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INTRODUCTION

Peer review and medical malpractice litigation ostensibly coexist in the United States body of law affecting health care to achieve many of the same social goals; the goals in common include the improvement of health care quality by establishment of best practices and reduction of medical error.[1] The current health care debate has focused, however, on the degree to which the tort system adds substantial transactional costs (attorneys fees and insurance premiums) and clinical costs (so-called defensive medicine, both the over use of testing and aggressive procedures, and the avoidance of complex cases to avoid vulnerability to litigation),[2] while its affirmative impact on quality

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1. *See, e.g.,* Address Before a Joint Session of the Congress on Health Care Reform, 155 CONG. REC. H9391 (daily ed. Sept. 9, 2009).

2. *See* Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment*

is questionable.[3]

By contrast, peer review marshals the resources of health care providers to engage in a targeted analysis of quality without the costs for which the tort system has been justly criticized. The problem is that peer review and medical malpractice litigation are in tension with each other in that medical malpractice litigation feeds off candid criticism of care by converting peer review into a tool to achieve higher verdicts and settlements in individual cases. Since the stifling effect of medical malpractice litigation on aggressive and effective peer review to improve patient care was first identified, one by one, states have adopted some level of protection in an attempt to create a balance. The result is a confusing hodgepodge that varies among states. This lack of uniformity is increasingly deleterious for efficacious peer review in a health care system where the parochialism of the past needs to give way to regional and national standards of excellence.

This Article proposes that the relationship between peer review and medical malpractice should be reset to give preeminence to the former, at least with respect to immunity, confidentiality, and privilege. The vehicle to do so already exists – the Patient Safety Quality Improvement Act ("PSQIA") – and the mechanism is simple. Congress should revisit the PSQIA and create a federal peer review privilege that unambiguously and effectively removes the entire peer review process from the threat of the tort system by expanding the definition of "patient safety work product" to avoid the loophole otherwise created by the pre-

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to Improve Quality and Safety in Healthcare, 30 AM. J.L. & MED. 501, 530 (2004).

3. Others disagree. Professor Issacharoff views "tort reform" as part of a broader attack on "ex post accountability" generally. Samuel Issacharoff, *Regulating after the Fact,* 56 DEPAUL L. REV. 375, 385-86 (2007). Rather than facilitating the exchange of information, peer review in particular perpetuates a "conspiracy of silence." B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy,* 10 AM. J.L. & MED. 151, 160 (1984). *See, e.g.,* Maynard v. United States, 133 F.R.D. 107, 108 (D.N.J. 1990) (burden was on plaintiff to overcome decision by colonel at military hospital that documents were privileged quality assurance documents); Columbia/JFK Med. Ctr. Ltd. P'ship v. Sanguonchitte, 920 So. 2d 711, 712 (Fla. Dist. Ct. App. 2006) (documents in physician's credentialing file were protected from discovery in patient's action against hospital for negligent credentialing); Alexander v. Super. Ct., 23 Cal. Rptr. 2d 397, 403 (Cal. 1993) (same).

emption clause in the PSQIA.

Part I of this Article adumbrates what peer review means in the state and federal courts, and why it has value. In particular, it focuses on the importance of immunity, confidentiality and privilege to peer review. Part II of this Article addresses the status of the peer review privilege in Rhode Island and its relationship to Rule 407 of the Rhode Island Rules of Evidence. Part III of this Article explicates the PSQIA and points out the flaw in the Act that excludes certain peer review materials[4] from its coverage. Part IV of this Article explains why the PSQIA does not pre-empt state laws mandating the provision of peer review materials to state regulators, leaving those materials outside the protection of the PSQIA. Finally, Part V of this Article presents a proposal to improve health care by amending the PSQIA to expressly preempt state law that fails to protect peer review materials.

I. WHAT IS PEER REVIEW?

"Errors have always been a part of . . . medic[ine] . . . ."[5] Historically, errors have been addressed through the tort system, which "encourages good decision making, compensates persons

4. This Article intentionally uses the generic term "peer review materials" to describe documents that are somehow associated with the peer review process. *See* Doe v. Unum Life Ins. Co. of Am., 891 F. Supp. 607, 611 (N.D. Ga. 1995) ("[T]here are two kinds of privileged information covered by [the peer review] statute: (1) material that relates directly to the peer review investigation, which is always nondiscoverable, despite its source; and (2) information that would have existed regardless of the institution's investigation, but is sought *from the peer review body* itself."). It is beyond the scope of and not necessary to this Article to parse each state's law to identify exactly which documents are covered, which are not, and whether their dissemination can be limited by other legal doctrines such as the remedial action privilege (FED. R. EVID. 407), the attorney-client privilege, or the work-product doctrine. For a discussion of the application of these other legal doctrines to peer review materials, see, for example, Cynthia J. Dollar, *Promoting Better Health Care: Policy Arguments for Concurrent Quality Assurance and Attorney-Client Hospital Incident Report Privileges,* 3 HEALTH MATRIX 259, 273-87 (1993).

5. Marshall B. Kapp, *Medical Error Versus Malpractice*, 1 DEPAUL J. HEALTH CARE L. 751, 751 (1997) (citing CHARLES L. BOSK, FORGIVE AND REMEMBER: MANAGING MEDICAL FAILURE (1979)); *see also* David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 948 (2005) (human frailties make some errors inevitable).

who have been wrongfully harmed, promotes social dialogue on questions of . . . treatment, and serves to guide the conduct of third parties."[6]

The tort system, however, should be the "regulator of last resort."[7] Given the potentially drastic economic, reputational and psychological impact of an adverse litigation outcome, the tort system creates a perverse incentive for health care providers to hide mistakes and "near-misses" as opposed to learning from them.[8] The analysis of "near-misses" is particularly crucial because they afford health care providers the opportunity "to identify and remedy vulnerabilities in systems before the occurrence of harm."[9] Rather than acknowledge error, health care providers may pretend that incidents never occurred, or even worse, cover them up.[10] As a result, valuable data about misses and near-misses is irretrievably lost to the detriment of both physicians and their patients, and the fiduciary relationship between physician and patient is violated.[11]

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6. Robin Fretwell Wilson, *Hospital Ethics Committees as the Forum of Last Resort: An Idea Whose Time Has Not Come*, 76 N.C. L. REV. 353, 394 (1998); *see also* P.T. v. Richard Hall Cmty. Mental Health Care Ctr., 837 A.2d 436, 445 (N.J. Super. Ct. Law Div. 2002) ("duties of care owed by professionals to their patients . . . are important duties for they safeguard all of us from excesses at the hands of professionals"); Hyman & Silver, *supra* note 5, at 947-48 (malpractice system prompted the informed consent doctrine and improved health care generally).

7. Michelle M. Mello, Carly N. Kelly & Troyen A. Brennan, *Fostering Rational Regulation of Patient Safety*, 30 J. HEALTH POL. POL'Y & L. 375, 418 (2005).

8. Bryan A. Liang & Steven D. Small, *Communicating About Care: Addressing Federal-State Issues in Peer Review and Mediation to Promote Patient Safety*, 3 HOUS. J. HEALTH L. & POL'Y 219, 220-21, 223 (2003).

9. Institute of Med., TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 87 (Linda T. Kohn et al. eds., 2000); *see also* Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J.L. MED. & ETHICS 346, 357-58 (2001); Paul Barach & Steven D. Small, *How the NHS Can Improve Safety and Learning: By Learning Free Lessons from Near Misses*, 320 BRIT. MED. J. 1683, 1684 (2000).

10. Kapp, *supra* note 5, at 757; Liang & Small, *supra* note 8, at 221. *But see* Bryan A. Liang, John Bramhall & Bruce Cullen, *Which Syringe Did I Use? Anesthesiologist Confusion and Potential Liability for a Medical Error*, 14 J. OF CLINICAL ANESTHESIA 371 (2002) (describing a case of potential medical error in which the erring physician "fessed up" to the patient; the patient subsequently sued).

11. Kapp, *supra* note 5, at 758-59; *see also* Thomas L. Hafemeister &

Peer review, by contrast, generally seeks to accomplish the same goals, other than compensation. It is a process by which health care providers evaluate their colleagues' work to determine if it complied with the standard of care by understanding the root cause of why a preventable adverse event occurred.[12] Peer review can also apply to the credentialing process.[13] Peer review is based on three premises: (1) only health care providers can effectively evaluate each other from a clinical perspective; (2) to do so, participants in peer review processes must engage in candid communication; and (3) participants act in good faith.[14]

Selina Spinos, *Lean on Me: A Physician's Fiduciary Duty to Disclose an Emergent Medical Risk to the Patient*, 86 WASH. U.L. REV. 1167, 1194-95 (2009) (proposing a cause of action for breach of fiduciary duty for failing to disclose a material emergent medical risk to a patient).

12. George E. Newton, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723 (2001); Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Laws for Physicians*, 24 J. LEGAL MED. 541, 541-42 (2003).

13. *See* Craig W. Dallon, *Understanding Judicial Review of Hospitals' Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 610-12 (2000) (discussing new applications for privileges, renewals of existing privileges, and review of problems). *See, e.g.*, United States *ex rel.* Roberts v. QHG of Ind., Inc., No. 1:97-CV-174, 1998 WL 1756728, at *1 n.3 (N.D. Ind. Oct. 8, 1998); Larson v. Wasemiller, 738 N.W.2d 300, 302 (Minn. 2007); Pastore v. Samson, 900 A.2d 1067, 1074-76 (R.I. 2006); St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503, 509 (Tex. 1997); *see also* Humana Hosp. Desert Valley v. Super. Ct., 742 P.2d 1382, 1388 (Ariz. Ct. App. 1987) (rejecting argument that peer review only refers to retrospective review of patient care and not credentialing).

14. Ilene N. Moore, James W. Pichert, Gerald B. Hickson, Charles Federspiel & Jennifer U. Blackford, *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1177 (2006); *see also* Mathews v. Lancaster Gen. Hosp., 87 F.3d 624, 633 (3d Cir. 1996) (there is a strong presumption that peer review is conducted in good faith); LeMasters v. Christ Hosp., 791 F. Supp. 188, 191 (S.D. Ohio 1991) ("[M]ost physicians feel an ethical duty to the profession and to the public to keep the standard of health care high."); Young v. Western Pa. Hosp., 722 A.2d 153, 156 (Pa. Super. Ct. 1999) ("'[B]ecause of the expertise and level of skill required in the practice of medicine, the medical profession itself is in the best position to police its own activities.'" (quoting Cooper v. Delaware Valley Med. Ctr., 630 A.2d 1, 14 (Pa. Super. Ct. 1993), *aff'd*, 654 A.2d 547 (Pa. 1995))). *But see* Patrick v. Burget, 486 U.S. 94, 98 n.3, 101-06 (1988) (peer review in that case was "'shabby, unprincipled and unprofessional'"); United States v. Kubrick, 444 U.S. 111, 128 n.4 (1979) (Stevens, J., dissenting) (questioning whether one doctor will tell a patient that another doctor "failed to live up to minimum standards of medical proficiency").

