed physician's deficiency.[17] Although some questions surround the effectiveness of peer review,[18] an increased concern for quality health care has resulted in both state[19] and federal legislation[20] to protect the peer-review process. The effective

physicians resulting from adverse peer-review decisions discourages physician participation in the peer-review process).

16. Although peer review effectively prevents an inept physician from practicing at a particular hospital, it fails to prevent inept physicians from moving elsewhere to continue their practice. Morter, *supra* note 9, at 1125. However, the Health Care Quality Improvement Act provides for reporting to a national practitioner databank that ameliorates this concern. 42 U.S.C. §§ 11133–11134 (1994 & Supp. V 1998). *See* Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 453, 471 (1990) (discussing the reporting provision of the Health Care Quality Improvement Act of 1986).

17. *See* COMPREHENSIVE ACCREDITATION MANUAL, *supra* note 10, at §§ 3.1.6.1.3 to 3.1.6.1.5.

18. *See, e.g.*, Scheutzow, *supra* note 9, at 8 (questioning the effectiveness of peer review due to the low rate at which it occurs); Verner S. Waite & Robert Walker, *Medical and Surgical Peer Review*, 168 AM. J. SURGERY 1, 1 (1994) (noting that hospitals increasingly use peer review to serve their business interests); James R. Jensen, Medical Staff Peer Review—A Peek Behind the Veil, Risk Management Reports vol. 2 (1998), http://www.riskmanco.com/Reports6.htm (criticizing the ineffectiveness of peer review and citing such factors as review done by economic competitors, professional resentment, and "good ol' boy" syndrome as responsible for the inefficacy of peer review).

19. *See, e.g.*, ARK. CODE ANN. § 20-9-502 (Michie 1987); CONN. GEN. STAT. ANN. § 38-19a-17b (West 1997); GA. CODE ANN. § 31-7-132 (2001); 210 ILL. COMP. STAT. ANN. 85/10.2 (West 2000); IND. CODE § 16-10-1-6.5 (1976); LA. REV. STAT. ANN. § 37:1287 (West 2001); MD. CODE ANN., HEALTH OCC. §§ 14-502 to 14-504 (2000 & Supp. 2001); N.C. GEN. STAT. § 131E-95 (1999); OHIO REV. CODE ANN. § 2305.25 (Anderson 2001); OKLA. STAT. ANN. tit. 76, §§ 25-28 (West 1995); 63 PA. CONS. STAT. ANN. § 425.3 (West 1996); R.I. GEN. LAWS § 5-37-1.5 (1999); S.D. CODIFIED LAWS § 36-4-25 (Michie 1999); TENN. CODE ANN. § 63-6-219 (Supp. 2001); UTAH CODE ANN. § 26-25-1 (1998); VT. STAT. ANN. tit. 26, § 1442 (1989); VA. CODE ANN. § 8.01-581.16 (Michie 2000); WASH. REV. CODE ANN. § 4.24.240 (West Supp. 2002); W. VA. CODE ANN. § 30-3C-2 (Michie 1998); WIS. STAT. ANN. § 146.37 (West Supp. 2001); *see also* Brief of Amici Curiae The North Carolina Hospital Association & The North Carolina Medical Society at 8, Virmani v. Novant Health Serv. Corp. (*In Re* Knight Publ'g Co.), 350 N.C. 449, 515 S.E.2d 675 (1999) (No. 62PA97-2) [hereinafter Hospital Brief].

20. In 1986 Congress enacted the Health Care Quality Improvement Act of 1986, §§ 402, 411–432, 42 U.S.C. §§ 11101, 11111–11152 (1988), after recognizing the need to protect physicians participating in peer review. *Id.* at § 11101(5). HCQIA provides immunity to participants in peer-review proceedings for "damages under any law of the United States or of any state . . . with respect to the action." *Id.* at § 11111(a)(1).

functioning of peer review is a crucial means of safeguarding public health, which has particular significance, especially considering a recent study by the Institute of Medicine of the National Academy of Sciences, estimating that as many as 98,000 hospital patients may be injured each year as a result of medical errors.[21]

Strictly observed since its inception, North Carolina's Medical Review Committee Privilege[22] represents a legislative choice to value the confidentiality of the medical peer-review process over access to relevant evidence in a civil action.[23] Codified in the North Carolina Hospital Licensure Act,[24] the intent of the statute is to protect the confidentiality of the peer-review proceeding.[25] The statute provides that the peer-review committee materials and records are (1)

However, HCQIA specifically does not extend this immunity to damages arising under laws protecting the civil rights of individuals. *Id.* A distinction can be drawn, however, between the granting of a privilege and providing immunity. *See* BLACK'S LAW DICTIONARY 1216 (7th ed. 1999) (defining the peer-review privilege as "[a] privilege that protects from disclosure the proceedings ... of a medical facility's peer-review committee"). In the former situation, certain materials are privileged and cannot be used in a civil action. In the latter context, the plaintiff's civil action is barred entirely. *See id.* at 752 (defining absolute immunity as a "complete exemption from civil liability"). However, some courts have noted that denying a plaintiff access to the peer-review proceedings effectively prevents a plaintiff's meaningful access to the courts. *See, e.g.*, Holly v. Auld, 450 So. 2d 217, 223 (Fla. 1984) ("To deny discovery under these circumstances is to deny access to the courts for redress of injury.") (Shaw, J., dissenting). In addition, HCQIA does not provide any confidentiality measures to prevent the discovery of peer-review materials. *Id.* at § 11137(b)(1). For a general discussion on the Heath Care Quality Improvement Act of 1986, see Morter, *supra* note 9, at 1120–30 (discussing the protection afforded by the Act and the nationwide system it created for reporting incompetent physicians).

