SUPREME COURT OF THE STATE OF FLORIDA

CASE NO. 68-920

MARK H. FELDMAN,

Appellants,

vs.

STEPHEN GLUCROFT, M.D., et al,

Appellees.

_____/

BRIEF BY AMICUS CURIAE THE FLORIDA HOSPITAL ASSOCIATION AND THE FLORIDA MEDICAL ASSOCIATION

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INTRODUCTION

This amicus brief is filed on behalf of the Florida Hospital Association (FHA), a Florida non-profit corporation, and the Florida Medical Association (FMA), a Florida non-profit corporation.

The FHA's membership consists of 221 Florida hospitals. These hospitals are either not-for-profit, for profit or governmental. The FMA membership consists of more than 14,000 physicians who are licensed to practice medicine in the State of Florida.

SUMMARY OF THE ARGUMENT

The legislative intent of Section 768.40(4), Florida Statutes (1983) is to protect the confidentiality of its medical peer review process. Section 768.40(4) is intended to prohibit the discovery of the records or deliberations of medical peer review committees and to prohibit the deliberations of committee members, which deliberations take place during the review of a practitioner, from being the basis of actions against said committee members. If practitioners who are reviewed by members of the medical peer review committee could bring actions against said members based upon what occurs during their deliberations (as opposed to activities outside of the deliberation process), such a possibility would, as a practical matter, prevent effective medical peer review and as a result thwart the legislative intent which created Section 768.40(4).

This Court, in Holly v. Auld, 450 So.2d 217 (Fla. 1984) recognized the need to uphold the legislative intent of the Statute. There is an overpowering public necessity to uphold the legislative intent. More than ever hospitals and medical staffs are mandated to perform effective peer review in order to assure quality care for the public to assist in reducing the costs of health care, again for the benefit of the public. If actions for defamation or other causes of action can be filed against members of peer revciew committee based upon what occured during their deliberations, no one will serve on medical peer review committees or if they serve they will not make critical judgments which could upset the practitioners whom they review.

STATEMENT OF THE CASE AND FACTS

The FHA and the FMA adopt the Statement of the Case and Facts set forth in the Answer Brief of Appellees.

ARGUMENT

> The intent of F.S. 768.40(4) is to prevent discovery of the deliberations of medical peer review committees and to prohibit actions which would expose the deliberations of medical peer review committee members. The legislative intent of the Statute would be frustrated if actions based on deliberations which occured during the peer review meetings could be brought against participants on peer review committees.

Both the FHA and the FMA are filing this amicus brief to advise the Court of the need to continue to protect the confidentiality of the medical peer review process utilized in Florida Hospitals to review questions concerning the granting, curtailing or removing of hospital privileges for health care providers. The FHA and the FMA take the position that §768.40(4) Fla. Stat. was intended by the legislature to prohibit the discovery of the records and deliberations of medical peer review committees and to encourage full and frank discussions by peer review committee members. Action by practitioners who are reviewed by peer review committees which would attempt to expose the deliberations of committee members would thwart the legislative intent.

The FHA and the FMA, through the undersigned attorney, filed an amicus brief in Holly v. Auld, 450 So.2d 217 (Fla. 1984).

In that brief it was pointed out that the narrow interpretation given to §768.40(4), Fla. Stat. 1977 by the Fourth District Court of Appeal would prevent frank and honest evaluations by members of medical review committees. The concern cited was that if discovery of the deliberations of peer review committees were allowed, it would be very difficult to find persons who would serve on such committees, and if persons did serve, there would be a reluctance of those persons to provide effective review of medical practitioners' activities.

In the amicus brief filed in Holly v. Auld, it was stated that the process of reviewing the quality of care provided in the hospital by medical review committees was mandated by a number of sources. One of the regulatory bodies requiring an effective review of the quality of care provided in hospitals is the Joint Commission on Accreditation of Hospitals. Accreditation Manual for Hospitals, (1982 Ed.) set forth the requirements imposed upon hospitals and medical staffs for review of quality care and review of practitioners who request or have medical staff privileges.

