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Peter F. Daniel

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THE MISSOURI RULE: HOSPITAL PEER REVIEW IS DISCOVERABLE IN MEDICAL MALPRACTICE CASES

State ex rel. Chandra v. Sprinkle

Missouri Rule 56.01 sets forth the general provisions governing discovery in civil cases. Unless otherwise limited by order of the court, the rule delineates the scope of discovery as "any matter, not privileged, which is relevant to the subject matter involved in the pending action." Missouri statutorily recognizes numerous privileges. Generally, matter is privileged from discovery if it would be privileged at trial under the applicable rule of evidence. A claim of privilege is an exception to the rule that all relevant material shall be revealed. Courts are reluctant to expand or create a new privilege in the absence of statutory support. Consequently, attempts to establish a claim of privilege are given strict scrutiny and allowed in only a few instances.

In State ex rel. Chandra v. Sprinkle, the Missouri Supreme Court held that no peer review privilege exists for factual statements under Missouri law. The court found that Missouri statutory provisions give no basis for a peer review privilege. Additionally, the court noted that the major policy underlying the peer review system is to provide benefits for patients and prospective patients, whose care would be enhanced by the earlier peer review proceedings. The court, in turn, rejected the argument that confidentiality is essential to maintaining the benefits to be derived from peer review activities.

1. 678 S.W.2d 804 (Mo. 1984) (en banc).
2. See MO. R. CIV. P. 56.01; see also FED. R. CIV. P. 26.
3. MO. R. CIV. P. 56.01(b).
5. C. WRIGHT, THE LAW OF FEDERAL COURTS § 81, at 549 (4th ed. 1983); FED. R. EVID. 1101(e); see also United States v. Reynolds, 345 U.S. 1, 6 (1953) ("privilege" refers to privileges as understood in the law of evidence).
7. See, e.g., Nazareth Literary & Benevolent Inst. v. Stephenson, 503 S.W.2d 177, 179 (Ky. 1973) (denying peer review privilege).
8. 678 S.W.2d 804 (Mo. 1984) (en banc).
9. Id. at 806.
10. Id. at 807.
The existence of a medical peer review privilege became an issue in the Chandra case when the plaintiff requested hospital reports pertaining to emergency treatment received at the hospital. Anjali Kathryn Chandra, an infant one month old, was taken to Independence Sanitarium and Hospital for treatment in connection with worsening cold and respiratory congestion. In the hospital x-ray department, the child suffered respiratory arrest. Her father, an internist at the hospital, administered cardiopulmonary resuscitation and rushed the child back to the emergency room for further treatment. Plaintiff alleged that prior to and subsequent to this event, the doctor on duty and two other physicians failed to respond to the emergency. Furthermore, plaintiff alleged that the staff could not locate the emergency medical equipment used to treat infants. Finally, plaintiff alleged that due to the defendant’s negligence, the child suffered cerebral hypoxia (lack of oxygen to the brain), resulting in permanent brain damage.

Anjali, by and through Relator Ingrid Chandra, brought a malpractice action against the doctors and the hospital. Following the incident, the hospital appointed an “Ad Hoc Committee” to investigate the matter. Relator requested discovery of the hospital’s “Ad Hoc” committee report and the standing peer review committee report. The defendant hospital failed to comply with the discovery request, claiming a peer review privilege. Respondent, Judge Richard P. Sprinkle, denied Relator’s motion to compel discovery. Following Judge Sprinkle’s ruling, Relator filed a mandamus order. The Missouri Supreme Court permitted transfer and consolidated Chandra with State ex rel. Lester E. Cox Medical Center v. Keet.

11. Id. at 805-06.
12. Id. at 805.
13. Id. at 805-06.
14. Id. at 806.
15. Mo. R. Civ. P. 94.01 provides:
Proceedings in mandamus in a circuit court shall be as prescribed in this Rule 94 and in this Court or the court of appeals shall be as prescribed in Rule 84.22 to Rule 84.26, inclusive, and this Rule 94. In all particulars not provided for by the foregoing provisions, proceedings in mandamus shall be governed by and conform to the rules of civil procedure and the existing rules of general law upon the subject and the court may, by order, direct the form of such further details of procedure as may be necessary to the orderly course of the action or to give effect to the remedy.
16. 678 S.W.2d 813, 814 n.2 (Mo. 1984) (en banc). The Chandra and Cox cases were decided concurrently and essentially involve the same issues. Larry Ferguson was treated by Dr. Newt Wakeman for injuries sustained in a motorcycle accident. On January 28, 1981 Ferguson was admitted to Lester E. Cox Medical Center so Dr. Wakeman could surgically remove a “zikel” nail device. Plaintiff in the underlying suit, Freda R. Ferguson, alleged that her husband, Larry Ferguson died on February 3, 1981 as a result of post-operative infection contracted while under the care of Dr. Wakeman and Cox Hospital. Cox, 678 S.W.2d at 814. The plaintiff requested discovery of (1) documents and materials used by any peer review committee concerning the care provided by Dr. Wakeman and Cox, (2) disclosure of information concerning the makeup and membership of the peer review committee, (3) information as to whether
The basic purpose of a peer review committee is to provide a mechanism to collect information and exchange ideas in order to maintain and improve the standard of professional care in a hospital. Peer review committees, comprised of physicians and non-medical hospital personnel, review the staff performance of functions and procedures throughout the hospital. Typically, these functions are broken down by department in large hospitals. Each department plays an integral role in the medical care review system by providing a framework for peer-group analysis within that department. A common breakdown in a departmentalized hospital includes the following committees: credentials, tissue, utilization review, medical audit, and executive. In small, non-departmentalized hospitals, with less than fifteen active staff members, the review is typically handled by the staff as a committee of the whole. The results of committee investigations are coordinated to the highest degree possible and used throughout the hospital to foster identification and resolution of problems.

In reviewing a physician's credentials, peer review committees generally examine whether the physician exercises his specialized skills competently and

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Cox had ever revoked, restricted, or expanded the staff privileges of Dr. Wakeman, and (4) the medical records of any patient at Cox from 1978 forward who had developed bacterial infection or shock after surgery at Cox and disclosure of the reason of hospitalization of any person in the same room or ward with Mr. Ferguson. Id. at 814. The plaintiffs agreed that the names of any patient could be removed before the records were turned over. Id. at 814 n1. The hospital refused to comply with the request. Relators then obtained a preliminary writ of prohibition against Respondent Honorable James H. Keet, Jr. Id. at 813. Chandra and Cox were decided on the same day. Id. at 813; Chandra, 678 S.W.2d at 804. The Cox court upheld the trial court's motion to compel discovery against both grounds asserted by the hospital. First, the court relied on their public policy discussion in Chandra to put aside the claim of privilege for medical peer review reports. Cox, 678 S.W.2d at 813. The second ground asserted was not argued in the Chandra case. Relator Cox argued that the medical records of patients that are not party to the suit are protected by the physician-patient privilege. Mo. Rev. Stat. § 491.060(5) (1978) (see infra note 51 for text). The Respondent argued that redacting the patients name removes any claim of privilege. Id. at 814. The Cox court relied on State ex rel. Friedman v. Provaznik, 668 S.W.2d 76, 79 (Mo. 1984) (en banc) (disclosure after in camera inspection of the law firm's billing sheets and other fee information), for the proposition that in camera inspection can protect the identity and privacy of non-party patients. Judge Welliver, in dissent, distinguished the Friedman case on the grounds that it involved unique and compelling reasons for disclosure and was not a broad invitation to invade the attorney-client privilege. Cox, 678 S.W.2d at 815-16.

