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# THE PEER REVIEW AND SELF-EVALUATION PRIVILEGES AND IMMUNITIES – HAS THE PENDULUM SWUNG TOO FAR?

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## INTRODUCTION

The peer review and self-evaluation privileges and immunities are well-recognized and frequently relied upon in the health care arena. They are loved by hospital and physician defendants in medical malpractice lawsuits and despised by the plaintiffs' bar. However, these privileges and immunities are not uniformly embraced by physicians either, particularly those who seek to go behind an adverse credentialing decision of a hospital. Like just about any privilege, there is a constant tension between the right to know and the right to confidentiality. Notwithstanding this ongoing battle, the privileges appear to be here to stay, having seemingly won the argument over whether the greater good is served by the preservation of confidentiality versus full disclosure. However, there is legitimate concern over whether the pendulum has swung too far and whether the overall quality of health care may be harmed more than helped by the current status quo. This paper seeks to address the privileges and immunities issue from the perspective of its authors, Texas trial lawyers whose practices focus on the representation of hospitals and other health care professionals, while acknowledging that the issues are national in scope and not limited to any particular jurisdiction.

## I. POLICY RATIONALE FOR THE PRIVILEGES AND IMMUNITIES

Like most privileges, the overall policy rationale or justification for the peer review and self-evaluation privileges is that the greater good is served by the facilitation of candid communications and that this can best be accomplished by ensuring the confidentiality of such communications. Peer review statutes are generally based upon a two-fold rationale: (1) that exacting a critical analysis of the competence and performance of physicians and other health care providers by their peers will result in better medical care; and (2) that confidentiality will facilitate candid communication and analysis.[1]

The privileges relating to physicians and hospitals[2] basically fall into two categories: (1) communications relating to the credentialing of a physician; and (2) communications

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1 See *Memorial Hospital - The Woodlands v. McCown*, 927 S.W.2d 1, 3 (Tex. 1996); Graham, *Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges*, 30 Cumb. L. Rev.111, 112-113 (2000); Schentzow, *State Medical Peer Review: High Cost But No Benefit — Is It Time For a Change?*, 25 Am. J.L. & Med. 7, 16-17 (1999); Griffith & Parker, *With Malice Toward None: The Metamorphis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation*, 22 Tex. TECH L. REV. 157, 158-59 (1991); Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C.L.Rev. 179, 179 (1988).

2 Texas law also contains a nursing peer review statute designed to protect the confidentiality of communications and documents generated in the nursing peer review process. TEX. OCC. CODE ANN. §303.006 (Vernon 1999).

involving hospital committee investigations into questionable professional conduct by a physician, which conduct often results in a medical malpractice lawsuit. Of course, these two categories frequently overlap. With respect to the former, most peer review statutes serve the two-fold purpose of protecting the proceedings, records, and materials considered by a peer review committee from disclosure and affording immunity from liability for committee members participating in the peer review process in good faith.[3]

One of the challenges presented to hospitals on a regular basis is the credentialing of physicians. Without question the linchpin of any quality hospital is its medical staff. Negotiating the mine field of physician credentialing is a full time job. In addition to ensuring that they are staffed with qualified, competent physicians, hospitals and hospital credentialing committee members must also be concerned with confidentiality and protecting themselves from liability for their credentialing actions. The system is designed to increase the chances of having a qualified, competent medical staff by fostering candid communications through the preservation of confidentiality and protection of those charged with making the tough credentialing decisions.

As the United States District Court for the District of Columbia discussed:

> 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. Candid and conscientious evaluation of clinical practices is a *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 the names of those participating were to be opened to the discovery process.[4]

The other typical use of the privileges relates to the protection of an investigation into a physician's professional actions which have given, or may give, rise to a medical malpractice lawsuit. This use of the privilege is somewhat akin to Federal Rule of Evidence 407 which bars the admissibility of subsequent remedial measures to prove negligent conduct. Of course, a key distinction is that the peer review and self-evaluation privileges on their face bar discovery, not just admissibility. Moreover, as discussed in greater detail later in this paper, me thinks the plaintiffs' bar doth protest too much about their professed need for full disclosure. A stronger case can be made, however, for the discovery and admissibility of such information in connection with a negligent credentialing claim. The upshot of the privileges is that they have pretty much placed the physician's credential

3 *See* 42 U.S.C. 11111(a), 11112(a) (1999); TEX. OCC. CODE ANN. §160.010 (Vernon Pamph. 2002); TEX. HEALTH & SAFETY CODE ANN. §161.033 (Vernon 2001); *see also* Creech, *supra*, 179-80.