At the time Holly v. Auld was decided, Federal law and regulations required that as a condition of receiving reimbursement under the medicare program hospitals have a medical staff which has an organized and active program for monitoring

the quality of health care provided within the hospital and which reviewed the qualifications of those seeking appointment or reappointment to the hospital's staff. 42 C.F.R., §405.1023 (1981). §395.065, Fla. Stat., Hospital Disciplinary Powers, and §395.0653(2), Fla. Stat., Use of Hospital Staff, and §458.337, Fla. Stat., Reports of Disciplinary Actions by Medical Organizations, evidenced the State of Florida's understanding that peer review is essential to assure quality health care is provided within the hospital.

After reciting the governmental mandates for peer review, the amicus brief in Holly v. Auld argued:

> "To perform their functions properly, committee members established pursuant to these requirements must be willing and able to uncover both problems within the hospital and problems which particular practitioners are having in their handling of patient care. Committee members must openly discuss these problems and their solutions with the hospital personnel or practitioners involved and take steps, including the termination of staff privileges, to improve the quality of health care.
>
> If these committee members cannot function with the understanding that their discussions and reports will remain confidential, they will not frankly criticize their colleagues and will be unwilling to make recommendations to limit or revoke the staff privileges of practitioners whose work does not comply with the hospital's standards. These committees will be less likely to prepare and keep detailed records of their proceedings if those records might be ordered produced; and the lack of detailed records will greatly impede the long-term effectiveness of hospitals. The result will be a great reduction in the quality of health care in Florida."

A quote from 81 ALR 3d 944, Hospital's Internal Records, at page 946 was cited in the amicus brief, which quote gives an understanding of the function and value of a medical peer review committee:

> "Though the hospital's governing board retains the ultimate responsiblity for the quality of care provided, that responsibility is normally delegated to the hospital staff, and discharged in practice by medical staff review committees. The organization and function of these committees in accredited hospitals are described in publication of the Joint Commission Accredited Hospitals. Concern that the candor necessary to the effective functioning of these committees would be destroyed if their proceedings were discoverable has led to the adoption of statutes in a number of states conferring a privilege from discovery upon the proceedings of such committees."

The specific issue before the Supreme Court in Holly v. Auld was whether the discovery privilege set out in §768.40(4) was limited to civil actions against providers of health services based on medical malpractice or whether it also applied when other causes of action were involved. The statute was not, on its face, unambiguous on the issue. But it was clear that the legislature, in its enactment of §768.40, intended to encourage meaningful peer review by physicians assigned to medical review committees. The Supreme Court in Holly v. Auld recognized such a legislative intent and the strong public policy favoring confidentiality of the peer review process as reflected by numerous Florida cases and cases from other jurisdictions cited in the amicus brief. One case reflecting the importance of

confidentiality for the peer review process is Bredice v. Doctors Hospital, Inc., 50 F.R.D. 249 (D.C. D.C. 1970), adhered to, 51 F.R.D. 187 (D.D.C. 1970), affd., 156 U.S. App. D.C. 199, 479 F.2d 920 (1973). In that case at 50 F.R.D. 250, 251, the court held:

> "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 quo non of adequate hospital care. To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.
>
> The purpose of these staff meetings is the improvement, through self-analysis, of the efficiency of medical procedures and techniques. They are not a part of current patient care but are in the nature of retrospective review of the effectiveness of certain medical procedures. The value of these discussions and reviews in the education of the doctors who participate, and the medical students who sit in, is undeniable. This value would be destroyed if the meetings and the names of those participating were to be opened to the discovery process.
>
> 'The public interest may be a reason for not permitting inquiry into particular matters by discovery.' 4 Moore, Federal Practice Paragraph 26.22(2) at 1287 (2d Ed. 1969). As doctors have a responsibility for life and death decisions, the most up-to-date information and techniques must be available to them. 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. Absent evidence of extraordinary circumstances, there is not cause shown requiring disclosure of the minutes of these meetings."