Medical systems are complex, and in a complex system even a 99.9% level of proficiency may not be adequate.[15] The purpose of peer review is to "improve hospital conditions and patient care or to reduce the rates of death and disease."[16] As Judge Lipez of the United States Court of Appeals for the First Circuit has noted, "[i]f patients are being subjected to unnecessary procedures and tests, the consequences are both economic and medical."[17]

The impact of peer review on medical care is direct: "Hospitals gain a lot of valuable information by evaluating the safety of new brain surgery techniques, the appropriateness of certain types of patient restraints, whether nursing rounds are being performed frequently enough to monitor the patients sufficiently, causes of a patient's death, or the circumstances surrounding the birth of an infant with cerebral palsy."[18] When hospital conditions and patient care improve and the rates of death and disease decline, the number of medical malpractice lawsuits should decline.[19] Peer review thus seeks to identify and eliminate these systemic "accidents waiting to happen," thereby maximizing efficient health care outcomes.[20]

A key variable in the success of peer review is the

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15. Lucian L. Leape, *Error in Medicine,* 272 J. AM. MED. ASS'N 1851, 1851 (1990). Professor Reason has analogized error systems to Swiss cheese; the holes are potential failures, and the solid areas represent defenses. An error can pass through the system when the holes line up. James Reason, *Human Error: Models and Management,* 320 BRIT. MED. J. 768, 769 (2004).

16. Niven v. Siqueira, 487 N.E.2d 937, 942 (Ill. 1985); *see also* Logue v. Velez, 699 N.E.2d 365, 367 (N.Y. 1998). *But see* Ehlen v. St. Cloud Hosp., No. C4-96-632, 1996 WL 589042, at *2 (Minn. Ct. App. Oct. 10, 2006) (denying peer review protection to discussion of a rule that would affect all urologists at a hospital as opposed to single urologist challenging credentialing decision).

17. Singh v. BlueCross/Blue Shield of Mass., Inc., 308 F.3d 25, 39 (1st Cir. 2002).

18. Dollar, *supra* note 4, at 298; *see, e.g.,* Mathews v. Lancaster Gen. Hosp., 87 F.3d 624, 628-29 (3d Cir. 1996) (granting immunity where plaintiff physician injured patient with high speed drill); Unnamed Physician v. Bd. of Trustees of St. Agnes Med. Ctr., 113 Cal. Rptr. 2d 309, 321 (Cal. Ct. App. 2001) (privileging dispute involving physician whose infection rate was quadruple the national average of his peers); Lo v. Provena Covenant Med. Ctr., 796 N.E.2d 607, 611, 617 (Ill. App. Ct. 2003) (upholding hospital's decision to suspend privileges of doctor whose mortality rate was almost double the national average).

19. *See Pastore,* 900 A.2d at 1079.

20. *See* Liang & Ren, *supra* note 2, at 523.

receptiveness of team leaders to discussing mistakes.[21] When properly done, peer review incorporates continuous quality improvement and "focuses on the cause of adverse events from a 'systems' perspective and asks about the context or conditions that led to the error."[22] Rather than individualizing blame as the tort system does, peer review encourages learning and safety enhancements.[23] By looking at problems from a "systems" perspective, peer review can then address what might otherwise seem to be isolated incidents occurring one at a time—"'an injury here, a mistake there, an accident here, a death here.'"[24] These "[l]atent failures often go unrecognized and remain within the system, 'increasing the potential for adverse events in the future because they predispose the system to failure.'"[25] Even when these failures can be identified, "shame and blame" mechanisms push these problems underground.[26]

Peer review has not, however, been without its critics. In the past, commentators have argued on the basis of empirical analysis that peer review does not work.[27] Their conclusion is not surprising; badly done peer review that merely focuses on "[r]aw

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21. *See* Amy C. Edmondson, *Learning from Mistakes Is Easier Said Than Done: Group and Organizational Influences on the Detection and Correction of Human Error,* 40 J. APPLIED BEHAVIORAL SCI. 66, 70 (2004).

22. Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 YALE J. ON REG. 383, 388 (2001).

23. Leape, *supra* note 15, at 1851; Liang & Small, *supra* note 8, at 220; Oliver Quick, *Outing Medical Errors: Questions of Trust and Responsibility*, 14 MED. L. REV. 22, 39 (2006).

24. Quick, *supra* note 23, at 27. Plaintiff's counsel can also connect the dots. Jason M. Healy, William M. Altman & Thomas C. Fox, *Confidentiality of Health Care Provider Quality of Care Information*, 40 BRANDEIS L.J. 595, 618 (2002) (plaintiff's attorney will often use the discovery phase to turn a single incident into a pattern of neglect).

25. Liang & Small, *supra* note 8, at 223.

26. Liang & Ren, *supra* note 2, at 524.

27. *See, e.g.*, Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit-Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 8-9 (1999) (data from the National Practitioner Data Bank "suggests that peer review protection statutes do not encourage peer review"); Gregory G. Gosfield, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L.Q. 552, 575 (1979) ("[E]ven if peer review activity is increased, it is unclear whether the result will be lower cost and higher quality of health care."). *But see* Chiang, *supra* note 22, at 388-89 n.28 (discussing how continuous quality improvement in the delivery of anesthesia has dramatically reduced mortality rates).

percentages" obviously create "incentives for physicians to abandon high risk patients."[28] As peer review has become more sophisticated, however, it has become more effective.

Critics have also argued that peer review potentially muffles the "deterren[t] signal" that litigation generates.[29] According to these fault finders, only the "specter of stiff recoveries and increased insurance premiums," not analyses of systems, will force health care providers to address medical errors.[30] According to them, a focus on systems should not become a substitute for individual professional responsibility. Cases should not be allowed to "'dribble away into a general amalgam of agents and conditions, reactions and counter-reactions, which brings social certainty and popularity to the concept of system.'"[31]

An additional criticism that has enjoyed some popularity in the past is that the peer review privilege protects health care

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28. Harris v. Bellin Mem'l Hosp., 13 F.3d 1082, 1090 (7th Cir. 1994) (Flaum, J., concurring).

29. Wilson, *supra* note 6, at 395.

30. Joan Vogel & Richard Delgado, *To Tell the Truth: Physicians' Duty to Disclose Medical Mistakes*, 28 UCLA L. REV. 52, 56 (1980-1981).

31. Quick, *supra* note 23, at 42 (quoting Ulrich Beck, RISK SOCIETY: TOWARDS A NEW MODERNITY 33 (1992)); *see also* Michael R. Flick, *The Due Process of Dying*, 79 CAL. L. REV. 1121, 1165 (1991) ("Doctors must be held accountable for their personal involvement in healing . . . . Cementing the locus of medical decision-making power in any party . . . [allows] the people involved to assign responsibility for their actions to someone else."); Michael J. Trebilcock, *Incentive Issues in the Design of "No Fault" Compensation Systems*, 39 U. TORONTO L.J. 19, 53 (1989) (idea that accidents should be a community responsibility ignores the fact that accident rates are influenced by individuals who respond to economic incentives); Hyman & Silver, *supra* note 5, at 916-17 (liability rules make physicians more careful). *But see* Bryan A. Liang, *Assessing Medical Malpractice Jury Verdicts: A Case Study of an Anesthesiology Department*, 7 CORNELL J.L. & PUB. POL'Y 121, 145-47 (1997) (physicians do not understand the jury system and, consequently, its deterrent effect is misplaced). The ultimate example of systems analysis subsuming common sense was the statement of a British judge to a surgeon convicted of manslaughter:

> It was not your fault that you were allowed to go on operating, subject to restrictions, for another two years. Much of the evidence of these events was known at the time and the balance of the evidence was easily discoverable had it occurred to anyone making elementary inquiries.

Quick, *supra* note 23, at 42 (quoting *Hospital Did Not Stop Killer Surgeon*, THE TIMES 21 (June 24, 2004)).

providers, not patients.[32] Seen in this light, peer review is another device by which health care providers maintain control over health care delivery. Statutes like the Health Care Quality Improvement Act ("HCQIA") are nothing more than "special interest legislation developed by effective lobbying efforts of medical and hospital lobby groups to protect their members."[33] Peer review is also inconsistent with the "de-expertification" of health care, whether through increased lay control of medical decisions by way of managed care,[34] or greater public participation on medical licensing boards.[35]

Yet another concern is that peer review, like any privilege, lends itself to abuse on the part of the entity claiming it.[36] Just as the defense bars summons up the damages arising from the hot cup of coffee, the plaintiffs' bar points to the invocation of the peer review privilege to shield the production of an incident report involving a collapsed chair in a clinic waiting room.[37] The fact that specious assertions of privileges like this one have failed shows that specious claims are the exception that prove the rule.

Finally, critics also see peer review as cultivating

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32. *See, e.g.*, Goldberg, *supra* note 3, at 151 (quoting SISELLA BOK, SECRETS 131 (1982)); Scheutzow, *supra* note 27, at 20; *see also* Nazareth Literary & Benevolent Inst. v. Stephenson, 503 S.W.2d 177, 179 (Ky. 1973) ("Although [a peer review privilege] might be regarded as an initially appealing argument, on reflection, one might well debate wherein the public interest lies.").

33. Scheutzow, *supra* note 27, at 19.

34. Lu Ann Treviño, *The Health Care Quality Improvement Act: Sword or Shield?*, 22 T. MARSHALL L. REV. 315, 317 (1997) (Congress lets doctors use peer review to "circle the wagons" against public scrutiny); *cf.* Adam M. Freiman, *The Abandonment of the Antiquated Corporate Practice of Medicine Doctrine: Injecting a Dose of Efficiency into the Modern Health Care Environment*, 47 EMORY L.J. 697, 743-46 (1998) (reviewing the impact of increased lay control of medical decisions through managed care).

35. James N. Thompson, *The Future of Medical Licensure in the United States*, 81 ACAD. MED. S36, S36 (2006) (citing the work of the Pew Health Professions Commission).

36. *See, e.g.*, Marte v. Brooklyn Hosp. Ctr., 779 N.Y.S.2d 82, 84 (N.Y. App. Div. 2004) (hospital sought to use peer review privilege to shield information about hospital security where patient was assaulted while at the hospital); Sonsini v. Mem'l Hosp. for Cancer & Diseases, 693 N.Y.S.2d 17, 18 (N.Y. App. Div. 1999) (maintenance log for mammography machine was not peer review material).

37. Berggren v. St. Vincent's Catholic Med. Ctr. of N.Y., Inc., 5 Misc. 3d 1028(A), 2004 WL 2903641, at *1 (N.Y. Sup. Ct. 2004).

opportunities for "corrupt and ulterior motives" where doctors have competing economic interests.[38] Not all peer review has been for the purpose of improving health care.[39] Perfection should not, however, become the enemy of good. [40]

In fact, not all health care providers are enamored with peer review. While the greatest deterrent to peer review is the fear of future litigation by participants,[41] peer review also entails criticizing peers, losing time with patients in order to participate in the peer review process and a fear of reprisals in the form of diminished patient referrals even if there is absolutely no litigation.[42] More fundamentally, peer review entails acknowledging error, and doctors are not supposed to make mistakes,[43] let alone admit[44] and apologize for them.[45]

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38. *See, e.g.*, Yann H.H. van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. CONTEMP. HEALTH L. & POL'Y 239, 240 (2001) (citing Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324, 1335 (10th Cir. 1996)).

39. *Patrick*, 486 U.S. at 98 & n.4; Oltz v. St. Peter's Cmty. Hosp., 861 F.2d 1440, 1451 (9th Cir. 1988); Weiss v. York Hosp., 745 F.2d 786, 819-20 (3d Cir. 1984).

40. *See* VOLTAIRE, LA BÉGUEULE (1772) ("Le mieux est l'ennemi du bien").

