Bring in the (Rule 53) Refs: How North Carolina's Procedural Rubric for Resolving Medical Review Committee Privilege Disputes Is an Improper Substitute for Substantive Review and How Rule 53 Can Fix It*

North Carolina's Hospital Licensure Act codifies a powerful evidentiary privilege, medical review committee privilege, that shields from discovery and introduction into evidence in civil actions the proceedings of a medical review committee, the records and materials it produces, and the materials it considers. In principle, the benefits of medical review committee privilege are universal—thorough and frank assessments of care rendered to patients by providers result in improved patient care outcomes, and providers can effectively evaluate and be evaluated by their peers. However, in practice, medical review committee privilege invokes competing public concerns. In an effort to reconcile the competing public concerns underlying medical review committee privilege, North Carolina courts have created a common-law procedural rubric delineating a two-part analysis to determine whether or not evidence may be afforded the protection of medical peer review. This procedural and mechanical analysis substitutes a meaningful, substantive review of evidence for which medical peer review is being invoked in exchange for a "substantive" evidentiary showing, which does a disservice to plaintiffs, defendants, and the public alike. This Comment explores how mandatory incorporation of Rule 53 of the North Carolina Rules of Civil Procedure in medical malpractice actions better serve not only the parties to malpractice actions, but the policies implicated by medical review committee privilege.

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INTRODUCTION

North Carolina's Hospital Licensure Act (the "Act") created a powerful evidentiary privilege,[1] medical review committee privilege, that in civil actions shields from discovery and introduction into evidence "[t]he proceedings of a medical review committee, the records and materials it produces and the materials it considers."[2] At the pith of the privilege is "the fear 'that external access to peer investigations conducted by [hospital] staff committees stifles candor and inhibits objectivity'" when the care provided by a health care worker is scrutinized by a formal committee of their peers.[3] Thus, the premise of the privilege supposes that "[c]onstructive 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."[4] To that end, the privilege contemplates that health care outcomes and public-health interests are best improved upon and served when medical providers are able to internally evaluate and ameliorate issues relating to patient care themselves.[5]

Medical review committee privilege is intended to exist as an internal measure of quality improvement,[6] improving health care outcomes by ensuring that the prevailing standards of care are being met.[7] Indeed, by its own terms, the purposes of North Carolina's Hospital Licensure Act are to "establish

1. Statutory medical review committee privilege supplants North Carolina's common-law right of public access to information regarding such materials. *See* Virmani v. Presbyterian Health Servs. Corp., 350 N.C. 449, 477–78, 515 S.E.2d 675, 693–94 (1999) ("The General Assembly has recognized the public's compelling interest in such confidentiality by enacting N.C.G.S. § 131E-95 and making the confidentiality of medical peer review investigations part of our state's public policy . . . . The public's interest in access to these court proceedings, records and documents is outweighed by the compelling public interest in protecting the confidentiality of medical peer review records in order to foster effective, frank and uninhibited exchange among medical peer review committee members . . . . [W]e conclude that the compelling countervailing public interest in such high quality public medical care overcomes the qualified public right to open civil court proceedings and records of those proceedings."); *see also* Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 81–82, 347 S.E.2d 824, 828 (1986) (standing for the proposition that a document qualifying for protection under medical review committee privilege does not lose its protection through dissemination to third parties); Est. of Ray v. Forgy, 245 N.C. App. 430, 436–39, 783 S.E.2d 1, 6–7 (2016) (reiterating the same principle).

2. Hospital Licensure Act, ch. 775, 1983 N.C. Sess. Laws 895, 922 (codified as amended at N.C. GEN. STAT. § 131E-95(b) (2022)). Another form of medical peer review is also codified in North Carolina, § 90-22.21, which pertains to medical peer review committees consisting of both healthcare and nonhealthcare workers. This form of peer review is functionally equivalent to the medical review committee privilege created by the North Carolina Hospital Licensure Act. *See id.*

3. *Shelton*, 318 N.C. at 82, 347 S.E.2d at 828 (quoting Cameron v. New Hanover Mem'l Hosp., 58 N.C. App. 414, 436, 293 S.E.2d 901, 914 (1982)).

4. Bredice v. Drs. Hosp., 50 F.R.D. 249, 250 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973).

5. *See* JOINT COMM'N ON ACCREDITATION OF HOSPS., ACCREDITATION MANUAL FOR HOSPITALS 151 (1983).

6. *See id.*

7. *See* George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723 (2001).

hospital licensing requirements which promote public health, safety and welfare and to provide for the development, establishment and enforcement of basic standards for the care and treatment of patients in hospitals."[8] Thereby, the medical review committee privilege has many worthy purposes, especially in a state with 120 hospitals,[9] some of which rank among the best nationally.[10]

In principle, the benefits of medical review committee privilege are universal—thorough and frank assessments of care rendered to patients by providers result in improved patient care outcomes, and providers can effectively evaluate and be evaluated by their peers.[11] However, in practice, medical review committee privilege invokes "competing public concerns."[12] Favoring the privilege is the notion that better health care and better outcomes are best realized when medical staff are able to candidly and objectively evaluate the care provided by their peers.[13] Thus, the information considered, generated, and produced by reviewing committees is not discoverable in civil suits as disclosure of such information undermines the stated purposes of the Act.[14]

Weighing against the privilege is the fact that its invocation fundamentally impairs a plaintiff's access to relevant evidence in medical malpractice actions,[15] namely, materials that result from internal investigations conducted by a hospital's medical review committee after an adverse outcome or after a sentinel event is reported related to the care provided to a medical malpractice plaintiff.[16] As North Carolina courts have acknowledged, "[the Act] represents

8. Hospital Licensure Act, ch. 775, 1983 N.C. Sess. Laws 895, 918 (codified as amended at N.C. GEN. STAT. § 131E-75 (2022)).

9. N.C. DIV. OF HEALTH & HUM. SERVS., HOSPITALS LICENSED BY THE STATE OF NORTH CAROLINA BY COUNTY 16 (2022), https://info.ncdhhs.gov/dhsr/data/hllistco.pdf [https://perma.cc/QQ5B-D5KZ].