21. Public Citizen's Health Research Group: Questionable Doctors, http://www.citizen.org/hrg/qdsite/introduction.htm (last visited Mar. 17, 2002) (citing a recent study by the Institute of Medicine of the National Academy of Sciences) (on file with the North Carolina Law Review).

22. North Carolina General Statute Section 131E-95 provides that the proceedings of a medical review committee, as well as the materials and records it produces, shall be confidential, and not subject to discovery in a civil action against a professional health care provider. N.C. GEN. STAT. § 131E-95 (1999).

23. *See* Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 82, 347 S.E.2d 824, 828 (1986) (stating that the purpose of section 131E-95 is to promote "candor and frank exchanges" in peer-review proceedings); Cameron v. New Hanover Mem'l Hosp., Inc., 58 N.C. App. 414, 436, 293 S.E.2d 901, 914 (1982) (stating that section 131E-95 "represents a legislative choice" that "embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence").

24. N.C. GEN. STAT. §§ 131E-75 to 131E-99. The Act states that its purpose is to "establish hospital licensing requirements which promote public health, safety and welfare and to provide for the development, establishment and enforcement of basic standards for the care and treatment of patients in hospitals." *Id.* at § 131E-75(b).

25. *Id.* at § 131E-95(b) ("The proceedings of a medical review committee ... shall be confidential and not considered public records ....").

confidential, (2) not available to the public, and (3) "not subject to discovery or introduction into evidence in any civil action" resulting from matters that are the subject of the committee's review.[26]

North Carolina courts consistently have interpreted section 131E-95 broadly,[27] as illustrated by *Shelton v. Morehead Memorial Hospital*.[28] In *Shelton*, a corporate negligence action, the plaintiff sought to compel production of certain records held by the defendants, the hospital and its former chief executive officer. In its analysis, the court stated that section 131E-95 "is designed to encourage candor and objectivity in the internal workings of medical review committees."[29] The court recognized that the purposes of the North Carolina Hospital Licensure Act are to promote the public health, safety, and welfare and to provide for basic standards of care and treatment of hospital patients.[30] The confidentiality and immunity provisions contained in section 131E-95 provide a crucial means to that end.[31] The court concluded that the privilege protects both medical review proceedings and the records and materials that the committee produces and considers from discovery.[32] Furthermore, the court determined that the privilege protects all disciplinary investigations and hearings; peer evaluations and recommendations to grant, continue, or discontinue staff privileges; personnel information; credentials evaluations and recommendations; and meetings and hearings of the executive committee of the medical staff.[33] Other courts, following *Shelton*'s lead, have recognized and supported the strong public policy favoring candid peer review by

26. *Id.*; *see also* Hospital Brief, *supra* note 19, at 8 (discussing the policy of confidentiality embedded in N.C. GEN. STAT. § 131E-95).

27. *See, e.g.*, *Shelton*, 318 N.C. at 80–84, 347 S.E.2d at 827–30; Whisenhunt v. Zammit, 86 N.C. App. 425, 427–28, 358 S.E.2d 114, 116 (1987). In *Whisenhunt*, the North Carolina Court of Appeals refused to allow a patient, the plaintiff in a negligence action, access to Forsyth Memorial Hospital's credentialing records pertaining to the defendant doctor. 86 N.C. App. at 428, 358 S.E.2d at 116. The court stated, "The purpose of [section] 95 is to promote candor in peer review proceedings, and we will not undercut that purpose." *Id.* at 428, 358 S.E.2d at 116.

28. 318 N.C. 76, 347 S.E.2d 824 (1986).

29. *Id.* at 83, 347 S.E.2d at 829.

30. *Id.*; N.C. GEN. STAT. § 131E-75(b) (1999).

31. *Shelton*, 318 N.C. at 82, 347 S.E.2d at 828; *see* Hospital Brief, *supra* note 19, at 8.

32. *Shelton*, 318 N.C. at 86–87, 347 S.E.2d at 829, 831. The court did, however, note that information used by the peer-review committee from sources available outside the peer-review process is not protected. *Id.* at 83–84, 347 S.E.2d at 828.

