IN THE UNITED STATES DISTRICT COURT
FOR THE DISTRICT OF COLORADO

Civil Action No. 03-D-0488 (BNB)

BRENDA ATTEBERRY,

Plaintiff

v.

LONGMONT UNITED HOSPITAL,
a Colorado nonprofit corporation; and
JOHN D. LEONARD, M.D.

Defendants

AMICUS CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE COLORADO MEDICAL SOCIETY IN SUPPORT OF MAINTAINING THE CONFIDENTIAL AND PRIVILEGED NATURE OF PEER REVIEW AND HOSPITAL QUALITY MANAGEMENT INFORMATION

The American Medical Association and the Colorado Medical Society, through counsel, Montgomery Little & McGrew, P.C. submit the following amicus curiae brief discussing the reasons why the Court should recognize the privileged and confidential nature of peer review and quality assurance records.

STATEMENTS OF INTEREST

I. American Medical Association

The AMA, an Illinois not-for-profit corporation, has approximately 250,000 members and is the largest professional association of physicians and medical students in the United States. AMA members practice in every state, including Colorado, and in every medical specialty. The objectives of the AMA are to promote the science and art of medicine and the betterment of public health.[1]

AMA policies are determined by majority vote of representatives of the principal medical associations in the United States. Thus, those policies represent the consensus viewpoint of the overwhelming majority of America's physicians. The AMA files this brief because of the importance it attaches to the confidentiality of physician peer review.

The AMA believes that the process of peer review, in the hospital setting and elsewhere, serves many important purposes, including a free exchange of dialogue that ultimately allows physicians to provide the best care to their patients. This free exchange is fostered when the peer review process is conducted with a view toward improving patient care, rather than fixing legal blame for past conduct. For that reason, AMA policy opposes disclosure of peer review records in legal actions. If physicians believe that peer review will be used to determine legal liability, the openness and candor needed for effective peer review will be degraded. In the long run, discovery of peer review records

[1] The AMA appears in this brief on its own behalf as a corporate entity and also as a representative of the Litigation Center of the American Medical Association and the State Medical Societies. The Litigation Center is an unincorporated association of the AMA and the medical societies of each state, plus the District of Columbia. It was formed to represent the viewpoint of organized medicine in the courts, consistent with AMA policies. Among other activities, the Litigation Center files *amicus curiae* briefs in cases of national importance to the medical profession.

will not appreciably improve the administration of justice, but it will harm the quality of institutional health care.

II. Colorado Medical Society

CMS is a not-for-profit organization whose membership includes the majority of the physicians practicing in Colorado. CMS and its constituents believe that any ruling that abrogates Colorado's statutory peer review and quality management privileges threatens the continued viability of effective peer review and will reduce the quality of health care offered by physicians. Rather than serving as arbiters in a legal process, Colorado physicians voluntarily participate in peer review and quality management processes to help improve the quality of patient care.

The willingness of physicians to continue to participate depends, in large part, upon the courts' continuing recognition that peer review and quality management processes serve educational purposes and operate as a constructive forum for achieving quality. The Colorado General Assembly enacted Colorado's peer review and quality management privileges to ensure that these processes have a quality, rather than punitive, focus. If peer review and quality management materials are discoverable in federal malpractice proceedings, the statutes lose their effectiveness in encouraging physicians to engage in peer review as a means of improving care and patient safety.

STATEMENT OF ISSUES

1. Whether the Magistrate Judge erred in determining that he should not recognize Colorado's peer review or quality management privileges under Federal Rule of Evidence 501?

2. Whether the Magistrate Judge erred in disregarded the Health Care Quality Improvement Act's express language recognizing state law incentives that foster peer review.

3. Whether the Magistrate Judge erred in determining that the federal common law of privilege, rather than state statutory privileges, applies to discovery requests that are primarily relevant to pendent state law tort claims and hope to generate little, if any, evidence relevant to a federal claims?