10. Simone Jasper, *What Are the Triangle's Best Hospitals? Latest Rankings Are Released*, NEWS & OBSERVER (July 29, 2020), https://www.newsobserver.com/news/local/article244539307.html [http://perma.cc/G3ZN-AA76].

11. *See* Shelton v. Morehead Mem'l Hosp., 318 N.C. 76, 82, 347 S.E.2d 824, 828 (1986).

12. *Id.* (quoting Cameron v. New Hanover Mem'l Hosp., 58 N.C. App. 414, 436, 293 S.E.2d 901, 914 (1982)).

13. *See id.* at 83–84, 347 S.E.2d at 829 ("The statute is designed to encourage candor and objectivity in the internal workings of medical review committees.").

14. *See id.* at 83, 347 S.E.2d at 829 ("The statute protects only a medical review committee's (1) proceedings; (2) records and materials it produces; and (3) materials it considers."); Virmani v. Presbyterian Health Servs. Corp., 350 N.C. 449, 464, 515 S.E.2d 675, 685–86 (1999) ("The purpose of N.C.G.S. § 131E-95 is to promote candor and frank exchange in peer review proceedings. . . . The statute attempts to accomplish this goal by preventing discovery or introduction into evidence of a medical review committee's proceedings and the records and materials produced or considered by the committee." (citations omitted)).

15. *See* N.C. GEN. R. CIV. P. 26(b)(1) ("Parties may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action . . . ."); *see also* United States v. Nixon, 418 U.S. 683, 710 (1974) ("[E]xceptions to the demand for every man's evidence are not lightly created nor expansively construed, for they are in derogation of the search for truth.").

16. *See, e.g.*, Hammond v. Saini, 229 N.C. App. 359, 365–67, 748 S.E.2d 585, 589–91 (2013) (seeking Root Cause Analysis documents that contained a "Brief Overview" of the incident resulting

a legislative choice between competing public concerns. It embraces the goal of medical staff candor at the cost of impairing plaintiffs' access to evidence."[17] This acknowledgement, by itself, presents a paradox. Another means to achieve quality improvement in the delivery of health care and provider accountability is through legal redress. A plaintiff's ability to bring a medical malpractice action also serves as a measure of quality improvement in health care, one that arguably better serves the purposes of the Act. Who better to address the needs of public health and evaluate whether the care a patient received met the standard of care than the public themselves?

In an effort to reconcile the competing public concerns underlying medical review committee privilege, North Carolina courts have created a common-law procedural rubric delineating a two-part analysis to determine whether or not evidence may be afforded the protection of medical peer review.[18] The first part of the analysis is guided by a strict statutory reading of the definitions as to what constitutes a medical peer review committee to which the privilege may be attributed.[19] The second part of the analysis requires an evidentiary showing from the party seeking to assert the privilege.[20] In other words, in order to effectuate the privilege, a defendant must demonstrate that the documents they

in the operating room fire that injured the plaintiff and included a post-fire review process that was undertaken by the hospital defendant's Root Cause Analysis Team).

17. *Cameron*, 58 N.C. App. at 436, 293 S.E.2d at 914 (quoting Matchett v. Superior Ct. of Yuba Cnty., 115 Cal. Rptr. 317, 320–21 (Ct. App. 1974)).

18. *See Hammond*, 229 N.C. App. at 366–68, 748 S.E.2d at 590–91 (citing the lack of evidence from the defendants as to "who produced or prepared" the evidence for which the defendants sought medical review committee production to be dispositive to defendant's claim of privilege); Est. of Ray v. Forgy, 245 N.C. App. 430, 441–42, 783 S.E.2d 1, 9 (2016) ("We find *Hammond* distinguishable from the circumstances of the present case. In *Hammond*, the affidavit produced by the defendants failed to demonstrate that each of the statutory requirements concerning the existence of the privilege under N.C. Gen. Stat. § 131E-95 were met. Here, the hospital defendants presented . . . affidavits and the Medical Staff bylaws of Grace to establish that their MRCs qualified as MRCs pursuant to the meaning contemplated in [the statute]. [The] affidavit also explicitly stated that the subject documents contained 'the records and materials produced by and/or considered by' the MRCs of [the hospital]. Significantly, [the] affidavit also incorporated a detailed privilege log . . . [that] included a description of each document, the author or source of each document, the date of the document, and the recipient of the document. The privilege log established that the subject documents were records and materials produced by the MRCs of [the hospital] and/or materials considered by the MRCs of [the hospital]."). The aforementioned cases, in addition to every other case since *Shelton*, reflect judicial analysis that first examine the statutory language of Sections 131E-95 and 131E-76(5) of the General Statutes of North Carolina and then proceed to evaluate whether or not the contested documents are adequately represented by the submitted affidavit and privilege log to the extent that they clearly fall within the protections of Section 131E-95. *See id.*

19. *See, e.g.*, *Hammond*, 229 N.C. App. at 366, 748 S.E.2d at 590 (finding that because a hospital defendant's Root Cause Analysis Team does not constitute a medical review committee *as statutorily defined*, defendants' entire argument premised on the medical review privilege fails).

20. *See, e.g.*, *Est. of Ray*, 245 N.C. App. at 439–42, 783 S.E.2d at 7–9 (finding that a defendant's evidentiary showing of an affidavit of a hospital risk manager, with attached exhibits of hospital bylaws, and a detailed privilege log, showing the protected communications and documents, were in fact exchanged at the behest of medical review committee members and were privileged).

are seeking to protect were reviewed by a medical review committee as statutorily defined and that the documents were reviewed by the committee through submission of affidavits, hospital bylaws, and detailed privilege logs.[21] As discussed later in this Comment, this approach has yielded superficial and inconsistent results.[22]

By providing defendants a way to circumvent a meaningful, substantive analysis as to whether evidence is protected under medical peer review, a plaintiff's fundamental right to probative and relevant evidence decays, as does the public's ability to hold their providers accountable. On the other hand, materials that are rightfully produced or considered by a medical review committee may be subject to disclosure if a court decides the reviewing committee does not strictly adhere to the statutory definition of medical review committee or if a privilege log is deemed inadequate.[23] Substituting a meaningful, substantive review of evidence for which medical peer review is being invoked for a "substantive" evidentiary showing does a disservice to plaintiffs, defendants, and the public alike.