In Morse v. Gerity, 520 F.Supp. 470, 472, a 1981 decision of the U.S. District Court in Connecticut, that Court took the position that a statute similar to §768.40(4) should be liberally interpreted both as a matter of statutory construction and public policy citing several authorities:

> "Indeed, if the purpose of the statute is to encourage doctors to evaluate their peers without fear of disclosure, that purpose would be hampered by public release of any proceedings, not just those involving the patient who has sued. The danger of inhibiting candid professional peer review exists by the mere potential for disclosure. . . . The overriding importance of these review committees to the medical profession and the public requires that doctors have unfettered freedom to evaluate their peers in an atmosphere of complete confidentiality."

In Holly v. Auld the Florida Supreme Court discerned what the legislative intent of §768.40(4), Fla. Stat. must necessarily have been. The Supreme Court concluded at page 219 there are:

> "...substantial legislative policy reasons to restrict discovery of hospitals' committee proceedings and it is not the court's duty or preogative to modify or shade clearly expressed legislative intent in order to uphold a policy favored by the court. See McDonald v. Roland, 65 So.2d 12 (Fla. 1953).

The Supreme Court in Holly v. Auld made the following pronouncements:

A. To control the cost of health care the legislature encouraged self-regulation by the medical profession through peer review and evaluation.

B. Meaningful peer review is not possible without a guarantee of confidentiality for the information and opinions elicited from physicians regarding the competence of their colleagues.

C. The need for confidentiality is great when a reviewing committee attempts to elicit doctor's honest opinions about their colleagues.

D. The discovery privilege of subsection (4) was clearly designed to provide that degree of confidentiality necessary for the full and frank medical peer review evaluation which the legislature sought to encourage.

The Supreme Court recognized that the discovery privilege set forth in §768.40(4) will impinge upon the rights of some civil litigants. But it recognized that the legislature balanced this potential detriment against the benefits to come from the discovery privilege.

> "It is precisely this sort of policy judgment which is exclusively the province of the legislative rather than the courts". At page 220.

The Supreme Court in Holly v. Auld in effect determined the legislature had found, in its enactment of §768.40(4), existence of an "overpowering public necessity" to prevent the deliberations and records of a medical peer review committee to be exposed to public view. This is the same type of "overpowering necessity" discussed in Kluger v. White, 281 So.2d

1 (Fla. 1973) which would allow a person's right to redress a perceived injury to be limited due to legislative enactments resulting from perceived needs of the public. While Dr. Feldman attempts to rely upon Kluger v. White for his own arguments, he avoids recognizing that the "overpowering public necessity" which exists in the instant care is the promotion of candid and frank deliberations by medical peer review committees in order to assure that quality medical care is provided by physicians and practitioners within the hospital.

Today, even more so than at the time of the court's decision in Holly v. Auld, it is imperative that the legislative intent set forth in the privilege specified in §768.40(4) be upheld. Regulation of hospitals mandating their responsibility for effective quality control is even more demanding today than when Holly v. Auld was decided and the only way to have effective quality control is for medical peer review committees to be able to act without the fear of their deliberations being discoverable and peer review committee members being exposed to lawsuits for what occurred during those deliberations.

Current Requirements of the Joint Commission on Accreditation of Hospitals. Hospitals are accredited by the Joint Commission on Accreditation of Hospitals. The current Accreditation Manual is referred to as AMH/86, Accreditation Manual for Hospitals (1986 Edition). The Joint Commission has in the past 2 years intensified its activities to monitor compliance

by hospitals and their medical staffs with its requirements. Some of the provisions in the current manual relating to the quality of care provided in the institution are as follows:

1. The Standard entitled, Governing Body, attached hereto as Attachment "A", states the governing body is responsible for seeing to it that the medical staff has effective quality assurance mechanisms; that all practioners are competent to provide the services for which they receive privileges; and that mechanisms are in place, "to assure the provision of one level of patient care in the hospital." Page 43, AMH/86. The governing body must require, "...the medical staff and staffs of departments/services to implement and report on activities and mechanisms for monitoring and evaluating the quality of patient care, for identifying and resolving problems, and for identifying opportunities to improve patient care.". Page 43, AMH/86. The governing body is described as the ultimate authority on recommendations concerning medical staff appointments, reappointments, termination of appointments and the granting or revision of clinical privileges.