4 *Bredice v. Doctors Hospital, Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970).

file off limits to a litigant.[5] Ironically, if a plaintiff is able to make a *prima facie* claim of negligent credentialing without the physician's credential file, the defendant hospital may be put in the position of having to waive the privilege to defend itself.

## II. OVERVIEW OF FEDERAL AND STATE PRIVILEGES AND IMMUNITIES

The Texas Legislature has formally adopted the Health Care Quality Improvement Act ("HCQIA") regarding physician credentialing.[6] At least forty-eight states and the District of Columbia have enacted privilege statutes,[7] almost all of which contain immunity provisions.[8] While there is a split of authority as to whether HCQIA creates a privilege, the majority and better rule is that it does not.[9]

The Texas peer review privilege statute provides, *inter alia*, "each proceeding or record of a medical peer review committee is confidential, and any communication made to a medical peer review committee is privileged."[10] Similarly, the Texas Health and Safety Code provides in relevant part: "The records and proceedings of a medical committee are confidential and are not subject to court subpoena."[11] A medical peer review committee is defined under both the Texas Occupations Code and the Texas Health and Safety Code as "a committee of a health care entity . . . authorized to evaluate the quality of medical and health-care services or the competence of physicians."[12] Medical peer review is "the evaluation of medical and health care services, including evaluation of the qualifications of professional health care practitioners . . . ."[13] The Supreme Court of Texas has held that documents and communications relating to the proceedings of medical peer review committees are protected from discovery, even in a suit by a physician claiming that false information was supplied to the committees with malice.[14]

The Supreme Court of Texas has interpreted both Section 160.007's predecessor statute, Article 4495b of the Texas Revised Civil Statutes,[15] and Section 161.032 as expressly protecting from disclosure "records maintained by a peer review committee in connection with the credentialing process."[16] Furthermore, the Supreme Court of Texas has made clear that such records "are not routine business records."[17] Records maintained in the regular course of business of a hospital are not protected by the privilege.[18] Therefore, medical records of a patient are not privileged, even though they may be protected by other statutes related to the confidentiality of medical records. Consistent with other privileges, one should not be able to protect a troublesome document by gratuitously submitting it to a peer review committee.