33. *Id.* at 88, 347 S.E.2d at 832.

upholding the protections the statute affords and by yielding to legislative intent.[34]

The Fourth Circuit's holding in *Virmani v. Novant Health*[35] significantly reduces the effectiveness of North Carolina's Medical Review Committee Privilege in federal court. In 1995, Novant revoked Dr. Virmani's staff privileges after he punctured a patient's iliac artery during a pelvic laparoscopy.[36] Alleging that the termination of his privileges constituted discrimination against him based on his race and national origin,[37] Dr. Virmani argued that the hospital's peer review committee conducted its proceedings in a discriminatory manner by treating non-Indian physicians differently and disciplining them less harshly, thus violating 42 U.S.C.A. sections 1981[38] and 1985.[39] In order to prove his claim, Dr. Virmani sought access to "all peer review records related to all reviews for any reason, during the twenty years preceding his request."[40] Although the trial court reduced the scope of his request to documents pertaining to competency reviews of obstetricians/gynecologists in the past fifteen years,[41] it denied Novant's motion for a protective order.[42] The Fourth Circuit affirmed.[43]

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34. *See* Virmani v. Presbyterian Health Servs. Corp. (*In Re* Knight Publ'g Co.), 350 N.C. 449, 457, 515 S.E.2d 675, 681 (1999) (concluding that "the compelling public interest in protecting the confidentiality of the medical peer review process outweighs the right of access in this case"); Whisenhunt v. Zammit, 86 N.C. App. 425, 428, 358 S.E.2d 114 (1987); *see also* Christina A. Graham, Comment, *Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges*, 30 CUMB. L. REV. 111, 125 (1999) (recognizing that North Carolina courts have "adopted an expansive approach to the peer-review privilege, and stretched the privilege to the outer limits allowed under [its] state review statute").

35. 259 F.3d 284 (4th Cir. 2001).

36. Virmani v. Presbyterian Health Servs. Corp., 127 N.C. App. 71, 72, 488 S.E.2d 284, 285 (1997). After investigating Dr. Virmani's practice, Novant's Medical Board unanimously voted to recommend that the hospital's Board of Trustees terminate Dr. Virmani's staff privileges. *Id.* at 73–74, 488 S.E.2d at 286. The Board of Trustees upheld the decision. *Id.* Dr. Virmani sued, alleging breach of contract for the hospital's alleged noncompliance with its bylaws with respect to the administrative processes under which his staff privileges were revoked. *Id.* at 73, 488 S.E.2d at 285.

37. *Virmani*, 259 F.3d at 285.

38. 42 U.S.C. § 1981 (1994) (providing for equal rights under the law for all citizens in every United States jurisdiction).

39. 42 U.S.C. § 1985 (1994) (proscribing conspiracy to interfere with an individual's civil rights by impeding the due course of justice with the intent to deny an individual equal protection under the law); *Virmani*, 259 F.3d at 285–86.

40. *Virmani*, 259 F.3d. at 286.

41. *Id.*

42. *Id.*

43. *Id.* at 293.

The Fourth Circuit began its analysis with a structural explication of Federal Rule of Evidence 501. According to Rule 501, federal courts are to determine whether to recognize an evidentiary privilege by looking to an evolving federal common law of privilege that is based on "reason and experience."[44] The general test that courts apply in assessing whether to recognize a federal privilege is whether the privilege promotes sufficiently important interests to outweigh the need for probative evidence.[45] Noting that evidentiary privileges are not "lightly created"[46] the court concluded that only those privileges that are "the most compelling candidates" will overcome the "law's weighty dependence" on the accessibility of evidence.[47]

Having laid the foundation for a Rule 501 analysis, the Fourth Circuit began its substantive analysis. The court correctly identified the issue as "whether the interest in promoting candor in medical peer review proceedings outweighs the need for probative evidence in a discrimination case."[48] The court first considered Novant's argument that the reasons underlying the Supreme Court's decision in *Jaffee v. Redmond*[49] to uphold the patient-psychotherapist privilege in a discrimination action should also apply in the present case. Novant advanced three main arguments asserted in *Jaffee*: "the privilege serves a compelling public end; rejection of the privilege would result in only a modest evidentiary benefit; and all fifty states and the District of Columbia have recognized the privilege."[50]

Without considering whether the public policies underlying the medical peer-review privilege were analogous, the court rejected the applicability of *Jaffee* due to the different context in which the evidentiary issue arose.[51] The court determined that because Dr. Virmani's claim arose from the peer-review proceedings, the

44. FED. R. EVID. 501; *see also* Kenneth S. Broun, *Giving Codification a Second Chance—Testimonial Privileges and the Federal Rules of Evidence*, 53 HASTINGS L.J. 1 (forthcoming 2002) (discussing Federal Rule of Evidence 501 and defending the benefits of a codified set of privilege rules).

45. Jaffee v. Richmond, 518 U.S. 1, 9–10 (1996) (quoting Trammel v. United States, 445 U.S. 40, 51 (1980)).

46. *Virmani*, 259 F.3d at 287 (quoting United States v. Nixon, 418 U.S. 683, 710 (1974)).

47. *Id.* at 287 (quoting Pearson v. Miller, 211 F.3d 57, 67 (3d Cir. 2000)).

48. *Id.*

49. *Jaffee*, 518 U.S. at 18 (recognizing as privileged the communications between a psychotherapist and patient).

50. *Virmani*, 259 F.3d at 288.