2. The Standards entitled, Medical Staff, in AMH/86, attached hereto as Attachment "B", impose requirements on the medical staff to assure the quality of the care provided by the practitioners on the staff. The criteria for all applicants for staff privileges is designed to assure that patients will receive quality care. Mechanisms for corrective action,

automatic and summary suspension of medical staff membership, and for clinical privileges must be in place. The medical staff must have in place, "a mechanism to assure the same level of quality of patient care by all individuals with delineated clinical privileges, within medical staff departments, across departments/services, and between members and non-members of the medical staff who have delineated clinical privileges." Page 108, AMH 86.

The point to be made is that under the provisions of AMH/86 (which provisions were found in substantially the same form in AMH/85 and AMH/84) both the governing body and the medical staff have significant responsibilities to assure that those who apply for privileges in a hospital or those on the staff who have privileges provide quality care. In order to carry out these responsibilities, the committees of the medical staff and of the governing body who are charged with peer review must be able to freely and frankly discuss the practitioner's activities.

Recent Legal Decisions Imposing Responsibility for Monitoring the Quality of Care on Hospitals. As the Joint Commission places the ultimate responsibility for quality review on hospital boards, legal decisions increasingly place the responsibility for failure to effectively review practitioner's activities within a hospital upon the governing boards of hospitals. Although the physician himself is liable for his professional malpractice in the care and treatment of patients, where the hospital knows or has reason to know that the doctor is

not qualified to exercise the clinical privileges he pursues, or is not capable of practicing medicine in accordance with established standards of care, the hospital itself becomes accountable to the patient and must respond by the payment of damages for its separate negligence in failing to limit the physician's professional services to those for which he is qualified. Darling v. Charleston Community Memorial Hospital, 211 N.E. 2d 253 (Ill. 1965).; Purcell v. Zimbelman, 500 P.2d 335 (Ariz. 1973); Fridena v. Evans, 622 P.2d 463 (Ariz. 1980); Corletto v. Shore Memorial Hospital, 350 A.2d 534, (N.J. Sup. Ct. 1975).; Cooper v. Curry, 589 P.2d 201 (N.M. 1978); Joiner v. Mitchell County Hospital Authority, 186 S.E.2d 307 (Ga. App. 1971), aff'd., 189 S.E.2d 412 (Ga. 1972).

Florida Statutes in Existence at Time of the Instant Case. Florida Statutes in effect at the time of the instant case imposed responsibility upon hospitals and medical staffs to effectively monitor the quality of care being provided within the institutions. Examples are found in §395.065, Fla. Stat., Hospital Disciplinary Powers; §395.0653(2), Fla. Stat. Use of Hospital Staff; and §458.337, Fla. Stat., Reports of Disciplinary Actions by Medical Organizations.

Federal Regulations. Examples of Federal regulations regarding monitoring of quality care are found in Medicare regulations which state a medical staff must have an active program for monitoring the quality of health care provided by the

hospital and must review the qualifications of those seeking appointment or reappointment to the hospital staff. 42 C.F.R., §405.1023 (1981).

Florida's Current Laws Relating to Responsibility for the Quality of Care Provided in Hospitals. Florida's New Medical Malpractice Law imposes significant responsibilities on hospitals and their medical staffs to review quality of care being provided by practitioner's. Fla. Stat. 395.0115 requires that if the governing body of a hospital has reasonable belief that conduct by a staff member may constitute one or more grounds for discipline set out in the Statute, "...the Board shall investigate and determine whether grounds for discipline exist with respect to the staff member.".

Fla. Stat. 395.041 creates the requirement of Internal Risk Programs in hospitals whereby reports of all disciplinary actions pertaining to patient care taken against any medical staff member are to be reported to the Department of Health and Rehabilitative Services.