Part I of this Comment begins by explaining the genesis of medical peer review privilege. Part II examines its evolution in North Carolina and discusses North Carolina's current two-part test under which an affirmative showing is required to assert medical peer review privilege. Part III proposes reformation of the medical peer review privilege to better realize the purposes the privilege was created to serve in the first place.

I. HISTORICAL GENESIS OF MEDICAL PEER REVIEW

The underlying rationale of medical peer review is that qualified practicing physicians are best able to evaluate the performance of their peers[24]—specifically, whether the care delivered by their colleagues meets the appropriate standard of care in a particular field when that care is called into question because of an adverse outcome.[25] Medical peer review assumes that physicians who routinely work together are uniquely qualified to effectively evaluate one another's performance given their shared level of expertise.[26] In this way, medical peer review functions as a self-regulating quality assurance

21. *See id.*; *Hammond*, 229 N.C. App. at 366–68, 748 S.E.2d at 590–91.

22. *See infra* Part II.

23. *See* Bryson v. Haywood Reg'l Med. Ctr., 204 N.C. App. 532, 540, 694 S.E.2d 416, 422 (2010) (noting that one of the two reasons the documents did not qualify for medical review committee privilege included that the hospital "submitted no affidavits or other evidence to support its claim that the documents at issue were protected from discovery under N.C. Gen. Stat. § 131E-95(b)"); *Hammond*, 229 N.C. App. at 366, 748 S.E.2d at 590.

24. *See* Newton, *supra* note 7, at 723.

25. *See id.*

26. *Id.*

that is theoretically designed to achieve better health care outcomes for patients.[27]

The first medical peer review program was established in the United States by the American College of Surgeons ("ACS") in the early 1900s.[28] In 1952, the ACS, in addition to the American Medical Association, the American Hospital Association, and the American College of Physicians, organized the Joint Commission on the Accreditation of Hospitals which promulgated national peer review standards and guidelines.[29] Now known as the Joint Commission on Accreditation of Healthcare Organizations ("the Joint Commission"), the Joint Commission mandates that hospitals and health care organizations conduct peer review of staff members to qualify for accreditation.[30] Additionally, in recognizing the importance of medical peer review, all fifty states have adopted statutory provisions[31] establishing standards for medical peer review that must be adopted by hospitals and local health care organizations to receive state accreditation.[32]

Medical peer reviews are generally conducted for four primary reasons.[33] First, as part of peer review accreditation, medical peer review committees review privilege requests for newly hired physicians or current physicians who wish to expand the scope of their privileges at their current institution.[34] Second, per the Joint Commission, peer review will be automatically triggered by "substandard" physician performance.[35] Third, medical peer review can be triggered at the request of a colleague or hospital administrator.[36] And fourth, peer review can be used as a quality improvement measure, wherein the medical review committee selects random cases to review, with a specific interest in cases with unexpected adverse outcomes.[37]

Because of the nature of medical peer reviews, physicians were apprehensive about participating in medical peer review committees out of concern that doing so would expose them to future claims and be used as

27. *Id.*

28. *Id.* at 726.

29. *Id.*

30. *See* JOINT COMM'N ON ACCREDITATION OF HOSPS., *supra* note 5, at 106.

31. *See* Jeanne Darricades, *Medical Peer Review: How Is It Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 263 (1992).

32. Newton, *supra* note 7, at 726.

33. *See* Dinesh Vyash & Ahmed E. Hozain, *Clinical Peer Review in the United States: History, Legal Development and Subsequent Abuse*, 20 WORLD J. GASTROENTEROLOGY 6357, 6358 (2014).

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

evidence to condemn their colleagues.[38] In response, all fifty states enacted legislation to protect the confidentiality of the peer review process by affording immunity in the form of evidentiary privilege to shield physicians from liability "for their actions or statement performed within the scope and function"[39] of the committee.[40]

II. EVOLUTION OF MEDICAL REVIEW COMMITTEE PRIVILEGE IN NORTH CAROLINA

The North Carolina General Assembly codified the medical review committee privilege in 1983.[41] The statutes governing medical peer review committees have two primary parts. First, they define what constitutes a medical peer review committee.[42] Second, they enumerate the protections afforded to committees qualifying as medical peer review committees.[43] North Carolina statutorily defines "medical review committee" as "[a] committee of a medical staff of a hospital" which is "formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing."[44] In order to benefit from the applicable statutory protections, a medical review committee *must* meet one of the following criteria:

> a. A committee of a state or local professional society.
>
> b. A committee of a medical staff of a hospital.
>
> c. A committee of a hospital or hospital system, if created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital or system.
>
> d. A committee of a peer review corporation or organization.[45]

Assuming a committee qualifies, the statute expressly enumerates the protections afforded to the qualifying committee:

> The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records within the meaning of G.S. 132-1 . . .

38. *See* Amy Young, *Limits to Peer Review Privilege: Privacy Laws and Concerns Regarding Confidentiality Often Prevent Physicians from Serving on Peer Review Boards*, 5 VIRTUAL MENTOR 423, 424 (2003).

39. *See* Newton, *supra* note 7, at 729–30.

40. *Id.*

41. *See* N.C. GEN. STAT. § 131E-95 (LEXIS through Sess. Laws 2021-162 of the 2021 Reg. Sess.).

42. *See id.* § 131E-76(5).

43. *See id.* § 131E-95.

44. *Id.* § 131E-76(5).

45. *Id.* § 131E-76(5)(a)–(d).

> and shall not be subject to discovery or introduction into evidence in any civil action against a hospital . . . which results from matters which are the subject of evaluation and review by the committee. . . . However, information, documents, or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee.[46]

North Carolina courts have interpreted these statutes to effectively protect three categories of information from discovery and admissibility at trial in a civil action: (1) proceedings of a medical review committee, (2) records and materials produced by a medical review committee, and (3) materials considered by a medical review committee.[47] In considering whether medical review privilege applies to hospital records, the circumstances surrounding the actual preparation and use of the contested documents guides the court's inquiry on a case-by-case basis.[48]

There are, however, ways in which documents claiming medical review committee privilege may be substantively reviewed by the court. First, the disputed documents may be subject to an in camera review at the trial court level.[49] In these instances, the documents are substantively reviewed by the presiding judge to determine whether or not the medical review committee privilege claimed by the defendant applies.[50] The privilege under Section 131E-95 of the General Statutes of North Carolina does not mandate in camera review of documents. That determination remains at the discretion of the court and the parties.[51]

The documents will also be afforded substantive review at the appellate level.[52] When the trial court enters an order relating to the discoverability of documents claiming medical review committee privilege, the order is automatically subject to an interlocutory appeal.[53] This is because the

46. *Id.* § 131E-95(b).

