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Peer Review Protection: The Pennsylvania Approach at the Crossroads

Joseph A. Ricci

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I. Introduction

The ethical conflict of professionalism[1] is particularly apparent in the area of medical regulation. Although the medical profession has been actively regulated for over a century,[2] the modern practice of medicine has produced unique problems for the medico-legal community. In this context, one must give particular attention to the medical malpractice problem[3] and to society's response to growing concerns about the quality of medical care.

Implementation of peer review[4] is one approach to insuring quality medical care. This particular method of quality review, however, is particularly susceptible to manifestations of the ethical conflict of professionalism.[5] The medical community steadfastly main-

1. This conflict has been defined as the conflict between the rights of a profession, the rights of the government, and the rights of society generally. The conflict manifests itself as the professional seeks to maintain his integrity and remain free from bureaucratic controls, while the government seeks to regulate the professional's conduct to protect the public from incompetent practitioners of the profession. Feinstein, *Special Report: The Ethics of Professional Regulation*, 312 NEW ENG. J. MED. 801 (1985).

2. For a discussion of the Pennsylvania history of medical regulation, see Comment, *Pennsylvania Law of Hospital Supervision: Its Origin and Present Meaning*, 51 TEMP. L.Q. 187 (1978).

3. The medical malpractice problem has been described as having reached crisis proportions. This "crisis" is the product of many factors "including a disturbing level of negligent and improper medical care, frequently unrealistic patient expectations, and the growing 'philosophy of entitlement' which is rampant among Americans." Hall, *Medical Malpractice Problem*, 443 ANNALS 82 (1979). Physicians view the "crisis" as the result of spiraling liability insurance costs and overly litigious plaintiff attorneys. *See* American Medical Association, PROFESSIONAL LIABILITY IN THE '80S (pts. 1-3) (1984-1985) [hereinafter cited as PROFESSIONAL LIABILITY IN THE '80S]. Attorneys, on the other hand, are of the opinion that the "crisis" is attributable to excessive amounts of medical negligence. *See* Association of Trial Lawyers of America, THE AMERICAN MEDICAL ASSOCIATION IS WRONG — THERE IS NO MEDICAL MALPRACTICE INSURANCE CRISIS (1985) [hereinafter cited as THE AMA IS WRONG].

4. Peer review is that process by which the medical profession regulates itself. A panel of medical professionals will review the work of their colleagues to determine if proper care was administered in a particular situation. For a discussion of the various forms in which this review takes place, *see infra* notes 48-65 and accompanying text. It should be noted that "a peer review committee is not a court. Its purpose is not to determine guilt or to impose punishment. Rather, its purpose is to evaluate and to improve the quality of medical care in a given area." Suber, *Peer Review: A Legal Update*, 46 CONN. MED. 651 (1982).

5. Because peer review is an attempt at self-regulation of a highly trained professional community, physicians have determined that they can best conduct reviews of their peers by remaining free from government interference. The government, on the other hand, feels without outside influences there will be no incentive to perform proper review. For a more complete discussion of the debate surrounding peer review, *see infra* notes 66-93 and accompanying text.

tains that there is no "crisis" in the quality of medical care.[6] Consequently, physicians contend that they are capable of effectively monitoring the quality of medical care without outside interference.[7] On the other hand, the legal community maintains that the medical malpractice "crisis" continues simply because physicians are treating patients negligently.[8] It is argued that physicians perpetuate a "conspiracy of silence"[9] and do not effectively police themselves in an attempt to ignore the problem. Thus, monitoring medical care cannot proceed without outside involvement.[10] As a direct result of this conflict over self-regulation, medical malpractice litigation has begun to focus on the discoverability of documents produced during the peer review process.

This comment will explore the discoverability issue created by the implementation of peer review. This discussion begins with an overview of medical malpractice problems followed by an examination of the peer review process, the justification for preserving the confidentiality of peer review committee documents and the justifications for allowing discovery of the documents produced by peer review committees. The comment then focuses upon the Pennsylvania approach to peer review as governed by the Pennsylvania Peer Review Protection Act,[11] and judicial interpretations of the Act. Finally, the author suggests possible directions courts should take in establishing the Pennsylvania rule regarding peer review.[12]

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6. *See generally* PROFESSIONAL LIABILITY IN THE '80s, *supra* note 3 (The American Medical Association (AMA) report hides the medical malpractice problem behind the euphemism of professional liability and focuses its concerns not on negligent physicians but spiraling insurance costs and litigation-prone plaintiffs' attorneys.).

7. As this relates to peer review, physicians would like to protect the proceedings of such committees from discovery. *See infra* notes 66-76 and accompanying text.

8. *See generally*, THE AMA IS WRONG, *supra* note 3 (malpractice "crisis" is attributable to excessive amount of medical negligence).

9. The conspiracy of silence has been defined as a refusal on the part of the medical community to comment on the quality of care provided by individual physicians. This is particularly troublesome to plaintiffs' attorneys since it greatly decreases the ability of the bar to obtain expert witnesses in medical malpractice actions. Lectures by Donald Farage, Esq., Civil Trial Preparation and Techniques, Dickinson School of Law (Fall 1985). *See also, Public Policy v. The Protection of Peer Review*, 53 U.M.K.C. L.R. 63, 74 (1984).

10. It has been argued that discoverability of peer review proceedings will allow the resultant litigation to act as a check on malpractice as physicians are forced to provide better care to avoid litigation. *See infra* note 89 and accompanying text.

11. PA. STAT. ANN. tit. 63, § 425 (Purdon 1985).

12. The issue of the discoverability of peer review committee documents is currently on appeal to the Pennsylvania Superior Court in Sanderson v. Bryan, Doc. No. 236 HBG 86. This case was argued before Judges Wickersham, Rowley and Tamilia on October 2, 1986.

II. The Medical Malpractice Problem

It is generally agreed that a malpractice problem is plaguing our nation's health care system.[13] The difficulty, however, lies in precisely defining that problem. Various attempts at definition have reached different conclusions. Most of these studies verify that doctors' negligence is at the root of the problem.

A. The American Medical Association Approach

During the final months of 1984 and the initial months of 1985, the American Medical Association Special Task Force on Professional Liability and Insurance published a series of three reports and an action plan which addressed the issue of medical malpractice.[14] Interestingly, the American Medical Association (AMA) chose to define the problem as one of "professional liability" rather than "malpractice."[15] The AMA Task Force identified two areas which give rise to what they consider to be a "crisis" situation.[16] The primary area of concern is the spiraling cost of liability insurance. A secondary concern is the increasing prevalence of "defensive medicine."[17] The determination that negligent physicians may be a cause of the "crisis" was conspicuously absent from the AMA's list of factors giving rise to the malpractice problem.[18]

The AMA Task Force perceived the spiraling cost of liability insurance as the greatest area of concern. The Task Force reports noted that medical liability insurance premiums increased by more than eighty percent during the eight year period between 1975 and 1983.[19] In terms of financial impact, the rising costs have created a

13. The extent of the problem has been described in many ways, from a smoldering issue, *see, e.g.*, Derbyshire, *Malpractice, Medical Discipline, and the Public*, HOSPITAL PRACTICE 209 (1984), to a full blown crisis, *see, e.g.*, PROFESSIONAL LIABILITY IN THE '80S, *supra* note 3, Report 1 (1984).

14. PROFESSIONAL LIABILITY IN THE '80S, *supra* note 3, at 1.

15. By defining its terms in this way, *see* PROFESSIONAL LIABILITY IN THE '80S, *supra* note 3, Report 1 at 3, the AMA diverts attention from the connotations of negligence typically associated with "malpractice." Instead, malpractice is cast as simply another cost of doing business.

16. *See* Professional Liability in the 80's, *supra* note 3.