41. H.R. REP. NO. 99-903, at 3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385; *see also* Ayash v. Dana-Farber Cancer Inst., 822 N.E.2d 667, 691 (Mass. 2005) ("Physicians would be far less willing candidly to report, testify about, and investigate concerns of patient safety if their actions would be subject to later scrutiny and possible litigation."); Cruger v. Love, 599 So. 2d 111, 114-15 (Fla. 1992) ("The privilege afforded to peer review committees is intended to prohibit the chilling effect of the potential public disclosure of statements made to or information prepared for and used by the committee in carrying out its peer review function."); Cal. Eye Inst. v. Super. Ct., 264 Cal. Rptr. 83, 87 (Cal. Ct. App. 1989) ("Participation in peer review would be inhibited if a committee member's comments could be discovered in a damage action against a committee member or others.").

42. Reed E. Hall, *Hospital Committee Proceedings and Reports: Their Legal Status*, 1 AM. J.L. & MED. 245, 254 (1975); Newton, *supra* note 12, at 729; Scheutzow, *supra* note 27, at 18.

43. David Hilfiker, *Sounding Board: Facing Our Mistakes*, 310 NEW ENG. J. MED. 118, 121 (1984); *cf.* Carlo Fonseka, *To Err Was Fatal*, 313 BRIT. MED. J. 1640, 1640 (1996) ("Error free patient care is the ideal standard but in reality unattainable."); Robert Levy, *Code Blue*, 7 HARV. PUB. HEALTH REV. 36, 39 (1995) (discussing the "culture of infallibility"); Kapp, *supra* note 5, at 756 ("[P]hysicians tend to envision themselves as lifeguards upon whose shift no one should be allowed to drown.").

44. A growing number of states, however, require hospitals to disclose

Despite these legitimate concerns, peer review is seen as a public good.[46] Peer review encourages practices that seek to avoid preventable adverse events in the first place, thereby reducing costs.[47] Health care providers can and want to learn from their errors, and the sooner they learn, the better.[48] Health care providers, therefore, use peer review in a range of settings as an ex ante means to quickly prevent mistakes from recurring.[49]

Congress has recognized the value of peer review, albeit slowly. Pursuant to its spending power, Congress has mandated that hospitals must have peer review programs to participate in Medicare.[50] In addition, Congress has afforded peer review

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adverse events to patients. *See, e.g.*, CAL. HEALTH & SAFETY CODE § 1279.1 (West 2008); FLA. STAT. ANN. § 395.0197(4)(d) (West 2006); 40 PA. STAT. ANN. § 1303.308(b) (2009).

45. *See* MASS. GEN. LAWS ch. 233, § 23D (2000) (creating a safe harbor for apologizers); *see also* Marlynn Wei, *Doctors, Apologies, and the Law: An Analysis and Critique of Apology Laws*, 40 J. HEALTH L. 107, 110-13 (2007) (reviewing the role of apologies and disclosure in malpractice cases); *cf.* Lee Taft, *Apology Within a Moral Dialectic: A Reply to Professor Robbennolt*, 103 MICH. L. REV. 1010, 1016 (2005) (expressions of sympathy that become rituals detract from the policies behind apologies). *But see* David M. Studdert et al., *Disclosure of Medical Injury to Patients: An Improbable Risk Management Strategy*, 26 HEALTH AFF. 215, 221 (2007) (questioning whether disclosures reduce litigation).

46. *See, e.g.*, State *ex rel.* St. Anthony's Med. Ctr. v. Provaznik, 863 S.W.2d 21, 23 (Mo. Ct. App. 1993); Penland v. Georgetown Univ. Hosp., Civ. A. No. 87-1247, 1987 WL 25668, at *1 (D.D.C. Nov. 12, 1987); Fox v. Kramer, 82 Cal. Rptr. 2d 513, 521 (Cal. Ct. App. 1999), *aff'd*, 994 P.2d 343 (Cal. 2000); Campbell v. St. Mary's Hosp., 252 N.W.2d 581, 587 (Minn. 1977).

47. *See* Donald M. Berwick, *Sounding Board: Continuous Improvement as an Ideal in Health Care,* 320 NEW ENG. J. MED. 53, 56 (1989). Another option is regulation. While regulation is prospective, it lacks flexibility.

48. In 1999, the Institute of Medicine determined that between 44,000 and 98,000 Americans died annually as a result of medical errors in hospitals. Most of these deaths were the results of system failures that could be reduced by instituting better procedures. Institute of Med., *supra* note 9, at 1, 4-5.

49. *See* CAL. BUS. & PROF. CODE § 809(a)(7) (West 2003) ("It is the intent of the Legislature that peer review . . . be done . . . with an emphasis on early detection of potential quality problems and resolutions through informal educational interventions."); *cf.* Kaya v. Partington, 681 A.2d 256, 260 (R.I. 1996) (describing the tort system as "cumbersome and often lengthy").

50. 42 U.S.C. § 1320c-3(a) (2008); *see also* Fischer v. United States, 529 U.S. 666, 672 (2000) ("Peer review organizations monitor providers' compliance" with the "statutory obligation of providing 'medically necessary' services 'of a quality which meets professionally recognized standards of health care.'").

protection for medical programs offered by the Department of Defense[51] and the Department of Veterans Affairs.[52]

In 1986, Congress enacted the HCQIA to afford participants in peer review activities qualified immunity from liability for monetary damages brought by physicians who were the subject of peer review activities, including the Sherman Antitrust Act.[53] The purpose of the HCQIA was "to prevent patient harm, not to assure an adequate response after it occurred."[54] Enactment of the HCQIA was a tradeoff; physicians who participated in peer review activities secured qualified immunity but agreed to the reporting of adverse actions against physicians to the National Practitioner Data Bank.[55]

The HCQIA succeeded in squashing a raft of lawsuits challenging credentialing decisions as violations of the Sherman Act, even though the Sherman Act does not preclude the dismissal of incompetent physicians.[56] Many of these cases were beyond frivolous, essentially preventing hospitals and other physicians

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51. 10 U.S.C. § 1102(a) (2006); *see, e.g.*, *In re* United States, 864 F.2d 1153, 1156 (5th Cir. 1989) (overturning order compelling production of peer review records from military hospital); Maynard v. United States, 133 F.R.D. 107, 108 (D.N.J. 1990) (refusing to compel production of documents classified by hospital as quality assurance documents).

52. 38 U.S.C. § 5705(a) (2006); *see, e.g.*, Utterback v. United States, 121 F.R.D. 297, 299 (W.D. Ky. 1987). *But see* Bethel v. United States *ex. rel.* Veterans Admin. Med. Ctr., 242 F.R.D. 580, 585-86 (D. Colo. 2007) (root cause analyses not protected by the Veterans Administration's quality assurance privilege).

53. Pub. L. No. 99-660, Tit. IV, § 402, 100 Stat. 3784 (codified as amended at 42 U.S.C. §§ 11101 (2006)); *see, e.g.*, Austin v. McNamara, 979 F.2d 728, 737 (9th Cir. 1992); Untracht v. Fikri, 454 F. Supp. 2d 289, 327 (W.D. Pa. 2006), *aff'd*, 249 Fed. Appx. 268 (3d Cir. 2007), *cert. denied*, 128 S. Ct. 1666 (2008); Rogers v. Columbia/HCA of Cent. La., Inc., 971 F. Supp. 229, 237 (W.D. La. 1997).

54. Singh v. BlueCross/Blue Shield of Mass., Inc., 308 F.3d 25, 44-45 (1st Cir. 2002).

55. Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 453, 495-96 (1990); Scheutzow, *supra* note 27, at 19-20; Charity Scott, *Medical Peer Review, Antitrust and the Effect of Statutory Reform*, 50 MD. L. REV. 316, 329-32 (1991).

56. Pontius v. Children's Hosp., 552 F. Supp. 1352, 1372 (W.D. Pa. 1982). Limiting privileges to competent doctors is pro-competitive. Weiss v. York Hosp., 745 F.2d 786, 821 n.61 (3d Cir. 1984); Marin v. Citizens Mem'l Hosp., 700 F. Supp. 354, 361 (S.D. Tex. 1988); Friedman v. Del. County Mem'l Hosp., 672 F. Supp. 171, 190 (E.D. Pa. 1987).

from examining the ability of a physician who engaged in sub-par treatment of patients to continue to do so.[57] Congress reset the priorities by putting the rights of patients to treatment by competent providers as judged by their peers above the rights of physicians to litigate their ability to compete.

On the other hand, by its express terms, nothing in the HCQIA affects the application of state peer review statutes to patient malpractice claims.[58] The HCQIA does not protect the confidentiality of peer review materials other than those documents relating to information provided to the National Practitioner Data Bank.[59] It does not support a civil rights cause

57. *See, e.g.*, Ezpeleta v. Sisters of Mercy Health Corp., 800 F.2d 119, 122 (7th Cir. 1986) (warning litigants that future antitrust challenges to credentialing decisions under the Indiana peer review process would be deemed frivolous); Harron v. United Hosp. Ctr., Inc., 522 F.2d 1133, 1134 (4th Cir. 1975) (per curiam) ("frivolous to urge that employment of a single doctor to operate the radiology department of a hospital invokes the Sherman Act"); Husain v. Helene Fuld Med. Ctr., Civ. No. 89-2107 (AET), 1989 WL 150536, at *4 (D.N.J. Dec. 8, 1989) ("not every act that causes a person to suffer a personal or professional set-back can be turned into a Sherman Act matter").

Professor Scheutzow questions whether physicians' fears regarding lawsuits for participating in peer review activities were legitimate "because the federal judiciary has not often entertained lawsuits over staff privileges." Scheutzow, *supra* note 27, at 20. The fact that such lawsuits achieved only limited success does not obviate the burden that they placed on defendants. *See, e.g.*, Nanavati v. Burdette Tomlinson Mem'l Hosp., 857 F.2d 96, 99 (3d Cir. 1988) (describing how a dispute involving two doctors at a small hospital had "raged in state as well as federal courts, trial and appellate"). As the Supreme Court has since noted, "antitrust discovery can be expensive." Bell Atl. Corp. v. Twombley, 127 S. Ct. 1955, 1967 (2007). Professor Scheutzow also does not address all of the credentialing claims that were never litigated because hospitals did not want to incur the cost. *Cf. id.*

58. Freilich v. Upper Chesapeake Health, Inc., 313 F.3d 205, 214 (4th Cir. 2002) (citing 42 U.S.C. § 11115 (2006)).

59. 42 U.S.C. § 11137(b)(1); *see also* Virmani v. Novant Health, Inc., 259 F.3d 284, 292 (4th Cir. 2001) ("Congress will create a medical peer review privilege when it is so inclined."); Mattice v. Mem'l Hosp., 203 F.R.D. 381, 385 (N.D. Ind. 2001) (in enacting the HCQIA, "Congress . . . has specifically addressed the issues of confidentiality and protection of the medical peer review process, but it has chosen not to include a privilege for peer review materials."); Teasdale v. Marin Gen. Hosp., 138 F.R.D. 691, 694 (N.D. Cal. 1991) ("Congress spoke loudly with its silence in *not* including a privilege against discovery of peer review materials in the HCQIA."). *But see* Cohn v. Wilkes Gen. Hosp., 127 F.R.D. 117, 121 (W.D.N.C. 1989) (recognizing a federal privilege), *aff'd on other grounds*, 953 F.2d 154 (4th Cir. 1991).

of action for breach of the physician's privacy or the impairment of confidentiality clauses in medical malpractice settlements.[60]

Beyond this effective but limited federal foray under the HCQIA, peer review has traditionally been a function of state law pursuant to each state's exercise of its police power.[61] The power granted to physicians to credential other physicians, for example, goes back to the colonial times.[62] States began to formalize the credentialing process and impose minimum standards by enacting licensing statutes in the late nineteenth century.[63] These state statutes set minimum competency standards to be determined by physicians themselves.[64] More recently, states have exercised their police power to enact peer review statutes.[65] While these state peer review statutes afford some protection to the participants in peer review proceedings, the breadth and depth of that protection in terms of immunity, confidentiality and privilege

60. Med. Soc'y of N.J. v. Mottola, 320 F. Supp. 2d 254, 276 (D.N.J. 2003).

61. *Developments in the Law—Medical Technology and the Law*, 103 HARV. L. REV. 1584, 1599, 1612 n.183 (1990) (state may exercise its police power to protect public safety and welfare thereby protecting peer review committee records from disclosure); *see also* Medtronic, Inc. v. Lohr, 518 U.S. 470, 475 (1996) (regulation of health and safety issues has traditionally been a state function under the police power); Jacobson v. Massachusetts, 197 U.S. 11, 38 (1905) (police power extends to regulation of health care); Gibbons v. Ogden, 22 U.S. (9 Wheat.) 1, 78 (1824) (same).