47. Woods v. Moses Cone Health Sys., 198 N.C. App. 120, 126, 678 S.E.2d 787, 791–92 (2009).

48. *See, e.g.*, Bryson v. Haywood Reg'l Med. Ctr., 204 N.C. App. 532, 539, 694 S.E.2d 416, 421–22 (2010) (reviewing the circumstances under which the contested documents were created and the purpose they serve).

49. *See, e.g.*, Medlin v. N.C. Specialty Hosp., LLC, 233 N.C. App. 327, 337–38, 756 S.E.2d 812, 819 (2014) (upholding the trial court's right to perform an in camera review of documents claiming privilege under Section 131E-95 and finding the court does not have to rely on the representations of privilege made by counsel).

50. *See id.*

51. *See id.*; Est. of Ray v. Forgy, 245 N.C. App. 430, 433, 783 S.E.2d 1, 4 (2016) (referencing that the defendants made a motion for an in camera review of the documents for which they claimed privilege).

52. *See Est. of Ray*, 245 N.C. App. at 435–36, 788 S.E.2d at 5–6.

53. *See id.* at 435, 783 S.E.2d at 5 ("As a preliminary matter, we note that the 19 November 2014 order is an interlocutory order. 'An interlocutory order is one made during the pendency of an action, which does not dispose of the case, but leaves it for further action by the trial court in order to settle

discoverability of the disputed document affects a substantial right of the appellant—the right to evidence that could be determinative of the entire case.[54] But just because documents for which medical review committee privilege is claimed have been substantively reviewed at the appellate level[55] does not mean that they are substantively reviewed in every case at the trial court level. Moreover, it does not mean that the precedent resulting from substantive reviews has translated into more meaningful consideration of medical review committee disputes at the trial court level. Rather, the opposite has occurred.

Each case implicating medical peer review privilege is decided on its facts. Therefore, cases such as *Bryson v. Haywood Regional Medical Center*,[56] *Hammond v. Saini*,[57] and *Estate of Ray v. Forgy*[58] provide a helpful demonstration of North Carolina's approach to judicial interpretation of medical peer review and why it has become a problem. In *Bryson*, the defendant hospital sought to protect two categories of documentation, internal and external, under North Carolina's medical review privilege.[59]

The first category contained three internal hospital documents, including an email to the director of risk management bearing the subject "Peer Review Request."[60] This email summarized six instances of patient care at the hospital, noting whether any occurrence reports were received and discussing any quality concerns.[61] Importantly, the email did not identify the sender's position within the hospital or the purpose for which the sender generated the email.[62] The second document, a memorandum to the director of clinical services requesting a review of patients' charts, contained summaries of patient care but did not indicate the author, recipient, or purpose of the document.[63] The third document was a memorandum from the ICU Chairman to two other hospital employees analyzing the appropriateness of care provided to six patients.[64] While this document did indicate it was prepared at the behest of a physician,

and determine the entire controversy.'" (quoting Stanford v. Paris, 364 N.C. 306, 311, 698 S.E.2d 37, 40 (2010))).

54. *See id.*

55. *See id.* at 442, 783 S.E.2d at 9 ("Having carefully reviewed the subject documents . . . ."); Hammond v. Saini, 229 N.C. App. 359, 366, 748 S.E.2d 585, 590 (2013) ("After carefully reviewing the record . . . ."); Bryson v. Haywood Reg'l Med. Ctr., 204 N.C. App. 532, 540, 694 S.E.2d 416, 422 (2010) ("[T]he documents on their face do not establish they are privileged.").

56. 204 N.C. App. 532, 694 S.E.2d 416.

57. 229 N.C. App. 359, 748 S.E.2d 585.

58. 245 N.C. App. 430, 783 S.E.2d 1.

59. *Bryson*, 204 N.C. App. at 536, 694 S.E.2d at 420.

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.* at 535–36, 694 S.E.2d at 419–20.

it failed to identify the capacity in which the physician was requesting the document and the purpose the document was intended to serve.[65]

The second category of documentation was comprised of external documents exchanged between the hospital and a third-party peer review company called MDReview.[66] These documents were entitled "Peer Review Report" and warned "THIS IS A CONFIDENTIAL PEER REVIEW DOCUMENT" at the top of the reports.[67] The documents further stated that they were "prepared at the request of the hospital in order to provide an independent professional opinion of the care rendered" to a specific patient.[68] Again, the hospital defendant argued the documents were protected from discovery by medical review privilege.[69]

Disagreeing with the defendant, the North Carolina Court of Appeals held that the documents did not qualify for medical review privilege. The court came to this conclusion because the hospital defendant did not provide any evidence indicating that the senders and recipients of the emails were medical review committee members, that the documents were generated by members of a medical review committee, or that the documents were generated for a medical review committee's consideration.[70] Further, the court reiterated that the document identified as originating "from the Hospital Board" on the privilege log would not be afforded privilege because a hospital's Board of Trustees does not fit the definition of a medical review committee.[71]

Medical review privilege was not extended to the second category of documents either, as the record was void of evidence indicating that MDReview was either a peer review organization or that it authored the documents for the purpose of peer review.[72] In noting that the defendant hospital's failure to provide affidavits or any affirmative evidence completely defeated defendant's claim, the court held the documents were not discoverable.[73]

A few years after *Bryson*, the question of whether a hospital defendant met its burden of proof to qualify for medical review privilege was again before the court. In *Hammond v. Saini*, the defendant hospital sought to withhold a Root Cause Analysis ("RCA") Report, Risk Management Worksheets ("RMWs"), and meeting notes taken by the hospital's risk manager by asserting the medical