FACTUAL BACKGROUND

I. Events Giving Rise to Suit

On April 28, 2001, 24-year-old Scott Atteberry was severely injured in a motorcycle accident and transported to Longmont United Hospital, where he was seen by John Leonard, M.D. Mr. Atteberry died several hours later from injuries he suffered in the accident.

Ms. Atteberry, the decedent's mother, filed suit against both the Hospital and Dr. Leonard. The only claim against the Hospital was that it violated the federal Emergency Medical Treatment and Active Labor Act (EMTALA) by improperly attempting to transfer Mr. Atteberry to another facility. Ms. Atteberry advances two Colorado common

law tort claims against Dr. Leonard: (1) that he negligent cared for Mr. Atteberry and failed to treat the injuries that caused his death; and (2) that he negligently misrepresented the nature and extent of Mr. Atteberry's injuries. Ms. Atteberry made no claims arising under federal law against Dr. Leonard. The EMTALA claims against the Hospital are within the Court's federal question jurisdiction under 28 U.S.C. §1331, and the Court exercised supplemental jurisdiction over the Colorado common law claims against Dr. Leonard under 28 U.S.C. §1367.

II. Ms. Atteberry Requested Peer Review and Quality Management Records

Ms. Atteberry served Longmont United Hospital with discovery requests seeking records related not only to Dr. Leonard's care of Mr. Atteberry, but also about Dr. Leonard's care of other patients, including specific requests for:

> Any reports, files or reviews that refer or relate to Scott Atteberry's care on April 28, 2001, including, but not limited to <u>any quality assurance reports, peer review reports and morbidity/mortality reports</u>.
>
> Any and all reports relating to Dr. Leonard, including, but not limited to <u>credentialing files, peer review files, quality assurance reports, morbidity/mortality reports, hospital privileges, and any reports relating to the deaths of patients under his care</u>.

(emphasis added)

III. Statutory Basis for the Peer Review and Quality Management Privileges

Longmont United Hospital objected to these discovery requests because they sought information that is privileged pursuant to the Colorado Peer Review Act C.R.S. §12-36.5-101, *et. seq*. and the quality management privilege contained at C.R.S. §25-3-109.[2] To understand the Hospital's objections, the Court must appreciate the activities that Colorado physicians conduct as peer review and in furtherance of quality management.

Peer review is the process by which physicians review each other's qualifications and performance of their professional duties. Frederick Y. Yu, *The Committee on Anticompetitive Conduct: New Agency on the Block,* Vol. 21 *Colorado Lawyer* 31 (January 1992). The Colorado General Assembly recognizes that peer review serves an important purpose in protecting the health and safety of patients who seek care at hospitals and other health care facilities. Accordingly, it passed the Colorado Professional Review Act, which applies to the committees that review and evaluate physicians' professional conduct and patient care. *C.R.S. §12-36.5-102(3); C.R.S. §12-36.5-103(3)(b).* In enacting the Colorado Professional Review Act, the Colorado General Assembly's stated goals were to encourage physicians to engage in peer review and to provide immunity to the physicians that provide their services so that they may "exercise their professional knowledge" and judgment without undue fear of litigation. *C.R.S. §12-36.5-103(2); C.R.S. §12-36.5-103(3)(b).*

---

[2] The Hospital also objected to these discovery reeests on the grounds that the the requested documents were subject to the attorney-client and attorney work product privileges. The Hospital did not pursue these objections. The AMA and CMS will not address whether any of the discovery requests potentially invaded the attorney-client privilege or sought attorney work product.

To further encourage physicians to engage in peer review and to ensure that peer review does not simply become a weapon for parties litigating civil claims, the Colorado General Assembly specifically enacted a privilege to ensure that peer review records would not be discoverable:

> The records of a professional review committee, a governing board, or the committee on anticompetitive conduct shall not be subject to subpoena or discovery and shall not be admissible in any civil suit brought against a physician who is the subject of such records.