20. Id. at 20.
whether those skills are used appropriately in particular situations.21 Numerous sources are used to gather information in order to identify problems. Internal sources commonly include medical reports, incident reports, infection control and other quality assurance reports, patient bills, staff and patient surveys, and direct observation.22 External sources include Professional Service Review Organization23 reports, Health Systems Agency reports,24 third party payor reports,25 and literature related to health care.26

Peer review is required by private regulators, state regulation, and federal legislation. Private regulation is spearheaded by the Joint Commission on Accreditation of Hospitals (JCAH), organized in 1952. The current members of the JCAH include the American College of Surgeons, the American College of Physicians, the American Hospital Association, the American Medical Association, and the American Dental Association.27 As a powerful private regulator, the JCAH seeks to establish and maintain rigorous standards for hospitals.28 Although accreditation by the JCAH is technically voluntary, hospitals wishing to participate in federal Medicare funding are required to meet standards essentially identical to those promulgated by the JCAH. Generally, that standard requires delivery of optimal patient care with available resources.29

Essential to the JCAH standard is the idea that the hospital must ultimately police the quality of patient care.30

22. K. KAPLAN & J. HOPKINS, supra note 17, at 49.
23. See infra notes 35-37.
24. Health Systems Agencies contract with the Department of Health and Human Services to carry out comprehensive planning and regulatory programs on the state and local levels. See REPRESENTING HEALTH CARE FACILITIES 62 (M. Strickler & F. Ballard eds. 1981).
25. Third party payors account for sixty-five to ninety-five percent of most hospitals’ cash flow. See id. at 119.
26. Id. at 49-50.
27. JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS at x (1983 ed.) (hereinafter cited as JCAH).
29. JCAH, supra note 27, at x-xi.
30. The JCAH guidelines provide an example of a typical peer review committee:

Surgical case review (tissue committee function) shall be performed on a monthly basis for cases in which a specimen (tissue or nontissue) was removed, as well as for those cases in which no specimen was removed. The review shall include the indications for surgery and all cases in which there is a major discrepancy between the preoperative and postoperative (including pathologic) diagnosis. A screening mechanism based on predetermined criteria, may also be established for those cases involving no specimens . . . . Regardless of the mechanism used, written reports shall be maintained that reflect the results of all evaluations performed and actions taken.

Id. at 106.
Because the JCAH provides guidelines and not models, the exact form and substance of committee reports differ from hospital to hospital. JCAH guidelines for documentation suggest a brief statement on the known or suspected problem amenable to improvement, the source or criteria used to identify the problem, a summary of the extent of the problem, anticipated benefits of improving the problem, and possible explanation of the problem.

Missouri mandates peer review in order to meet licensure requirements authorized by the State Department of Health. The Missouri regulation dealing with peer review states that the medical staff of the hospital must meet at least quarterly to review and evaluate the quality of clinical practice throughout the hospital. Enumerated areas of review are selected deaths, unimproved cases, tissue, infections, complications, errors in diagnosis, and results of treatment.

The federal government requires a peer review of sorts. Institutions that provide health care and health care related services that are partly or totally funded by the federal government are reviewed by entities known as Professional Service Review Organizations (PSRO). The federal government con-

31. Holbrook & Dunn, supra note 18, at 58.
32. See JCAH, supra note 27, at 151-52.
35. See 42 U.S.C. § 1320c-3(a)(1) (1982). Section 1320c-3(a) provides: Any utilization and quality control peer review organization entering into a contract with the Secretary under this part must perform the following functions:

(1) The organization shall review some or all of the professional activities in the area subject to the terms of the contract, of physicians and other health care practitioners and institutional and noninstitutional providers of health care services in the provision of health care services and items for which payment may be made (in whole or in part) under subchapter XVIII of this chapter for the purpose of determining whether-

(A) such services and items are or were reasonable and medically necessary and whether such services and items are not allowable under subsection (a)(1) or (a)(9) of section 1395y of this title;

(B) the quality of such services meets professionally recognized standards of health care; and

(C) in case such services and items are proposed to be provided in a hospital or other health care facility on an inpatient basis, such services and items could consistent with the provision of appropriate medical care be effectively provided more economically on an outpatient basis or in an inpatient health care facility of a different type.
tracts with a PSRO to monitor hospital costs and quality of services. This form of review is external and should be distinguished from the internal peer review system at issue in *Chandra*. Significantly, federally-funded review organizations are protected from disclosure by statute.

In *Chandra*, the court refused to recognize a privilege for peer review committee reports. Privileges are restrictions on what is otherwise broad discovery. Privileged communications are those made by persons maintaining certain confidential relationships. Relationships that typically command privileged status are those of husband and wife, attorney and client, juror and fellow juror, government and informer, priest and penitent, and physician and patient. Additionally, statutes create privileged communications which vary from jurisdiction to jurisdiction.

Any finding that information is protected from discovery reflects a balancing of interests. Society’s interest in a full and fair adjudication of the litigated issues culminates in a party’s right to discovery. By contrast, society’s interest in protecting the confidentiality of disclosures made within the context of certain relationships of acknowledged social value compels privileged communications. In balancing these competing interests, the Missouri legislature

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*See generally New Developments* in *Law/Medicine* 50-54 (G. Morris & M. Norton eds. 1974)

36. *See* 42 U.S.C. § 1320c-2 (1982). Subsection (c) provides that:
Each contract with an organization under this section shall provide that—

1. the organization shall perform the functions set forth in section 1320c-3(a) of this section, or may subcontract for the performance of all or some of such functions (and for purposes of paragraphs (2) and (3) of subsection (b) of this section, a subcontract under this paragraph shall not constitute an affiliation with the subcontractor);

2. the Secretary shall have the right to evaluate the quality and effectiveness of the organization in carrying out the functions specified in the contract . . . .

37. *See* 42 U.S.C. § 1320c-9 (1982). Section 1320c-9(c) provides that:
It shall be unlawful for any person to disclose any such information described in subsection (a) of this section other than for the purposes provided in subsections (a) and (b) of this section, and any person violating the provisions of this section shall, upon conviction, be fined not more than $1000, and imprisoned for not more than 6 months, or both, and shall be required to pay the costs of prosecution.

Although PSRO’s operate from the outside, they gather much the same information as internal peer review committees. *See* 42 U.S.C. § 1320c-3a(1-3).