62. Jonathan P. Tomes, MEDICAL STAFF PRIVILEGES AND PEER REVIEW 10 (1994).

63. *See, e.g.*, Dent v. West Virginia, 129 U.S. 114, 122 (1888) (states have the power to regulate entry into a vocation as long as the regulation was not arbitrary and its purpose was to protect the public welfare); State Bd. of Health v. Roy, 48 A. 802, 803-04 (R.I. 1901) (medical licensing statute was valid exercise of the police power and did not violate separation of powers).

64. *See Dent*, 129 U.S. at 123; *see also* Hayman v. City of Galveston, 273 U.S. 414, 416 (1927) (public hospital's power to control privileges does not violate due process); Newton v. Board of Comm'rs, 282 P. 1068, 1070 (Colo. 1929) (same).

65. *See, e.g.*, Claypool v. Mladineo, 724 So. 2d 373, 381 (Miss. 1998) (peer review statute was constitutionally permissible exercise of police power and did not violate separation of powers); Southwest Cmty. Health Servs. v. Smith, 755 P.2d 40, 42 (1988). By contrast, courts have generally declined to create the privilege. *See, e.g.*, Kenney v. Super. Ct., 63 Cal. Rptr. 84, 87 (Cal. Ct. App. 1967); Shibilski v. St. Joseph's Hosp., 266 N.W.2d 264, 268 (1978); Nazareth Literary & Benevolent Inst. v. Stephenson, 503 S.W.2d 177, 179 (Ky. 1973). *But see* Bredice v. Doctor's Hosp., Inc., 50 F.R.D. 249, 251 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973) (recognizing the privilege of self-critical evaluation).

varies greatly among the states.[66] This hodgepodge of rules is no more acceptable than the impact of the antitrust suits that prompted enactment of the HCQIA.

A. The Importance of Immunity

Immunity is "an exemption from liability or obligation against" a suit brought by a plaintiff.[67] Immunity seeks to allocate costs for a public good by prohibiting certain types of suits. For example, society expects judges to make decisions without fear of personal liability; consequently, judges have immunity for damage actions no matter how bad their decisions.[68] Since immunity deprives a plaintiff of a potential remedy, it is typically construed narrowly.[69]

To encourage health care providers to engage in peer review, Congress and practically every state legislature[70] have enacted statutes that immunize those persons participating in the peer review process.[71] These provisions often are invoked by

66. Trinity Med. Ctr., Inc. v. Holum, 544 N.W.2d 148, 153 (N.D. 1996) ("[A]lthough nearly every state has some form of statutory privilege for medical peer review, it appears that no two statutes or courts' interpretations of them, are alike."); *see also* Nijm, *supra* note 12, at 542; Susan O. Scheutzow & Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined than Real,* 7 J.L. & HEALTH 169, 186 (1992-1993) ("Despite almost universal mention of peer review privilege, there is extremely wide variation in the privilege granted by the states.").

67. St. Louis, Iron Mountain & S. Ry. Co. v. McWhirter, 229 U.S. 265, 287 (1913).

68. *See, e.g.,* Stump v. Sparkman, 435 U.S. 349, 364 (1978) (judge not liable for damages for erroneous sterilization decision); Estate of Sherman v. Almeida, 747 A.2d 470, 475 (R.I. 2000) (judge not liable for damages to litigant even though judge was convicted of accepting bribes); *cf.* Pulliam v. Allen, 466 U.S. 522, 541-42 (1984) (upholding injunctive relief against a judge).

69. Weissman v. Nat'l Ass'n of Secs. Dealers, Inc., 500 F.3d 1293, 1297 (11th Cir. 2007).

70. Scheutzow, *supra* note 27, at 28. In Florida, the voters have taken the question out of the hands of legislators and used a referendum to abolish peer review apparently altogether. *See* Fla. Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478, 494 (Fla. 2008); *see generally,* Laura V. Yaeger, *Amendment 7: Medical Tradition v. The Will of the People: Has Florida's Peer Review Privilege Vanished?,* 13 MICH. ST. U.J. MED & L. 123 (2009).

71. *See, e.g.,* Adkins v. Christie, 488 F.3d 1324, 1330 (11th Cir. 2007); Syposs v. United States, 63 F. Supp. 2d 301, 308 n.3 (W.D.N.Y. 1999); Carr v. Howard, 689 N.E.2d 1304, 1307 (Mass. 1998); *cf.* Bakare v. Pinnacle Health Hosps., Inc., 469 F. Supp. 2d 272, 291 (M.D. Pa. 2006) (defamation claim

defendants when a health care provider's privileges are limited, denied, or revoked, and the health care provider brings suit.[72] They do not create a cause of action for health care providers challenging how peer review was conducted.[73]

The immunity afforded by the HCQIA applies to damage actions arising under state and federal law.[74] It is not a general immunity and does not extend to other forms of relief.[75] As such, there is no interlocutory appeal from an order denying a motion to dismiss on the basis of the HCQIA.[76] Although the decision that the HCQIA applies is often made at the time of summary judgment, it may be deferred until the conclusion of the trial.[77]

Under the HCQIA and in many states, this immunity is qualified; the peer review must have been conducted "(1) in the reasonable belief that the action was in furtherance of quality of care (2) after a reasonable effort to obtain the facts of the matter (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts."[78] The rebuttable presumption, however, is that those participating in peer review activities have

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involving statements made by a doctor in an operating room lounge was not covered by the HCQIA since the claim did not arise out of the peer review process).

72. Scheutzow, *supra* note 27, at 27-28 (citing cases).

73. *See, e.g.*, Wayne v. Genesis Med. Ctr., 140 F.3d 1145, 1147-48 (8th Cir. 1998); Bok v. Mutual Assur., Inc., 119 F.3d 927, 928 (11th Cir. 1997) (per curiam); Hancock v. Blue Cross-Blue Shield of Kan., 21 F.3d 373, 374-75 (10th Cir. 1994).

74. 42 U.S.C. § 11111(a) (2006).

75. Singh v. BlueCross/Blue Shield of Mass., Inc., 308 F.3d 25, 44-45 (1st Cir. 2002); Imperial v. Suburban Hosp. Ass'n, Inc., 37 F.3d 1026, 1031 (4th Cir. 1994); Mathews v. Lancaster Gen. Hosp., 883 F. Supp. 1016, 1035 (E.D. Pa. 1995), *aff'd*, 87 F.3d 624 (3d Cir. 1996).

76. Manion v. Evans, 986 F.2d 1036, 1042 (6th Cir. 1993); Decker v. IHC Hosp., Inc., 982 F.2d 433, 437 (10th Cir. 1992).

77. Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318, 1332 (11th Cir. 1994); Islami v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361, 1378 (N.D. Iowa 1992).

78. 42 U.S.C. §§ 11112(a)(1)-(4); *see also* Smith v. Our Lady of the Lake Hosp., Inc., 639 So. 2d 730, 742 (La. 1994) (explaining qualified immunity); St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503, 507-08 (Tex. 1997) (same).

met those standards.[79] All four standards are objective based on the totality of circumstances; bad faith, on the other hand, is immaterial.[80]

By contrast, in cases outside the medical malpractice context, courts have interjected other countervailing policy considerations that effectively limit the value of the peer review process.[81] These considerations have included the "strong public interest in the prevention and compensation of serious personal injuries caused by government employees," the "interest in eradicating and compensating for violations of a person's civil rights," and ultimately the "need for probative evidence."[82]

In addition to variations as to when the immunity applies, different states have different rules as to who can claim the immunity. In some states the immunity extends to committee members, the hospitals, and individuals providing information to the committee so as to defeat negligent credentialing claims,[83]

79. 42 U.S.C. § 11112(a); *see, e.g., Singh*, 308 F.3d at 32-33 (presumption does not deprive plaintiff of Seventh Amendment right to a jury trial); Bakare v. Pinnacle Health Hosps., Inc., 469 F. Supp. 2d 272, 287-90 (M.D. Pa. 2006) (presumption not rebutted); Austin v. McNamara, 731 F. Supp. 934, 942 (C.D. Cal. 1990) (same), *aff'd*, 979 F.2d 728 (9th Cir. 1992).

80. *Singh*, 308 F.3d at 32; *Mathews*, 87 F.3d at 635; *Imperial*, 37 F.3d at 1030.

81. *See, e.g.*, Virmani v. Novant Health, Inc., 259 F.3d 284, 268-88 (4th Cir. 2001) (42 U.S.C. § 1985 (2006)); Marshall v. Spectrum Med. Group, 198 F.R.D. 1, 5 (D. Me. 2000) (ADA); Burrows v. Redbud Cmty. Hosp. Dist., 187 F.R.D. 606, 611 (N.D. Cal. 1998) (EMTALA); United States *ex rel.* Roberts v. QHG of Ind., Inc., No. 1:97-CV-174, 1998 WL 1756728, at *3 (N.D. Ind. Oct. 8, 1998) (False Claims Act); Johnson v. Nyack Hosp., 169 F.R.D. 550, 560-61 (S.D.N.Y. 1996) (Title VII). *But see* Hadix v. Caruso, No. 4:92-CV-110, 2006 WL 2925270, at *2 (W.D. Mich. Oct. 6, 2006) (recognizing peer review privilege in Eighth Amendment prisoner civil rights claim); Pardo v. Gen. Hosp. Corp., 841 N.E.2d 692, 701 (Mass. 2006) ("The focus must be on the committee member's actions within the peer review process itself, not on possible discriminatory reasons for initiating a review of the plaintiff's work.").

82. *Syposs*, 63 F. Supp. 2d at 304 (quoting Univ. of Pa. v. EEOC, 493 U.S. 182, 189 (1990)). *But see* Bredice v. Doctor's Hosp., Inc., 50 F.R.D. 249, 251 (D.D.C. 1970) ("'[W]hat someone . . . at a subsequent date thought of these acts or omissions is not relevant to the case.'" (quoting Richards v. Me. Cent. R., 21 F.R.D. 590, 592 (D. Me. 1957)), *aff'd*, 479 F.2d 920 (D.C. Cir. 1970).