C.R.S. §12-36.5-104(10). In fact, the General Assembly so strongly believed that Colorado physicians needed the ability to freely share their views during peer review that it specifically exempted "investigations, examinations, hearings, meetings, or other proceedings" from any law that might otherwise require that the proceedings be held publicly or allow for public inspection of peer review records. *C.R.S. §12-36.5-104(12).*

The quality management privilege serves purposes very similar to the peer review privilege. The Colorado General Assembly found that quality assurance and risk management activities "improve patient and resident care" and are "essential to the operation of health care facilities." *C.R.S. §25-3-109(1); C.R.S. §25-3-109(2).* For this reason, the General Assembly created a series of statutory protections to ensure that the "collection of information and data by such licensed or certified health care facilities be reasonably unfettered so a complete and thorough evaluation and improvement of the quality of patient and resident care can be accomplished." *C.R.S. §25-3-109(1).*

The quality management privilege extends as broadly as the peer review privilege in an effort to encourage physicians and other medical personnel to engage in activities that ultimately improve patient care:

> [A]ny records, reports, or other information of a licensed or certified health care facility that are part of a quality management program designed to identify, evaluate, and reduce the risk of patient or resident injury associated with care or to improve the quality of patient care shall be confidential information. . . .

C.R.S. §25-3-109(3).

> The records, reports, and other information described . . . shall not be subject to subpoena or discoverable or admissible as evidence in any civil or administrative proceeding. No person who participates in the reporting, collection, evaluation, or use of such quality management information with regard to a specific circumstance shall testify thereon in any civil or administrative proceeding.

C.R.S. §25-3-109(4).

Despite the existence of these broad privileges and the recognized public interest in maintaining the confidentiality of both peer review and quality management functions, Ms. Atteberry moved to compel the production of records that were clearly privileged under Colorado law.

IV. Judge Boland's Order Compelling Discovery

On June 15, 2004, United States Magistrate Judge Boland granted Plaintiff's Motion to Compel and ordered the Hospital to produce any peer review and quality management records in its possession. Judge Boland's Order essentially ordered the Hospital to produce the records for three reasons: (1) he determined that Federal Rule of Evidence 501 governs evidentiary questions in federal court and gives him discretion as to whether he should recognize any privileges available to the Hospital and Dr. Lenoard

under Colorado law; (2) he determined that he should not exercise his discretion to recognize Colorado's peer review and quality management privileges as a matter of comity because Congress declined to create a federal peer review privilege when it enacted HCQIA; and (3) he determined that the discovery requests sought information that was discoverable under *Fed R.Civ. P. 26(b).* For the reasons that the AMA and CMS discuss below, the Court should overturn Judge Boland's Order and recognize Colorado's peer review and quality management privileges in light of current legal authority and important state and federal interests served by effective peer review.

ARGUMENT

I. The Court Should Recognize Peer Review and Quality Management Privileges Because of the Public Interest in Quality Medical Care

Judge Boland's Order stems from his conclusion that federal courts recognize evidentiary privileges only as permitted under Federal Rule of Evidence 501. *Fed. R. Evid. 501* states:

> [T]he privilege of a witness . . . shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience.

Consequently, federal courts generally look to federal common law when asked to determine whether a particular record is privileged.

While generally requiring courts to determine privileges under federal common law, *Fed. R. Evid. 501* also recognizes the importance of upholding privileges arising under state law whenever a party's liability might be determined under state law. The second sentence of *Fed. R. Evid. 501* states:

> However, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness. . . shall be determined in accordance with State law.

Although *Fed. R. Evid. 501* could have been drafted to allow courts to determine privileges without any regard to state law, the drafters instead required the federal courts to recognize state law privileges whenever state law would govern a party's substantive liability.