51. In *Jaffee*, the Supreme Court recognized a "psychotherapist privilege," determining that the privilege would serve significant interests that outweighed the "modest" evidentiary benefit that would be realized by denying the privilege. *Jaffee*, 518 U.S. at 11.

circumstances differed from the situation in *Jaffee*, in which the plaintiff sought materials produced in counseling sessions that occurred after the event that gave rise to the lawsuit.[52] Instead, the court viewed *University of Pennsylvania v. EEOC*[53] as controlling precedent.[54] The issue in *University of Pennsylvania* involved the question of recognizing a privilege for materials that were considered in the context of review proceedings for academic tenure. The Fourth Circuit explained that "[t]he Court declined to create such a privilege because it determined that the costs associated with discrimination outweighed the costs that would ensue from the disclosure of peer review materials."[55] Noting that, as in *University of Pennsylvania*, the evidence that Dr. Virmani sought arose from the peer-review proceedings themselves, the Fourth Circuit concluded that the interests served by the peer-review privilege did not outweigh the costs associated with preventing Dr. Virmani from pursuing his claim.[56]

Novant also advanced the holding in *Jaffee* that federal recognition of a privilege under Rule 501 was confirmed by the fact that all fifty states had enacted "some form" of the privilege, as the "policy decisions of the States bear on the question whether federal courts should recognize a new privilege."[57] The Fourth Circuit, however, rejected Novant's argument, asserting that the policy decisions of "some" states to enact peer-review legislation differed from the policy decisions of other states.[58] Therefore, the court concluded that there was not enough of a consensus among the states to warrant recognition of a federal privilege.[59]

As additional support for its holding, the Fourth Circuit also examined the Health Care Quality Improvement Act ("HCQIA").[60] In 1986, Congress enacted the HCQIA in response to "an overriding national need to provide incentive and protections for physicians engaging in effective professional peer review."[61] HCQIA provides a

52. *Virmani*, 259 F.3d at 288.
53. 493 U.S. 182 (1990).
54. *Virmani*, 259 F.3d at 288.
55. *Id.* at 287 (quoting *University of Pennsylvania*, 493 U.S. at 193).
56. *Id.* at 289.
57. Jaffee v. Redmond, 518 U.S. 1, 12–13 (1996).
58. *Virmani*, 259 F.3d at 291. Specifically, the Fourth Circuit noted that the decision in some states to enact peer-review legislation was based on the effect of the privilege on plaintiffs in malpractice suits. *Id.* at 290.
59. *Id.* at 291.
60. *See supra* note 20 (discussing the HCQIA).
61. 42 U.S.C. § 11101(5). Other purposes of the Act include combatting the increasing rate of medical malpractice and providing a national repository for reporting

qualified immunity for peer-review participants in federal and state civil actions arising from peer-review participation.[62] In addition, the Act created a national repository in which to report adverse actions taken with respect to a physician's staff privileges so as to prevent the undetected movement of incompetent physicians.[63] The court could not conclude that Congress had considered and rejected a privilege for peer-review materials when enacting the HCQIA.[64] However, the court determined that because Congress had created an express exception to the immunity provision in the HCQIA for civil rights claims, "Congress has considered the competing interests, [and] it has not elevated the interest in encouraging peer review over the interest in combating discrimination."[65]

Finally, the court rejected Novant's contention that other circuit court decisions supported recognizing the privilege.[66] The court concluded that the interest in obtaining relevant evidence in a discrimination claim outweighed the interest that would be furthered by recognizing a privilege for medical peer-review materials.[67]

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adverse actions regarding physicians' staff privileges, so as to restrict the ability of incompetent practitioners to move undetected to another hospital. Horner, *supra* note 15, at 456.

62. 42 U.S.C. § 11111(a)(1) (1988) (stating that physicians participating in peer review that "meets all the standards specified . . . shall not be liable in damages under any law of the United States or of any State . . . with respect to the action"). However, the Act does not provide for immunity in civil rights actions.

63. 42 U.S.C. §§ 11131–11134.

64. However, in *Cohn v. Bond*, 953 F.2d 154 (4th Cir. 1991), *aff'g* Cohn v. Wilkes Gen. Hosp., 127 F.R.D. 117 (W.D.N.C. 1989), the Fourth Circuit affirmed the district court's holding that the peer-review proceedings in an anti-trust action were privileged in state and federal court. The court relied on the existence of the HCQIA to conclude that Congress had endorsed the privilege, stating that the HCQIA "support[s] the public policy which protects as privileged the medical review process." *Cohn*, 127 F.R.D. at 121.

65. *Virmani*, 259 F.3d at 292. However, the court does not acknowledge the difference between granting absolute immunity from a discrimination claim and recognizing a privilege in the context of a discrimination claim. *See supra* note 20 (explaining the difference between granting immunity and recognizing a privilege).

66. The Court found that the Seventh Circuit in *Memorial Hospital v. Shaddur*, 664 F.2d 1058, 1063 (7th Cir. 1981) (per curiam) expressly declined to recognize a peer-review privilege. *Virmani*, 259 F.3d at 292. In addition, the Court determined that in *Marrese v. American Academy of Orthopaedic Surgeons*, 726 F.2d 1150 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985), the "Seventh Circuit did not address the issue of whether peer-review documents should be privileged." *Id.* Finally, the Court determined that *United States v. Harris Methodist Fort Worth*, 970 F.2d 94 (5th Cir. 1992) did not even involve the issue of peer-review privilege. *Id.* at 292–93.

67. *Virmani*, 259 F.3d at 293.