40. For a list of statutorily privileged relationships in Missouri, see *supra* note 4. *See* 8 J. Wigmore, *supra* note 39, § 2286, at 528-30, for a list of privileges asserted in other jurisdictions (government-informer, partner-partner, clerk-employer, banker-depositor, journalist-source).

41. Brief for Relator at 15, *State ex rel.* Lester E. Cox Medical Center v. Keet, 678 S.W.2d 813 (Mo. 1984) (en banc).
has displayed an awareness of the value of certain confidential relationships by creating numerous statutory privileges. Moreover, Missouri courts have interpreted the statutes to meet legislatively desired purposes. Missouri statutes also provide privileges of varying degrees of protection with regard to professional peer review.

Prior to Chandra, Missouri courts had never confronted the issue of discoverability of peer review committee reports by malpractice plaintiffs. The Chandra court commenced its analysis with an examination of Missouri Revised Statutes section 537.035. It first determined that the statute provides "no basis for recognition of a peer review privilege." Rather, the statute protects peer review committee members against civil liability for actions taken pursuant to or arising out of the committee's investigation. The Chandra court found that the underlying policy of the statute was to eliminate peer review committee members' apprehension of lawsuits for their good faith appraisal of fellow professionals.

The hospital argued that section 537.035 should be expanded beyond its express terms to protect committee members from the discoverability of peer review committee reports as well as from civil liability. The Chandra court, however, found a clear difference between the immunity from civil liability

42. See supra note 4.
43. See, e.g., Metropolitan Life Ins. Co. v. Ryan, 237 Mo. App. 464, 470, 172 S.W.2d 269, 272 (St. L. 1943) (recognized value to be protected in the physician-patient relationship is allowing patients to make full and frank disclosures to their medical advisor in order to enhance treatment).
44. MO. REV. STAT. § 326.134 (Supp. 1984) (certified public accountants peer review); MO. REV. STAT. § 331.045 (1978) (chiropractor exempt from liability when serving on insurance peer review board); id. § 335.031 (1978) (nursing board).
45. MO. REV. STAT. § 537.035 (1978) provides that no licensed physician, surgeon, dentist, podiatrist, optometrist, or pharmacist while acting, within their scope of practice, as an authorized member of a hospital review, medical review, dental review, pharmacy review, utilization review, or peer review committee functioning for the sole purpose of maintaining the professional standards of those engaged in the practice of the above professions, or for maintaining professional standards in a hospital as established by its medical society or by the medical staff of the hospital creating the committee, and no governing board or member of such a board of a hospital licensed under the provisions of chapter 197, RSMo, acting upon a recommendation of any such committee, shall be liable in damages to any person subject to the actions of the committee or board for any action taken or recommendation made by the committee or board or by a person acting in his official capacity as a member of any such committee or board when such action or recommendation was made within the scope and function of the committee if such action or recommendation was made without malice and was supported by creditable evidence upon consideration of the whole record.
46. Chandra, 678 S.W.2d at 806-07. Other courts have examined the issue of statutory immunity. See Hall, supra note 18, at 254-64; Comment, Medical Peer Review Protection In The Health Care Industry, 52 Temp. L.Q. 552, 571-75 (1979).
47. Chandra, 678 S.W.2d at 806.
granted by the statute and the privilege of confidentiality requested by the hospital and refused to endorse the latter protection.48

In support of its position, the court relied on Klinge v. Lutheran Medical Center.49 In that case, the physician-plaintiff sought a restraining order to enjoin the hospital, its board of directors, employees, and physician staff members from examining the records of the plaintiff's patients in order to evaluate the physician's competency.50 The Klinge court held that Missouri Revised Statutes section 491.060(5),51 which sets forth the statutory physician and patient privilege, did not preclude the hospital review committee from examining medical records of a staff physician's patients to determine the doctor's competency and qualifications.52 The Klinge court expressed the belief that peer review exists for the benefit of the public by insuring that individual patients receive hospital care performed at a highly professional level.53 Applying the policy considerations espoused in Klinge, the Chandra court found that peer review encourages the improvement of medical care because the doctor knows that his work will be analyzed by his peers at a later date.54

The Chandra court further expressed the belief that the peer review system exists for the benefit of patients. From this statement of policy, the court found that the public interest lies in the discoverability and not the confidentiality of peer review committee reports.55 To give effect to this policy choice, the court held that peer review is discoverable as to factual matters.56

In apparent response to the lack of direct Missouri authority, the Chandra court turned to federal and state case law. Though the issue of discoverability of peer review records has seldom been litigated in either federal or state courts, several unifying themes emerge from the decisions which address the issue. Those courts which have denied the creation of a peer review privilege have done so for four major reasons. Primarily, courts refuse to create a privilege where no statutory grounds exist. Essentially these courts recognize that privileges are impediments to facts which may lead to the proper resolution of the lawsuit.57 Second, a consequence of the belief that privileges in

48. Id. at 807.
49. 518 S.W.2d 157 (Mo. App., St. L. 1975).
50. Id. at 161.
   The following persons shall be incompetent to testify:
   A physician or surgeon, concerning any information which he may have
   acquired from any patient while attending him in a professional character,
   and which information was necessary to enable him to prescribe for such
   patient as a physician, or do any act for him as a surgeon.
52. Klinge, 518 S.W.2d at 166.
53. Id. at 167.
54. Chandra, 678 S.W.2d at 807.
55. Id. at 807.
56. Id. at 808.
57. See Memorial Hosp. v. Shadur, 664 F.2d 1058, 1061 (7th Cir. 1981) (evidentiary privileges operate to exclude relevant evidence and block fact finding); Ott v.
general are not favored is the idea that a state regulation or statute not specifically granting a privilege from discovery cannot be expanded.68

Third, courts tend to favor plaintiffs in cases where the policy choice between a plaintiff's right to discover and the chilling effect discovery may have on peer review has been examined.69 Finally, in actions by doctors whose staff privileges have been revoked or denied, discovery has been allowed to avoid the fear that shrouding the peer review process from public disclosure would lead to use of the system for anti-competitive or other improper purposes.60

Generally, those states that have refused to create judicially a peer review privilege have done so by statute.61 However, two courts have allowed a medi-


58. See Wesley, 234 Kan. at 18-19, 669 P.2d at 213-14 (regulation does not rise to the level of privilege created by statute); Cronin, 392 Mass. at —, 467 N.E.2d at 147 (in absence of statute courts are reluctant to create a privilege); Davison, 75 Wis. 2d at 199, 248 N.W.2d at 439 (limited privilege or confidentiality cannot be expanded).