The question that the plain language of *Fed. R. Evid. 501* leaves unanswered is whether the federal courts should apply state law privileges when a single lawsuit presents claims arising under both federal and state law. Judge Boland, as well as other federal courts, determined that federal courts faced with this question should apply the federal law of privilege. *Hancock v. Hobbs*, 967 F.2d 462, 467 (11th Cir. 1992).

Certainly, Judge Boland did not err when he considered the Hospital's privilege claims in light of federal common law, but his analysis should have been guided by the Advisory Committee's comments that guide courts in the application of *Fed. R. Evid. 501*, which include:

> [F]ederal law should not supersede that of the States in substantive areas such as privilege absent a compelling reason. . . [The provision of Rule 501] under which the federal courts are bound to apply the State's privilege law in actions founded upon a State-created right or defense, removes the incentive to [forum] "shop."

(emphasis added). From this language, the Court can determine that the Advisory Committee was concerned about the potential that federal courts could create incentives for forum shopping by failing to recognize privileges available under state law, which counsels in favor of recognizing those privileges absent some compelling reason.

With this background knowledge of how the Advisory Committee intended federal courts to apply *Fed. R. Evid. 501,* and understanding the important purposes that Colorado's peer review and quality management privileges serve, the Court should join the federal courts that have recognized federal common law peer review and quality management privileges.[3] These well-reasoned cases each recognize that maintaining the confidentiality of the peer review and quality management process serves a compelling federal interest in promoting measures that allow patients to enjoy a high standard of medical care.

The leading case recognizing the privileges that prevent discovery of peer review and quality management documents is *Bredice v. Doctors Hospital, Inc*., 50 F.R.D. 249, 250-51 (D.D.C. 1970), *aff'd., Bredice v. Doctors Hospital, Inc*., 51 F.R.D. 187 (D.D.C. 1970). In *Bredice*, a plaintiff filed a motion to compel the production of peer review and quality management records in a medical malpractice suit, but the United States District Court for the District of Columbia refused the request and denied the motion to compel. In doing so, the court reasoned that a compelling public interest justified limiting discovery. *Bredice*, 50 F.R.D. at 250.

To explain why maintaining the confidentiality of peer review and quality assurance serves a compelling public interest, the court explained:

> 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

[3] The cases discussed in the following paragraphs recognize privileges based upon the application of federal common law. There is no discussion in these cases that the federal courts recognized privileges under *Fed. R. Evid. 501* merely because only state law claims were asserted in diversity cases.

> 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.

Bredice, 50 F.R.D. at 250 (emphasis in original). The court then explained why allowing discovery of these peer review materials would adversely affect the availability of quality health care:

> The purpose of these 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 . . . is undeniable. This value would be destroyed if the meetings and the names of those participating were to be opened to the discovery process.

Bredice, 50 F.R.D. at 250. Weighing the potential value of the discovery to the plaintiff against the injury that discovery would cause to the peer review process, the court ultimately concluded that discovery should not be had:

> As doctors have a responsibility for life and death decisions, the most up-to-date information and techniques must be available to them. <u>There is an overwhelming public interest in having those staff meetings held on a confidential basis so that the flow of ideas and advice can continue unimpeded.</u> Absent evidence of extraordinary circumstances, there is no good cause shown requiring disclosure of the minutes of these meetings. Further, what someone at a subsequent date thought of these acts or omissions is not relevant to the case.

Bredice, 50 F.R.D. at 250 (emphasis added, internal quotations omitted, and internal citations omitted).

More recently, the United States District Court for the District of New Mexico cited *Bredice* as "the seminal federal case recognizing the self-critical or self-evaluative privilege in the context of a hospital peer review conference on the care and treatment of patients." *Weekoty v. United States*, 30 F. Supp. 2d 1343, 1345 (D.N.M. 1998). Applying *Fed. R. Evid. 501*, the court then recognized that it had "the flexibility to develop rules of privilege on a case-by-case basis" and reasoned that it should recognize a self-critical analysis privilege "in the medical context as it promotes frank and honest discussions which protect lives and improve patient care." *Weekoty*, 30 F. Supp. 2d at 1345.