In *Virmani*, the Fourth Circuit faced an issue that required a delicate balance of competing policy considerations.[68] A plaintiff's right to access relevant evidence to prove his claim is fundamental to our adversarial system.[69] Furthermore, eradicating unlawful discrimination is an extremely important social goal. Conversely, by enabling doctors to review their peers, the confidentiality that the state medical peer-review statutes ensure ultimately safeguards public health.[70] The significant interest on both sides of this conflict demand a fair and careful analysis. An examination of the Fourth Circuit's opinion, however, reveals a discussion that focuses mainly on the evidentiary difficulties encountered by a plaintiff seeking evidence that is protected by the Medical Review Committee privilege. The opinion does not explore adequately the public health issues that are protected by the privilege.

First, the court's Rule 501 analysis was not as thorough as the analysis from other courts that have encountered similar issues. Aware of the significant nature of the issues involved, other federal courts have engaged in a careful and conscientious discussion that demonstrates an effort to respect state legislative and judicial decisions to the extent possible.[71] In applying Rule 501 in the context of medical peer review, other courts have examined the policies embodied in the state law privilege at issue.[72] For example, the Court

68. *See generally* Newton, *supra* note 12, at 734–42 (providing a general discussion of the competing policy concerns); Creech, *supra* note 2, at 205–07 (discussing the policy debate between the privilege and the ability to access relevant evidence); Graham, *supra* note 34, at 113 (noting that the public policy behind peer-review legislation is "noble" and at the same time problematic because it prevents plaintiffs from acquiring evidence from the peer-review proceeding).

69. *See* Creech, *supra* note 2, at 205–07 (noting that justice, public policy, and every state constitution demands that plaintiffs be allowed to assert any legally recognized claims).

70. *Supra* notes 9–34 and accompanying text (discussing the policy considerations underlying the enactment of peer-review statutes).

71. *See, e.g.*, Mattice v. Mem'l Hosp. of South Bend, 203 F.R.D. 381, 384 (N.D. Ind. 2001) (asserting that a federal court should, as a "matter of reason, experience, [and] comity," take into account the law and the evidentiary privilege of the state in which the claim arises); Marshall v. Spectrum Med. Group, 198 F.R.D. 1, 3–4 (D. Me. 2000) (looking to Maine's privilege in the first step of its Rule 501 analysis); Holland v. Muscatine Gen. Hosp., 971 F. Supp. 385, 389 (S.D. Iowa 1997) (stating that the court should respect privileges of the forum state); Doe v. St. Joseph's Hosp., 113 F.R.D. 677, 679 (N.D. Ind. 1987) (analyzing the application of Indiana's medical peer-review privilege "in the spirit of" Rule 501).

72. *See, e.g.*, Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1062 (7th Cir. 1981) (per curiam) (stating that the Illinois Medical Studies Act's policy to bolster the effectiveness of peer-review committees is substantial); *Marshall*, 198 F.R.D. at 4 (noting the significant policy considerations behind Maine's adoption of peer-review legislation, and restricting

of Appeals for the Seventh Circuit in *Memorial Hospital for McHenry County v. Shadur*[73] stated that "a strong policy of comity" compels federal courts to consider the law and policy of the state in which the case arises in assessing whether to recognize a privilege as a matter of federal law.[74]

The Fourth Circuit in *Virmani*, however, neither attempted to examine North Carolina's crucial policy considerations surrounding the confidentiality of peer-review proceedings, nor acknowledged any deference to the North Carolina legislature's intent in the enactment of the privilege, as set out in North Carolina court decisions. The Fourth Circuit tentatively began a discussion of the policy concerns implicated in medical peer review stating: "We agree with Novant that the privilege it seeks would serve important interests."[75] However, this brief statement comprises the court's entire discussion of these policies.[76] Instead of taking the opportunity to explore the interests advanced by the peer-review privilege, the court reverted to its espousal of the evidentiary detriment Dr. Virmani would have faced in his discrimination claim if it upheld the privilege.[77]

In addition to ignoring North Carolina's Medical Review Committee Privilege and its underlying policies, the court also failed to explore adequately the public health interests expressed in peer-review statutes. This approach is evident where the court distinguished *Jaffee* and instead viewed *University of Pennsylvania* as

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disclosure to "narrowly tailored circumstances"); Brem v. Drs. DeCarlo, Lyon, Hearn, & Pazourek, P.A., 162 F.R.D. 94, 97 (D. Md. 1995) (examining Maryland's medical review committee statute as well as citing Maryland decisions that discuss the underlying policy of the statute); *St. Joseph's Hosp.*, 113 F.R.D. at 678 (asserting that policing the quality of health care providers was an extremely high priority as evidenced by the General Assembly's decision to enact peer-review legislation).

73. 664 F.2d 1058 (7th Cir. 1981) (per curiam).

74. *Id.* at 1061 (quoting United States v. King, 73 F.R.D. 103, 105 (E.D.N.Y. 1976)); *see also* Weekoty v. United States, 30 F. Supp. 2d 1343, 1347 (D.N.M. 1998) (noting that comity compels consideration of the New Mexico Legislature's conclusion that the public interest in confidential morbidity and mortality conferences outweighs discovery of the discussions in those conferences).