83. *Compare St. Luke's Episcopal Hosp.* 952 S.W.2d at 507-09 (HCQIA defeats negligent credentialing cases) *with* Kalb v. Morehead, 654 N.E.2d 1039, 701-02 (Ohio Ct. App. 1995) (Ohio's peer review statute does not provide hospital with immunity from negligent credentialing claims).

whereas in other states, the immunity is limited.[84]

As critics are quick to point out, all of these exceptions tend to protect the rights of physicians, not patients.[85] The easy retort to the criticism is that society has developed a variety of rules that preclude the use of evidence to further a greater good.[86] Thus, not surprisingly, peer review statutes have withstood equal protection challenges.[87]

The existence of immunity for peer review activities has also been criticized as an unnecessary subsidy for hospitals to protect them from the damage arising from negligent credentialing suits.[88] According to these critics, if Congress were to repeal the HCQIA tomorrow, and all the state legislatures were to follow suit, hospitals would still have the oft-cited incentive of improving patient care as an impetus to continuing their peer review activities. The flaw in that argument is that the cost of those improvements would increase dramatically, and as the price went up, less health care would be available. To the extent that physicians declined to participate in peer review activities, hospitals could easily rectify that problem by indemnifying them or procuring insurance. In doing so, the cost of peer review would be borne by hospitals, not patients.[89] Even if that were true, however, the issue would be whether the total cost to society still increased.[90]

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84. Newton, *supra* note 12, at 730 & nn. 63-64 (comparing states with statutes that afford broad immunity like California, Maine, and West Virginia with states where the immunity is limited like Alabama and Georgia); Nijm, *supra* note 12, at 549-50 (describing differences among states); Scheutzow, *supra* note 27, at 28-29 (same).

85. *See, e.g.,* Goldberg, *supra* note 3, at 155; Wilson, *supra* note 6, at 400.

86. *See, e.g.,* Miranda v. Arizona, 384 U.S. 436, 467 (1966) (exclusion of evidence obtained in violation of the Fifth Amendment); Weeks v. United States, 232 U.S. 383, 393 (1914) (exclusion of information or things obtained in violation of the Fourth Amendment).

87. *See, e.g.,* Jenkins v. Wu, 468 N.E.2d 1162, 1168 (Ill. 1984); Atkins v. Walker, 445 N.E.2d 1132, 1136 (Ohio Ct. App. 1981).

88. Scheutzow, *supra* note 27, at 25 (citing Greenwood v. Wierdsma, 741 P.2d 1079, 1089 (Wyo. 1987)).

89. Wilson, *supra* note 6, at 400 n.234; Goldberg, *supra* note 3, at 155; Hall, *supra* note 42, at 265-66.

90. *See* Melissa Morgan Hawkins, *Amendments 7 and 8 Update: Legislation Enabling the Patient's Right to Know Act and Three Strikes Rule*, 25 TRIAL ADVOC. Q. 7, 7-8 (2006) (some "[p]laintiffs' attorneys were using [the repeal of Florida's peer review privilege by referendum] as a cast-net to fish

B. The Importance of Confidentiality

Immunity from suit is not the same as a requirement that peer review materials be kept confidential.[91] Confidentiality is the obligation to refrain from disclosing information to third parties.[92] It is a prerequisite to the candid communication among health care providers that peer review requires.[93] Paradoxically, confidentiality also serves a value by promoting confidence in the medical system: "Patients are not likely to trust medical staff so implicitly if they have full knowledge of the mistakes made in the wards and on the operating tables."[94] Consequently, it has been widely argued that "[c]onfidentiality is essential" to effectuating improvement in the care and treatment of patients.[95]

Confidentiality also protects information as a species of property.[96] The interest of the plaintiffs' bar in peer review materials is self-evident, but "other entities such as insurance companies, the media, consumer groups, and competing health care providers may also have an interest in peer review information for various reasons."[97] While the ownership of this

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for cases"); *cf.* Mark J. Greenwood, *The Physician Profile Database: Publishing Malpractice Information on the Internet*, 21 J. LEGAL MED. 477, 516 (2000) (risk averse doctors will avoid complex procedures to avoid damage to their reputations). Perhaps the most famous application of the peer review privilege involved the malpractice case that followed Dr. Denton Cooley's implantation of the first mechanical heart. *See* Karp v. Cooley, 493 F.2d 408, 425-26 (5th Cir. 1974) (applying the Texas privilege).

91. *See, e.g.*, Dir. of Health Affairs Pol'y Planning v. Freedom of Info. Comm'n., 977 A.2d 148, 158 (Conn. 2009) (credentialing documents at state university health center were public records and subject to disclosure, notwithstanding peer review protection).

92. Trinity Med. Ctr., Inc. v. Holum, 544 N.W.2d 148, 156 (N.D. 1996) (quoting Scheutzow & Gillis, *supra* note 66, at 192).

93. Bredice v. Doctor's Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1970); *see also* Pardo v. Gen. Hosp. Corp., 841 N.E.2d 692, 700 (Mass. 2006); *Ex parte* Krothapalli, 762 So. 2d 836, 839 (Ala. 2000).

94. Quick, *supra* note 23, at 36 (quoting Anthony Giddens, THE CONSEQUENCES OF MODERNITY 86 (1990)).

95. *Bredice*, 50 F.R.D. at 250.

96. *See* Ruckelshaus v. Monsanto Corp., 467 U.S. 986, 1002-04 (1984).

97. Murray G. Sagsveen & Jennifer L. Thompson, *The Evolution of Medical Peer Review in North Dakota*, 73 N.D.L. REV. 477, 481-82 (1997); *see, e.g.*, Public Citizen, Inc. v. Dep't of Health & Human Servs., 151 F. Supp. 2d 64, 75-77 (D.D.C. 2001) (consumer group); Baltimore Sun Co. v. Univ. of Md. Med. Sys. Corp., 584 A.2d 683, 685 (Md. 1991) (media).

property right as between health care providers and patients is debatable, the putative rights asserted by these third parties are not.

In the case of peer review, confidentiality actually rectifies market failure in one sense. Peer review is a collective action problem; everyone sees the need for it, but there is no incentive for any individual to address it.[98] By affording confidentiality to all participants, the cost of rectifying this problem to any one participant is diminished.

On the other hand, confidentiality comes with costs. First, it distorts the market for health care by limiting the ability of patients to give their informed consent founded on the duty of a physician to inform a patient of all the risks.[99] "Trust me, I'm a doctor," no longer works.[100] Notwithstanding their white coats and stethoscopes, doctors are not all the same. Patients are the ultimate consumers of health care,[101] and they expect more information, not less.[102] The result of this absence of information is market failure when it comes to judging the quality of health care providers.[103]

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98. *See* Howard Burde, *The Implementation of Quality and Safety Measures: From Rhetoric to Reality*, 35 J. HEALTH L. 263, 274 (2002) ("challenge for governments is to limit the cost and potential liability inherent in the collection and submission of data").

99. *See, e.g.*, Howard v. Univ. of Med. & Dentistry of N.J., 800 A.2d 73, 84-85 (N.J. 2002) (no informed consent if physician objectively misrepresented credentials); Hidding v. Williams, 578 So. 2d 1192, 1196 (La. Ct. App. 1991) (surgeon's failure to disclose alcohol abuse defeated informed consent); Johnson v. Kokemoor, 545 N.W.2d 495, 498 (Wis. 1996) (no informed consent where doctor failed to disclose lack of experience). *But see* Whiteside v. Lukson, 947 P.2d 1263, 1265 (Wash. Ct. App. 1997) (lack of experience not relevant to informed consent determination); Flick, *supra* note 31, at 1139.

100. *See* Quick, *supra* note 23, at 36; *see also* Treviño, *supra* note 34, at 316 (deriding Congress for its paternalistic view that the nation's doctors "know best").

101. Schloendorf v. Soc'y of N.Y. Hosp., 105 N.E., 92, 93 (N.Y. 1914) (Cardozo, J.). *But see* Gregory Vistnes, *Hospitals, Mergers and Two-Stage Competition*, 67 ANTITRUST L.J. 671, 671 (2000) (regulators view health plans as the relevant customers for antitrust analyses of hospital mergers).

102. *See* Marshall B. Kapp, *Patient Autonomy in the Age of Consumer-Driven Health Care: Informed Consent and Informed Choice*, 2 J. HEALTH & BIOMEDICAL L. 1, 10 (2006); Quick, *supra* note 23, at 36.

103. Chiang, *supra* note 22, at 386 (discussing the practical problem of creating a market for quality); Mello et al., *supra* note 7, at 392-93 (consumers do not use quality comparisons in choosing health care

Second, confidentiality impairs the ex post rights of patients.[104] Patients want to know what happened to them and why.[105] Moreover, without access to peer review materials, patients may not even know that they have been wronged.[106] Even if they know they have been wronged, their right of access to the courts, putatively guaranteed by many state constitutions, is effectively limited. Some states have tried to mitigate these information problems by coupling peer review statutes with a requirement that hospitals must self-report certain types of incidents.[107]

Several states have established their own analogs to the National Practitioner Data Bank, which are accessible to the public.[108] Further, some states protect the confidentiality of some, but not all, peer review materials.[109] Still other states cabin peer review either by case law or statute when the party seeking the

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providers).

104. Matchett v. Super. Ct., 115 Cal. Rptr. 317, 320-21 (Cal. Ct. App. 1974); *see also* Katherine Mikk, Note, *Making the Plaintiff's Bar Earn its Keep: Rethinking the Hospital Incident Report*, 53 N.Y.L. SCH. L. REV. 133, 154-55 (2008/2009); Treviño, *supra* note 34, at 317.

105. *See* Hafemeister & Spinos, *supra* note 11, at 1176; Vogel & Delgado, *supra* note 30, at 61 n.55.

106. *See* Lori Andrews, *Studying Medical Error in Situ: Implications for Malpractice Law and Policy*, 54 DEPAUL L. REV. 357, 362 (2005).

107. *See, e.g.*, FLA. STAT. ANN. § 395.0197 (West 2006 & Supp. 2009); MASS. GEN. LAWS ANN. ch. 112, § 5B-5F (West 2003); MINN. STAT. ANN. § 144.7065 (West 2005 & Supp. 2009); N.Y. PUB. HEALTH LAW § 2805-l (McKinney 2007); R.I. GEN. LAWS § 23-17-40(c) (2008); *see also* Beth Israel Hosp. Assoc. v. Bd. of Registration in Med., 515 N.E.2d 574, 577-81 (Mass. 1987) (upholding regulations promulgated pursuant to statutory authority to mandate self-reporting).

108. *See, e.g.*, CAL. BUS. & PROF. CODE § 27 (West 2003 & Supp. 2009); MASS. GEN. LAWS ANN. ch. 112, § 5 (West 2003 & Supp. 2009); FLA. STAT. ANN. § 456.041 (West 2007); N.J. STAT. ANN. §§ 45:9-22.21 to 22.25 (West 2004 & Supp. 2009); N.Y. PUB. HEALTH LAWS § 2995-a (McKinney 2007 & Supp. 2009); *see also* Med. Soc'y of N.J. v. Mottola, 320 F. Supp. 2d 254, 271-75 (D.N.J. 2004) (upholding the constitutionality of New Jersey's statute). *See generally,* Jeffrey P. Donohue, Comment, *Developing Issues Under the Massachusetts "Physician Profile" Act*, 23 AM. J.L. & MED. 115 (1997) (describing the public accessibility of the Massachusetts Board of Registration in Medicine Physician Profile database, available at http://profiles.massmedboard.org/MA-Physician-Profile-Find-Doctor.asp).