59. See Ott, 522 F. Supp. at 711 (plaintiff's ability to bring claim would be totally negated if privilege allowed); Wesley, 234 Kan. at 26, 669 P.2d at 219 (decline to adopt privilege though in some instances it may be warranted); Nazareth, 503 S.W.2d at 179 (public policy in favor of broad discovery); Cronin, 392 Mass. at —, 467 N.E.2d at 149 (trial court exercised discretion in allowing discovery in face of conflicting public policy); see also Kenney v. Superior Court, 255 Cal. App. 2d 106, 110, 63 Cal. Rptr. 84, 87-88 (1967) (court denies privilege but without analyzing the chilling effect of discovery on peer review); Davison, 75 Wis. 2d at 204, 248 N.W.2d at 441 (allows discovery although statutory privilege enacted after trial court decision but prior to appeal).

60. See Memorial Hosp., 664 F.2d at 1062-63 (policy of private enforcement of anti-trust law too strong to permit exclusion of evidence); Ott, 522 F. Supp. at 711 (danger physician might be removed simply because he "made waves"); Cronin, 392 Mass. —, 467 N.E.2d at 147 (important to assure that decisions are made on proper grounds). The policy supporting a privilege for peer review in medical malpractice cases is not as persuasive in the area of denial or revocation of staff privileges. Denying discovery of the committee reports wherein doctors are evaluated for fitness would effectively deny the plaintiff-doctor any possibility of contesting the dismissal. Moreover, any affirmative action taken by the committee, e.g., revoking staff privileges, would probably become publicly available, thus there is less feeling initially that the communication would be kept confidential. Interview with Douglas Harpool, Representative 134th District, Missouri House of Representatives (February 14, 1985). However, a plaintiff in a malpractice action, may have numerous sources outside the peer review committee reports. See infra note 109 and accompanying text.

cal peer review privilege in the absence of a statute. In these cases, the courts recognized two factors in denying or limiting the discoverability of peer review documents. First, confidentiality is necessary for the effective functioning of peer review committees. Constructive criticism will not occur in an atmosphere of apprehension generated by the potential use of peer review records in a medical malpractice suit. Second, there is an indication that some of the requested matter was not relevant to the malpractice suit and therefore not discoverable.

Numerous courts have discussed the application of a peer review privilege where statutory protection has been provided. Although the cases apply or construe statutes of varying degrees of protection, a number of unifying ideas identify the scope of a peer review privilege. First, courts in states which have passed some type of protection for peer review generally construe the statutes broadly to give effect to the legislature's policy choice. Second, courts have

63. Bredice, 50 F.R.D. at 250 (professional criticism cannot occur in atmosphere of apprehension); Gillman, 53-F.R.D. at 318 (constructive criticism suppressed by fear of consequences). Numerous courts have recognized but not adopted this reasoning. See, e.g., Wesley, 234 Kan. at 22, 669 P.2d at 216 (quoting Bredice at length).
64. See Gillman, 53 F.R.D. at 319 (plaintiff sought production of various reports made after husband committed suicide while in care of defendant); Bredice, 50 F.R.D. at 251 (plaintiff sought minutes of board meeting and reports to malpractice carrier concerning death of plaintiff's decedent). Some of the matter was irrelevant in that it related to suggestion for future improvement or was one person's opinion as to what was relevant after the incident. See Gillman 53 F.R.D. at 319; Bredice, 50 F.R.D. at 251.
65. See Karp v. Cooley, 493 F.2d 408, 425 (5th Cir. 1974) (federal court in diversity jurisdiction recognizing state-created privilege protects university hospital investigative committee); Schulz v. Superior Court, 66 Cal. App. 3d 440, 445, 136 Cal. Rptr. 67, 70 (1977) (construction of statute which would lead to discovery of peer review when either staff doctor or hospital are parties leads to an absurd result); Posey v. District Court, 196 Colo. 396, 398-99, 586 P.2d 36, 37-38 (1978) (broad policy interpretation to include "physicians" where statute only said "physicians"); Segal v. Roberts, 380 So. 2d 1049, 1051-52 (Fla. Dist. Ct. App. 1979) (statute only protects peer review committee reports related to the lawsuit and not those reports made several years earlier at a different hospital, but policy behind peer review process so compelling it dictates disclosure only in most necessitous circumstances), cert. denied, 388 So. 2d 117 (Fla. 1980); Dade County Med. Ass'n v. Hlis, 372 So. 2d 117, 119 (Fla. Dist. Ct. App. 1979) (medical society committee records not discoverable in auto accident case though statute limited privilege to actions against health care providers); Mennes v. South Chicago Community Hosp., 100 Ill. App. 3d 1029, 1032, 427 N.E.2d 952, 953 (1981) (court refuses to give narrow reading to statute that would undermine the goal of candid commentary in peer review committee). But see Baxter County Newspapers, Inc., v. Medical Staff, 273 Ark. 511, 514, 622 S.W.2d 495, 496 (Ark. 1981) (county-owned hospital required to allow reporter to sit in on credentials committee hearing under Arkansas Freedom of Information Act even though committee reports were statutorily protected from discovery); American Mut. Liab. Ins. Co. v. Superior Court 38 Cal. App. 3d 579, 587, 113 Cal. Rptr. 561, 568 (1974) (information only nondiscoverable and not absolutely privileged could be waived by partial disclosure); Matviuw v.
consistently refused to apply the privilege to material that is available from
original or other unprivileged sources. Finally, peer review committee privi-
leges have survived challenges on constitutional equal protection grounds.

The Chandra court also considered the application of a peer review privi-
lege in areas outside the medical field. The court noted that a privilege for
such peer review committees has not been widely recognized.

Achieving the proper balance between a perceived need to protect com-
munications in a confidential relationship and a court’s interest in obtaining all
facts relevant to an issue is a difficult task. The Chandra court, had it believed
that policy considerations would support the creation of a privilege, in effect
had its hands tied by the absence of statutory guidance.

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Johnson, 70 Ill. App. 3d 481, 488, 388 N.E.2d 795, 799 (1979) (statutory peer review
protection not extended to defamatory remarks motivated by ill will or malice), aff’d,
111 Ill. App. 3d 629, 444 N.E.2d 606 (1982); Hood v. Phillips, 554 S.W.2d 160, 167
(Tex. 1977) (statute does not protect communications between patient and physician or
records of patients appearing in surgical journal).

66. See Lipschultz v. Superior Court, 128 Ariz. 16, 19, 623 P.2d 805, 808
(1981) (en banc) (evidence not privileged if it was not privileged before it came into
hands of peer review committee); Beth Israel Hosp. & Geriatric Center v. District
Court, 683 P.2d 343, 345 (Colo. 1984) (merely because patients’ records are used in
peer review proceedings does not bring them within the purview of statute); Eubanks v.
Ferrier, 245 Ga. 763, 767, 267 S.E.2d 230, 233 (1980) (plaintiff’s attorney should be
allowed to question committee doctors who had previously treated plaintiff’s deceased
husband) (also allowed to use committee members as expert witnesses but no hypothet-
ical question may include reference to membership on the committee); Jenkins v. Wu,
102 Ill. 2d 468, 1116, 468 N.E.2d 1162, 1168 (1984) (patients have full access to their
own records, can depose all persons involved in their treatment, and hire experts to give
their opinion as to the treatment the plaintiff received); Atkins v. Walker, 65 Ohio
App. 2d 136, 140, 416 N.E.2d 651, 654 (1979) (documents available from other
sources may not be barred simply by passing them through credentials committee);
Texarkana Memorial Hosp. v. Jones, 551 S.W.2d 33, 36 (Tex. 1977) (presentation in
hospital committee does not make it privileged if proved by means apart from the
record).