75. *Virmani*, 259 F.3d at 289.

76. Although the court addressed the policy considerations underlying peer review at the beginning of its analysis, it did so in one sentence by recognizing that some courts have determined that a privilege is necessary to encourage physicians to serve on peer-review committees and to speak candidly if they do serve, otherwise, the quality of health care would suffer. *Id.* at 287. This attempt to enumerate the policy concerns is perfunctory and qualified by the words "some courts." *Id.* This treatment of the public health issues involved seems blithe, as well as inaccurate, for indeed, fifty states and Congress have enacted some type of privilege to encourage medical staff candor. *See* notes 19–20.

77. *Virmani*, 259 F.3d at 289.

persuasive.[78] An obvious parallel exists between the *University of Pennsylvania* and *Virmani* cases, as both deal with a claim of discrimination arising from peer-review proceedings.[79] However, the costs associated with denying a privilege that protects faculty tenure decisions are different than the costs associated with denying a privilege for medical peer review.[80] Denying the academic peer-review privilege would reduce freedom in tenure decisions, whereas denying the medical peer-review privilege could have the more detrimental effect of sacrificing adequate health care. The Fourth Circuit does not address this glaring distinction. The court's disregard for the important difference between the policy concerns underlying academic and medical peer reviews reveals an inadequate balancing of the interests involved.

The Fourth Circuit also made a number of unfounded conclusions and leaps in logic that demonstrate a superficial analysis. First, in distinguishing *Jaffee*, the court concluded that a doctor's sense of duty to the public at large, coupled with his personal desire to maintain quality health care may "overcome any reluctance to serve and be forthcoming on a peer-review committee, even in the absence of a privilege."[81] Indeed, surveys demonstrate that the opposite is true.[82] This conclusion fails to account for the doctors'

78. *See infra* notes 51–56 and accompanying text (discussing the court's rejection of the applicability of *Jaffe* to the case and its adoption of the reasoning of *University of Pennsylvania*).

79. The Fourth Circuit emphasizes that *University of Pennsylvania* is especially relevant to *Virmani* because in that case the discrimination charge arose from the proceedings themselves. In further support of this argument, the court cites *Marshall*, 198 F.R.D. at 5, asserting that the district court refused to recognize a privilege "in part because the suit alleged abuse of the peer review process." Virmani v. Novant Health Inc., 259 F.3d 284, 289 (4th Cir. 2001). However, the Fourth Circuit does not mention that the other reason that the *Marshall* court did not recognize the privilege was that the information contained in the peer-review proceedings had been disclosed already. *See Marshall*, 198 F.R.D. at 5 (citing the viewing of the peer-review documents by plaintiff and his psychologist as one of two bases to compel disclosure). In addition, the Fourth Circuit relies on *Holland*, 971 F. Supp. at 385. However, partially influencing that district court's decision was the fact that the relevant peer-review material was factual and not truly self-critical in nature. *See Holland*, 971 F. Supp. at 391 (noting that disclosure of hostile work environment claims were in the hospital's best interest).

80. The Fifth Circuit noted in *United States v. Harris Methodist Fort Worth* that, "[u]nlike the privilege claim for faculty tenure decisions ... the medical peer review process 'is a sine qua non of adequate hospital care.' " 970 F.2d 94, 103 (5th Cir. 1992) (quoting Bredice v. Doctors Hosp., 50 F.R.D. 249, 250 (D.D.C. 1970)).

81. *Id.* at 290 n.7.

82. For example, a Public Citizen's Health Research Group's survey analyzed data compiled by the Federation of State Medical Boards, showing that the rate of serious disciplinary action per 1,000 doctors was 3.49 in 2000. The director of the Public Citizen's Health Research Group, Dr. Sidney Wolfe, stated, "When people are getting killed

reluctance to participate in peer review without protection from liability compelled fifty states and Congress to enact peer-review privilege legislation in order to have effective peer review.[83] The Fourth Circuit garners no support for its conclusion other than a statement from an Ohio district court asserting that "most physicians feel an ethical duty to the profession and to the public to keep the standard of health care high."[84] While physicians ideally feel an ethical duty to keep the standard of health care high, they are reluctant to police other members of their profession without the protections peer-review privileges provide.[85]

Furthermore, according to the Supreme Court in *Jaffee*, the "policy decisions of the States bear on the question whether federal courts should recognize a new privilege."[86] In support of that contention, Novant argued that all fifty states and the District of Columbia have enacted some form of medical peer-review privilege.[87] The Fourth Circuit countered this argument, stating that at least "some" states "appear[ed]" to have enacted the privilege based on the policy decision that the interest in promoting candor among medical staff members outweighs the interest of obtaining evidence in malpractice claims.[88]

By focusing on the discrete context of malpractice, the Fourth Circuit narrowed the underlying public policy purpose considered by

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because of crimes that continued because of an inadequate number of police officers, people make that an issue. Well, this is a public health issue, a policing issue." Michael Romano, *More Docs Disciplined: State Medical Boards Report Uptick in Actions; Consumers' Group Unmoved*, MODERN HEALTHCARE, Apr. 16, 2001, at 14, *available at* http://www.modernhealthcare.com/archive/main.php3 (on file with the North Carolina Law Review); *see also* R. A. Brennan et al., *Incidence of Adverse Events and Negligence in Hospitalized Patients: Results of the Harvard Practice Study I*, 324 NEW ENG. J. MED. 370–76 (1991).