17. There appears to be no clear consensus on what is properly classified as "defensive medicine." *See* THE AMA IS WRONG, *supra* note 3, at 4. Generally, however, defensive medicine is classified as those procedures which are performed, not as an essential element of quality care, but as a means to guard against future malpractice suits.

18. This omission is particularly conspicuous since the AMA report is replete with charts and graphs which indicate that the number of malpractice claims has been steadily rising. PROFESSIONAL LIABILITY IN THE '80'S, *supra* note 3, report 1 at 13, 15.

19. PROFESSIONAL LIABILITY IN THE '80S, *supra* note 3, Report 1 at 8.

situation more serious than the cost crisis of the 1970's.[20] The Task Force concluded that these rising costs are directly attributable to the frequency and severity of indemnity payments.[21] The AMA report argued further that as physicians seek to decrease the costs associated with medical practice, they will be forced to increase the costs to the patients.[22]

The AMA proposes a four-step plan to alleviate the perceived crisis situation facing the nation's medical professionals. First, the AMA Task Force calls for increased public education aimed at showing the public how the "professional liability" problem affects patients by raising health care costs and simultaneously decreasing the availability of certain "high risk" services.[23] Second, the Task Force argues for reform of the tort system.[24] Third, it calls for the creation of a national defense coordination system to provide physicians with a source of information useful in defending lawsuits.[25] Finally, the Task Force suggests that changes be made in the medical profession's approach to risk control and quality review.[26] Interestingly, the AMA Task Force's order of priorities relegates the review of the quality of care to the bottom of the list. The conclusion that can be drawn from the AMA reports and suggested courses of action is that medical negligence is not a problem which requires immedi-

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20. "This crisis [1984] is being caused by the same components that caused the mid 1970's crisis, only magnified . . . ." *Id.* at 14 (quoting Thomas P. Fox, Wisconsin Insurance Commissioner). Charles P. Hall points out that the financial strains upon the medical profession cause crisis situations:

> [t]he first major concern has to do with the potential paralysis of the delivery of medical services. This can be manifested dramatically, as it was during the "work slowdown" (strike) carried out by members of the New York State Medical Society in several New York counties from June 1-10, 1975. In less dramatic fashion, hospitals and physicians may, either individually or collectively, choose to withhold certain types of service or treatment if they are perceived to involve excessive potential for malpractice claims.

Hall, *supra* note 3, at 83.

21. PROFESSIONAL LIABILITY IN THE '80s, *supra* note 3, Report 1 at 6, 11.

22. "Ultimately it is the public who will pay the costs . . . either through increases in health care costs or by having their access to health care services limited because providers, unable to pay the fees, withdraw from the market." *Id.* at 14 (*quoting*, Thomas P. Fox, Wisconsin Insurance Commissioner).

23. American Medical Association, AMA SPECIAL TASK FORCE ON PROFESSIONAL LIABILITY AND INSURANCE ACTION PLAN 3 (1985) [hereinafter cited as ACTION PLAN].

24. *Id.* at 5. These reforms are meant to accomplish four goals: 1) provide adequate compensation for injuries arising from medical negligence; 2) efficiently resolve liability claims; 3) recognize a physician's unusual vulnerability from suits and hence provide protections; and 4) provide protection from meritless suits.

25. *Id.* at 8.

26. *Id.* at 8. Among the suggested reforms is improving the quality of peer review. Of the seven suggested reforms, contained in the AMA's four-step plan only two deal directly with the evaluation of medical care. The remaining reforms advocate information exchange and statistical evaluations.

ate attention.[27] Since the AMA reports indicate a general increase in the number of suits against physicians, it may be inferred that the AMA Task Force concluded that addressing the review of patient care is not crucial because current review processes are deemed sufficient.

B. The Association of Trial Lawyers of America Approach

The Association of Trial Lawyers of America (ATLA)[28] disagrees with the medical community's inferences of adequate self-regulation. In a response to the AMA report on professional liability, ATLA laid the blame for the malpractice crisis squarely on the shoulders of the medical community.[29] ATLA's initial response refuted physicians' claims that liability insurance costs are rising. The trial lawyers argued that "[s]ince 1976, the cost of malpractice insurance has actually been steadily declining as a percentage of total health care costs, until it now, at $1.5 billion in 1983, is less than one-half of one percent of total health care costs ($355.4 billion)."[30] To further refute physician allegations of rising insurance costs, the ATLA response to the AMA noted: "The average American physician spends only 2.9 percent of his or her gross income (currently estimated around $200,000) on medical malpractice insurance. This is just slightly more than the 2.3 percent spent on 'professional car upkeep,' but, interestingly enough, well over the 1.2 percent spent on continuing education."[31] Turning to the AMA's claims of the rising costs of "defensive medicine," ATLA dismissed the claims out of hand. ATLA points out that defensive medicine is really only careful, quality medical care.[32] According to ATLA, the cause of the

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27. The AMA Task Force's conclusion could have been predicted based upon the observations of sociologist Elliot Freidson. Mr. Friedson notes that professionals make three claims which distinguish themselves from other workers:

> [f]irst of all, they claim to possess such an unusual degree of skill and knowledge that non-professionals are not equipped to evaluate or regulate the members of the profession. Secondly, they claim that the professional is responsible and can be trusted to work conscientiously without the supervision that is necessary for other types of workers. Thirdly, they claim that on the rare occasion when a member is found to be incompetent or unethical, the profession itself can take proper regulatory and disciplinary action, without outside interference.

Feinstein, *Special Report: The Ethics of Professional Regulation*, 312 NEW ENG. J. MED. 801 (1985) (citing E. FRIEDSON, PROFESSION OF MEDICINE: A STUDY OF THE SOCIOLOGY OF APPLIED KNOWLEDGE 170 (1970)).

28. ATLA is a professional organization of attorneys who specialize in the area of litigation.

29. *See generally*, THE AMA IS WRONG, *supra* note 3.

30. *Id.* at 2 (footnotes omitted).

31. *Id.* at 4 (footnotes omitted).

32. *Id.* at 5.

medical malpractice problem is clearly medical negligence.[33]

With respect to future medical care, the ATLA response indicated serious doubts about the efficacy of the AMA Action Plan proposals. ATLA opined that the AMA proposals represent nothing more than self-serving special interest legislation.[34] The proposals are not even internally consistent. ATLA observed that the medical profession seeks protection from tort liability through judicial recognition of special privileges for physicians characterized by more stringent negligence standards. Yet, it also observed that it is the medical profession itself which defines the standard of care to which physicians will be held.[35]

Unfortunately, the ATLA response to the AMA failed to make positive suggestions for reforms which could lead to a more stable medical community. ATLA declared the malpractice problem to be solely a medical problem, in the same way that the AMA passes responsibility for the malpractice problem to insurers and "ambulance-chasing" attorneys.[36]

C. *Public Perceptions*

Although the views of the AMA and ATLA should be recognized as self-serving expression of polar views,[37] they are indispensible in coming to grips with the problem of providing quality medical care. These views are particularly useful because they provide insight into the perceptions from which the competing groups operate. An understanding of competing perceptions is crucial to reaching an effective solution to the current crisis. Any effective solution must incorporate elements of both views without alienating either party. Before a solution may be fashioned, however, it is important to examine other reasons for the existence of the current malpractice crisis.

Numerous studies conclude that the potential pool of malpractice claims is substantially greater than the number of claims actu-

33. *Id.* at 6.

34. *Id.* at 8 *passim.*

35. *Id.*

36. "Efforts directed toward tort reform and legislative relief must be reasonable and not self-serving. *Malpractice is a medical problem, not a legal one,* and those injured as a result of negligence are entitled to fair and prompt compensation." *Id.* at 11 (emphasis added).