67. See Jenkins, 102 Ill. 2d at 468, 468 N.E.2d 1162, 1166-68 (no suspect clas-
sification, reasonable and not arbitrary difference bearing substantial relation to a
proper legislative purpose); Young v. Gersten, 56 Ohio Misc. 1, 381 N.E.2d 353,
355 (1978) (test is reasonableness according to attendant circumstances).

68. Chandra, 678 S.W.2d at 806; see Bergman v. Kemp, 97 F.R.D. 413, 416
(W.D. Mich. 1983) (self-examination privilege for FBI task force); Lloyd v. Cessna
Aircraft Co., 74 F.R.D. 518, 520 (E.D. Tenn. 1977) (plaintiff sought information from
executive committee designed to review, analyze, and evaluate operations for self-im-
provement); see also Flanagan, supra note 21, at 551 (rejecting a general privilege for
self-critical analysis).

69. In State ex rel. Husgen v. Stussie, 617 S.W.2d 414, 417 (Mo. App., E.D.
1981), the court, with regard to the court’s and the legislature’s relative roles in estab-
lishing a privilege stated:

[T]he physician-patient privilege embodies the legislature’s balancing of
societal interests of confidentiality in furthering full disclosure thereby facilitat-
ing treatment and interests served by disclosure of such information in
court. If a new balance is to be struck . . . this is the proper role for the
Contrary to the Chandra court’s finding, there are strong policy considerations favoring peer review which weigh heavily on the proper balance between privilege and discovery. Bredice v. Doctors Hospital70 best summarizes this statement of policy:

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 evaluations 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.71

The purpose of medical peer review is to improve the quality of medical care by collecting and comparing information.72 To be effective, peer review must be a critical process.73 Because members of peer review committees are required to be critical in their analyses, the possibility of disclosure in a medical malpractice suit creates two primary fears. First, peer review committee members may fear that suggestions for improvement or alternative treatment will be perceived by a jury as a denunciation of a colleague’s conduct.74 In some instances, the introduction of peer review committee reports into evidence may be a problem.75 However, if the reports are admitted or used for impeachment, committee members may be called upon to defend or explain statements made in the peer review committee deliberations. The proceedings of a peer review committee are primarily retrospective views reflecting opinions, not facts,76 and thus are not designed for use in judicial proceedings. Even if a peer review committee member were not called as a witness, he would still fear that a comment made in committee would tend to incriminate

legislature and not for this court. See also Sherman v. District Court, 637 P.2d 378, 384 (Colo. 1981) (en banc) (context of statutory interpretation is a different matter than judicial creation of a privilege in face of opposing policy choices). But see State ex rel. Cain v. Baker 540 S.W.2d 50, 54-56 (Mo. 1976) (en banc) (judicially extending attorney-client privilege to include insured’s statements to adjuster).

70. 50 F.R.D. 249 (D.C. Cir.), aff’d, 479 F.2d 920 (1970).
71. Id. at 250.
72. See K. Kaplan & J. Hopkins, supra note 17, at xii.
73. Flanagan, supra note 21 at 562 (hypercritical scrutiny prevents stagnation).
74. Bredice, 50 F.R.D. at 250.
75. In some cases the peer review reports may not be relevant to the plaintiff’s cause of action. See supra note 64. Moreover, since the JCAH requirements do not specifically outline how the records should be made or maintained, not all hospital records will qualify as business records in that they may not be made in the regular course of business. Unless some other exception to the hearsay rule is found, the reports will be inadmissible. See Hall, supra note 18, at 278.
76. Hall, supra note 18, at 279.
his colleague even where no fault has occurred.\textsuperscript{77}

Establishing negligence in a medical malpractice case requires more than an unsuccessful result. A physician who exercises his own best judgment will not be convicted of negligence as long as there is room for an honest difference of opinion among competent physicians.\textsuperscript{78} An honest opinion expressed at a peer review committee proceeding may be misunderstood when a plaintiff's attorney presents the record to the jury. It is clear that there exists a difference between a doctor's finding made in the spirit of improving health care\textsuperscript{79} and the degree of medical certainty required to establish negligence in a malpractice case.\textsuperscript{80} Given the different atmosphere of the educationally oriented peer review committee\textsuperscript{81} and the adversarial nature of a medical malpractice case, there is no reason to doubt that a committee member would fear the use of a comment or opinion in the context of a malpractice case.\textsuperscript{82}

The possibility of peer review disclosure also produces the fear of increased professional and social pressure.\textsuperscript{83} For example, co-workers may be pressured not to disclose a difference of opinion because to do so would reflect poorly on the profession in general.\textsuperscript{84} Moreover, discovery inhibits peer review in that subtle pressure to minimize or not report an untoward incident is placed on employees who provide information to peer review committees. This pressure increases with the availability of discovery in that the fear of reprisal for reporting something which might lead to liability for their employers is greater.\textsuperscript{85} Therefore, permitting disclosure of peer review studies in medical malpractice actions affects the objectivity and dedication of those who conduct the studies.\textsuperscript{86} Of course, the degree to which this chilling of objectivity and candor occurs depends in large part on the integrity of the medical profession and its interest in maintaining its good reputation.\textsuperscript{87}

\textsuperscript{77} Wesley, 234 Kan. at 32, 669 P.2d. at 223 (Schroeder, C.J., dissenting) (reality of human nature is to refrain from criticism of a colleague where it might be used in a future lawsuit).

\textsuperscript{78} Haase v. Garfinkel, 418 S.W.2d 108, 114 (Mo. 1967) (plaintiff must show that treatment was clearly against care recognized as correct by the profession); Snyder v. St. Louis S.F. Ry., 228 Mo. App. 626, 640, 72 S.W.2d 504, 512 (Spr. 1934) (mistaken diagnosis alone provides no basis for action); see also W. Prosser & W. Keeton, Prosser & Keeton on Torts § 32, at 186 (5th ed. 1984) (doctor not liable for an honest mistake).

\textsuperscript{79} See Hall, supra note 18, at 279-80.

\textsuperscript{80} See generally W. Prosser & W. Keeton, supra note 78, § 32, at 187 (doctor must have and use the knowledge, skill, and care ordinarily possessed and employed by a member of the profession in good standing).

\textsuperscript{81} See supra notes 72, 76.

\textsuperscript{82} See Bredice, 50 F.R.D. at 250.

\textsuperscript{83} Flanagan, supra note 21, at 559.

\textsuperscript{84} M. Millman, The Unkindest Cut, Life in the Backrooms of Medicine 117 (1978).

\textsuperscript{85} Note, supra note 38, at 1091-92.