65. *Id.* at 536, 694 S.E.2d at 420.
66. *Id.*
67. *Id.*
68. *Id.*
69. *Id.* at 538, 694 S.E.2d at 421.
70. *Id.* at 539, 694 S.E.2d at 421.
71. *Id.*, 694 S.E.2d at 422.
72. *Id.* at 540, 694 S.E.2d at 422.
73. *Id.*

review privilege applied to the documents because they were produced by the hospital's RCA Team.[74]

All of the documents for which the defendant claimed the privilege related to risk management's investigation of an operating room fire that caused the plaintiff to incur serious injuries when an electrocautery device ignited the oxygen trapped under the drapes by the plaintiff's face during surgery.[75] The defendant's argument for application of medical review privilege was buttressed solely by an affidavit from the hospital's risk manager stating, "In general, the peer review committees established to . . . prepare a root cause analysis are created by the medical staff and governing board of [the hospital] and operate under the [RCA] policy."[76]

The North Carolina Court of Appeals found the conclusory statements provided by the risk manager's affidavit insufficient to support a finding that the RCA Team is a medical review committee as a matter of law.[77] First, the court noted the absence of any evidence suggesting the RCA Team met the statutory requirements necessary to be considered a medical review committee: (1) nothing suggested the RCA Team was comprised of "medical staff of a hospital" and (2) that it was "formed for the purpose of evaluating the quality, cost of, or necessity for hospitalization or health care, including medical staff credentialing."[78] Citing to the record, the court similarly failed to find evidence indicating the RCA Team was "created by the governing board or medical staff of the hospital or system or operating under written procedures adopted by the governing board or medical staff of the hospital system."[79]

Assuming arguendo that the RCA Team qualified as a medical review committee, the court found that the defendant was still required to show that the disputed documents were part of the RCA Team's proceedings, produced by the RCA Team, or considered by the RCA Team in order to be shielded from discovery under the medical review privilege.[80]

As seen in *Bryson*, the court declined to rule in favor of the hospital defendant due to an inadequate evidentiary showing under the medical peer review statutes.[81] First, even though the cover page of the report identified the event and members of the RCA Team, the court held it did not qualify as a

74. Hammond v. Saini, 229 N.C. App. 359, 365, 748 S.E.2d 585, 589 (2013).

75. *Id.* at 361–62, 748 S.E.2d at 587.

76. *Id.* at 366, 369, 748 S.E.2d at 590, 592 ("The mere submission of affidavits by the party asserting the medical review privilege does not automatically mean that the privilege applies. Rather, such affidavits must demonstrate that each of the statutory requirements concerning the existence of the privilege have been met.").

77. *Id.*

78. *Id.* (citations omitted).

79. *Id.*

80. *Id.* at 367, 748 S.E.2d at 590.

81. *Id.* at 368, 748 S.E.2d at 591.

document produced by the RCA Team because the RCA Report failed to identify a specific author.[82] Next, the RMWs were discredited because the RCA policy specifically referenced "Quality Care Control Reports" and nothing indicated that the RMWs were the Quality Care Control Reports contemplated by the RCA policy.[83] Finally, the court held the risk manager's meeting notes did not fall within any of the three statutory categories allowing for medical review privilege to apply.[84] On this basis, the North Carolina Court of Appeals overruled defendant's arguments and held the documents discoverable.[85]

The hospital defendant then appealed the decision to the Supreme Court of North Carolina.[86] In agreeing with the decision reached by the court of appeals, the Supreme Court of North Carolina found the defendants failed to meet their burden of proof by supporting their argument with an affidavit reciting "mere conclusory assertions" without providing "specific evidence that could serve as the basis of finding of fact or conclusions of law."[87] Specifically, the hospital defendant failed to provide evidence supporting the RCA Team and policy met the requirements of Sections 131E-76(5) and 131E-95(b) of the General Statutes of North Carolina; the failure to identify the departments and personnel of the RCA Team; and the failure to prove the RCA policy was adopted by the governing board of the medical staff of the hospital were fatal to the defendant's argument.[88]

The most recent decision pertaining to medical review privilege, *Estate of Ray v. Forgy*, provides an important contrast to *Bryson* and *Hammond* by juxtaposing an affirmative example of a sufficient procedural evidentiary showing on the part of the hospital defendant seeking to invoke medical review privilege.[89] The plaintiffs in *Ray* sought documents from the hospital defendants relating to the defendant physician's malpractice insurance coverage, recredentialing, and queries made and responses received by the National Practitioner Database ("NPD").[90] The hospital defendants claimed that medical review privilege applied to the documents.[91] In support of their claim, the defendants submitted an affidavit from the director of medical staff services of the hospital that stated the sealed exhibits attached to the affidavit, containing the contested documents, met the statutory requirements necessary

82. *Id.* at 367, 748 S.E.2d at 591.
83. *Id.*
84. *Id.*
85. *Id.* at 368, 748 S.E.2d at 591.
86. *See* Hammond v. Saini, 367 N.C. 607, 608, 766 S.E.2d 590, 591 (2014).
87. *Id.* at 610–11, 766 S.E.2d at 592.
88. *Id.* at 611, 766 S.E.2d at 593.
89. Est. of Ray v. Forgy, 245 N.C. App. 430, 430, 783 S.E.2d 1, 9 (2016).
90. *Id.* at 432–33, 783 S.E.2d at 4.
91. *Id.* at 433, 783 S.E.2d at 4.

to be afforded statutory protection.[92] The sealed exhibits included the hospital bylaws creating and empowering the hospitals' medical review committees; a privilege log describing the author, date, source, and nature of the privileged documents; and the documents produced by or considered by the medical review committees.[93]

Citing *Hammond*, the plaintiffs argued the affidavit was conclusory and failed to fulfill the statutory tenets required for the hospital defendant to appropriately invoke medical review privilege.[94] The court distinguished the case from *Hammond*, noting that the *Ray* defendants perfected insufficiencies by attaching a detailed privilege log supplying the key categories of information, identified by the *Hammond* court as lacking, and providing the hospital's bylaws relevant to the medical review committee.[95] In doing so, the *Ray* court held, "[T]he hospital defendants have fulfilled their burden of demonstrating that the subject documents are privileged pursuant to N.C. Gen. Stat. § 131E-95."[96]

Bryson, *Hammond*, and *Ray* exemplify North Carolina's current approach to medical peer review. In each of the three cases, the fulcrum in determining whether the disputed documents would be afforded protection under medical peer review privilege was ultimately the defendants' ability to provide the court with enough "summary evidence"—an affidavit and a privilege log—justifying the claim of privilege, that would enable the court to choose to believe the documents were in fact protected by medical peer review.[97] Even though the courts in each case did perform a substantive review of the documents,[98] the opinions in *Hammond* and *Ray* nonetheless function as a rubric for defense counsel, detailing a burden of proof for summary evidence—an affidavit and privilege log—that can be used to circumvent substantive evidentiary review.