37. The fact that these views are diametrically opposed is not unexpected. The phenomenon of reaching conclusions based upon identical facts is known as cognitive dissonance. It is widely found in political relationships where the actors are operating from widely different perspectives.

ally submitted.[38] It is therefore very difficult to grasp the scope of the malpractice problem accurately. Further clouding the issue is the fact that there has been a "tremendous increase in the volume of 'illegitimate' claims in recent years, claims which allege malpractice under circumstances which, by any reasonable definition, involve neither negligence nor wrongdoing on the part of the provider."[39] On the basis of the above stated facts, two conclusions may be drawn. First, the medical profession does have a negligence problem. Second, attorneys are representing clients who should not be bringing suit. Consequently, when examining the reasons for the increase in both legitimate and illegitimate malpractice claims, it can be seen that physicians, attorneys, and patients are all responsible for the increase in the number of lawsuits that have been filed.

Moreover, patients now find it increasingly easier to sue their physicians because personal relationships no longer create bonds between doctors and patients. The practice of medicine has become highly specialized; the days of the family doctor have all but passed into history. Today's physician is a highly-trained technician specializing in circumscribed areas of medical expertise. Consequently, few individuals can develop the close personal relationships with their physicians characteristic of earlier times.[40] In addition to the deteriorating doctor-patient relationships, patients have grown to expect more from their physicians. With the widespread reporting of medical "miracles,"[41] patients lose sight of the fact that medicine is still an inexact science and come to expect miraculous cures for themselves.[42] With daily news reports of artificial organs and miracle discoveries, the individual patients grow to believe that physicians should be able to restore them to perfect health.

Because they are not physicians themselves, many attorneys foster the same views about medical science as their clients. High qual-

38. *See generally*: REPORT OF THE SPECIAL ADVISORY PANEL ON MEDICAL MALPRACTICE, State of New York (New York, NY, 1976) pp. 32-33; REPORT OF THE SECRETARY'S COMMISSION ON MEDICAL MALPRACTICE (DHEW Publications No. [OS] 73-89), Washington, D.C. Government Printing Office, 1973, pp. 50-70.

39. Hall, *supra* note 3, at 84.

40. *Id.* at 86.

41. *See, e.g., Medicine's New Triumphs: Birth, Surgery, Genes, Artificial Parts, Drugs, Burns, the Brain, Radiology*, U.S. NEWS & WORLD REPORT, November 11, 1985 at 46 *et. seq.*; Ubell, *How Today's Surgeons Perform "The Impossible,"* PARADE, November 3, 1985 at 4 *et. seq.* These two articles are typical examples of those that spur heightened public expectations.

42. "In no small part because of the widespread reporting of medical 'miracles,' many people believe that the failure of the doctor to restore them to perfect health constitutes malpractice." Derbyshire, *Malpractice, Medical Discipline, and the Public*, HOSPITAL PRACTICE, January 1984 at 220.

ity medical care which produces less than perfect results is often hastily labeled malpractice. As a result, many attorneys are too willing to represent potential malpractice victims. It has been speculated that market forces at work during the 1970's also contributed to the willingness of the legal profession to litigate medical malpractice cases.[43] Interestingly the explosion of malpractice cases seems to parallel a reduction in automobile insurance litigation.[44] Under this view, as the latter became less profitable, attorneys shifted their case loads to more lucrative areas of law.

A final factor contributing to the proliferation of medical malpractice claims is public perception of society as a whole. The mass consumption society in which we live is capable of satiating a person's wants and desires almost immediately. In addition to instant satisfaction of his wants, a person is also confronted with a society characterized by a large number of government entitlement programs. When these two societal elements combine, a situation results which produces what one commentator calls a "philosophy of entitlement."[45] Individuals who adopt this philosophy grow to expect entitlement to flawless medical care. When such care is not received, these individuals feel they have a right to sue their physician. Further, the Medical Director of PHICO Insurance Company,[46] argues that when persons believe they are entitled to sue their physicians, they feel justified in demanding excessively high settlement figures. This is because insurance companies are increasingly being viewed as mechanisms not to compensate victims for their injuries, but mechanisms to redistribute wealth.[47]

D. Conclusions

Our inability to reach a solution to the medical malpractice problems plaguing society is realistically understandable. Because the parties involved view the problems from such widely different perspectives, "solutions" which force a course of action upon the parties, without considering how that action will be viewed, will not produce the desired outcomes. Instead continued resistance to change

43. "It has been speculated that trial lawyers who had their case loads adversely affected by the growing adoption of no-fault insurance laws in the automobile insurance field simply shifted their attention to malpractice." Hall, *supra* note 3, at 87.

44. *Id.*

45. *Id.* at 85.

46. PHICO is a medical liability company which insures doctors, hospitals, and medical schools around the country.

47. Telephone interview with Dr. Joseph A. Ricci, Medical Director, PHICO Insurance Company (October 29, 1985).

will result. An increased threat of litigation will only foster greater animosity between the medical and legal communities because physicians place the blame for the malpractice crisis upon the insurers and the attorneys. On the other hand, the tort reforms proposed by the AMA will not eliminate the cause of the problem. These reforms will merely hide the problem from view. Obviously, physicians are concerned with the economic impact of malpractice litigation. This economic impact could be greatly reduced if the problem of negligent doctors could be eliminated. The solution, therefore, must lie in better policing the doctors' ranks without losing the existing threat of litigation.

III. The Peer Review Process

Self regulation of the medical profession is primarily administered through the peer review process.[48] Although the concept of peer review has only recently been brought to public attention, the AMA states that the concept of peer review is "as old as organized medicine itself."[49] Currently, peer review is mandated by the federal government's Medicare and Medicaid programs.[50] To qualify for reimbursement of funds expended to administer these federal programs, hospitals must meet the federally approved standards established by the Joint Committee on Accreditation of Hospitals (JCAH).[51] These standards govern peer review as well as all other aspects of hospital operation. The ultimate goal of these standards, as stated by the JCAH, is to "improve the quality of care and services and the quality of the environment of care provided in health care settings through the voluntary accreditation process."[52] Although the JCAH attempts to improve medical care by establishing minimum standards of professionalism, the peer review process is the primary mechanism available for enforcing those standards in individual hospitals.

The chief concern of the JCAH is that "the medical staff strives

48. *See supra* note 4.

49. Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552, 563 (1979) (quoting AMA, 1 PEER REVIEW MANUAL forward at 1 (1972)).

50. 42 U.S.C.A. §§ 1395-1396 (West 1985).

51. The JCAH is a private organization founded by the American College of Physicians, the American Hospital Association, and the American Medical Association. The Commission functions as a non-profit organization and is meant to develop minimum standards to insure quality medical care. Holbrook, *Medical Malpractice Litigation: The Discoverability and Use of Hospitals' Quality Assurance Committee Records*, 16 WASHBURN L.J. 54, 57 (1976).

52. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, 1985 ACCREDITATION MANUAL FOR HOSPITALS iii (1984) [hereinafter cited as JCAH MANUAL].

to assure the provision of high-quality patient care through the monitoring and evaluation of the quality and appropriateness of patient care."[53] Typically, this goals is achieved through the use of a committee that is charged with "monitoring and evaluation of the quality and appropriateness of patient care by all individuals with clinical privileges."[54] This committee is most commonly referred to as an Executive Committee and is generally comprised of the chiefs of clinical departments and physicians elected for membership by the entire staff.[55] As the major quality control mechanism, the Executive Committee is responsible for developing and enforcing standards of medical care.[56] Additionally, the committee is responsible for coordination of the hospital's overall quality assurance program.[57] Thus, it is responsible for overseeing the activities of other review committees acting within the hospital.[58]

Another important committee within the framework of the hospital's peer review process is the Credentials Committee. As its name implies, this committee is responsible for evaluating the credentials of physicians applying for hospital staff privileges. Subsequent to this review, completed evaluations are forwarded to the Executive Committee. After review of the Credentials Committee's recommendations, it is incumbent upon the Executive Committee to determine who should be granted staff privileges.[59]

The Utilization Review Committee is another committee crucial to the review process. Although this committee is described as a committee needed for JCAH accreditation, it is also required by the federal government regulations.[60] The purpose of the committee is to insure that hospital facilities are not being utilized unnecessarily. In the words of the JCAH, "[t]he utilization review program shall endeavor to provide high quality patient care in the most cost effective manner."[61]

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53. *Id.* at 84.