In analyzing whether a compelling public interest justified protecting medical peer review information from disclosure, the court compared the values served by effective peer review with the values served by other evidentiary privileges and found that a peer review privilege serves a greater public benefit;

> [T]he public interest served by protecting medical peer review conferences from disclosure is perhaps greater than that served by the individual based spousal, attorney-client, and psychotherapist-patient privileges. A single conference in this context promotes knowledge and understanding among numerous physicians about life saving techniques and potentially life threatening decisions. Thus, the public good is multiplied far beyond an individual patient's care, as the information promotes more effective patient care throughout a hospital.

Weekoty, 30 F. Supp. 2d at 1346 (emphasis added and internal citations omitted). Failing to treat these meetings as privileged and confidential will destroy this public good

because "the mere possibility of disclosure would undermine this necessarily open and unconstrained self-examination." *Weekoty,* 30 F. Supp. 2d at 1346.[4]

In contrast to the authorities recognizing the importance of maintaining the confidentiality of the peer review and quality management processes when the plaintiff brings claims questioning the adequacy of the medical care provided to a particular patient, Ms. Atteberry relies heavily on authorities declining to recognize peer review privilege in cases involving federal civil rights and antitrust claims. *See e.g. Memorial Hospital for McHenry County v. Shaddur*, 664 F.2d 1058, 1061 (7th Cir. 1981) (antitrust); *LeMasters v. Christ Hospital*, 791 F.Supp. 188, 191 (S.D. Ohio 1991) (gender discrimination); *Virmani v. Novant Health, Inc.*, 259 F.3d 284, 293 (4th Cir. 2001) (racial discrimination). These cases do not apply here because they all stemmed from situations where a party was using the peer review process for an improper purpose.

When a party departs from the proper purpose of peer review, which is to retrospectively evaluate past patient care, and uses it as a means of inflicting prospective harm upon other physicians for reasons motivated by greed or rooted in discrimination, the peer review serves no beneficial public purpose and is not worthy of any protection. For this reason, Colorado law specifically allows physicians to seek discovery of peer review materials when they present claims before Colorado's Committee on Anticompetitive Conduct. *C.R.S. §12-36.5-104(10)(b)(I).* No evidence in this case, other

[4] Another federal court commented that "the principles enunciated in *Bredice* in 1970 are still viable today and indeed there may be even greater reason to preclude such discovery in view of the recent amendments to the Federal Rules of Civil Procedure, effective August 1, 1983, to curtail discovery abuse and to limit discovery to what is necessary to develop the facts which will support a litigant's claim." *Mewborn v. Heckler*, 101 F.R.D. 691, 692-694 (D.D.C. 1984). For these reason, may courts have not hesitated to enforce state peer review and quality management privileges in medical malpractice cases. *See e.g. Spinks v. Children's Hospital National Medical Center*, 124 F.R.D. 9, 12 (D.D.C. 1989); *Balk v. Dunlap*, 163 F.R.D. 360, 363 (D. Kan. 1995); *Gilman v. United States*, 53 F.R.D. 316, 318-19 (S.D.N.Y. 1971).

than sheer speculation, would suggest that the Hospital's peer review was anything other than a retrospective analysis for Dr. Leonard's care and treatment of Mr. Atteberry for legitimate medical purposes.

Ms. Atteberry cites only two cases seeking discovery of peer review materials for reasons related to the underlying medical care in medical malpractice claims. In *Burrows v. Redbud Comm. Hosp. Dist*., 187 F.R.D. 606 (N.D. Cal. 1998), a plaintiff sought discovery of peer review materials in a case arising from an infant's death after a transfer that allegedly violated EMTALA, but the order compelling discovery was grounded upon the fact that a physician was instructed during peer review to alter and destroy medical records related to the transfer. Presumably because the physician's misconduct created unique circumstances and the court did not wish to vitiate peer review processes without good reason, the *Burrow* decision was not published and is not considered precedential. *Rule 36-3 of the 9th Circuit Court of Appeals*. The remaining case that Ms. Atteberry cites involved an incident report prepared by an ambulance driver, not a document that was generated during a deliberative peer review or quality assurance process, and provides little guidance in determining whether the Hospital's peer review and quality management files should be discoverable. *Smith v. Botsford General Hospital*, No. 00-71549 (E.D.Mich. 2000).