\textsuperscript{86} Flanagan, supra note 21, at 559.

\textsuperscript{87} Wesley, 234 Kan. at 25, 669 P.2d at 219 (integrity of profession will main-
The Missouri legislature has recognized the need for enhancing the medical peer review system by providing immunity from liability for actions or recommendations made by members of peer review committees. By providing immunity, the legislature insures that members of a medical review committee can function without the fear of exposure to libel, slander, or related actions. Similar statutory immunity is granted to other professional peer review committees. In addition to providing immunity for members of certified public accountant (CPA) peer review committees, the legislature has provided a statutory discovery privilege. The express purpose of the privilege is to "assure a free flow of information." Like medical peer review, CPA peer review is required by state law.

Medical peer review systems are worthy of the same type of double protection (immunity and discovery) that is afforded to CPA peer review. As pointed out by the dissent in Chandra, the most common approach for determining whether a discovery privilege should be allowed is Wigmore's four-pronged test. First, the parties must agree that the communication should be confidential. Second, confidentiality must be a necessary ingredient to the maintenance of the agreement. Third, the confidential relation must be one that the community actively encourages. Fourth, the harm from disclosure

tain quality of peer review); see also K. KAPLAN & J. HOPKINS, supra note 17, at 41 (a few isolated people from any professional group can disrupt a quality assurance activity).

88. MO. REV. STAT. § 537.035; see also supra note 45. The similarity between the immunity granted by this statute and the privilege requested in Chandra is the desire to shield the peer review committee from external pressures. See generally Hall, supra note 18, at 255.

89. Hall, supra note 18, at 254-55.

90. MO. REV. STAT. § 326.134 (Supp. 1984) (certified public accountant peer review); MO. REV. STAT. § 331.045 (Supp. 1984) (chiropractor's immunity for participating in insurance peer review); id. § 335.031 (nursing board).

91. Id. § 326.134.1 (Supp. 1984).

1. In order to assure a free flow of information for peer review pursuant to section 326.055, or proceedings before the board pursuant to section 326.132, all complaint files, investigation files, and all other investigation reports and other investigative information in the possession of the board or peer review committee or firm, acting under the authority of section 326.055 or 326.132, or its employees or agents, which relate to such hearings or review shall be privileged and confidential and shall not be subject to discovery, subpoena, or other means of legal compulsion for their release to any person, other than the permit or certificate holder and the board or peer review committee or firm or their employees and agents involved in such proceedings, or be admissible in evidence in any judicial or administrative proceeding, other than the proceeding for which such material was prepared or assembled. A final written decision and finding of fact of the board, pursuant to section 326.132, shall be a public record.

Id.

92. Id.


94. 678 S.W.2d 804, 810 (Welliver, J., dissenting).
must outweigh the benefit to be gained by the party seeking the information.\textsuperscript{95}

An examination of these four principles reveals that the medical peer review process would qualify for such a privilege in Missouri. As to the first requirement, the state of affairs in Missouri prior to \textit{Chandra} was such that doctors participated in peer review proceedings with the understanding that communications made in the course of peer review proceedings would be confidential.\textsuperscript{96} Furthermore, state regulation of peer review proceedings provide for confidentiality.\textsuperscript{97} In all likelihood, these regulations contributed to a doctor's belief that communications were made in confidence. Thus, the first element of a qualified privilege is satisfied.\textsuperscript{98}

The requirement that confidentiality must be essential to the maintenance of the relationship encompasses the policy underlying the privilege. As discussed above, permitting discovery will create a direct chilling effect on the peer review system and its individual members. This effect operates to discourage the analyst from investigating thoroughly and frankly.\textsuperscript{99} Moreover, "common sense suggests that opening up the peer review process to the multitude of malpractice victims will indirectly, if not directly, affect the manner in which medical personnel criticize or evaluate their colleagues."\textsuperscript{100}

The third requirement—that the confidential process or relation be one that the community actively encourages—is clearly met. The sheer number of private rules and state and federal regulations indicates that the community

\textsuperscript{95} 8 J. Wigmore, \textit{supra} note 39, § 2285, at 527-28; see also Wesley, 234 Kan. at 29-30, 669 P.2d at 221-22 (Schroeder, C.J., dissenting) (endorsing Wigmore four-pronged test).

\textsuperscript{96} No cases have directly dealt with the issue of peer review discovery in Missouri prior to \textit{Chandra}. It is therefore assumed that plaintiffs did not press the issue of discovery and doctors did not worry about the possibility of disclosure by legal compulsion.

\textsuperscript{97} See, e.g., 13 MO. ADMIN. CODE 50-20.021(2)(c)(9) (1982). This portion of the Administrative Code provides that "written minutes shall be signed and permanently filed on a confidential basis in the hospital." \textit{Id}. The regulations fail to establish a privilege in and of themselves because they do not speak to the discovery question. Furthermore, it is unclear whether the confidentiality applies exclusively to the medical staff meetings required under 13 MO. ADMIN. CODE 50-20.021(2)(c)(8) which provides that: "The organized medical staff shall meet at least once each six (6) months. A mechanism shall be established for monthly decision-making by or on behalf of the medical staff," or includes the peer review requirement found in 13 MO. ADMIN. CODE 50-20.021(2)(c)(10) which states:

The medical staff as a body or through committee shall review and evaluate the quality of clinical practice of the staff throughout the hospital at least once each quarter. Such review and evaluation shall include selected deaths, unimproved cases, tissue, infections, complications, errors in diagnosis, and results of treatment.

\textsuperscript{98} See Wesley, 234 Kan. at 30, 669 P.2d at 222 (Schroeder, C.J., dissenting); \textit{Chandra}, 678 S.W.2d at 811 (Welliver, J., dissenting).

\textsuperscript{99} Note, \textit{supra} note 38, at 1092.

\textsuperscript{100} \textit{Chandra}, 678 S.W.2d at 811 (Welliver J., dissenting).
actively encourages the peer review system. Medical peer review committees serve essentially the same purpose as licensure laws and regulation: maintaining and improving the quality of health care. Thus, peer review is a useful tool in improving health care and is fostered by the medical community represented by the JCAH as well as the general community.

Finally, the condition that the harm from disclosure be greater than the benefit thereby gained necessarily requires a balancing of interests test. In support of discovery is the idea that only in special circumstances should an impediment to obtaining the truth in a judicial proceeding be allowed. The Chandra court found that future patients and patients presently being treated are to benefit from peer review and, therefore, the public interest lies in discoverability. Discovery in this light would improve health care. Since doctors are aware that their comments will be scrutinized by plaintiff’s attorneys, they will be anxious to review each situation carefully.