54. *Id.*

55. Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM. J.L. MED. 245, 248 (1975).

56. Holbrook, *supra* note 51, at 59.

57. This responsibility arises because the Executive Committee collects and analyzes the reports developed by other peer review committees.

58. JCAH MANUAL, *supra* note 52, at 151.

59. Holbrook, *supra* note 51, at 60.

60. 42 U.S.C.A. § 1395x(k) (West 1983).

61. JCAH MANUAL, *supra* note 52, at 197. The mandates require that this review examine all means of utilization of resources — underutilization, overutilization, and inefficient scheduling. Interestingly, if this committee is effective, it should be able to prevent the occurrence of "defensive medicine" since "defensive medicine" is technically defined as an overutilization of a hospital's resources.

The final committee,[62] which is important to insuring quality hospital care, is the Medical Audit Committee.[63] This committee is primarily responsible for evaluating the care provided by individual physicians. It seeks to evaluate the physician's application of medical knowledge in relation to the current state of the art.[64] Since direct observation of the physician is impossible, the committee must achieve its goals by evaluating the medical records of individual patients.[65]

The records produced by these committees can be vital weapons in the litigation process because the committees are directly responsible for evaluating the quality of a physician's care in a given situation. The medical community believes that these records should be protected from discovery. Attorneys, on the other hand, are anxious to discover the findings and conclusions of review committees. All fifty states and the District of Columbia have now enacted legislation that restricts the discoverability of peer review proceedings. Despite this legislative action, judicial opinions have, in many instances, eroded the protections provided by the legislatures.

A. Arguments in Support of Protection

Medical professionals have clearly stated their desire to have the records of peer review committees remain privileged from discovery. Various reasons are advanced to support this position. Probably the most frequently cited reason for preserving confidentiality is to foster frank and open discussion with no fear of legal reprisals.[66] Other arguments can be advanced to support confidentiality of peer review proceedings. For example, medical review must occur on an individual case basis and discovery of peer review documents relating to previous investigations will allow incorrect conclusions to be drawn about the care administered in the matter subject to litiga-

62. The reader should be aware that the committees discussed in this comment are not the only committees which conduct peer review. Individual hospitals are free to conduct other types of peer review which their bylaws may dictate.

63. It has been suggested that this is the committee most feared by physicians since it suggests criticisms of the care provided by individual doctors. *See* Holbrook, *supra* note 51, at 60.

64. *Id.*

65. *Id.*

66. This view was most persuasively argued in Bredice v. Doctors Hospital, 50 F.R.D. 249 (D.C. 1970). The court concluded that confidentiality was essential to the effective operation of peer review committees. *See infra* note 71 and accompanying text. Since publication of the *Bredice* opinion, it has been cited in numerous cases and articles arguing for the protection of peer review committee documents. *See also infra* note 70-74 and accompanying text.

tion.[67] Medical professionals are the only ones qualified to adequately judge their peers.[68] Finally, confidentiality would prevent plaintiffs from engaging in "fishing expeditions" to find a theory upon which they can base liability of the physician.[69]

Given the medical community opinion that it can effectively police itself, it is not surprising that physicians generally believe there is no need for outsiders—especially attorneys, who are viewed as adversaries—to intrude into the peer review process. The medical community asserts that this intrusion will discourage open and frank discussion among committee members.[70] The possible chilling effect of discoverability upon peer review could manifest itself in two ways. First, permitting discovery will directly reduce institutional and individual self analysis.[71] Second, discoverability would make it more difficult for the review committee to encourage witnesses to come forward with testimony.[72] This latter view is particularly persuasive when viewed from the economic perspective of doctors. One commentator notes:

> [i]n a disturbing number of cases, whether or not any action was taken against the offending doctor, the physicians doing the crit-

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67. *See infra* note 75 and accompanying text.

68. *See infra* notes 75-76 and accompanying text.

69. *See infra* notes 76-77 and accompanying text.

70. *See*, Owens, *Peer Review: Is Testifying Worth the Hassle*, MED. ECON., August 20, 1984, at 167; Owens, *Peer Reviewers are Ready to Sell Your Track Record*, MED. ECON., June 11, 1984 at 39.

71. Comment, *Public Policy v. Peer Review Protection*, 53 U.M.K.C. L.R. 63, 74 (1984). The incentives to provide full and complete disclosure of facts relevant to effective review are greatly diminished if it is perceived that anything produced before the committee will subsequently be used to establish liability in a malpractice action. This view was persuasively argued by District Judge Corcoran in Bredice v. Doctors Hospital:

> [c]onfidentiality 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. Candid and conscientious evaluation of clinical practices is *sine qua non* of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.The purpose of these staff meetings is the improvement, through self-analysis, of the efficiency of medical procedures and techniques. They are not a part of current patient care but are in the nature of a retrospective review of the effectiveness of certain medical procedures. The value of these discussions and reviews in the education of the doctors who participate, and the medical students who sit in, is undeniable. This value would be destroyed if the meetings and names of those participating were to be opened to the discovery process.

Bredice, 50 F.R.D. at 250.

72. Comment, *Public Policy v. Peer Review Protection*, 53 U.M.K.C. L.R. 63, 74 (1984). (Referencing Relator's Brief, State *ex. rel.* Chandra v. Sprinkle, No. 65400 at 21 (Mo. 1984)).

> icizing also suffered adverse effects—sometimes finding themselves on the wrong side of law suits. Many say they lost referrals and had to endure the hostility of colleagues in addition to the wrath of the accused.[73]

With findings such as these, it is not surprising that physicians are reluctant to appear before peer review committees as witnesses.[74]

Reluctance to testify can also be related to the view that each incident of alleged malpractice is unique and must be treated as such. "In most cases, there are several choices of treatment available, and therefore for one doctor, with the benefit of hindsight, to brand the work of another as malpractice is beyond the pale of good conscience."[75] It cannot be said that following one course of action rather than another is necessarily negligence. Each individual case of patient care involves several acceptable alternatives. Consequently, if information revealed in peer review proceedings is discoverable, arguably, attorneys will not properly interpret those documents. Medical professionals fear that prior reviews of a physician's ability will be used to create a presumption of guilt.

The objective analysis of individual cases is also a ground for protecting peer review proceedings from discovery. Physicians argue that non-physicians do not possess the expertise to objectively and accurately review the quality of care rendered in a given case because medicine is a highly technical and complex profession. Since objective evaluation of patient care is the purpose of peer review,[76] peer review committees should be allowed to proceed without fear of outside interference.

A final justification for protecting peer review materials from discovery is that protection will prevent the filing of nuisance suits. If discovery is allowed, plaintiffs without meritorious cases would have an incentive to file suit in hopes of discovering a cause of action hidden within the documents produced by a peer review committee. If plaintiffs had the ability to find liability based upon peer review committee documents, the incentive to conduct prompt review of patient treatment would be eliminated. Peer review committees would simply avoid conducting evaluations until they were sure their reports

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73. Owens, *Peer Review: Is Testifying Worth the Hassle*, MED. ECON., August 20, 1984 at 167.