Finally, if the Court has any doubt about whether it should recognize peer review and quality management privileges, it may examine state law and the policies served by state law privileges. *W.T. Thompson Co. v. General Nutrition Corp*., 671 F.2d 100, 103 (3rd Cir. 1982). Legislatures in every state have codified privileges protecting the

confidentiality of peer review.[5] If the Court refuses to recognize a privilege consistent with those available in every state court, it will create a tremendous disparity between the manner in which claims are litigated in federal and state courts. Rather than create an incentive for plaintiffs to manufacture a federal claim that would justify the filing of an otherwise routine medical malpractice claim in federal court, the Court should uphold the confidentiality of the peer review and quality management processes, particularly because a medical malpractice plaintiff possesses many alternative means of proving a medical malpractice claim, including their own review of the medical records, cross examination of the medical witnesses, and presenting their own experts.

II. Judge Boland Failed to Recognize that HCQIA Encourages Federal Courts to Apply State Law Peer Review Privileges

As one of the grounds for failing to recognize and apply Colorado's peer review and quality management privileges as a matter of comity, Judge Boland's July 15, 2004 Order cites *Robertson v. Neuromedical Center*, 169 F.R.D. 80, 83-84 (M.D.La. 1996) and *United States v. OHG of Indiana, Inc.*, 1998 WL 1756728 *7 (N.D. Ind. Oct. 8, 1998) for the proposition that the absence of an express privilege in the Health Care Quality Improvement Act "speaks loudly" as evidence that Congress did not intend for peer review material to enjoy privileged status at the federal level. The AMA and CMS respectfully contend that Judge Boland misinterpreted Congress' intent when it passed HCQIA.

---

[5] Rather than cite all fifty statutes, the AMA and CMS provide the following examples: *Conn Gen. Stat. Ann §19a-17b(a)(4)(d)* (stating "the proceedings of a medical review committee conducting a peer review shall not be subject to discovery or introduction into evidence in any civil action"); *Del. Code Ann. §1768* (protecting records of peer medical review committees from discovery); *D.C. Code Ann. §32-505* (providing medical review committee records a qualified privilege from discovery); *Fla. Stat. Ch. §§766.101(5) & 395.0191(8)* (stating that "the investigations, proceedings, and records of the [medical review committee] shall not be subject to discovery or introduction into evidence"); *Ga. Code Ann. §31-7-143* (stating that "the proceedings and records of medical review committees shall not be subject to discovery or introduction into evidence in any civil action"); *Ill Comp. Stat.Ann. § 5/8-2101* (stating records of medical committees intended to reduce morbidity and mortality are privileged).

Like Colorado's General Assembly, Congress recognized that peer review can "improve the quality of medical care," but also felt that the task warranted "greater efforts than those that can be undertaken by individual states." *42 U.S.C. §11101(1).* Thus, Congress passed a series of statutes that provide immunity to physicians who engage in peer review. *42 U.S.C. §11111*. In doing so, the Congress noted that "there is an overriding national need to provide incentive and protection for physicians engaging in effective peer review." *42 U.S.C. §11101(5).*

As part of Congress' efforts to provide incentive and protection for physicians to engage in peer review, it expressly considered whether HCQIA should limit or abrogate any privileges arising under state law. Instead of weakening the protections afforded under state law, *42 U.S.C. §11115(a)* specifically directs courts that "nothing in this part shall be construed as "changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by [the HCQIA]." (emphasis added).