This approach is problematic for several reasons, but the most significant reason is that it deprives the parties of meaningful consideration of the disputed evidence. While the law must provide outlined guidance to hospitals and healthcare organizations regarding medical peer review, determining that something is protected by medical peer review simply based on the naming conventions of documents, as seen in *Hammond*, or by a privilege log containing "To" and "From" categories, as seen in *Ray*, still evades whether evidence was

92. *Id.*

93. *Id.* at 439–40, 783 S.E.2d at 8.

94. *Id.* at 440, 783 S.E.2d at 8.

95. *Id.* at 441, 783 S.E.2d at 9.

96. *Id.* at 442, 783 S.E.2d at 9.

97. *See* Bryson v. Haywood Reg'l Med. Ctr., 204 N.C. App. 532, 539, 694 S.E.2d 416, 421 (2010); Hammond v. Saini, 229 N.C. App. 359, 361, 748 S.E.2d 585, 589–90 (2013); *Est. of Ray*, 245 N.C. App. at 439–40, 783 S.E.2d at 8.

98. Again, appellate courts do perform a substantive view of the documents for which medical review committee privilege is claimed due to the implication of a substantial right. *See Est. of Ray*, 245 N.C. App. at 440, 783 S.E.2d at 8.

actually subject to medical peer review. This places medical peer review judicial decisions on capricious ground by reducing what should be a meaningful, substantive review of whether a hospital defendant intended in good faith for the materials to be the product of a medical review committee for quality assurance as intended by the statute, to an easily manipulable high-altitude evidentiary showing.

To be clear, courts are not expected to be experts when it comes to understanding the inner workings of medical peer review and quality assurance policies and procedures. In many respects, the courts are doing the best they can with what they have to work with. But, for a decision that fundamentally impacts such profound competing public policies—a guarantee of quality healthcare and a plaintiff's access to evidence—we need to do better, and we can do better.

III. REFORMATION OF MEDICAL PEER REVIEW PRIVILEGE IN NORTH CAROLINA: APPOINTMENT OF A REFEREE UNDER RULE 53 OF THE N.C. RULES OF CIVIL PROCEDURE

Long used by North Carolina courts in civil actions,[99] the appointment of "referees" in medical malpractice cases to resolve medical review committee privilege discovery disputes at the trial court level would be an easily applied, transplantable solution to resolving the medical peer review paradox.

The appointment of "referees,"[100] or special masters,[101] is facilitated by Rule 53 of the North Carolina Rules of Civil Procedure.[102] Under the rule, a judge may appoint a referee as follows:

> a. Where the trial of an issue requires the examination of a long or complicated account; in which case the referee may be directed to hear and decide the whole issue, or to report upon any specific question of fact involved therein.
>
> b. Where the taking of an account is necessary for the information of the court before judgment, or for carrying a judgment or order into effect.
>
> c. Where the case involves a complicated question of boundary, or requires a personal view of the premises.

99. Referees are appointed by judges in North Carolina in family law cases, complex business cases, and property disputes. *See generally* Dockery v. Hocutt, 357 N.C. 210, 581 S.E.2d 431 (2003) (appointing a referee in an adverse possession matter in which resolution required determination of boundaries on irregularly shaped land); Davis v. Davis, 58 N.C. App. 25, 293 S.E.2d 268 (1982) (referencing an appointment of referee to conduct accounting of partnership funds and property).

100. "Referees" or "Reference" is the technical term given to special masters by virtue of Rule 53. *See* N.C. R. CIV. P. 53.

101. "Special masters" is a synonym typically used for referees appointed under Rule 53. *See id.*

102. N.C. R. CIV. P. 53(a)(1)–(2) (noting that special masters may be appointed upon consent of the parties, upon application of a party or by its own motion).

d. Where a question of fact arises outside the pleadings, upon motion or otherwise, at any stage of the action.[103]

Ordering the appointment of a referee is within the discretion of the court and does not have to be authorized by statute.[104] Importantly, referees do not take cases away from the jurisdiction of the court.[105] Rather, they are an instrumentality of the court[106] designed to assist in areas designated by the superior court judge as falling within their purview.[107] The individual appointed to be a referee is typically one with specialized knowledge and expertise in the particular area for which his or her appointment was necessitated, making them more qualified than a generalist judge to evaluate the matter with which he or she has been charged.[108]

Judges employ Rule 53 when the appointment of a referee serves judicial "efficiency, practicality and justice."[109] Referees may be charged with evaluating testimony, ruling on the admissibility of evidence, and making recommended findings of fact and conclusions of law.[110] Referees are typically appointed in

103. N.C. R. CIV. P. 53(2)(a)–(d).

104. *See* Rudisill v. Hoyle, 254 N.C. 33, 46, 118 S.E.2d 145, 154 (1961); *see also* Shute v. Fisher, 270 N.C. 247, 253, 154 S.E.2d 75, 79 (1967) (finding that in the absence of a statutory provision or well-recognized applicable rule ordering the appointment of a referee, a judge is empowered to exercise discretion in the interest of efficiency, practicality, and justice). *But see* Veazey v. City of Durham, 231 N.C. 357, 365–66, 57 S.E.2d 375, 384 (1950) (holding there is no legal right that a judge direct a reference).

105. *See* Weaver v. Hampton, 204 N.C. 42, 42, 167 S.E. 484, 485 (1933) (noting that the appointment of a referee does not remove the cause of action from the jurisdiction of the superior court; rather, it removes the procedure or method of determining facts and law to the provenance of the referee as directed).