74. This reluctance to testify is often termed the "conspiracy of silence." *See generally*, Kelner, *The Medical Conspiracy of Silence*, CASE & COM., July-August 1982, at 10.

75. Hirsh, *Medical Professional Liability*, MEDICAL MALPRACTICE — THE ATL SEMINAR (1966).

76. *See* 158 PA. LEGIS. J., H.B. 1729 (daily ed. May 7, 1974) (statement of Rep. McClatchy).

could not be used to fuel the filing of meritless suits.

B. Arguments in Support of Discovery

Just as the medical profession has called for protection of peer review proceedings, the plaintiffs' bar has called for discoverability of peer review proceedings. Arguments for discovery usually proceed on two grounds. First, any chilling effect produced by discovery would be inconsequential because inherent in the system are mechanisms which provide incentives to conduct peer review.[77] Second, fundamental concepts of discovery require that the documents produced through peer review be discoverable.[78] The argument notes that there is no common law privilege for peer review documents and one should only be created in extreme circumstances. A final argument which has sometimes been advanced is that an increased threat of litigation will actually decrease the incidence of malpractice.[79]

Interestingly, arguments that claim discoverability produces no chilling effect focus on the integrity of the medical profession. Most commonly, the emphasis is on the "conspiracy of silence."[80] If a "conspiracy of silence" does in fact exist, extending a privilege to peer review proceedings will only legitimize the conspiracy. Once legitimized, plaintiffs will be unable to see that justice is served by receiving compensation for negligently inflicted injuries.

It is argued that hospitals have a dual incentive to see that peer review is effectively conducted regardless of the discoverability of peer review proceedings. First, peer review is a requirement for JCAH accreditation. This accreditation carries a great deal of prestige, and hospitals will not be willing to jeopardize their standing in the community by losing their JCAH accreditation.[81] Second, hospitals cannot afford to reduce the amount or quality of peer review. Current peer review practices occur at such minimal levels that peer

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77. *See infra* notes 80-83 and accompanying text.

78. *See infra* notes 84-87 and accompanying text.

79. *See infra* note 89 and accompanying text.

80. *See, e.g.*, Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. MED. 151 (1985). The author reasons:

> [t]o say that a physician . . . will not stand by his professional opinion of a colleague's action in the event of subsequent litigation unless he is guaranteed anonymity and immunity is to say, in effect, that physicians are unwilling or unable to police their own ranks — or that the universally denied "conspiracy of silence" in fact exists.

Id. at 160, n.48 (quoting Dunn, *Peer Review: A Secret Affair?*, 31 TRUSTEE 10 (1978)).

81. Holbrook, *supra* note 51, at 60. Further, loss of JCAH accreditation would mean a loss of federal funds to reimburse expenses incurred while caring for Medicare and Medicaid patients. *See supra* note 50 and accompanying text.

review is often more form than substance.[82] A further reduction in peer review might expose the hospital to excessive potential liability.[83]

A second ground for permitting discovery of the documents produced during peer review is based upon modern litigation theory. The scope of allowable discovery has broadened as rules of pleading have been liberalized.[84] The broadening of discovery rules is important because "discovery, the process which enables the parties to find evidence under the control of adverse parties, blunts the rough edge of the adversary system which approves a party's concealment of awkward facts."[85] Since discovery is so important to trial preparation, privileges should be granted only in rare and compelling circumstances.[86] The circumstances surrounding peer review are not compelling enough to justify protection since plaintiffs could be completely precluded from proving their case should discovery be disallowed.[87]

The final argument is that an increased threat of litigation supports the public policy of insuring quality medical care. To avoid involvement in a malpractice suit, physicians will exercise greater

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82. Comment, *Public Policy v. Peer Review Protection*, 53 U.M.K.C. L.R. 63, 74 (1984). This argument infers that physicians conduct review procedures perfunctorily in an effort to comply with regulations. Thus, emphasis is not placed on determining whether a physician subject to evaluation is qualified to practice medicine.

83. *Id.* at 75. *See* Darling v. Charleston Community Memorial Hosp. 33 Ill.2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1966) (hospitals are liable for failure to engage in effective quality control).

84. *See* PA.R.C.P. No. 4003.1 which provides:

> . . . a party may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action, whether it relates to the claim or defense of the party seeking discovery or to the claim or defense of any other party, including the existence, description, nature, consent, custody, condition and location of any books, documents, or other tangible things and the identity and location of persons having knowledge of any discoverable matter. It is not ground for objection that the information sought will be inadmissible at the trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

85. Goldberg, *supra* note 80, at 160.

86. Prof. Wigmore suggests a four part test to determine whether a privilege should be granted:

> (1) [f]irst, the communication must be intended to be confidential. But it is not merely the confidentiality of a communication that deserves protection. The further basis must be some extrinsic policy of protecting from injury some important social relation, even though at the expense of an incidental obstruction to the investigation of facts. Therefore, the further conditions of such a privilege are (2) a relation to which confidentiality of communications is essential; (3) and a relation which in public opinion merits careful conservation; and (4) an injury to the relation, by disclosure of confidences greater than the injury to justice by withholding them.

J. WIGMORE, A STUDENT'S TEXTBOOK OF THE LAW OF EVIDENCE § 386 (1935).

87. Goldberg, *supra* note 80, at 161.

care in treating their patients.[88] Thus, the fear of legal proceedings acts as a mechanism to improve the quality of treatment.[89]

IV. The Pennsylvania Approach to Peer Review Protection

The Pennsylvania legislature protected peer review proceedings from litigious attack in order to foster honest and critical review of health care. This protection came in the form of legislation entitled the Pennsylvania Peer Review Protection Act (PPRPA).[90] The PPRPA affords two types of protection to the medical community. First, the Act provides that members of the medical community acting in furtherance of a peer review committee's goals are immune from penalties for statements made to the committee.[91] Second, the Act protects documents produced by peer review committees from discoverability and admissibility in any civil actions based upon the subject matter of the review committee's work.[92] Apparently, the legislature felt that the best way to foster quality health care was to allow medical professionals to review the work of their peers without outside interference.[93]

A. An Examination of the PPRPA

The first type of protection afforded by the PPRPA is immunity from liability, granted by section 425.3 of the Act.[94] The legislature

88. THE INFLUENCE OF LITIGATION ON MEDICAL PRACTICE 45 (C. Wood ed. 1977).

89. Observation seems to confirm that litigation does increase physician accountability for malpractice. One commentator notes that "[a]s a result of the continuing malpractice crisis, plaintiffs' attorneys are uncovering an increasing number of incompetent, negligent physicians." Derbyshire, *Medical Discipline in Disarray Retrospective and Prospective*, HOSP. PRACT., June 1984, at 136 *D*.

90. PA. STAT. ANN. tit. 63, § 425 (Purdon 1985).

91. *See infra* notes 94-99 and accompanying text.

92. *See infra* notes 100-109 and accompanying text.

93. This legislative intent can also be seen in the official title of the PPRPA which describes the Act as "[a]n Act providing for the *increased use* of peer review groups by giving protection to individuals and data who report to *any* review group." 158 PA. LEGIS. J., H.B. 1729 (daily ed. May 7, 1974) (emphasis added).