In other words, the HCQIA provides a basic level of federal incentives and protection to promote peer review, but where state law provides greater incentives and protections for physicians to engage in peer review, those incentives and protections remain in full force and effect. Colorado's peer review and quality privileges are an incentive for physicians to engage in peer review, and, in fact, federal courts have recognized that "the mere possibility of disclosure would undermine this necessarily open and unconstrained self-examination." *Weekoty*, 30 F. Supp. 2d at 1346. Consequently, even though HCQIA does not create an express privilege, Judge Boland failed to give effect to Congress' intent that the federal courts honor the state law incentives that promote peer review.

Because Judge Boland did not consider *42 U.S.C. §11115*, the AMA and CMS respectfully request that the Court reevaluate his Order and recognize Colorado state law peer review and quality management privileges as a matter of comity. Comity is not a matter of absolute obligation, but federal courts generally recognize that they should recognize state privileges when there is no substantial cost to federal policies. *Memorial Hospital*, 664 F.2d at 1061 (7th Cir. 1981); *United States v. King*, 73 F.R.D. 103, 105 (E.D.N.Y. 1976). The federal courts apply these state law privileges because a state's promise that communications will be privileged should not be undermined by an overly rigid or unnecessary application of a federal rule. *Lora v. Board of Education*, 74 F.R.D. 565, 576 (E.D.N.Y. 1977).

As described throughout this brief, both Colorado law and federal law encourage physicians to engage in peer review, and the Court's application of Colorado's peer review and quality management privileges serves important state and federal interests. Colorado physicians, who voluntarily participate in peer review and quality management processes in reliance on these protections, should not find their participation used as a sword in malpractice litigation simply because a litigant finds a federal claim to assert along with their state malpractice claim.

III. The *Requested Documents Do Not Meet the Criteria for Discovery Under F.R.C.P. 26(b).*

Fed. R. Civ. P. 26(b)(1) governs the scope of discovery in federal proceedings. It states:

> Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action. . . . The information sought need not be admissible at trial if the information sought appears reasonably calculated to lead to the discovery of admissible evidence.

Notwithstanding the seemingly broad reach of the discovery rule, discovery should be limited to that which is necessary. This principle was expressed in *Mewborn*, which states, in pertinent part:

> The [1983] amendment to Rule 26(b) is specifically directed to limiting discovery, where the discovery sought is obtainable from some other source that is more convenient, less burdensome, or less expensive. Applying this rationale where the raw factual data can be obtained from hospital reports and records, there would be no need to require the report of a peer review committee setting forth evaluations, opinions, or findings from a retrospective view of a given fact situation.

Mewborn, 101 F.R.D. at 691.

While Ms. Atteberry's attempted discovery of peer review and quality management records might satisfy a broad definition of relevance, the AMA and CMS respectfully contend that the discovery requests cannot reasonably be construed as calculated to lead to discovery of admissible evidence as to the federal EMTALA claim. Instead, they are a thinly-veiled attempt to obtain Dr. Leonard's peer review records during the prosecution of a medical malpractice claim. This is undoubtedly true when Ms. Atteberry seeks:

> Any and all reports relating to Dr. Leonard, including, but not limited to credentialing files, peer review files, quality assurance reports, morbidity/mortality reports, hospital privileges, and any reports relating to the deaths of patients under his care.

Dr. Leonard's peer review and quality assurance files for patients other than Mr. Atteberry could not reasonably be expected to provide any information that is relevant to Ms. Atteberry's federal EMTALA claim, which is based upon Dr. Leonard's alleged transfer of an individual patient.

Indeed, such a request for discovery disregards not only the expectation of privacy for peer review and quality management purposes, but it is also in conflict with patients' expectation of privacy under the privacy regulations of the Health Insurance Portability and Accountability Act of 1996. HIPAA creates a broad classification of "protected health information," which includes any information that describes the provision of or payment for health care that relates to past, present or future physical or mental health of an individual. *45 C.F.R. §164.501; 45 C.F.R. §160.103*. HIPAA places limitations upon how a health care provider may "use" or "disclose" protected health information. The general rule is that a health care provider may not use or disclose any patient's protected health information without the patient's consent or explicit statutory authorization. *45 C.F.R. §164.502(a).* None of the patients whose care might be described in Dr. Leonard's peer review records have consented to Ms. Atteberry's counsel's use of their protected health information.