83. *See supra* notes 13–20 and accompanying text (discussing the enactment of state and federal peer review legislation and the policies underlying the statutes).

84. LeMasters v. Christ Hosp., 791 F. Supp. 188, 191 (S.D. Ohio 1991).

85. *See* Morter, *supra* note 9, at 1119 (noting that while ethical considerations ideally should motivate physician participation in peer review, historically they have not done so); *see also* Weekoty v. United States, 30 F. Supp. 2d 1343, 1346 (D.N.M. 1998) (stating that if peer-review were open to discovery, physicians would not be as candid in their discussions, thus substantially undermining the goal of improving health care); Newton, *supra* note 12, at 726–27 (stating that despite the abstract notion that a physician's ethical duty of improving the quality of health care might lead him to participate in peer review, reality demonstrates that numerous disincentives thwart physician participation in the peer-review process).

86. Jaffee v. Redmond, 518 U.S. 1, 12–13 (1996).

87. Virmani v. Novant Health, Inc., 259 F.3d 284, 290 (4th Cir. 2001).

88. *Id.* at 290.

state legislatures in the enactment of the peer-review privileges.[89] The court relied on *HCA Health Services of Virginia, Inc. v. Levin*,[90] in which the Virginia Supreme Court noted that the Virginia statute making peer review privileged is codified in the medical malpractice chapter of the title on civil procedure.[91] However, the *Levin* court totally refuted the argument that because the statute was codified in the medical malpractice chapter the peer review statute was limited to medical malpractice claims.[92] The *Levin* court stated that to restrict the privilege to medical malpractice claims "ignores the underlying purpose of the statute," which is "to promote open and frank discussion during the peer review process . . . in furtherance of the overall goal of improvement of the health care system."[93]

The Fourth Circuit also relied on *Eubanks v. Ferrier*[94] for the contention that the decision to enact peer-review statutes involved a choice between impairing a malpractice plaintiff's access to evidence and fostering medical staff candor.[95] However, in *Eubanks*, the Supreme Court of Georgia also stated that "the purpose for the enactment of [the peer-review statute] is to foster the delivery of quality medical services by preserving the candor necessary for the effective functioning of hospital medical review committees."[96] Therefore, the very cases on which the Fourth Circuit relied indicate that the privilege was not enacted solely based on the policy considerations found in the malpractice context. Instead, they recognized that the overriding purpose of the privilege is to improve the quality of health care by protecting physicians participating in peer review, regardless of the type of litigation involved.

In addition, the Fourth Circuit stated: "There is no evidence that state legislatures considered the potential impact on discrimination cases of a privilege for medical peer review proceedings."[97] However, one can infer from Indiana's peer-review statute, for example, that

89. The Fourth Circuit mentioned other reasons that legislatures considered when enacting peer-review statutes, such as concern for liability for defamation and loss of referrals. *Id.* However, the Fourth Circuit focused on physician self-interest instead of the underlying public health impetus in enacting the statutes. In other words, the state legislatures were not enacting the statutes solely to protect physicians, but to protect them for the purpose of improving quality health care.

90. 530 S.E.2d 417 (Va. 2000).

91. *Virmani*, 259 F.3d at 290 (citing *Levin*, 530 S.E.2d at 420).

92. *Levin*, 530 S.E.2d at 420.

93. *Id.*

94. 267 S.E.2d 230 (Ga. 1980).

95. *Virmani*, 259 F.3d at 290.

96. *Eubanks*, 267 S.E.2d at 232–33.

97. *Virmani*, 259 F.3d at 291.

the state legislature did in fact consider discrimination in enacting the peer-review statute.[98] Indiana explicitly acknowledged that they would not extend immunity to actions that violate "any federal law relating to the civil rights of a person."[99] The statute also provides, however, for the confidentiality of the peer-review proceedings.[100] Because the legislature included a civil rights exception in the statute's immunities provision without providing a similar exception in the confidentiality provision, evidence does exist that at least one state legislature and perhaps others considered the impact on discrimination of a peer-review privilege.

Finally, by manipulating the policy discussion to apply only to malpractice, the court was able to highlight the evidentiary inequities that the discrimination plaintiff faces when his only evidence allegedly lies in the peer-review proceedings themselves. However, by focusing its discussion on the distinction between the medical malpractice plaintiff, who can access evidence for his claim that exists outside the peer-review proceedings, and the discrimination plaintiff, whose ability to access evidence for his claim is limited severely by the privilege, the Fourth Circuit's language leaves the sanctity of privilege vulnerable in subsequent suits in which the plaintiff argues his inability to prove a meritorious claim without access to peer-review materials. For example, a claim for negligent credentialing alleges that the hospital was negligent in giving staff privileges to the physician.[101] A peer-review body makes the decision whether to grant the physician these privileges. The plaintiff's only evidence is the peer-review proceedings;[102] therefore, after *Virmani*, the plaintiff could more easily argue that he cannot otherwise prove his claim without access to the peer-review proceedings. Thus, future litigants are likely to rely on the Fourth Circuit's analysis to circumvent North Carolina's Medical Review Committee statute.