94. PA. STAT. ANN. tit. 63, § 425.3 states:

> (a) [n]otwithstanding any other provision of the law, no person providing information to any review organization shall be held, by reason of having provided such information, to have violated any criminal law, or to be civilly liable under any law, unless:
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> (1) such information is unrelated to the performance of the duties and functions of such review organization, or
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> (2) such information is false and the person providing such information knew, or had reason to believe, that such information was false.
>
> (b)(1) No individual who, as a member or employee of any review organization or who furnishes professional counsel or services to such organization, shall be held by reason of the performance by him of any duty, function, or activity authorized or required of review organizations, to have violated any

evidenced its intent to provide broad protection by explicitly identifying a broad class of persons to whom immunity should extend. The first group upon which immunity is conferred is composed of persons "providing information to any review committee."[95] Committee witnesses can lose their immunity, however, if the information which they produce is: 1) unrelated to the function of the review committee, or 2) false and the person providing the testimony knew, or had reason to know that the testimony was false.[96] The second group upon which immunity is conferred is composed of members or employees of the peer review committee.[97] The immunity granted to members of the review committee cannot be lost unless the testimony given was motivated by malice.[98] It should be noted that the immunities conferred by the legislature extend to *both* civil and criminal actions. Thus, the section grants all persons appearing in the peer review process some form of immunity from prosecution for their statements.[99]

Section 425.4 of the PPRPA also protects the operation of peer review committees. This section protects "the proceedings and records" of a "review committee" from "discovery or introduction into evidence."[100] This protection is specifically limited to "any civil

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criminal law, or to be civilly liable under any law, provided he has exercised due care.

(2) The provisions of paragraph (1) of this subsection shall not apply with respect to any action taken by any individual if such individual, in taking such action, was motivated by malice toward any person affected by such action.

95. *Id.* at § 425.3(a).

96. *Id.* at §§ 425.3(a)(1), 425.3(a)(2).

97. *Id.* at § 425.3(b)(1).

98. *Id.* at § 425.3(b)(2).

99. See generally, Comment, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 553 (1979), for a more complete discussion of the immunity provisions of the PPRPA.

100. PA. STAT. ANN. tit. 63, § 425.4 provides:

The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof: Provided, however, That information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, but the said witness cannot be asked about his testimony before such a committee or opinions formed by him as a result of said committee hearings.

action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee."[101] Further protection of the sanctity of the peer review process is provided by prohibiting the introduction of the testimony of witnesses or other participants in the peer review process into evidence in any civil action.[102] Although the protections afforded by section 425.4 of the PPRPA are broad, they are circumscribed in such a way as to protect the ability of plaintiffs to prosecute a medical malpractice suit. The PPRPA specifically exempts "information, documents, or records otherwise available from other sources."[103]

To more fully understand the operation of section 425.4 of the PPRPA, it is necessary to examine the legislative definition of terms used in the Act. The broad protections afforded by section 425.4 are directed toward documents of "review committees."[104] These committees are defined in section 425.2 of the Act as "any committee engaging in peer review . . . to gather and review information relating to the care and treatment of patients."[105] Further clarification of the intended interpretation of the PPRPA is found in the definition of peer review. Peer review is broadly defined as "the procedure for evaluation by professional health care providers of quality and efficiency of services ordered or performed by other professional health

101. *Id.* Interpretation of this phrase is directly responsible for the split in the interpretation of the PPRPA by the Pennsylvania courts. *See infra* notes 131-37 and accompanying text.

102. *Id.*

103. *Id.* This exemption is evidence that the legislature believes that malpractice actions should be treated as individual occurrences. Evaluation of these records by a peer review committee will not preclude a plaintiff from obtaining the evidence necessary to prove his case because a patient can discover his own medical records. Since malpractice actions are based upon the care given to the individual plaintiff, § 425.4 of the PPRPA will not preclude such actions.

104. *See supra* note 100.

105. More specifically, PA. STAT. ANN. tit. 63, § 425.2 (Purdon 1985) states:

> "[r]eview organization" means any committee engaging in peer review, including a hospital utilization review committee,a hospital tissue committee, a health insurance review committee, a hospital plan corporation review committee, a professional health service plan review committee, a dental review committee, a physicians' advisory committee, a nursing advisory committee, any committee established pursuant to the medical assistance program, and any committee established by one or more State or local professional societies, to gather and review information relating to the care and treatment of patients for the purposes of (i) evaluating and improving the quality of health care rendered; (ii) reducing morbidity or mortality; or (iii) establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. It shall also mean any hospital board, committee or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto. It shall also mean a committee of an association of professional health care providers reviewing the operation of hospitals, nursing homes, convalescent homes or other health care facilities.

care providers."[106] Finally, professional health care providers are defined as "individuals or organizations who are approved, licensed, or otherwise regulated to practice or operate in the health care field under the laws of Pennsylvania."[107] Applying these definitions to section 425.4 of the PPRPA, the statute can be paraphrased as follows: the proceedings and records of any committee comprised of individuals or organizations approved, licensed, or regulated to practice in the health care fields engaged in the evaluation of the quality and efficiency of services provided by health care professionals shall be held in confidence and shall not be subject to discovery of introduction into evidence. Obviously, protections granted to peer review organizations should be interpreted broadly since the records of *any* committee concerned with the evaluation of health care are protected.

The conclusion that broad protections are granted by section 425.4 of the PPRPA is supported by the plain words of the statute. The words chosen by the legislature, however, do not always control in questions of statutory interpretation.[108] Instead, the object of statutory interpretation is to ascertain the legislative intent behind the enactment of the statute in question. One means available to statutory analysts involves examination of the comments entered into the legislative journals of the governmental body enacting the legislation. In the case of PPRPA, a floor debate occurred prior to adoption of

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106. PA. STAT. ANN. tit. 63, § 425.2 (Purdon 1985) provides:

> "[p]eer review" means the procedure for evaluation by professional health care providers of the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, claims review, and the compliance of a hospital, nursing home or convalescent home or other health care facility operated by a professional health care provider with the standards set by an association of health care providers and with applicable laws, rules, and regulations.

107. PA. STAT. ANN. tit. 63, § 425.2 (Purdon 1985) states:

> "[p]rofessional health care provider" means individuals or organizations who are approved, licensed or otherwise regulated to practice or operate in the health care field under the laws of the Commonwealth, including, but not limited to, the following individuals or organizations:
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> (1) A physician.(2) A dentist.(3) A podiatrist.(4) A chiropractor.(5) An optometrist.(6) A psychologist.(7) A pharmacist.(8) A registered or practical nurse.(9) A physical therapist.(10) An administrator of a hospital, a nursing or convalescent home, or other health care facility.(11) A corporation or other organization operating a hospital, a nursing or convalescent home or other health care facility.

108. "The object of all interpretation and construction of laws is to ascertain and effectuate the intention of the legislature." PA. STAT. ANN. tit. 46, § 551. *See* Girard Trust Co. v. City of Philadelphia, 369 Pa. 499, 87 A.2d 277 (1952) (the reason of the law should prevail over its letter); Null v. Staiger, 333 Pa. 370, 4 A.2d 883 (1939) (provision of statute must be construed with reference to the object intended to be accomplished by it).

the statute by the Pennsylvania House of Representatives. During the debate, Mr. Wells, a sponsor of the PPRPA, was called upon to explain the purpose behind the legislation. Explaining the intent of section 425.4's confidentiality provisions, Mr. Wells paraphrased the section, stating:

> [a]ll data and information acquired by a review organization, in the exercise of its duties and functions, shall be held in confidence and *shall not be disclosed to any person except to the extent that may be necessary to carry out the purpose of the review organization and shall not be admissible as evidence in any other civil proceedings.*[109]

Arguably, Mr. Wells' comments indicate that the legislature intended to provide complete protection to *all* data acquired during the peer review process. Thus, coupling the clear meaning of the PPRPA language with the legislative intent, there can be little doubt that the Pennsylvania legislature desired to foster increased use of peer review by conferring the broadest possible protection to peer review proceedings.