Fla. Stat. 768.60 places significant, affirmative responsibility upon health care facilities to monitor the quality of care in their institution. The pertinent provisions of the Statute are as follows:

768.69. Liability of health care facilities
(1) All health care facilities, including hospitals and ambulatory surgical centers, as defined in chapter 395, have a duty to assure comprehensive risk management and the competence of their medical staff and personnel through careful selection and review, and are liable for a failure to exercise due care in fulfilling these duties. These duties shall include, but not be limited to:

(a) The adoption of written procedures for the selection of staff members and a periodic review of the medical care and treatment rendered to patients by each member of the medical staff;

(b) The adoption of a comprehensive risk management program which fully complies with the substantive requirements of s. 395.041 as appropriate to such hospital's size, location, scope of services, physical configuration, and similar relevant factors;

(c) The initiation and diligent administration of the medical review and risk management processes established in paragraphs (a) and (b) including the supervision of the medical staff and hospital personnel to the extent necessary to ensure that such medical review and risk management processes are being diligently carried out.

Each such facility shall be liable for a failure to exercise due care in fulfilling one or more of these duties when such failure is a proximate cause of injury to a patient.

If deliberations and records of medical review committees are not protected from discovery and if peer review committee members are not protected from actions brought against them based upon their deliberations during such reviews, attempting to comply with the mandates for peer review will cause significant confrontation in today's health care climate. While the hospital and the medical staff as a group are required by the various regulations previously cited to monitor the quality of

care in the hospital, both bodies have limited control over the physicians on the staff to compel them to do the monitoring of quality care which is mandated. The reasons for this are several. Physicians on the staff of a hospital are not, except in limited situations, employees of the hospital. They are independent practitioners. A unique situation exists in hospitals due to the relationship between the hospital and its medical staff. The medical staff is composed of persons who practice in the hospital but, except in rare occasions, the staff itself is not a legal entity. It derives its authority from the hospital but its members belong to an unincorporated group with its own By-laws and Rules and Regulations. Additionally, in today's health care climate, many physicians have memberships on multiple hospital staffs and at alternative health care facilities. If they are requested by one hospital to serve on a peer review committee and they object to doing so because of concern with the deliberation process exposing them to the risk of litigation, the hospital has little leverage over the physician to compel him to perform the peer review responsibility.

Other reasons the hospital has limited control over its staff members result from the dramatic changes in the health care field over the past few years. Many staff members do not need the access to hospital facilities as they once did. Many physicians have become engaged in endeavors which are in competition with hospitals such as ambulatory surgery centers,

walk-in clinics, Health Maintenance Organizations, and Rehabilitation Centers. There is less need for staff members to be actively involved with hospitals in order to maintain their practices and meet the needs of their patients. Concomitantly hospitals have experienced financial losses because physicians have used other facilities in which to treat their patients. Therefore, hospitals want to encourage physicians to use their facilities rather then impose assignments on them which will cause them to go elsewhere.

Confrontation will exist by virtue of the fact that the hospital and the medical staff leadership would be forced to require reluctant staff members to serve on medical review committees. Attempts to impose such responsibilities will be difficult to accomplish and may cause staff members to move their staff allegiances rather than being exposed to the risks that would come from serving on such committees when their deliberations might expose them to the risk of litigation by someone whom they review. It is only the physicians on a medical staff who have the training and experience to evaluate the competence and performance of practitioners. Most members of hospital governing bodies are not physicians and therefore they must rely upon meaningful judgments made by effective peer review committees composed of physicians. Anything that would discourange physicians from serving on peer review committees would not be in the public interest.

Over the past several years, it is apparent that the American public is increasingly concerned about the cost of medical care and the quality of medical care. Some feel that the cost of medical care has escalated in part due to injuries resulting from inappropriate medical care. Others feel the cost of medical care has escalated because of unfounded actions brought by patients with unreasonable expectations of what their care should have been. But regardless of the reason, the medical malpractice insurance rates have dramatically increased due to litigation based on medical malpractice suits. It is a matter of general knowledge that nationwide there is heightened concern over the costs of medical care and high medical malpractice premiums. See Attachment "C". In the preamble to House Bill 1352, which is the current Medical Malpractice Law, the Legislature referred to the high costs of health care services due in part because of the high professional liability premiums. The Legislature referred to the magnitude of the problem demanding immediate and dramatic legislative action and pointed out it believes that effective monitoring of the quality of health care is essential in order to correct the current situation. The preamble in part reads:

> "Whereas, medical injuries can often be prevented through comprehensive risk management programs and monitoring of physician quality."