Aligned against a plaintiff’s right to discover relevant information are a number of policy considerations and practical problems. First and most important is the notion that to be effective, peer review must be afforded confidentiality. While it is true that peer review is designed to serve present and future patients, it can serve neither if peer review committee members are so intimidated by the prospect of malpractice actions that they are not objective or candid. The second policy consideration stems from the very fact that peer review committee proceedings originate in confidence. Private regulation and state law mandate that peer review be conducted in a confidential manner. Simple fairness suggests that a communication made between parties, with the requirement and understanding that it is confidential to their relation, should not be breached by an outside party. In the absence of statutory protection, members of peer review committees are subjected to a “Catch 22” requirement—namely that they maintain confidentiality and at the same time anticipate that they may have to give testimony or produce subpoenaed records.

The third factor which weighs in favor of a discovery privilege is the lack of harm that a limited privilege would cause a plaintiff’s case. Allowing a

101. See supra notes 32-37 and accompanying text.

102. Peer review committees work to maintain high standards of health care. Arguably, because peer review committees monitor institutional clinical care on a day-to-day basis they are more effective than state licensure boards. Hall, supra note 18, at 247.

103. See supra note 5 and accompanying text.

104. Chandra, 678 S.W.2d at 807.

105. Id. at 811 (Welliver, J., dissenting) (lawyers will constantly scour the records).

106. Gillman, 53 F.R.D. at 318 (comment will more easily flow if it is known to be privileged); Bredice, 50 F.R.D. at 250 (confidentiality is essential to effective peer review); see also supra notes 70-86 and accompanying text.

107. 13 Mo. ADMIN. CODE 50.20.021(2)(c)(9) (1982) (see supra note 97 for text); see also JCAH, supra note 27, at 193.

108. Chandra, 678 S.W.2d at 811, (Welliver, J., dissenting) (denying access to
privilege would not lead to immediate summary judgment for the defendant. The plaintiff will still have access to his own medical records as well as any other relevant business records. Persons with firsthand knowledge of an incident could be compelled to testify. Finally, the malpractice victim can hire his own expert witness to evaluate and give his opinion of the disclosed facts.¹⁰⁹

A related practical problem is the possibility that plaintiffs may use the peer review committee member as an unwilling witness. A plaintiff should be required to build his own case and should be prohibited from taking advantage of the opinions contained in a peer review committee report.¹¹⁰ The foregoing factors serve to satisfy the fourth prong of Wigmore's test by showing that the policy of protecting peer review outweighs the policy in favor of discovery.

To recap, it is clear that medical peer review meets the Wigmore four-pronged test. Peer review conferences originate with the understanding that confidentiality will be maintained. Confidentiality is necessary to the maintenance of the peer review system which has widely recognized social value. Finally, the harm from disclosing peer review committee reports outweighs the plaintiff's minimal loss.

The Missouri legislature should consider the strong policies in favor of peer review and provide a statutory privilege.¹¹¹ Forty-five states have some

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¹⁰⁹ See Jenkins, 102 Ill. 2d at __, 468 N.E.2d. at 1168 (patients have full access to their own records, can depose all persons involved in their treatment, and hire experts to give their opinion as to the treatment the plaintiff received).

¹¹⁰ See Flanagan, supra note 21, at 576; see also Chandra, 678 S.W.2d at 811 (Welliver J. dissenting) (litigant can obtain his own witness).


4. Except as otherwise provided in this section, the proceedings, findings, deliberations, reports, and minutes of peer review committees concerning the health care provided any patient are privileged and shall not be subject to discovery, subpoena, or other means of legal compulsion for their release to any person or entity or be admissible into evidence in any judicial or administrative action for failure to provide appropriate care. Except as otherwise provided in this section, no person who was in attendance at any peer review committee proceeding shall be permitted or required to disclose any information acquired in connection with or in the course of such proceeding, or to disclose any opinion, recommendation, or evaluation of the committee or board, or any member thereof; provided, however, that information otherwise discoverable or admissible from original sources is not to be construed as immune from discovery or use in any proceeding merely because it was presented during proceedings before a peer review committee nor is a mem-
degree of statutory limitation on the discovery, evidentiary use, or disclosure of peer review committee reports. \textsuperscript{112} The statutes provide various methods and degrees of protection, but a number of definable trends are present. The vast majority of states provide that all the proceedings, records, reports, events and testimony of peer review committees are privileged and not subject to disclosure, discovery, or admittance into evidence. \textsuperscript{113}

Of the states that provide statutory privilege, two have limited the privilege by allowing discovery in extraordinary circumstances where a party shows good cause. \textsuperscript{114} Other states have taken different approaches to limiting the privilege. For instance, in an action where the subject matter is the care and treatment of a party, one state allows discovery for impeachment purposes.


\textsuperscript{113} W. VA. CODE § 30-3C-3 (Supp. 1984) provides a typical example.

\textsuperscript{114} See Neb. Rev. Stat. § 71-2408 (1981); Va. Code § 8.01-581.17 (1984); see also Ind. Code Ann. § 16-4-3-1 (Burns 1983) (requiring that the proponent of disclosure show the materiality and relevancy of the documents requested).
only, provided the defendants receive thirty days notice.115 Another limitation is achieved by statutes that make the reports publicly available but eliminate any means of direct or indirect identification of patients and health care providers.116 One state does not expressly grant nondiscovery status to peer review committee reports but provides that the information must be used solely for the improvement of health care.117 Finally, some statutes simply state that the records shall be confidential.118 By contrast, the majority of statutes allow discovery in actions by physicians who have lost or been denied their staff positions.119

Perhaps the most important provision commonly found in statutes which provide a peer review privilege is the distinction between matters otherwise discoverable, which are not protected, and those which are purely the product of the peer review committee.120 The statutes provide that material otherwise discoverable is not privileged simply because it passed through the committee. Thus, a potential witness could not clothe his personal knowledge of a matter with a prohibition against disclosure merely by reciting his knowledge in a peer review proceeding. Conversely, a matter learned only because the person was a member of a peer review committee is not subject to discovery.121

Similar distinctions can be drawn in two additional ways. First, a distinction may be made between facts contained in a peer review committee report and the opinions and conclusions drawn from those facts. This distinction was made in Gillman v. United States,122 one of the few cases to create a privilege judicially. In Gillman, the plaintiff sought a report that contained a review of circumstances surrounding a patient's suicide. The report consisted of factual testimony as to how the incident occurred and opinion testimony relating to improvement of hospital procedure.123 Relying on Bredice, the Gillman court held that factual statements relating to the occurrence and made by hospital personnel were discoverable. However, doctoral conclusions and recommendations relating to future procedures were deemed privileged.124 The court further distinguished mere conclusions and factual statements taken shortly after an occurrence. The latter are unique and can never be duplicated, whereas the former are the product of deliberation.125 Likewise, in Tucson Medical Center v. Misevch,126 the court drew a line between factual investigative matters,

120. Id.
121. Id.
123. Id. at 318.
124. Id. at 319.
125. Id.
126. 113 Ariz. 34, 545 P.2d 958 (1976).
which are discoverable, and materials that are the product of reflective consider-
eration or a policy-making process, which are not discoverable.127