B. Judicial Interpretation of the PPRPA

Pennsylvania courts have been presented with seven opportunities to apply the PPRPA to unique fact situations. Despite the PPRPA's apparently clear meaning, the courts have not reached a uniform conclusion about the protections afforded by section 425.4 of the Act. Four courts have precluded discovery of peer review documents based upon interpretations of the PPRPA.[110] In direct opposition to this interpretation, however, three courts have concluded that discovery should be restricted only to matters concerning the facts giving rise to the instant litigation.[111]

1. Cases Supporting Protection

Schwartz v. Tri-County Hospital[112] presented the first opportunity for interpretation of the PPRPA. The plaintiff brought a wrongful death and survival action alleging negligent medical treatment as the cause of the decedent's death. In an effort to prepare the case for trial, the plaintiff served interrogatories upon the three defendant

109. 158 PA. LEGIS. J., H.B. 1729 (daily ed. May 7, 1974) (statement of Rep. Wells) (emphasis added).

110. *See infra* notes 112-30 and accompanying text.

111. *See infra* notes 131-43 and accompanying text.

112. 74 Pa. D & C.2d 52 (C.P. Philadelphia Co. 1975).

physicians. The interrogatories requested information "concerning appearances by Dr. Rosner, or others, before any medical committees, official boards of medical associations, or other like review groups, with regard to the actions taken by Dr. Rosner or others in treating decedent."[113] Dr. Rosner and his co-defendants refused to answer the interrogatories on the ground that the information sought was protected from discovery pursuant to section 425.4 of the PPRPA.[114] The court agreed with Dr. Rosner and sustained the physician's objections to the interrogatories.[115] The court did not, however, discuss the exact nature of the documents sought in the discovery request. Thus, it is not clear whether the plaintiff could have obtained a different result by a more careful wording of the questioned interrogatories.[116]

Holiday v. Klimowski[117] presented the second opportunity for courts to apply the PPRPA. In that suit, the plaintiff alleged that the hospital was negligent in permitting the defendant, Dr. Klimowski, to perform abdominal surgery on him.[118] The plaintiff sought to discover "internal hospital records dealing with the review of their case by the medical staff and various committees of the hospital."[119] The hospital responded by seeking a protective order.[120] The court concluded that a protective order sought prior to passage of the

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113. *Id.* at 53.

114. *Id.*

115. *Id.* The court reached its conclusion by noting:

> [t]he clear intent of the Peer Review Protection Act is to foster the greatest candor and frank discussion at such review meetings. The Act is prospective in its operation, but it is mandatory in its proscription of discovery. Hence, any discovery sought after the Act takes effect is barred.

Id. at 54.

116. One commentator notes:

> [m]ore specificity as to the information sought might have resulted in a different outcome in *Schwartz*. Thus, if the information sought originated in the defendant outside of the review organization or if the information sought was about the appearances rather than about the proceedings, the information may have been discoverable.

Comment, *Medical Peer Review Protection in the Health Care Industry*, 42 TEMP. L. Q. 553, 585 (1979). *See* Serafin v. Peoples Community Hosp. Auth., 67 Mich. App. 560, 242 N.W.2d 438 (1976) (circumstances surrounding peer review of defendant's patient not privileged).

117. 75 Pa. D.& C.2d 408 (C.P. Washington Co. 1976).

118. Specifically, the plaintiff alleged that the hospital was negligent in allowing Klimowski to operate when he lacked the training, skill, and expertise to do so and in not requiring Klimowski to use properly trained surgical assistance. *Id.* at 409.

119. *Id.*

120. The protection was sought on public policy grounds. Specifically, the hospital argued discovery would defeat the purposes of peer review and would consequently be detrimental to the public. *Id.* at 411. *See also*, Hallowell v. Jove, 247 Ga. 678, 279 S.E.2d 430 (1981) (protection is necessary to support the underlying purpose behind legislation designed to protect peer review).

PPRPA was denied for reasons which continued to be persuasive.[121] Consequently, the court compelled the discovery of all requested documents except those of the Utilization Review Committee. The court concluded that the Utilization Review Committee proceedings were specifically protected from discovery by section 425.4 of the PPRPA.[122]

It appears that this court may have misconstrued the meaning of the PPRPA. The court allowed discovery of: 1) recommendations made to the Board of Trustees regarding the application of Dr. Klimowski; 2) records of the Board of Trustees relating to the board's consideration of the Klimowski application; 3) written charges filed against Klimowski with the hospital staff; and 4) minutes of the meetings of the hospital's surgical or medical staff as those minutes related to Dr. Klimowski's professional conduct.[123] All of the granted discovery requests fell under the protection of the PPRPA. This information is of and concerning the professional qualifications of the defendant and, as such, is specifically protected by the PPRPA.[124]

The medical ability of Dr. Klimowski was again before the courts in *Bandes v. Klimowski*.[125] There, during depositions a hospital administrator was asked, "[h]as there ever been any infraction of the rules concerning Dr. Klimowski other than the late reporting of hospital records?"[126] The court ruled that the hospital administrator did not need to answer the question because "such an inquiry is exactly the type which the statute [PPRPA] is designed to protect."[127] This opinion, unfortunately, is too broad to be of guidance. If the

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121. *See* Petrusky v. Charleroi Monessen Hosp., No. 367, slip op., (Pa. C.P. Washington Co., May 14, 1974). The *Petrusky* court concluded:

> We are going to allow the discovery because to refuse it would be to tell the plaintiff that he *may not even try to prove* that the hospital staff, including the defendant dentists, engaged in either an actually deceitful, a merely willful, or an inexplicably negligent review of the case. It may turn out that some of the matters are too privileged within the processes of the hospital and organized medicine itself to wave around in the courtroom. They do not, however, seem to us too privileged to be inquired into at private deposition, the record of which we can always seal, if it becomes necessary.

Id. at 3 (emphasis in original).

122. *Holiday* at 411.

123. *Id.* at 409-10.

124. This type of information is defined as the type of information which peer review committees are to collect. Since a hospital board collecting this information meets the definition of a "review committee," the documents requested from the trustees should have received protection from discovery. Likewise, the minutes of staff committees should have been given protection. *See supra* notes 100-09 and accompanying text.

125. Pa. D.& C. 3d 11 (C.P. Fayette Co. 1977).

126. *Id.* at 15-16.

127. *Id.* at 16.

complaints sought were not produced through the peer review process, they would not come within the protections of the PPRPA. Hence, they would be discoverable.

The most recent decision precluding discovery of peer review proceedings is *Obenski v. Brooks*,[128] a medical malpractice action. This opinion is the least helpful in ascertaining the scope of the protections afforded by the PPRPA. The plaintiff sought to discover information relating to the defendant-physician's application for hospital staff privileges. The court noted that "if direct questioning of the defendant concerning these questions was to be prohibited, it would probably effectively foreclose plaintiffs from investigating this area."[129] Despite this observation, the court concluded that the PPRPA precluded discovery.[130] The court did not specifically state what documents were protected. Instead, the court simply stated discovery was precluded in the areas protected by the PPRPA.

2. *Cases Permitting Discovery*

The first departure from protecting peer review documents occurred in *Bolton v. Holy Spirit Hospital.*[131] The court sought to determine if section 425.4 of the PPRPA precluded discovery of documents relating to prior complaints, corrective actions taken by the hospital against the defendant physicians, and personnel files. The court focused on the limiting language found in section 425.4 of the PPRPA in search of the answer.[132] Specifically, the court interpreted the language to mean that section 425.4 limits the "privilege to those peer review matters which also gave rise to the civil action."[133] Thus,

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128. Pa. D.& C.3d 253 (C.P. Philadelphia Co. 1978).

129. *Id.* at 264.

130. The court stated:

> [d]ue to the Act, plaintiffs cannot go directly to the relevant association or hospital to explain the information they seek to discover which would be within their knowledge. This leaves defendant [sic] as the only practical source for such information. Discovery in this area must, however, exclude inquiries into areas that are immune to discovery by virtue of the Peer Review Protection Act.