In the final analysis, Ms. Atteberry's attempted discovery of Dr. Leonard's peer review records serves only to create the incentive to "forum shop" that the drafters of *Fed. R. Evid. 501* sought to avoid. If the Court does not modify Judge Boland's Order, it will provide every plaintiff with a powerful incentive to include an alleged federal statutory violation with every ordinary medical malpractice claim. For example, medical malpractice suits will contain claims that the physician improperly billed a service to an insurance company under federal payor program, *42 U.S.C. §1395*, or discriminated against a patient because of race or gender at a place of public accommodation in violation of *42 U.S.C. §2000a* or Title II of the Americans with Disabilities Act, *42 U.S.C. §12131 et seq*. Each of these federal claims will allow medical malpractice

plaintiffs in federal court to obtain discovery of peer review and quality management records, even though this discovery will undermine the peer review and quality management processes that both Congress and the state legislatures unequivocally hoped to foster.

The unfortunate effect of Judge Boland's Order is that it creates two different types of medical malpractice actions in the State of Colorado, even though a physician's adherence to standards of professional care is ultimately a question of state law. In Colorado state courts, physicians may rely upon the peer review and quality management privileges and rest assured that claims against them will not be judged by whether their colleagues engaged in the "constructive professional criticism" that is the hallmark of peer review. *Bredice*, 50 F.R.D. at 250. In the federal courts, physicians would not be able to rely upon the privileges clearly granted by state law, to not only their detriment, but also the detriment of the health care system.

CONCLUSION

Fed. R. Evid. 501 requires judges to recognize privileges "in the light of reason and experience," which should lead the Court towards recognizing a peer review and quality management privilege in malpractice litigation. Such a result is not only consistent with Congress' intent to uphold any state law incentives for physicians to engage in peer review, but it is also consistent with the principles of comity that apply between the state and federal courts. In the absence of these privileges, both the legal and medical system will suffer as plaintiffs forum shop and physicians avoid constructive peer review. The Court can avoid this undesirable result by either recognizing peer

review and quality assurance privileges under federal common law or by applying Colorado's established statutory privileges as a matter of comity.

Respectfully submitted this 23rd day of July, 2004:

MONTGOMERY LITTLE & McGREW, P.C.

_____

_____

Robert N. Spencer
Patrick T. O'Rourke
Kari M. Hershey

Attorneys for *Amicus Curiae*
American Medical Association and
Colorado Medical Society

CERTIFICATE OF SERVICE

I hereby certify that a true and correct copy of the foregoing **AMICUS CURIAE BRIEF OF THE AMERICAN MEDICAL ASSOCIATION AND THE COLORADO MEDICAL SOCIETY IN SUPPORT OF MAINTAINING THE CONFIDENTIAL AND PRIVILEGED NATURE OF PEER REVIEW AND HOSPITAL QUALITY MANAGEMENT INFORMATION** was deposited in the United States mail, postage prepaid on this 23rd day of July 2004, addressed to:

Baine P. Kerr
Kimberly M. Hult
Hutchinson Black and Cook
921 Walnut Street #200
Boulder CO 80302

Gilbert A. Dickinson
Molly P. Tighe
Dickinson, Prud'homme, Adams & Ingam
730 17th Street, Suite 730
Denver, Colorado 80202-3504

Daniel R. McCune
Kevin Perez
Paul E. Scott
Guy R. Cerasoli
Kennedy Christopher Childs & Fogg
Independence Plaza
1050 17th Street, Suite 2500
Denver, Colorado 80265

_____