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98. *See* IND. CODE ANN. §§ 34-30-15-1 to -15-23 (West 1999).

99. *Id.* § 34-30-15-20.

100. *Id.* at § 34-30-15-2 ("Except as otherwise provided in this chapter, a person who attends a peer review committee proceeding shall not be permitted or required to disclose: (1) any information acquired in connection with or in the course of a proceeding; (2) any opinion, recommendation, or evaluation of the committee; or (3) any opinion, recommendation, or evaluation of any committee member.").

101. *See, e.g.*, St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503, 504 (Tex. 1997) (alleging that the hospital was negligent in renewing an incompetent physician's staff privileges).

102. The plaintiff, however, can discover the hospital's general credentialing policies and use expert opinions as evidence to adjudicate a claim. *See* Humana Hosp. v. Superior Court, 742 P.2d 1382, 1386 (Ariz. Ct. App. 1987).

The Fourth Circuit could have accommodated the confidentiality needs of Novant, while at the same time allowing Dr. Virmani adequate access to probative evidence needed to prove his claim. By remanding the case to the district court with certain instructions, the Fourth Circuit could have better alleviated Novant's confidentiality concerns. First, the court could have ordered an in camera review of the documents Dr. Virmani sought to determine which documents were not relevant to his claim and thus unnecessary for Novant to produce. The Supreme Court in *Kerr v. United States District Court for the Northern District of California*[103] determined that an in camera review order "is a relatively costless and eminently worthwhile method to insure that the balance between petitioners' claims of irrelevance and privilege and plaintiffs' asserted need for the documents is correctly struck."[104] Likewise, in *Marrese v. American Academy of Orthopedic Surgeons*,[105] the Seventh Circuit suggested that the trial court could have reconciled the parties' competing needs by conducting an in camera review of the relevant documents.[106] Although the Fourth Circuit acknowledged the benefits provided by an in camera review, it did not order one in *Virmani*.[107]

Second, the Fourth Circuit could have ordered a more limited discovery order that could have prevented the exposure of extremely sensitive information. Although the district court limited the scope of Dr. Virmani's discovery request in terms of time period and medical specialty,[108] the order still spanned fifteen years and required production of all documents relating to the competency reviews of all obstetricians and gynecologists.[109] In order to accommodate Novant's confidentiality concerns, the court could have limited the order to a shorter time period or reduced the number of physician competency reviews that it ordered Novant to produce.

Third, the Fourth Circuit could have required more than a mere allegation of discrimination before affirming the district court's discovery order.[110] Once Dr. Virmani had demonstrated more than

103. 426 U.S. 394 (1976).
104. *Id.* at 405.
105. 726 F.2d 1150 (7th Cir. 1984).
106. *Id.* at 1160.
107. *See* Virmani v. Novant Health, Inc., 259 F.3d 284, 287 n.4 (4th Cir. 2001).
108. *Id.* at 286.
109. *Id.* at 287.
110. *See, e.g.*, Doe v. St. Joseph's Hosp., 113 F.R.D. 677, 680 (N.D. Ind. 1987) (stating that "the plaintiff [must] allege facts which create more than a mere inference that the actions of the peer review committee were discriminatory, before the court will permit even an *in camera* inspection [of the peer review materials]").

an allegation of discrimination, the court could have shifted the burden of proof to Novant to show legitimate, nondiscriminatory reasons why it had suspended Dr. Virmani's staff privileges. However, the Fourth Circuit's decision does not prevent a disgruntled but justifiably discharged physician from alleging a discrimination claim and having full access to all peer-review materials relevant to his claim. Plaintiff's attorneys could use this tactic to access documents that would not otherwise be available by alleging other state claims.

Finally, the court simply could have acknowledged Novant's confidentiality concerns. This acknowledgment could have demonstrated that the Fourth Circuit would attempt to accommodate the needs of both the parties involved to the extent possible. For example, in *Mattice v. Memorial Hospital of South Bend*,[111] the district court stated despite its holding that the peer-review documents were not privileged that "the Court appreciates the confidentiality concerns raised by Memorial,"[112] and thus it imposed guidelines to which the parties should adhere in handling the peer-review documents.[113]

In North Carolina, the Medical Review Committee statute has provided a means for physicians to participate in effective peer review. By not recognizing the statute in federal court, *Virmani* has diminished the protection given to peer-review participants and thus has undermined the public policy underlying North Carolina's peer-review statute. However, the detrimental precedent that *Virmani* established is not necessarily found in the outcome of its decision, but rather in the analysis utilized to reach its holding. Subsequent state and federal courts would be well served to use more circumspection in their decisions when presented with similar issues involving the Medical Review Committee statute. This will entail a more thorough and careful analysis of the public health and safety issues that the statute addresses. Furthermore, by implementing appropriate limitations on the amount and type of discovery and evidence obtained from peer-review deliberations, future courts could satisfy the confidentiality concerns of the party seeking to uphold the

111. 203 F.R.D. 381 (N.D. Ind. 2001).
112. *Id.* at 386.
113. *Id.* at 387.

privilege, as well as protect the rights of physicians who are subject to those proceedings.

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