109. *Compare* May v. Wood River Twp. Hosp., 629 N.E.2d 170, 174 (Ill. App. Ct. 1994) (allowing discovery of incident reports) *with* Bredice v. Doctors Hosp., Inc., 51 F.R.D. 187, 188 (D.D.C. 1970) (disallowing the discovery of incident reports).

records is a physician challenging a credentialing decision as opposed to a patient contesting a treatment decision.[110] Some states do not protect the confidentiality of peer review materials at all.[111] At the opposite pole, some states, including Rhode Island, provide civil or criminal penalties for breaching the confidentiality of peer review information.[112]

If peer review is premised on confidentiality, what happens when that confidentiality is waived? The notion that a party can selectively waive a privilege, such as by providing materials to a regulator but not to third parties, is dubious for it violates the privilege that it seeks to protect.[113]

In at least one case, a court held that peer review materials were admissible because the physician waived the privilege.[114] Since one of the purposes of the peer review privilege was to alleviate the burden on physicians having to testify, the privilege had no application when a physician testified voluntarily.[115] At the opposite extreme, the plaintiff in another case obtained a copy of the peer review material yet was unable to use it at trial, even though the peer review material, a letter, was the basis of his libel

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110. *See, e.g.*, CAL. BUS. & PROF. CODE § 809.2 (West 2003); CONN. GEN. STAT. ANN. § 19a-17b (West 2003); R.I. GEN. LAWS § 5-37.3-7 (2006); *see also* Hayes v. Mercy Health Corp., 739 A.2d 114, 117-18 (Pa. 1999) (construing statute to permit discovery of peer review proceeding in credentialing dispute). *But see* Grande v. Lahey Clinic Hosp., 725 N.E.2d 1083, 1084-86 (Mass. App. Ct. 2000) (prohibiting the deposition of a peer review participant in a defamation action where the physician was cleared by the peer review committee).

111. *See* Scheutzow, *supra* note 27, at 58 app. A (collecting states).

112. *See, e.g.*, R.I. GEN. LAWS §§ 5-37.3-9(a)-(b) (2004).

113. Every Court of Appeals but one that has considered the issue of selective waiver has rejected the doctrine. *See In re* Qwest Comm'cn, Int'l., 450 F.3d 1179, 1186-94 (10th Cir. 2006); *In re* Columbia/ HCA Healthcare Corp. Billing Practices Litig., 293 F.3d 289, 304 (6th Cir. 2002); United States v. Mass. Inst. of Tech., 129 F.3d 681, 686 (1st Cir. 1997); Westinghouse Elec. Corp. v. Republic of Phil., 951 F.2d 1414, 1425 (3d Cir. 1991); *In re* Martin Marietta Corp., 856 F.2d 619, 623-24 (4th Cir. 1988); *In re* John Doe Corp., 675 F.2d 482, 489 (2d Cir. 1982); Permian Corp. v. United States, 665 F.2d 1214, 1220 (D.C. Cir. 1981). *But see* Diversified Indus. v. Meredith, 572 F.2d 596, 611 (8th Cir. 1978) (en banc) (recognizing the doctrine of selective waiver); *cf. In re* M & L Bus. Mach. Co., 161 B.R. 689, 696 (D. Colo. 1993); Teachers Ins. & Annuity Ass'n of Am. v. Shamrock Broadcasting Co., 521 F. Supp. 638, 646 (S.D.N.Y. 1981) (recognizing selective waiver with an express reservation of rights such as a protective order).

114. *See* W. Covina Hosp. v. Super. Ct., 718 P.2d 124, 119 (Cal. 1986).

115. *See id.*

claim.[116] In that case, the privilege apparently adhered to the committee, not one individual.[117]

C. The Importance of Privilege

A requirement that participants in peer review proceedings are immune from liability or that peer review materials be kept confidential is not the same as an evidentiary privilege.[118] Ordinarily, a litigant is entitled to any information that is relevant to her case, even if the information is not admissible but appears "reasonably calculated" to lead to the discovery of admissible evidence.[119] An evidentiary privilege, however, is the "right not to have another testify as to certain matters as part of a judicial process."[120] In theory, an evidentiary privilege should not be an impediment to fact-finding: a "fact is one thing and a communication concerning that fact is an entirely different thing."[121]

The plaintiffs' bar may argue that privileges come with a cost

116. Atkins v. Walker, 445 N.E.2d 1132, 1136 (Ohio Ct. App. 1981).

117. *Id.; cf.* Holmes v. Farmer, 475 A.2d 976, 984-85 (R.I. 1986) (speech and debate privilege accrues to legislature, not individual legislators).

118. Trinity Med. Ctr. v. Holum, 544 N.W.2d 148, 156 (N.D. 1996) (quoting Scheutzow & Gillis, *supra,* note 66); *see also* Johnson v. Nyack Hosp., 169 F.R.D. 550, 559 n.13 (S.D.N.Y. 1996) (comparing N.J. STAT. § 2A:84A-22.8 (1994), which protects the confidentiality of information and data utilized by review committees, with N.Y. EDUC. LAW. § 6527, subd. 3 (2007), which creates a testimonial privilege); Hillsborough County Hosp. Auth. v. Lopez, 678 So. 2d 408, 409 (Fla. Dist. Ct. App. 1996) (per curiam) (even though the information was not kept confidential by the hospital, the records of its peer review committee were privileged); Walker v. Alton Mem'l Hosp. Ass'n, 414 N.E.2d 850, 852-53 (1981) (prohibition on use in evidence does not necessarily prevent discovery).

119. FED. R. CIV. P. 26(b); *see also, e.g.,* Cunningham v. Cannon, 654 S.E.2d 24, 28 (N.C. Ct. App. 2007) (information in consent order entered by the Georgia Board of Medical Examiners was not privileged and relevant under Rule 26); State *ex rel.* Dixon v. Darnold, 939 S.W.2d 66, 70 (Mo. Ct. App. 1997) ("It is not grounds for objection that the information may be inadmissible at trial, if the information sought appears reasonably calculated to the discovery of admissible evidence.").

120. *Trinity,* 544 N.W.2d at 156 (quoting Scheutzow & Gillis, *supra* note 66, at 192).

121. Upjohn Co. v. United States, 449 U.S. 383, 395-96 (1981) (quoting Philadelphia v. Westinghouse Elec. Corp. 205 F. Supp. 830, 831 (E.D. Pa. 1962)).

to the truth-seeking process that outweighs their benefit,[122] but the privileges do not obviate facts.[123] In reality, however, privileges are in derogation of the search for truth, and, therefore, are disfavored.[124] They make fact-finding less accurate, thereby reducing the rulemaking value of litigation.[125]

Courts consequently often construe peer review statutes narrowly.[126] Although some states take a functional approach in ascertaining the parameters of the privilege, others tightly limit themselves to statutorily defined categories of peer review

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122. *See, e.g.*, Jenkins v. DeKalb County, 242 F.R.D. 652, 659 (N.D. Ga. 2007) ("There is little data to suggest that states with more robust privilege statutes have more peer review."); Nilavar v. Mercy Health Sys.-W. Ohio, 210 F.R.D. 597, 608 (S.D. Ohio 2002) (court was not convinced that peer review process would not function properly in the absence of a federal evidentiary privilege); Pastore v. Samson, 900 A.2d 1067, 1081 (R.I. 2006) (court was not going to "oblige a plaintiff to track down the original source of unprivileged information that is within the custody of a party to the dispute"). *But see* Brathwaite v. State, 623 N.Y.S.2d 228, 230 (N.Y. App. Div. 1995) (value of open and candid discussion outweighs inconvenience to litigants).

123. *See, e.g., Ex parte* Krothapalli, 762 So. 2d 836, 839 (Ala. 2000) (peer review privilege applies to the committee's self-generated analysis but does not apply to underlying facts); Babcock v. Bridgeport Hosp., 742 A.2d 322, 342-43 (Conn. 1999) ("The privilege does not apply to those documents that were independently 'recorded' or 'acquired.'"); Munroe Reg'l Med. Ctr. v. Rountree, 721 So. 2d 1220, 1223 (Fla. Dist. Ct. App. 1998) ("[A] fact witness may be required to testify as to what he or she saw or heard during a surgery, but could not be required to testify as to what was told to the peer review committee.").

124. Univ. of Pa. v. EEOC, 493 U.S. 182, 189 (1990); Trammel v. United States, 445 U.S. 40, 50 (1980); United States v. Nixon, 418 U.S. 683, 710 (1974).

125. Goldberg, *supra* note 3, at 160 (citing Frank H. Easterbrook, *Insider Trading, Secret Agents, Evidentiary Privileges, and the Production of Information*, 1981 SUP. CT. REV. 309, 361 (1981)).

126. *See, e.g.*, Claypool v. Mladineo, 724 So. 2d 373, 385 (Miss. 1998); *Trinity*, 544 N.W.2d at 155; Menoski v. Shih, 612 N.E.2d 834, 836 (Ill. App. Ct. 1993); Moretti v. Lowe, 592 A.2d 855, 857-58 (R.I. 1991). *But see Babcock*, 742 A.2d at 344 (legislature has determined that value of peer review outweighs incidental burden on discovery); Pardo v. Gen. Hosp. Corp., 841 N.E.2d 692, 703 (Mass. 2006) ("[P]eer review privilege was enacted to promote 'the uninhibited expression of professional opinions before a [peer review committee] and protects the [peer review committee's] work product.'") (quoting Beth Israel Hosp. Ass'n v. Bd. of Registration in Med., 515 N.E.2d 574 (1987))); Mulder v. Vankersen, 637 N.E.2d 1335, 1338 (Ind. Ct. App. 1994) (Indiana court will extend peer review privilege to "all communications relating to the review of patient care, whether they are formally made in review proceedings or made in private in such a way as to shape the opinions of the persons charged with peer review.").

participants and documents.[127] Some courts disregard the privilege altogether where the plaintiff for good cause "needs" the information.[128] In at least two states, there is no peer review privilege in medical malpractice cases at all.[129]

II. THE PEER REVIEW PRIVILEGE IN RHODE ISLAND

The peer review privilege in Rhode Island is statutorily based and has been applied by the Rhode Island Supreme Court on three occasions and by the United States District Court for the District of Rhode Island once.

A. The Statutory Framework

The Rhode Island peer review privilege governing health care facilities[130] was enacted in 1978 and subsequently amended in 1986.[131] It is codified in four places. First, section 5-37-1(11)(i) of Rhode Island General Laws defines what constitutes a peer review board.[132] Second, section 5-37-5.1(27) of Rhode Island General Laws posits that it is "unprofessional conduct" by failing "to maintain standards established by peer review boards, including, but not limited to, standards related to proper utilization of

127. *Compare* Carr v. Howard, 689 N.E.2d 1304, 1310-11 (Mass. 1998) (opting for a functional approach to both the identity of the participants in the peer review process and the information protected) *and* Marshall v. Planz, 145 F. Supp. 2d 1258, 1264-67 (M.D. Ala. 2001) (privilege covers a communication to a peer review committee from a third party) *with Trinity*, 544 N.W.2d at 153 (privilege only extends to enumerated committees) *and* Romero v. Cohen, 679 N.Y.S.2d 264, 267 (N.Y. Sup. Ct. 1998) (privilege does not cover statements made by the defendant to the committee).

128. *See* NEB. REV. STAT. § 71-2048 (2003); VA. CODE ANN. § 8.01-581.17 (2007); *see also* Villano *ex rel.* Villano v. State, 487 N.Y.S.2d 276, 278 (N.Y. Ct. Cl. 1985) ("interests of justice significantly outweigh the need for confidentiality").

129. *See* Fla. Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478, 494 (Fla. 2008) (upholding the abolition of peer review by voter referendum); Sisters of Charity Health Sys. v. Raikes, 984 S.W.2d 464, 470 (Ky. 1999) (peer review statute does not extend to malpractice actions).