106. *See* Sharp v. Gulley, 120 N.C. App. 878, 879, 463 S.E.2d 577, 578 (1995) (holding a court-appointed referee is not an agent of the parties but of the court).

107. *See* N.C. R. CIV. P. 53(e) ("Powers.--The order of reference to the referee may specify or limit his powers and may direct him to report only upon particular issues or to do or perform particular acts or to receive and report evidence only and may fix the time and place for beginning and closing the hearing and for the filing of the referee's report. Subject to the specifications and limitations stated in the order, every referee has power to administer oaths in any proceeding before him, and has generally the power vested in a referee by law. The referee shall have the same power to grant adjournments and to allow amendments to pleadings and to the summons as the judge and upon the same terms and with like effect. The referee shall have the same power as the judge to preserve order and punish all violations thereof, to compel the attendance of witnesses before him by attachment, and to punish them as for contempt for nonattendance or for refusal to be sworn or to testify. The parties may procure the attendance of witnesses before the referee by the issuance and service of subpoenas as provided in Rule 45.").

108. *See, e.g.*, Godwin v. Clark, Godwin, Harris & Li, P.A., 40 N.C. App. 710, 713, 253 S.E.2d 598, 601 (1979) (referencing the appointment of a certified public accountant as referee in a case requiring the examination and valuation of disputed stock valuation resulting from a dispute over a stock redemption agreement).

109. *See Shute*, 270 N.C. at 253, 154 S.E.2d at 79.

110. *See* N.C. R. CIV. P. 53(e) (noting the powers of referees); *see also* Cleveland Constr., Inc. v. Ellis-Don Constr., Inc., 210 N.C. App. 522, 532, 709 S.E.2d 512, 520 (2011) (noting that a referee may conduct findings of fact and suggest conclusions of law).

cases implicating the review of "long or complicated account[s]"[111] that are in dispute by the parties for which the judge may lack the time or expertise to appreciably perform an in camera review. In these cases, the disputed evidence is referred to the referee for their substantive review and consideration.[112] Once a referee receives the evidence, the referee will issue a report as required by Rule 53(g)[113] elucidating their findings and conclusions.[114] At this point, the parties may file exceptions to the referee's findings and conclusions within thirty days.[115] If no exceptions are filed, or the time within which the parties may file the exceptions has lapsed, the superior court judge may affirm, disaffirm, or modify the report of the referee.[116]

The appointment of referees under Rule 53 in medical committee review privilege disputes is appropriate for several reasons. First, medical malpractice cases tend to be inherently voluminous. While much of the volume is attributable to the medical records themselves, documents for which medical review committee privilege is claimed likewise tend to be ample. This is in part due to the depth and extent of the investigations carried out by the medical review committees, as well as the number of health care providers and hospital administrators who are typically involved, in one way or another, in the review process. Allocating the review of medical review committee documents to a referee better assures that the documents are given the careful consideration that both parties deserve and that the policy underlying the privilege requires.

Next, the appointment of a referee would allow for an individual with specific knowledge of North Carolina's medical review committee privilege to perform the review. To be clear, a referee's review is not intended to supplant the formalities of the medical review committees prescribed by the statute.

111. N.C. R. CIV. P. 53(a)(2)(a).

112. The scope of a referee's review is outlined in the order appointing the referee entered by the court.

113. N.C. R. CIV. P. 53(g) ("Report.--(1) Contents and Filing.--The referee shall prepare a report upon the matters submitted to him by the order of reference and shall include therein his decision on all matter so submitted. If required to make findings of fact and conclusions of law, he shall set them forth separately in the report. He shall file the report with the clerk of the court in which the action is pending and unless otherwise directed by the order of reference, shall file with it a transcript of the proceedings and of the evidence and the original exhibits. Before filing his report, a referee may submit a draft thereof to counsel for all parties for the purpose of receiving their suggestions. The clerk shall forthwith mail to all parties notice of the filing.").

114. *Id.*

115. N.C. R. CIV. P. 53(g)(2) ("Exceptions and Review.--All or any part of the report may be excepted to by any party within 30 days from the filing of the report. Thereafter, and upon 10 days notice to the other parties, any party may apply to the judge for action on the report.").

116. *See id.* ("The judge after hearing may adopt, modify or reject the report in whole or in part, render judgment, or may remand the proceedings to the referee with instructions. No judgment may be rendered on any reference except by the judge."); *see also* Bullock v. Tucker, 262 N.C. App. 511, 517, 822 S.E.2d 654, 659 (2018) (suggesting that a trial judge must deliberate and decide issues of fact and law where a party takes exception to a referee's findings of fact and law).

Rather, it is intended to supplement the statute's standards by better squaring the statute's purpose with the evidentiary rubric that, if met, is deemed to be indicative of satisfying the statute's purpose. One of the incentives to appointing a referee is the level of expertise they bring to the subject matter.[117] Although judges bring expertise in the areas of practice in which they were engaged prior to ascending to the bench, they are not, and cannot be, experts in every area of law over which they preside. Appointing a referee who has knowledge and experience with North Carolina's medical review committee privilege would engender a more meaningful examination of the documents in dispute. The referee can provide the court with a more thorough description of what the documents are, whether they are implicated under the medical review committee privilege statute and would provide a more thorough explanation as to why or why not the privilege should extend to them. Not only will this practice better serve the underlying competing policy goals of the statute, it will also provide both the courts and practitioners with more stability and consistency in the medical review committee jurisprudence. This will be accomplished by creating more substance-based[118] precedent regarding medical review committee privilege than has been observed to date.

Though there are benefits of delegating medical review committee privilege discovery reviews to a referee, there are also drawbacks. The primary drawback is that court-appointed referees are required to be compensated.[119] In North Carolina, where tort reform has already substantially impeded plaintiffs' ability to file[120] and recover in medical malpractice actions,[121] the additional cost of a court-appointed referee may be viewed as an unnecessary billable line-

117. Rule 53 allows parties to submit to the presiding judge names and qualifications of individuals they seek to be appointed as a referee for the matter. N.C. R. CIV. P. 53(c). This allows judges to carefully consider the credentials of proposed referees when making their determination as to who is best qualified to conduct the review as well as the scope of the review that is to be conducted. *See id.*

118. Because Rule 53(g) requires the filing of a report by the referee, a referee who is required by the court to provide detailed findings and conclusions, if adopted by the court, would be able to provide a more detailed and thorough summary of the documents and their relevancy to the statute than will likely be captured in a privilege log and discovery responses. N.C. R. CIV. P. 53(g).