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5 *See St. Luke's Episcopal Hospital v. Agbor*, 952 S.W.2d 503 (Tex. 1997).
6 TEX. OCC. CODE ANN. §160.001 (Vernon Pamph. 2002).
7 Schentzow, *supra*, 33.
8 *Id.* at 28.
9 *LeMasters v. Christ Hospital*, 791 F. Supp. 188, 191-92 (S.D. Ohio 1991) (holding in Title VII sex discrimination lawsuit that HCQIA did not prevent plaintiff physician, who claimed that hospital terminated her employment for participating in EEOC proceedings against hospital, from discovering peer review materials); *Johnson v. Nyark Hospital*, 169 F.R.D. 550, 560-62 (S.D.N.Y. 1996) (holding in Title VII race discrimination lawsuit that HCQIA did not provide privilege preventing defendant hospital from discovering peer review materials from other non-defendant hospitals to help rebut plaintiff's claims that his medical performance record was unblemished and to support hospital's defense that the physician was denied privileges because of his failure to establish clinical competence); *Sypos v. United States*, 179 F.R.D. 406, 40812 (W.D.N.Y. 1998) (holding in medical malpractice lawsuit against veterans' hospital under the Federal Tort Claims Act that HCQIA did not establish privilege protecting peer review materials of non-party hospitals from discovery subpoenas of plaintiff); *but see Wei v. Bodner*, 127 F.R.D. 91, 98-101 (D.N.J. 1989) (holding, in Sherman Act antitrust lawsuit where plaintiff physician claimed that hospital and doctors prevented plaintiff from competing, that HCQIA did not prevent plaintiff from discovering peer review materials, especially when the materials sought were never reported to the National Practitioner Data Bank).
10 TEX. OCC. CODE. ANN. §160.007(a) (Vernon Pamph. 2000).
11 TEX. HEALTH & SAFETY CODE ANN. §161.032(a) (Vernon Supp. 2000).
12 TEX. OCC. CODE ANN. §151.002(8) (Vernon Pamph. 2002); *see* TEX. HEALTH & SAFETY CODE ANN. §161.032(a) (Vernon 2001) (providing that the term "medical peer review committee" is to be defined in accordance with TEX. REV. CIV. STAT. ANN. art. 4495b §1.03, which is now codified at TEX. OCC. CODE §151.002(8)); *see* also TEX. HEALTH & SAFETY CODE ANN. §161.031(a) (Vernon 2001) (defining "medical committee" to include "any committee . . . of a hospital").
13 TEX. OCC. CODE ANN. §151.002(7) (Vernon Pamph. 2002).
14 *Irving Healthcare System v. Brooks*, 927 S.W.2d 12, 14, 16 (Tex. 1996).
15 Texas Revised Civil Statutes article 4495b was repealed effective September 1, 1999 and its provisions codified in the Texas Occupations Code.
16 *Memorial Hospital – The Woodlands, supra*, 11-12.
17 *Id.* at 11.
18 *See* TEX. HEALTH & SAFETY CODE ANN. §161.032(c) (Vernon 2001); *McGee v. Bruce Hospital System*, 439 S.E.2d 257, 260 (information that is available from a source other than the committee does not become privileged simply by being acquired by the review committee); *Cruger v. Love*, 599 So.2d 111, 114 (Fla. 1992) (if an applicant obtains a document from a source that is not within the scope of the privilege, the document is not privileged).

HCQIA provides immunity from a lawsuit for damages for those involved in credentialing activities, provided that the professional action was taken (1) in the reasonable belief that the action was in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of this matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of number 3 above.[19] A professional review action is presumed to have met the preceding standards for protection unless the presumption is rebutted by a preponderance of the evidence.[20]

The governing document for physician credentialing will usually be the hospital's medical staff bylaws, which should set out detailed ground rules for how each physician is to be credentialed and re-credentialed. Hospitals should ensure their bylaws track the requirements of the HCQIA.[21] If a defendant (including hospital, physician, or anyone else) which has been sued for its involvement in a credentialing activity has met the standards set forth by HCQIA and as reflected in the medical staff bylaws and substantially prevails, the court *shall* award costs of suit, including attorneys' fees, if the plaintiff's claim or conduct during the litigation was frivolous, unreasonable, without foundation, or in bad faith.[22]

Texas law also provides immunity from any civil action brought against any individual who serves on a committee which makes decisions regarding the credentialing of physicians if such individual acted without malice.[23] Moreover, anyone who in *good faith* reports or furnishes information to such a committee is also immune from civil liability.[24] As with HCQIA, a presumption of absence of malice applies to medical committee actions.[25] As discussed in greater detail below, the Supreme Court of Texas has applied this malice standard to a negligent credentialing claim by a patient in a medical malpractice suit against a hospital.[26]

What all of this means is that for someone suing a hospital or committee member in connection with actions taken regarding the credentialing of a physician, the hurdles are very high. First of all, most if not all of the information provided and evidence relating to deliberations of the committee are protected from discovery. Secondly, one has to show not simply that the committee or committee members were negligent or wrong in their actions, but that they acted with malice. These additional legal protections are designed to facilitate candor and thoroughness in the credentialing of physicians. Physicians are often wary of serving on such committees and of making the tough decisions required of them from time to time. These statutory protections are designed to, and should, ensure the willingness of physicians to serve on such committees.