130. There are also similar statutory protections for other health care providers. *See, e.g.*, R.I. GEN. LAWS §§ 5-29-19, 20 (2004) (podiatrists); *id.* §§ 5-31.1-27, -29 (2004) (dentists); *id.* § 23-4.1-18 (2008) (operators of ambulances).

131. *See* 1978 R.I. Pub. Laws 1046; 1986 R.I. Pub. Laws 631.

132. R.I. GEN. LAWS § 5-37-5.1(11)(i) (2004).

services, use of nonaccepted procedure, and/or quality of care."[133] Third, section 5-37.3-7(c) of Rhode Island General Laws provides in relevant part that "the proceedings and records of medical peer review boards shall not be subject to discovery or introduction into evidence."[134] Finally, section 23-17-25 of Rhode Island General Laws contains a similar provision but then proceeds to denominate a host of exceptions.[135] The peer review privilege in Rhode Island does not extend to the imposition of any restriction of privileges or requirement of supervision on a physician; it does not apply to records "made in the regular course of business by a hospital," or "[d]ocuments or records otherwise available *from original* sources."[136] Of course, "[v]irtually all of the information considered during the peer review process originates from outside sources."[137]

While not a peer review statute, one other provision bears note. Section 23-17-40 of the Rhode Island General Laws mandates that hospitals must prepare root cause analyses for specific denominated events, including, but not limited to, brain injury, mental impairment, paraplegia, quadriplegia, any type of paralysis, loss of limb or organ, surgery on the wrong patient, subjecting a patient to a procedure other than that ordered or intended by the patient's attending physician and "[a]ny serious or unforeseen complication, that is not expected or probable, resulting in an extended hospital stay or death of the patient" which must be filed with state Department of Health.[138]

B. State Case Law Interpreting the Peer Review Privilege in Rhode Island

The Rhode Island Supreme Court has limned the parameters of the peer review privilege in Rhode Island on three occasions, in *Cofone v. Westerly Hospital*[139] in 1986, *Moretti v. Lowe*[140] in 1991,

133. R.I. GEN. LAWS § 5-37-5.1(27) (Supp. 2008).
134. R.I. GEN. LAWS § 5-37.3-7(c) (2004).
135. R.I. GEN. LAWS § 23-17-25 (2001).
136. *Id.*
137. Cruger v. Love, 599 So. 2d 111, 114 (Fla. 1992).
138. R.I. GEN. LAWS §§ 23-17-40(c)-(d) (2008).
139. 504 A.2d 998 (R.I. 1986).
140. 592 A.2d 855 (R.I. 1991).

and *Pastore v. Samson*[141] in 2006. Even though the peer review privilege in Rhode Island is statutorily based, the judiciary's hostility to the peer review privilege is palpable.[142] In contrast to the widely held view that the purpose of peer review is to improve patient care, the Rhode Island Supreme Court has stated: "The peer-review privilege was designed to alleviate an increase in medical malpractice lawsuits for substandard health care . . . ."[143] As such, the peer review "privilege must not be permitted to become a shield behind which a physician's incompetence, impairment or institutional malfeasance resulting in medical malpractice can be hidden from parties who have suffered because of such incompetence, impairment or malfeasance."[144] This harsh perspective may have made sense at one time, but it does not today.[145]

Peer review protection in Rhode Island is thus limited to "only the records and the proceedings which originate with the peer review board."[146] For example, in *Pastore*, the Rhode Island Supreme Court refused to apply the peer review privilege to a transcript of a peer review board meeting wherein the board discussed a doctor's bedside manner while working the emergency room.[147] According to the Supreme Court, the "peer review privilege was designed to alleviate an increase in medical

141. 900 A.2d 1067 (R.I. 2006).

142. The hostility of the Rhode Island Supreme Court to privileges in general is not unique to the peer review privilege. *See, e.g.*, Gaumond v. Trinity Repertory Co., 909 A.2d 512, 516-17 (R.I. 2006) (declining to recognize a "school-disabled student" privilege).

143. *Pastore*, 900 A.2d at 1079. *But see* Jenkins v. Wu, 468 N.E.2d 1162, 1168 (Ill. 1984) ("[T]he purpose of this [Illinois' peer review] legislation is not to facilitate the prosecution of malpractice cases. Rather, its purpose is to ensure the effectiveness of professional self-evaluation, by members of the medical profession, in the interest of improving the quality of health care.").

144. *Moretti*, 592 A.2d at 857-58.

145. Goldberg, *supra* note 3, at 158 & n.11 (older peer review statutes which predate claims for corporate negligence on the part of hospitals were written to protect doctors) (citing Matchett v. Super. Ct., 115 Cal. Rptr. 317, 321 (Cal. Ct. App. 1974)); *see also* Dorsten v. Lapeer County Gen. Hosp., 88 F.R.D. 583, 585 (E.D. Mich. 1980) (peer review privilege was "enacted in apparent response to increased medical malpractice litigation"); Atkins v. Walker, 445 N.E.2d 1132, 1136 (Ohio Ct. App. 1981) (peer review statute was directed at malpractice litigation).

146. *See* Cofone v. Westerly Hosp., 504 A.2d 998, 1000 (R.I. 1986).

147. *Pastore*, 900 A.2d at 1079.

malpractice lawsuits for substandard health care, not to reduce the number of rude or uncompassionate health-care professionals—although the latter is certainly a commendable objective."[148] If the Supreme Court's rendition of the facts is taken at its word, then the issue should be relevance; if the transcript regarding the doctor's bedside manner did not fall within the peer review privilege, how was his rudeness or lack of compassion relevant to the patient's malpractice claim?

The *Pastore* court also turned the "original source" rule on its head. The request for production at issue was directed to the hospital.[149] Notwithstanding that the document at issue was a transcript of the hospital's peer review committee, the Rhode Island Supreme Court upheld the order of production.[150] In a gratuitous remark that is nonetheless the law in Rhode Island, the *Pastore* court stated: "[T]o oblige a Plaintiff to track down the original source of unprivileged information that is within the custody of the party to the dispute would be to require burdensome labor for no good reason."[151] *Pastore* thus potentially opens up the discussions of every peer review board to second-guessing.[152]

In addition, the Rhode Island Supreme Court has taken a very narrow approach when it comes to limiting the discovery of the identity of participants in the peer review process. In *Moretti*, the Rhode Island Supreme Court required a doctor to answer interrogatories requesting the names of those who served on a

148. *Id.*

149. *Id.* at 1071.

150. *Id.* at 1080.

151. *Id.* at 1081; *see also* Coutu v. Tracy, No. Civ. A. 00-3720, 2004 WL 2821636, at *3 (R.I. Super. Ct. Nov. 10, 2004). *Pastore* is in direct contravention of the rule in other states that likens the peer review committee to a "black hole" – "what goes in cannot come out" by means of discovery directed to the peer review committee, but the plaintiff can look elsewhere for the same information. *See, e.g.*, Doe v. Unum Life Ins. Co. of Am., 891 F. Supp. 607, 610 (N.D. Ga. 1995); *see also* McGee v. Bruce Hosp. Sys., 439 S.E.2d 257, 260 (S.C. 1993) ("[T]he public interest in candid professional peer review should prevail over the litigant's need for information from the most convenient source.").

152. On the other hand, the Rhode Island Supreme Court could still limit the damage by denying further discovery into the details of what was said at the peer review board. *See* Henry Mayo Newhall Mem'l Hosp. v. Super. Ct., 146 Cal. Rptr. 542, 548 (Cal. Ct. App. 1978).

peer review committee.[153] The rule in Rhode Island ignores the reality that there is no reason to disclose the name of peer review participants other than to somehow discover information relevant to the peer review proceeding, which is supposed to be privileged.[154]

It appears that the only area where a Rhode Island court has favored peer review is in determining whether a particular committee engages in peer review activities. A justice of the Superior Court in *Cofone* held that an "Infection Control Committee" was a peer review board even though it was not denominated as such.[155] That finding was not challenged on appeal,[156] however, so its precedential value is limited.

There are other issues arising under the Rhode Island peer review statute that have not generated a published opinion but are nonetheless problematic. Not only is the scope of the privilege limited in Rhode Island, the breadth of the exceptions to the privilege is wide. For example, the "regular course of business" carve-out to the peer review privilege is particularly broad and could arguably sweep up the entire peer review privilege. In Rhode Island, root cause analyses of a set of denominated incidents are statutorily mandated and must be filed with the state Department of Health.[157] As such, they are prepared in the ordinary course of business regardless of whether they are prepared as part of peer review. Since some courts have held that

153. *See* Moretti v. Lowe, 592 A.2d 855, 858 (R.I. 1991); *Coutu*, 2004 WL 2821636, at *3. Massachusetts has adopted the opposite rule. *See* MASS. GEN. LAWS ANN. ch. 111 § 204(c) (West 2003 & Supp. 2009) (protecting the identity of participants in the peer review process).

154. *See* Yuma Reg'l Med. Ctr. v. Super. Ct., 852 P.2d 1256, 1259-60 (Ariz. Ct. App. 1993); *see also* Kenney v. Super. Ct., 63 Cal. Rptr. 84, 113 (Cal. Ct. App. 1967) ("Harassment of committee members by subjecting them to importunement to disclose information received from, or imparted to, defendant or his attorney would destroy the efficacy, if not the existence, of these committees.").

155. Cofone v. Westerly Hosp., 504 A.2d 998, 999 (R.I. 1986).

156. *See id.*; *cf.* El Gabri v. R.I. Bd. of Med. Licensure & Discipline, No. 97-4344, 1998 WL 961165, at *13 (R.I. Super. Ct. Dec. 30, 1998) (committee of the Medical Board was not a peer review board). At least one Massachusetts court has gone so far as to dispense with the requirement of a committee in order to protect the confidentiality of a peer review process as opposed to documents delivered to a particular group of people. *See* Peters v. Ling, No. 92-0413E, 1994 WL 879535, at *5 (Mass. Super. Ct. Sept. 1, 1994).

157. *See* R.I. GEN. LAWS §§ 23-17-40(c), (d) (2008).

peer review materials prepared in the ordinary course of business are not subject to the peer review privilege,[158] root cause analyses in the hospital context in Rhode Island arguably fall outside the peer review privilege.[159]

This narrow construction of the peer review privilege in the Rhode Island courts coexists with Rhode Island's unusual version of Rule 407 of the Rules of Evidence that makes subsequent remedial measures admissible.[160] Rhode Island's Rule is in direct contravention to Federal Rule of Evidence 407, which precludes the admission of subsequent remedial measures "on a social policy of encouraging people to take, or at least not discouraging them from taking, steps in furtherance of added safety."[161] More importantly, the relevance of subsequent remedial measures is dubious – the relevant time period is at the time of the accident, not after. [162]

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158. *See, e.g.*, State *ex rel.* AMISUB, Inc. v. Buckley, 618 N.W.2d 684, 695 (Neb. 2000) (incident reports kept in the ordinary course of business not protected by the peer review privilege); Columbia/HCA Healthcare Corp. v. Eighth Judicial Dist. Ct., 936 P.2d 844, 851 (Nev. 1997) (since occurrence reports were kept in the ordinary course of business they were discoverable, not peer review records); Harper v. Cadenhead, 926 S.W.2d 588, 589 (Tex. App. 1995) (credentialing committee's records were kept in the "regular course of . . . business" and therefore were not protected by the peer review privilege). *But see* Carr v. Howard, 689 N.E.2d 1304, 1315 (Mass. 1998) (incident report was privileged provided it was necessary to peer review committee work product).