119. N.C. R. CIV. P. 53(d) ("Compensation.--The compensation to be allowed a referee shall be fixed by the court and charged in the bill of costs. After appointment of a referee, the court may from time-to-time order advancements by one or more of the parties of sums to be applied to the referee's compensation. Such advancements may be apportioned between the parties in such manner as the court sees fit. Advancement so made shall be considered in the final fixing of costs and such adjustments made as the court then deems proper.").

120. N.C. R. CIV. P. 9(j); *see also* Eric S. Goodheart, Comment, *Two Tiers of Plaintiffs: How North Carolina's Tort Reform Efforts Discriminate Against Low-Income Plaintiffs*, 96 N.C. L. REV. 512, 516–19 (2018) (referencing the 2015 amendment to Rule 9(j) of the North Carolina Rules of Civil Procedure that increased the stringency of a plaintiff's prefiling expert witness requirement, ultimately increasing the pretrial cost of medical malpractice actions for plaintiffs by requiring more thorough review by expert witnesses in order to certify under 9(j)).

121. *See* Goodheart, *supra* note 120, at 527 (explaining the impact of statutorily limiting the noneconomic damages cap to $500,000).

item—why pay for something that you could otherwise get for free? This is certainly a question worthy of careful consideration. North Carolina common law currently provides for the right of an interlocutory appeal on an order pertaining to the discoverability of documents seeking to be protected under medical committee review privilege.[122] Thus, necessary to the consideration of whether a Rule 53 referee is worthwhile is whether a party would rather spend time and money on a referee to review the documents at the trial court level or on an interlocutory appeal at the appellate level.[123]

A benefit to incurring the cost of a review at the trial court level is that a review by a referee is likely to produce a more expedient result than will be afforded by the appellate process.[124] And like their trial court colleagues, there is no guarantee that any of the judges on the appellate panel[125] assigned to the interlocutory appeal will have legal expertise pertaining to medical committee review privilege or medical malpractice actions generally. However, and significantly, a review by a referee does not circumvent a party's right to an interlocutory appeal upon the entry of an order adopting, dismissing, or modifying a referee's report.[126] Decisions impacting a party's right to evidence or to withhold evidence based on privilege affects a substantial right.[127] Thus, any decision made regarding the discoverability of documents for which privilege is claimed at the trial court level will continue to be appealable. Nonetheless, given the value of the information contained in the documents to the parties in medical malpractice actions, the expertise and depth that a referee can provide, in contrast to a judge, is enough to warrant thoughtful consideration.

122. *See, e.g.*, Est. of Ray v. Forgy, 245 N.C. App. 430, 435, 783 S.E.2d 1, 5 (2016) ("[A] party may appeal an interlocutory order that 'affects some substantial right claimed by the appellant and will work an injury to him if not corrected before an appeal from the final judgment." (quoting Meherrin Indian Tribe v. Lewis, 197 N.C. App. 380, 383, 677 S.E.2d 203, 206 (2009) (citations omitted))).

123. When performing an interlocutory appeal related to medical review committee privilege, the appellate judges will perform an in camera review of the documents in reaching their determination as to the applicability of the privilege. *See id.* at 440, 783 S.E.2d at 8.

124. *See About the Court of Appeals: Average Days to Disposition*, N.C. JUD. BRANCH, https://www.nccourts.gov/court/court-of-appeal/about-the-court-of-appeals [http://perma.cc/8NKG-AX8M] (noting the average time to disposition as of 2016 was 181 days).

125. Cases on appeal in North Carolina are heard by a panel of three judges. *Id.*

126. *See, e.g.*, Bullock v. Tucker, 262 N.C. App. 511, 513, 822 S.E.2d 654, 656 (2018) (exemplifying one instance of an interlocutory appeal made after the trial court adopted the referee's report in its entirety after defendant's exception to the referee's report had been heard).

127. *Meherrin Indian Tribe*, 197 N.C. App. at 383, 677 S.E.2d at 206.

CONCLUSION

Medical review committee privilege is powerful—it is absolute and cannot be waived.[128] But so are the public policies it implicates—the right to quality health care and the right to evidence. Striking the balance between the competing policy concerns implicated by medical review committee privilege requires a substantive review of documents for which the privilege is claimed in each case where it is contested. By allowing defendants to procedurally circumvent a thorough evidentiary review by submission of an affidavit and privilege log made defensible by *Estate of Ray v. Forgy*, the court has put the thumb on the scale for the defense in a state with medical malpractice laws already overwhelmingly in their favor.[129] This is not to say that all documents for which the privilege is claimed are discoverable or that counsel is not being professionally aboveboard in their privilege representations to the court. Rather, it is in recognition of the significance of the public policies in the balance and the fact that where one must give, the other must take.

Mandatory incorporation of Rule 53 of the North Carolina Rules of Civil Procedure into medical malpractice actions is an easily implemented, reasonable measure that guarantees substantive review of medical review committee privileged documents in medical malpractice actions. The expertise and consideration that a qualified referee can provide better serves plaintiffs, defendants, and judges by guaranteeing a careful, substantive evidentiary review when medical review committee privilege challenges arise. Not only would this practice better serve the parties to medical malpractice actions, but the policies implicated by medical review committee privilege too.

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128. *See* Virmani v. Presbyterian Health Servs. Corp., 350 N.C. 449, 467, 515 S.E.2d 675, 687 (1999) ("We note that because N.C.G.S. § 131E-95 expressly prohibits the introduction of [medical review committee] documents 'into evidence in any civil action,' it was improper for [plaintiff] to attach them to his complaint as evidence or as a forecast of evidence. We emphasize that those documents continue to be inadmissible as evidence or as a forecast of evidence in this case, which is 'a civil action against a hospital or a provider of professional health services which results from matters which are the subject of evaluation and review by the [medical peer review] committee." (citing N.C. GEN. STAT. § 131 E-95)).

129. *See supra* notes 117–18 and accompanying text.

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