It is difficult enough to find good physicians who are willing to serve on credentialing committees. Everyone knows that it is largely a thankless, but absolutely necessary task. Even with the proceedings and deliberations kept confidential, the physician whose conduct is being reviewed will almost always know who voted to deny or restrict his privileges. Human nature being what it is, a considerable degree of integrity and courage is required for a committee member to vote against a physician on a credentialing matter.

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19 42 U.S.C. §§11111(a), 11112(a) (1999).
20 *Id.* at §11112(a).
21 42 U.S.C. §11101, *et seq*. (1999).
22 *Id.* at §11113.
23 TEX. OCC. CODE ANN. §160.010 (Vernon Pamph. 2002).
24 *Id.*
25 *Maewal v. Adventist Health System*, 868 S.W.2d 886, 893 (Tex. App. – Fort Worth 1993, writ denied).
26 *Agbor, supra*, 505-06.

Moreover, it is tough to justify limiting the protections provided by the current peer review privileges and immunities.

## III. HAS THE PENDULUM SWUNG TOO FAR?

Maybe. But the privileges and immunities require only minor adjustments, not wholesale evisceration. It has become fashionable to lay the problem of problematic physicians at the feet of hospitals. The logical whipping boy then becomes the credentialing bodies and the privileges and immunities which restrict discovery and arguably limit legal accountability. Presumably, the assumption is that if a bright light is shined on the process and legal protections eliminated or reduced, the quality control over incompetent physicians would be improved. Instead of figuring out a way to incentivize the medical community to clean up its own house, the popular theory is that we should make it easier for the legal community to do so. Why do it yourself when you can cede this responsibility to lawyers, judges and juries? However, the perceived proliferation of incompetent and/or improperly credentialed physicians is not primarily the fault of these privileges and immunities, and they should not bear the brunt of efforts calculated to fix the problem. It is worth remembering the adage "If you find a turtle on the top of a fence post, it's unlikely he got there by himself."

At the risk of slipping beyond the expertise of the authors, one recommendation is that the critics of the current system first take a look at the medical school programs where these physicians are trained and the medical licensing boards where they are licensed. Understanding that the immediate problem cannot be solved by improving future medical school training, it would appear that part of the long-term solution for this problem should include better training. These authors will leave for someone more qualified to address the issue of how best to weed out potential problem physicians at the medical school stage.

The various state medical licensing boards, however, will not receive such limited treatment. To begin with, at least in Texas, the privileges which preclude discovery by a patient litigant or physician unhappy with the credentialing process does not bar the Texas Board of Medical Examiners from reviewing peer review materials nor obtaining sworn testimony on the subject.[27] Furthermore, a Texas appellate court has rejected the argument of plaintiffs that they should be entitled to discovery of board documents.[28] A medical licensing board is simply not burdened with the discovery impediments that civil litigants must negotiate.

While acknowledging that medical licensing boards take disciplinary actions based on different criteria then hospitals, these boards are clearly more qualified to deal with problem physicians with a "scalpel" approach than the "sledgehammer" corrective measures used by plaintiffs' lawyers and juries. A well-considered restriction imposed by a medical licensing board should prove more effective in improving, limiting the practices of, or eventually getting rid of problem physicians. Moreover, in Texas just about anyone can make a complaint about a physician with the Texas Board of Medical Examiners without going through the filter of a hospital committee.[29] Thus, to the extent complaints about maintaining the status quo focus on the hurdles presented by the current peer review privilege laws, state medical licensing boards are in a better position to deal with and weed out incompetent and/or improperly trained physicians.

27 TEX. OCC. CODE ANN. §§153.007, 160.009 (Vernon Pamph. 2002).
28 *Gustafson v. Chambers*, 871 S.W.2d 938, 949 (Tex. App. – Houston [1st Dist.] 1994, no writ).
29 *See* TEX. OCC. CODE ANN. §§106.001, 162.159 (Vernon Pamph. 2002); *Attaya v. Shoukfeh*, 962 S.W.2d 237, 23840 (Tex. App. – Amarillo 1998, pet. denied).