Id. See also Holly v. Auld, 450 So.2d 217 (1984) (recognizing legislative enactments must be given support over policy favored by the courts).

131. 105 Dauphin Co. Rep. 40 (C.P. Pa. 1984).

132. The court was concerned with the effect of the phrase "arising out of the matters which are the subject of evaluation and review by such committees." *Id.* at 42.

133. *Bolton*, 105 Dauph. Co. Rep. at 45. This holding was harmonized with the concept of liberal discovery by concluding "the legislature intended to balance the competing interests of a litigant's right to evidence relevant to his claim against the need for full and frank discussions during peer review meetings by providing a privilege but limiting that privilege to matter that was the subject of the civil action." *Id.* at 45. *See* Segal v. Roberts, 380 So.2d 1049 (1979) (reaching a similar result), *but see* Hallowell v. Jove, 247 Ga. 678, 279 S.E.2d 430 (1981) (reaching the contrary result).

the court concluded that documents produced at other hospitals were subject to discovery.[134] Additionally, the court concluded that peer review concerning patients other than the plaintiff were discoverable.[135] Consequently, the court greatly limited the protection afforded by the PPRPA.

The limits placed upon the PPRPA by *Bolton* were clearly not intended by the Pennsylvania legislature. The intent of the legislature was to "provide for the increased use of peer review groups by giving protection to individuals and data who report to any review group."[136] The *Bolton* decision defeats this goal because all peer review data, except conclusions drawn about the plaintiff's case, are discoverable. The individual plaintiff's hospital records are specifically exempted from the Act's protection.[137] If *Bolton* is correct, the only result achieved by the PPRPA is to protect from discovery conclusions about the quality of the plaintiff's care. This in fact provides no protection since conclusions about the care administered to the plaintiff will be provided by the plaintiff's experts.

Sanderson v. Bryan[138] offered the same conclusion as *Bolton*. The defendant-physician sought a protective order from the court to preclude discovery of all documents, produced by a review committee, which did not relate to the plaintiff's care.[139] Noting that the discovery requests met the *Bolton* criteria, the court permitted discovery to proceed.[140] In doing so, the court found the *Bolton* reasoning persuasive. Unfortunately, the court did not advance the interpretation of the PPRPA beyond the analysis of the *Bolton* court. Instead, the *Sanderson* court largely repeated the *Bolton* arguments.

The most recent attempt to construe the PPRPA occured in *Trent v. Lancaster General Hospital*.[141] The defendant-hospital sought protection from discovery of information provided during Infection Review Committee[142] proceedings. The court, however, limited its analysis to a narrow issue as framed by the plaintiff.[143] Thus

134. *Bolton*, 105 Dauph. Co. Rep. at 46.
135. *Id.* at 49.
136. 158 PA. LEGIS. J., H.B. 1729 (daily ed. May 7, 1974).
137. PA. STAT. ANN. tit. 63, § 425.4 (Purdon 1985).
138. Cumberland L.J. 612 (C.P. Cumb. Co. 1985).
139. *Id.* at 613.
140. *Id.* at 618.
141. 70 Lanc. L. Rev. 170 (1986).
142. This committee is charged with the duty to evaluate and control patient infections which are acquired during hospital admissions.
143. The court noted:

> Plaintiff, however, in his brief, has limited the information which he seeks to discover to information concerning infection control policies and procedures and the rate of occurrence of staphilococcus aureus infections in other patients at

the opinion does not provide a broad based analysis of the PPRPA. The utility of the opinions for purposes of construing the PPRPA is further limited as, this court as did the *Sanderson* court before it, merely parroted the language of *Bolton*. Since the plaintiff requested information not specific to the plaintiffs case, the court, relying on *Bolton* ruled the requested information was not protected by the PPRPA.

3. Summary

The Pennsylvania appellate courts are now faced with the problem of reconciling the conflicting interpretations of the PPRPA. Lower courts have not paid strict attention to the language of the PPRPA in their interpretations. Decisions which too strictly construe the PPRPA are allowing plaintiffs benefits which were not intended by the legislature. On the other hand, decisions which give too broad a construction to the PPRPA effectively remove peer review organizations from public accountability and could hinder a plaintiff from pursuing a legitimate claim.

V. Conclusion

Judicial interpretations of the PPRPA have produced a conflict in Pennsylvania law. Consequently, medical professionals are unsure as to which of their peer review proceedings will receive protection from discovery. As long as this conflict remains unresolved, medical malpractice litigation will continue to provoke excessive controversy. It is now incumbent upon the Pennsylvania Superior Court to resolve the differences among the county courts regarding the protection afforded by the PPRPA.

The solution the superior court fashions must take into account all of the competing interests and perceptions. Although reconciliation of polar views seems impossible, workable solutions can be developed and implemented. The point of departure for the Pennsylvania solution should be the legislative intent behind the PPRPA. Clearly, the state legislature determined it was necessary to protect the proceedings of peer review committees by extending a privilege. Because privileges stand in the way of finding out the truth, they are not created without careful thought and attention to the competing

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> defendant hospital during the year of plaintiff's three hospitalizations. We therefore limit our inquiry and discussion to those interrogatories and requests for production of documents which seek to elicit that information.

Trent, 70 Lanc. L. Rev. at 171.

interests they affect. Since the legislature deemed it necessary to extend a confidentiality privilege, the superior court should adopt a position which affords broad protection to the proceedings of review committees.[144]

Judicial support of peer review protection will produce two clear results. First, the PPRPA will be interpreted in such a way as to implement the legislative intent. Peer review proceedings will receive actual protection and not just the nominal protection offered by the holdings of the Dauphin, Cumberland and Lancaster County Courts. Second, public policy will be served by providing physicians a forum in which to aggressively attack the problem of medical negligence without fear of legal reprisal. Naturally, this second result is desired by all parties—physicians, attorneys, and patients.

Unfortunately, both attorneys and the public remain unconvinced that physicians will aggressively and fairly police their ranks. Doubt exists that granting peer review protection will indeed reduce the severity of the medical malpractice crisis. Physicians, on the other hand, refuse to proceed with peer review in the absence of protection. It is therefore suggested that the judiciary support the integrity of peer review proceedings and interpret the PPRPA as providing a broad privilege. At the same time, the legislature should recognize the concerns of the public and create a higher authority to which peer review groups should mandatorily report their findings. If this authority is a non-partisan arm of the State Medical Licensing Board, the public will be assured that negligent physicians will be properly censured and will be subject to the risk of license revocation.

Implementation of the above policy will have several results. Most importantly, the quality of medical care will improve as effective quality review is made possible. Since physicians are best quali-

144. This position is obviously supported by the medical community. The American Bar Association (ABA) has also adopted this position. In 1976 the ABA House of Delegates adopted the following resolution:

> *[r]esolved*, that the American Bar Association, recognizing the importance of a strong medical discipline system in each state, and recognizing further that the effectiveness of medical disciplinary proceedings has been hampered by physicians' fears of civil liability and the disclosure of confidential material, supports the following recommendation regarding . . . confidentiality for medical disciplinary proceedings:
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> * * *
>
> 2. *Confidentiality* — Except as specifically authorized by law, the proceedings, records, and findings of a medical disciplinary board should be confidential and not subject to discovery or introduction into evidence in a civil proceeding.

Holbrook, *supra* note 51, at 67 (quoting resolutions adopted by the ABA House of Delegates (August 10, 1976)).

fied to evaluate medical care, they should be allowed to do so. Public fears that physicians are not effectively policing themselves will be allayed since peer review groups will be made accountable for their actions. Finally, physicians' complaints of rising costs will be answered since a reduction of medical negligence will lead to a reduction in the number of law suits, which will eventually lead to lower premiums for liability insurance, or, at least, reduce the current rate of increase in the cost of liability insurance.

Joseph A. Ricci