The undersigned attorney served on the Governor's Task Force on Medical Malpractice which was created from an appropriation by the legislature in the 1984 Appropriations Act. The

charge to the Task Force was to examine and identify issues and information relating to medical malpractice in Florida, and to develop policy recommendations addressing the legal, disciplinary, regulatory, financial and marketplace considerations necessary to assure a cost-effective, fair and reasonable system of compensation and justice in Florida. From the testimony presented to the Task Force over its six month life, it was apparent that the only way to effectively monitor the quality of care in hospitals and health care facilities is through meaningful peer review committees. While the governing bodies of hospitals may have the ultimate authority for monitoring the quality of care in their hospitals, it is only through peer review conducted by medical staff committees making judgments about their peers that effective monitoring can occur. In the report made to the Governor by the Task Force, it recommended any impediments to meaningful peer review be eliminated. See Attachment "D".

If physicians who are part of a peer review committee feel a practitioner should not have privileges on a hospital staff and take a position on that judgment, they risk not only the anger of the person who is being reviewed but also of his or her friends in the medical community. Often times their actions can negatively affect referral patterns. It is an extremely difficult job to be on a committee which does peer review in a hospital. For a staff member to agree to serve on such a

committee means a substantial contribution of his time and the risk of ill-will by others. For those reasons even in the past it was difficult to find people to serve. But today, if there is any possibility of the records and deliberations of those participating in the peer review process being discoverable and of actions being brought against committee members for their deliberations, it will be virtually impossible to find people to serve who will do an effective job. If they were confronted by a difficult issue, they would, without doubt, tend to look the other way rather than risk a suit against them by a disgruntled physicians. In these days where litigation over staff privilege issues seems to be abundant, a staff member does not want to risk being involved in the litigation as a result of being a member of a peer review committee. It used to be that if a physician were denied staff privileges or his privileges were revoked and he instituted litigation, he would file suit only against the hospital seeking a reversal of the decision. Now these staff privilege actions join not only the hospital but everyone whom the aggravated party felt took a part in the decision. Members of credentials committees, and ad hoc hearing committees and Hospital Board members are sued individually. The causes of action are defamation, anti-trust, conspiracy and a myriad of other creative causes of action.

In the vast majority of these actions, there are no recoveries by the aggravated practitioner. But in the course of

the litigation, the individual defendants incur public embarrassment; have to spend considerable time in interviews, depositions and negotiations; incur attorneys fees and costs which are often significant; experience disruption of their practice; and feel anxiety over the process. While many defendants in these actions are defended by the hospital which is also sued, in causes of action for conspiracy or anti-trust this is not always possible. In cases where not-for-profit hospitals are involved, providing a defense for individual physician defendants or paying any damages recovered against them might affect the tax-exempt status of the hospital in certain types of cases such as anti-trust or various conspiracy causes of action.

It is extremely difficult today to appoint members to medical review committees of the medical staff and medical review committees of the governing body. It is not just a matter of the time these people have to devote to the responsibility (which is not compensated time) but the burden and risks of their role. Why would someone who is an independent practitioner want to subject himself to the risks of making honest evaluations about a peer if he knew his deliberations, comments, reports, etc. would be subject to discovery or provide the basis for a cause of action for defamation, etc.? Yet how are the hospital and the medical staff as a body going to fulfill their responsiblities for effective monitoring of the quality of care in the

institution unless physicians who have the expertise to make judgments about practitioners serve on those peer review committees?

The legislature recognized the need to protct their peer review proceedings and those who participate on them in the enactment of §768.40(4). The Supreme Court in Holly v. Auld recognized the strong public policy intent of the legislature.