Anecdotal evidence in Texas at least suggests that the Texas Board of Medical Examiners could, and should, do much more in this area. Determining ways to incentivize licensing boards to be more responsive and aggressive in timely ferreting out and disciplining problem physicians is beyond the scope of this paper or the expertise of these authors. It is apparent, however, that public pressure is increasing on state licensing boards to do a better job. The public is beginning to demand that these boards exhibit a greater concern over protecting the health care consuming public and less concern about protecting the unfettered right of certain physicians to practice medicine who often do more harm than good. However, emasculating the privileges and immunities is highly unlikely to further this objective.

Furthermore, HCQIA contains a statutory scheme designed to ensure that privileges like the ones discussed above do not operate to protect bad doctors, the National Practitioner Data Bank (the "Data Bank"). Evidence suggests the results are mixed. HCQIA requires each health care entity which (1) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days, or (2) accepts the surrender of clinical privileges of a physician while the physician is under investigation by the entity relating to possible incompetence or improper professional conduct or in return for not conducting such an investigation or proceeding, to report this event to the appropriate state medical licensing board, which shall in turn report to the Data Bank.[30] Failure by a health care entity to comply with these reporting requirements may result in the loss of the immunity protections provided under §11111(a) of HCQIA. HCQIA also requires any entity which makes payment in satisfaction of a judgment or settlement in a medical malpractice action to report this information to the Data Bank.[31]

The purpose of these reporting requirements is to ensure that physicians who have checkered pasts will be identified. This permits hospitals to check the Data Bank for a physician's claims history and previous credentialing problems at other facilities prior to credentialing that physician at their facilities. The Data Bank is just what its name suggests, a repository of information concerning physicians which can be accessed by hospitals in connection with their credentialing activities.

Reports to the Data Bank may also be disclosed to an attorney, or an individual representing himself, in a claim for medical malpractice against a hospital or physician.[32] The information in the Data Bank will be disclosed only upon proof that the hospital failed to request the information regarding the physician as required by law, and it may be used solely with respect to the litigation resulting from the action or claim against the hospital.[33]

The Office of Inspector General of the Department of Health and Human Services found that in the first three and one-half years of the Data Bank's existence, hospitals reported 3,154 adverse actions and that over 75% of the hospitals never reported a disciplinary action.[34] Over the same period, more than twice as many disciplinary actions were taken by state licensing boards and reported to the Data Bank.[35]

Of course, physicians are very sensitive to having matters concerning them reported to the Data Bank. These sensitivities have become heightened over the last few years as the health care profession has continued to change and evolve. Physicians are worried about the reporting of any events and how that reporting might adversely affect their ability to

30 42 U.S.C. §§11133(a)-(b), 11134 (1999).
31 *Id.* at §§11131, 11134.
32 45 C.F.R. §60.11(a)(5) (2001).
33 *Id.*
34 *See* OFFICE OF INSPECTOR GENERAL, U.S. DEPT. OF HEALTH AND HUMAN SERVICES, HOSPITAL REPORTING TO THE NATIONAL PRACTITIONER DATA BANK 3 (1995); *see also* Schentzow, *supra*, 15.
35 *Id.*

maintain or obtain credentials at hospitals and to maintain or expand their relationship with payors. Hospitals tend to be willing to bend over backwards to accommodate the physician in his attempts to avoid a report to the Data Bank. For the reasons discussed above, hospitals avoid or circumvent these reporting obligations at their peril. However, an area which should be strengthened is the sanctions for failure to report to the Data Bank. At least one study has shown that states with stronger penalties for not reporting were much more likely to report physicians to the Data Bank.[36] The study revealed that hospitals in states with strong penalties were forty percent more likely to have reported an adverse action than states with no penalties.[37]

Data Bank concerns can also affect the judgment of a physician sitting on a credentialing committee. Most physicians feel uncomfortable denying another physician privileges when they know that such a decision will result in a report to the Data Bank that may adversely affect that physician's ability to obtain or maintain privileges at other hospitals and affect his relationship with payors. This should not affect the vote of a physician sitting on a committee. As a practical matter, however, it can and often does.