The difference between "ad hoc" reports and periodic review by standing
committees provides the third fact-opinion distinction. An ad hoc, or incident,
report is developed to shed light on the cause of an untoward happening in the
hospital and to help prevent its recurrence.128 To the extent that it generally
focuses on a single occurrence as opposed to a review of numerous case histo-
ries, the ad hoc report differs from regular, periodic peer review. At least as to
the patient-plaintiff, who is the subject of the ad hoc report, there is a greater
argument for allowing discovery. This type report would contain information
clearly relevant to the manner in which the plaintiff was injured.129 Like the
reports sought in Gillman, these reports contain purely factual material not
obtainable from other sources.130

The Chandra court failed to delineate expressly between factual and de-
liberative matter contained within peer review committee reports. Nor did it
consider the difference between ad hoc and regular peer review committee re-
ports. However, the court's holding did suggest that the difference should be
observed. The court held that no peer review privilege exists for factual state-
ments.131 To the extent that trial judges read the Chandra opinion to hold that
factual statements are discoverable and opinion matters are privileged, a dis-
tinction between the two types of reports may be made in practice.132

127. Id. at 37, 545 P.2d at 961.
128. Hall, supra note 18, at 267-68.
129. R. Morrisey, Risk Management For Hospitals & Health Care Insti-
tutions 58-64 (1979).
130. Gillman, 53 F.R.D. at 319 (factual portions of incident report
discernable).
131. Chandra, 678 S.W.2d at 808.
132. The Chandra court did note that their holding would not prohibit a trial
court from granting an appropriate protective order. Id. at 807-08. Mo. R. Civ. P.
56.01(c) provides:
Upon motion by a party or by the person from whom discovery is sought,
and for good cause shown, the court may make any order which justice re-
quires to protect a party or person from annoyance, embarrassment, oppres-
sion, or undue burden or expense, including one or more of the following:
(1) that the discovery not be had;
(2) that the discovery may be had only on specified terms and conditions,
including a designation of the time or place;
(3) that the discovery may be had only by a method of discovery other than
that selected by the party seeking discovery;
(4) that certain matters not be inquired into, or that the scope of the disco-
very be limited to certain matters;
(5) that discovery be conducted with no one present except persons designated
by the court;
(6) that a deposition after being sealed be opened only by order of the court;
(7) that a trade secret or other confidential research, development, or com-
mercial information not be disclosed or be disclosed only in a designated way;
(8) that the parties simultaneously file specified documents or information en-
The Missouri legislature should consider these distinctions in drafting a statute.133 By making the distinction between those matters originating in peer review and those which are otherwise discoverable,134 a greater balance between the interests of the plaintiff and the interest of enhancing peer review is achieved. The same may be said for the distinction between the facts contained in the peer review reports and the opinions and conclusions drawn from them. By allowing plaintiffs to discover factual matter, even though it is presented at peer review committee meetings, there is less chance that the peer review system will be abused. Furthermore, a privilege, because it withholds certain truths and therefore hinders the proper adjudication of an action, should be circumspect.135 The statutory privilege should not prevent the discovery of any more data than is necessary to protect the peer review function. A statute properly limited would not prevent a plaintiff from making his case on the basis of factual material available. Thus, surveys, eyewitness reports, the patient’s records, and other factual material should not be privileged.136

Conversely, peer review committee reports which are not factual should not be available to make the plaintiff’s case. The portions of the report which contain only opinion, conclusion, or other information of a deliberative nature should not be discoverable. A plaintiff should not be allowed to treat peer review participants as unwilling experts in lieu of hiring his own witnesses.137 Trial judges would be called upon to determine which matters are opinion and which are factual. An alternative or additional limitation is to provide a privilege for discovery but allow an exception, similar to the work product rule,138 for good cause in extraordinary cases. Hence, a plaintiff who could not otherwise state a case, or survive a directed verdict, might obtain the peer review

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133. This recommendation is in line with the apparent intent of the Chandra court in that it makes the fact-opinion distinction that the court implied. The court held that under Missouri law no factual privilege exists for factual statements. See Chandra, 678 S.W.2d at 813.
134. See, e.g., W. VA. CODE § 30-3C-3 (Supp. 1984).
135. See supra note 5 and accompanying text.
136. See supra notes 108-09 and accompanying text.
137. See supra note 110 and accompanying text.
138. C. WRIGHT, THE LAW OF FEDERAL COURTS § 82, at 553 (4th ed. 1983). The work product rule provides a limited privilege for material prepared by the attorney. It is limited in that, by making a showing of necessity and good cause, an adversary may discover the material.
reports.

In conclusion, it is clear that the consternation caused by the Chandra decision would be best alleviated by a statutory discovery privilege. Tension between the medical and legal professions is already at an uncomfortable level. Increased apprehension of malpractice in an already shell-shocked profession will not lessen the tension. Allowing each question of discoverability of peer review committee reports to be made at the trial court level furthers that apprehension in that hospitals have no real guidelines in preparing the reports. A carefully drawn statutory privilege would provide a measure of predictability to hospital administrators and members of peer review committees. Guidelines would allow the hospital to concentrate on improving health care through the medium of peer review without worrying about how to play "hide the ball" with committee reports. Members of peer review committees would operate with the knowledge that their opinions will not be used improperly.

Properly limited, a discovery privilege would not prevent a plaintiff from winning a lawsuit against a hospital or doctor. A plaintiff would still have access to his own charts and records and to the testimony of any person who provided or had other firsthand knowledge of the treatment. A plaintiff would also have the opportunity to hire an expert to examine and evaluate the quality of care the plaintiff received. In the event that no information other than peer review records are available, a statutory scheme might provide for discovery after a showing of necessity.

To reiterate, the policy behind providing a statutory privilege for peer review is compelling. Peer review is a vital function in improving health care. The peer review conference is conducted in the spirit of education and improvement. Critical conclusions and opinions stated at the committee meeting must be made with objectivity and candor to be effective. Allowing discovery of the entire peer review proceedings inhibits that objectivity and replaces it


140. Case-by-case determination has a deleterious effect because each ruling leaves the parties uncertain as to what protection is afforded. This criticism has also been leveled at the exception to statutory privilege which allows discovery in extraordinary circumstances. See Note, supra note 38, at 1098-99.

141. Chandra will change the way that hospitals conduct their internal investigations. See The Springfield (Mo.) News-Leader, Feb. 10, 1985, at 3B, col. 5 (statements of Dave Tapp and Jerry Sill).

142. One such instance might occur where a plaintiff is suing a hospital on a negligent hiring cause of action. Absent the peer review report on a doctor's competency it may be difficult to prove knowledge on the part of the hospital. See generally Holbrook & Dunn, supra note 18.
with apprehension of malpractice litigation. The *Chandra* court indicated that opinion material should not be discoverable. Therefore, enactment of a statutory privilege would serve to codify and refine the court’s suggested approach. Consequently, legislative action appears to be the preferable solution to resolving the scope of peer review discoverability recognized in *Chandra*.

PETER F. DANIEL