In the 1985 Medical Malpractice Bill, the legislature continued to recognize the need to protect those who participate in peer review by the adoption of §395.011(7) and (8); §395.0115(2), (4) and (5); and its modifications of §768.40. It is only by protecting those who participate in peer review from being drawn into vindictive litigation that those committees can perform the tasks required of them by the legislature, the JCAH and other governmental regulations.

While the provisions of the 1985 Medical Malpractice Law were not in existence at the time of the instant case, these provisions reflect the concern of the legislature that increased costs of health care resulting from inappropriate care can only be controlled by effective peer review, and effective peer review can only come about if those who participate in it are free to make their judgments without fear of legal retribution formented by the exposure of their deliberations.

Significantly the first provision referred to in the 1985 Medical Malpractice Act related to provisions making it more

difficult for persons involved in the medical review process to be sued for their activity. This is a statement in itself reflecting strong legislative policy to protect the peer review process.

In Holly v. Auld the court said:

> "Inevitably, such a discovery privilege will inpinge upon the rights of some civil litigants to discovery of information which might be helpful, or even essential, to their causes. We must assume that the legislature balanced this potential detriment against the potential for health care cost containment offered by effective self-policing by the medical community and found the latter to be of greater weight. It is precisely this sort of policy judgment which is exclusively the province of the legislature rather than the courts."

The argument made by the Plaintiff in the instant case and the amicus filed on behalf of the Plaintiff's position is in effect that the practitioner who receives an adverse determination by a medical peer review body has no recourse. This is not true. Under Margolin v. Morton F. Plant Hospital Association, Inc. 348 So.2d 57 (Fla. 2d DCA, 1977) a practitioner has recourse to see that there were no substantial failures to follow the medical staff By-laws in an action relating to denying or curtailing his privileges. If there is evidence independent of what occurred in the peer review deliberations of the practitioner's competency to practice or of the arbitrariness or prejudice of those making a decision as to his privileges, he would have redress. Additionally, if the practitioner could

prove there were substantial deviations from the By-laws, the practitioner would have redress.

One thing that needs to be kept in mind is that a decision to deny Hospital privileges or curtail privileges is not made by one or two people. On applications for staff priviliges a department reviews a person's credentials; a credentials committee deliberates on the issue; a medical executive committee of the medical staff (made up usually of department heads) makes a recommendation; and ultimately the governing body of the hospital makes the final decision. If there is an action to curtail a staff member's privileges or to revoke them, there is an ad hoc committee that conducts a hearing at which the practitioner may defend his position and an appellate review of the committee's recommendation. Again the governing body makes the final recommendations. As a result of this "fair hearing" process which is mandated by the Joint Commission or Accreditation of Hospitals as well as Florida Statutes, many people have had input into a decision relating to the practitioner which guards against arbitrariness or personal prejudices.

CONCLUSION

The Legislature in its enactment of §768.40(4) reflected its view that there was an overpowering public necessity to protect deliberations and records of peer review committees and to prohibit actions brought against committee members for their deliberations. The legislature weighed the respective interests of the public in having the assurance that effective peer review is conducted in hospitals against a practitioner's access to the deliberations and records of medical review committees and his opportunity to bring actions against committee members based upon their deliberations.

The result of such balancing of interests was a determination that the overpowering public interest compels protection of the deliberations of medical peer review committees. Without such protection there would be no effective medical peer review.

Respectfully submitted,

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CERTIFICATE OF SERVICE

I HEREBY CERTIFY that a true and correct copy of the foregoing Brief by Amicus Curiae has been furnished by regular U.S. Mail to CHARLES C. POWERS, ESQ., 1801 Austrialian Avenue South, Suite 201, Post Office Box 15021, West Palm Beach, FL 33409, DAN PAUL, ESQ., 100 South Biscayne Blvd., 13th Floor, Miami, FL 33131, DR. MARK H. FELDMAN, 1281 N.E. 163rd Street, North Miami, FL 33162 and MR. JOSEPH W. LITTLE, University of Florida, College of Law, Gainesville, FL 32611, this 8th day of October, 1986.

Emil C. Marquardt, Jr.