At what stage are hospitals obligated to report a physician to the Data Bank who has been the recipient of an adverse credentialing decision? This adverse decision could reflect the complete refusal by a hospital to grant the physician any staff privileges, or simply a decision by the hospital to restrict current privileges or deny a physician's application for additional privileges. It is now well settled that, with the exception of immediate, summary suspensions of clinical privileges, to the extent that decision is not final, it does not have to be reported to the Data Bank.[38] In other words, until the credentialing process is complete and all avenues of administrative appeal have been exhausted or waived, no report to the Data Bank is required.

## IV. EFFECT ON PATIENTS' ABILITY TO SEEK REDRESS IN THE COURTS

A related issue to ensuring that the system of privileges and immunities does not protect incompetent physicians from professional scrutiny is the issue of protecting the rights of injured patients to seek redress in the courts. While the authors admit to a defense bias, it does not appear that, as a general rule, the system of privileges and immunities materially hinders such redress. Typically, the discovery process in a medical malpractice lawsuit will eventually uncover the pertinent facts. Once the facts are discovered, the other hurdle for an injured plaintiff is to retain one or more expert witnesses who will testify about the relevant standard of care, the breach of this standard, and the causal connection between the breach and the injury.[39]

The discovery and review of a physician's credential file relating to the investigation of an incident or relating to other particulars of the defendant physician's background should add very little to the case. What the plaintiffs' bar really seeks is the ability to conduct a fishing expedition and comb through a physician's and hospital's investigation and credential files looking for a smoking gun or an admission of some sort. The plaintiffs are really looking for evidence which will obviate the need to go out and hire an expert. Some jurisdictions like Florida and North Carolina have a very restrictive view of discovery in this

36 Schentzow, *supra*, 44.
37 *Id.*
38 U.S. DEPT. OF HEALTH & HUMAN SERVS., PUB. NO. HRSA95255, NATIONAL PRACTITIONER DATA BANK GUIDEBOOK E33 (Sept. 2001).
39 *See Hood v. Phillips*, 554 S.W.2d 160, 165-66 (Tex. 1977).

litigation context,[40] while other jurisdictions like Illinois and Rhode Island permit more liberal discovery.[41]

A case can certainly be made that more benign documents like applications for privileges should be discoverable to the extent they do not contain candid assessments of the physician by other health care professionals.[42] The argument can certainly be made that the policy rationale for the peer review and self-evaluation privileges simply does not apply to privilege applications. The part of the credentialing process which is usually the most sensitive relates to recommendations by the applicant's peers. For the same reason that peer review privileges should protect candid assessments about a physician's abilities by members of a credentialing committee, so too should written comments made by non-committee members be protected. This is particularly true in the initial application process where the physician has never before practiced at the hospitals. In this situation, credentialing bodies typically rely heavily on the recommendations of other professionals who are often not associated with the credentialing hospital.

While one can certainly make a case that a given injured plaintiff's case would be made stronger if he had access to a credential or investigation file, these short-term benefits are far outweighed by the long-term problems which permitting such discovery would cause. It seems fairly predictable that once hospitals and physicians realize that heretofore privileged communications are now discoverable, meaningful peer review would soon become a thing of the past. If those clamoring for a wholesale evisceration of the peer review privileges in the name of physician accountability got their way, the long-term result would be only a worsening of the system they now decry. The chilling effect on full, fair, frank, "on the record" peer review would seem to be obvious. George Newton summarizes the predicable result of open discovery:

> If peer review material were readily discoverable, the process, in effect, would become little more than a source of highly prejudicial evidence of a physician's past instances of negligence and impropriety for use by a plaintiff in developing his or her case. In addition, the peer review committee would provide a pool of extremely valuable witnesses – experts in the field that have probably worked alongside the defendant and whose testimony is not tainted by the high fee accompanying typical expert witness testimony. As a result of access to such material and testimony, hospitals and health care professionals would quickly realize that their efforts to ensure quality care were creating a paper trail of the most valuable sort of evidence for plaintiffs. The collapse of meaningful self-policing within the medical community would follow shortly thereafter.[43]

Notwithstanding the problems which would be caused by permitting discovery of peer review matters by malpractice litigants, with respect to one aspect of this issue, many believe at least one court may have gone too far. In 1997 the Supreme Court of Texas held

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40 *See Cruger v. Love, supra*, 114-15 (applying broad interpretation of privilege, excluding physician application from discovery); *Munroe Regional Medical Center v. Rountree*, 721 So.2d, 1220, 1222-23 (Fla. Dist. Ct. App. 1998) (holding that hospital peer review privilege protected physician accused of malpractice during surgical operation from being compelled to testify about whether suspension of his staff privileges was related to the alleged malpractice or even if suspension had anything to do with his surgical practice); *Shelton v. Morehead Memorial Hospital*, 347 S.E.2d 824, 827-29 (N.C. 1986) (stating that legislature created privilege after deciding to embrace "medical staff candor at the cost of impairing plaintiff's access to evidence").

41 *Menoski v. Shih*, 612 N.E.2d 834, 836, 838 (Ill. App. Ct. 1993) (stating that privilege does not apply to any documents generated before peer review process, such as applications for privilege, or actions "taken as a result of the process," such as the nature and extent of restrictions placed on physician); *Moretti v. Lowe*, 592 A.2d 855, 857-58 (R.I. 1991) (holding that privilege must be strictly construed and forcing health care provider to supply more information about revocation of privileges).

42 *See Memorial Hospital – The Woodlands v. McCown*, *supra*, 11-12.

43 Newton, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 Ala. L. Rev. 723, 736 (2001).

that the malice immunity provision which bars an action based on a hospital's credentialing decisions made without malice also applied to a claim by a patient against a hospital for negligent credentialing.[44] In fact, the *Agbor* court even refused to acknowledge the existence of a negligent credentialing claim in Texas, indicating "we reserve for another day whether we recognize a common-law cause of action for negligent credentialing."[45] In a dissenting opinion, Chief Justice Phillips reasoned that since the statute at issue does not regulate physician-patient or hospital-patient relationships or discuss patient care liability, "the Legislature did not intend to apply the heightened immunity provisions to patient suits against hospitals.[46] Chief Justice Phillips goes on to conclude that given the privilege barring the discovery of peer review committee records, "such a claim [for malice], no matter how meritorious, would be virtually impossible to prove."[47] "In the eyes of some, the Supreme Court of Texas got it wrong.[48] To the extent the standard is malice and the peer review privilege limits discovery, a negligent credentialing claim becomes very difficult to make. However, as previously noted, if a plaintiff is able to make a *prima facie* case, the hospital may be put in the difficult position of having to decide whether to waive the privilege in order to prove it acted properly.

## V. CONCLUSION

It would be great to be able to say "If it ain't broke, don't fix it." However, this cannot be said of the medical profession's system for dealing with the problem of incompetent and/or improperly credentialed physicians, not simply the peer review and self-evaluation privileges and immunities which get blamed for the problem. Like most complex issues, there is no simple solution. While the solution may require major changes overall, it should not necessitate the wholesale evisceration of the existing privileges and immunities. It has been said that the first rule of medicine is "Do no harm." Logic and common sense suggest that taking a sledgehammer to these privileges and immunities could, and probably would, result in a worse situation than the one we're now in. Targeted, surgical revisions to the system of privileges and immunities and Data Bank reporting as discussed herein can help. However, the problem would seem to require assistance from other areas, such as medical schools and state licensing boards, along with a renewed resolve on the part of physicians to do a better job of policing those who practice at their hospitals. While improvements like the ones suggested in this paper may not solve the problem overnight, they are a step in the right direction.

44 *Agbor, supra*, 509.
45 *Id.* at 508.
46 *Id.* at 511.
47 *Id.* at 512.
48 *See* Schentzow, *supra*, 26, 48.