159. *See, e.g.*, Long v. Women & Infants Hosp., No. C.A. PC/03-0589, 2006 WL 2666198, at *2 (R.I. Super. Ct. Sept. 11, 2006) (occurrence screen prepared in the ordinary course of business was not protected by the attorney-client privilege in a medical malpractice claim).

160. R.I. R. EVID. 407; *see, e.g.*, Lieberman v. Bliss-Doris Realty Assocs., L.P., 819 A.2d 666, 672 (R.I. 2003) (evidence that defendant subsequently installed lights was admissible to show negligence). The Rhode Island Rule is based on Maine Rule of Evidence 407(a). R.I. R. EVID. 407 advisory committee's note. Maine is the only other state with this rule. DAVID P. LEONARD, THE NEW WIGMORE, SELECTED RULES OF LIMITED ADMISSIBILITY 146 (2002).

161. FED. R. EVID. 407 advisory committee's note; *see also* Flaminio v. Honda Motor Co., 733 F.2d 463, 469-70 (7th Cir. 1984) (explaining the social policy basis for the rule). *But see* R.I. R. EVID. 407 advisory committee's note (disputing this basis); STEPHEN A. SALTZBURG ET AL., FEDERAL RULES OF EVIDENCE MANUAL 407-4 to 407-5 (9th ed. 2006).

162. *See, e.g.*, Cook v. McDonough Power Equip., 720 F.2d 829, 831 (5th Cir. 1983); Rollins v. Bd. of Governors for Higher Educ., 761 F. Supp. 939, 940-41 (D.R.I. 1991) (evidence of repairs that occurred before electrocution was admissible but evidence of those that occurred after electrocution were

While the mere preparation of a report is not in and of itself a remedial measure,[163] the actions described in or taken as a result of the report are. Production of the report, therefore, is likely to lead to the discovery of admissible evidence unless the report is covered by the privilege. Given Rhode Island's narrow approach to peer review coupled with Rhode Island's version of Rule 407,[164] there is practically no incentive on the part of health care providers to engage in the type of rigorous peer review that will lead to better health care outcomes.

C. Federal Case Law Interpreting the Rhode Island Peer Review Privilege

In contrast to the crabbed approach taken toward the peer review privilege in the Rhode Island state courts, the federal court in Rhode Island has arguably applied the privilege where it should not in *Bennett v. Kent County Memorial Hospital*.[165] In *Bennett*, the plaintiff moved to compel testimony from the director of the hospital's emergency department.[166] The United States District Court denied the motion, relying on Rhode Island's peer review privilege.[167]

Bennett coupled a state law claim with a cause of action arising under the federal Emergency Medical Treatment and Active Labor Act ("EMTALA").[168] In actions arising under federal law, federal courts look to Rule 501 of the Federal Rules of Evidence.[169] Rule 501 sets forth three propositions: (1) in federal

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not). The Rhode Island Advisory Committee did not address this, the stronger, argument. *See* R.I. R. EVID. 407 advisory committee's note.

163. Prentiss & Carlisle Co. v. Koehring-Waterous Div. of Timberjack, Inc., 972 F.2d 6, 10 (1st Cir. 1992).

164. *See, e.g.*, Brokaw v. Davol, Inc., C.A. No. 07-5058, 2008 WL 4897928 (R.I. Super. Ct. Oct. 27, 2008) (refusing to recognize common law privilege of self-critical analysis in light of the policies behind Rhode Island's version of Rule 407).

165. 623 F. Supp. 2d 246 (D.R.I. 2009).

166. *Id.* at 255.

167. *Id.*

168. *Id.* at 248.

169. FED. R. EVID. 501; *see, e.g.*, Mem'l Hosp. for McHenry County v. Shadur, 664 F.2d 1058, 1061 (7th Cir. 1981); United States *ex rel.* Roberts v. QHG of Ind., Inc., No. 1:97-CV-174, 1998 WL 1756728, at *1-2 (N.D. Ind. Oct. 8, 1998); Robertson v. Neuromedical Ctr., 169 F.R.D. 80, 81-82 (M.D. La. 1996).

question cases, federal law generally provides the evidentiary rule;[170] (2) a federal court can recognize a state privilege in the jurisdictions in which it sits as a matter of comity or by "reason and experience[;]"[171] and (3) where state law provides the rule of decision with respect to an element of a claim or a decision, a federal court can look to a state law privilege.[172] A state cannot, however, mandate that a federal court adhere to state-created privileges in cases arising under federal law.[173]

The *Bennett* court nonetheless applied the privilege.[174] In reaching this conclusion, the *Bennett* court held that where the information sought was only relevant to the state law claim, the assertion of the federal law claim did not void the state law privilege.[175] While the decision in *Bennett* is consistent with precedent from at least one other federal court,[176] other federal courts have reached the opposite result in EMTALA cases with pendent state law claims.[177]

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170. *See, e.g.*, Adkins v. Christie, 488 F.3d 1324, 1326 (11th Cir. 2007); Virmani v. Novant Health, Inc., 259 F.3d 284, 293 (4th Cir. 2001); *Shadur*, 664 F.2d at 1063-64. *But see* Weekoty v. United States, 30 F. Supp. 2d 1343, 1345-46 (D.N.M. 1998) (recognizing a medical peer review privilege in an action arising under the Federal Torts Claim Act); Brem v. DeCarlo, Lyon, Hearn & Pazourek, P.A. 162 F.R.D. 94, 102 (D. Md. 1995) (applying Maryland peer review privilege in defamation action); Komlosi v. N.Y. State Office of Mental Retardation & Dev. Disabilities, No. 88 Civ. 1792 (JFK), 1992 WL 77544, at *2 (S.D.N.Y. Apr. 3, 1992) (applying policies underlying New York peer review privilege in federal civil rights act).

171. Jenkins v. DeKalb County, 242 F.R.D. 652, 655 (N.D. Ga. 2007) (quoting FED. R. EVID. 501); Pagano v. Oroville Hosp., 145 F.R.D. 683, 688 n.2 (E.D. Cal. 1993) (quoting FED. R. EVID. 501).

172. *Bennett*, 623 F. Supp. 2d at 254-55.

173. *Shadur*, 664 F.2d at 1061; *Pagano*, 145 F.R.D. at 688; *see also* Herron v. S. Pac. Co., 283 U.S. 91, 94-95 (1931) (state constitution cannot dictate the terms of a jury trial in federal court).

174. *See Bennett*, 623 F. Supp. 2d at 255.

175. *See id.*

176. *See, e.g.*, Guzman v. Mem'l Hermann Hosp. Sys., Civ. A. No. H-07-3973, 2009 WL 427268, at *7 (S.D. Tex. Feb. 20, 2009) (applying state peer review privilege to pendent state law claim).

177. *See, e.g.*, Atteberry v. Longmont United Hosp., 221 F.R.D. 644, 646-47 (D. Colo. 2004) ("[F]ederal law of privilege governs even where the evidence sought also may be relevant to pendent state law claims."); Burrows v. Redbud Cmty. Hosp. Dist., 187 F.R.D. 606, 609 (N.D. Cal. 1998) (applying federal law to pendent state law malpractice claims where state privilege was "inconsistent with the flexibility of federal privilege law.").

III. WHAT IS THE PSQIA?

Congress has been cognizant that the importance of collecting more information to reduce health care errors has been frustrated by state schemes like those in Rhode Island.[178] Consequently, in 2005, Congress revisited the issue of peer review and enacted the PSQIA.[179] In its simplest terms, the PSQIA guarantees confidentiality and provides a privilege to "patient safety work product" voluntarily[180] provided to a patient safety organization.[181] According to one of its sponsors, the PSQIA strikes a balance between a plaintiff's right to information and the health care community's need to analyze information without fear of legal sanction.[182] Although the PSQIA affords confidentiality and privilege protection to patient safety work product provided to a patient safety organization, it does not protect peer review materials required to be generated under state law apart from the PSQIA.

The PSQIA defines "patient safety work product" as:

> Except as provided in subparagraph (B), . . . data, reports records, memoranda, analyses (such as root cause analyses), or written or oral statements—
>
> (i) which—

178. *See* 150 CONG. REC. S8222, 8222-8223 (daily ed. July 15, 2004) (statement of Sen. Enzi).

179. Pub. L. 109-41, 119 Stat. 424 (2005) (codified as amended at 42 U.S.C. §§ 299b-1 to c-7 (2006)). For an excellent analysis of the PSQIA and its legislative history, see Kathryn Leaman, *Let's Give Them Something to Talk About: How the PSQIA May Provide Federal Privilege and Confidentiality Protections to the Medical Peer Review Process*, 11 MICH. ST. U. J. MED. & L. 177 (2007).

180. The voluntary aspect of the PSQIA has its critics: the PSQIA "adds virtually nothing to the real needs of a proper regulatory approach to medical errors – it provides no mandate for systematic data collection by providers nor any reimbursement for it; it does not compel use of data in any kind of national reporting system, and it fails to make a serious and systematic attempt to tie performance to solid measurements and reimbursement." Barry R. Furrow, *Regulating Patient Safety: Toward a Federal Model of Medical Error Reduction*, 12 WIDENER L. REV. 1, 18 (2005).

181. 42 U.S.C. § 299b-22(a); *see also* Leaman, *supra* note 179, at 192-93 (calling it a "Quid Pro Quo").

182. Leaman, *supra* note 179, at 188.

> (I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or
>
> (II) are developed by a patient safety organization for the conduct of patient safety activities;
>
> and which could result in improved patient safety, health care quality, or health care outcomes; or
>
> (ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.[183]

The PSQIA expressly clarifies that definition, such that:

> (i) Information described in subparagraph (A) does not include a patient's medical record, billing and discharge information, or any other original patient or provider record.
>
> *(ii) Information described in subparagraph (A) does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product.*
>
> (iii) Nothing in this part shall be construed to limit—
>
> (I) the discovery of or admissibility of information described in this subparagraph in a criminal, civil, or administrative proceeding;
>
> (II) the reporting of information described in this subparagraph to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or

183. 42 U.S.C. § 299b-21(7)(A).

> health oversight purposes; or
>
> (III) a provider's recordkeeping obligation with respect to information described in this subparagraph under Federal, State, or local law.[184]

A "patient safety organization" is defined in the PSQIA as: "a private or public entity or component thereof that is listed by the Secretary pursuant to section 299b-24(d) . . . ."[185]

The PSQIA provides that "patient safety work product" shall be privileged and confidential:

> Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c) . . . , patient safety work product shall be privileged and shall not be –
>
> (1) subject to a Federal, State, or local civil, criminal, or administrative subpoena or order, including in a Federal, State, or local civil or administrative disciplinary proceeding against a provider;
>
> (2) subject to discovery in connection with a Federal, State, or local civil, criminal, or administrative proceeding, including in a Federal, State, or local civil or administrative disciplinary proceeding against a provider;
>
> (3) subject to disclosure pursuant to section 552 of title 5, (commonly known as the Freedom of Information Act) or any other similar Federal, State, or local law;
>
> (4) admitted as evidence in any Federal, State, or local governmental civil proceeding, criminal proceeding, administrative rulemaking proceeding, or administrative adjudicatory proceeding, including any such proceeding against a provider; or
>
> (5) admitted in a professional disciplinary

184. *Id.* § 299b-21(7)(B) (emphasis added).
185. *Id.* § 299b-21(4).

> proceeding of a professional disciplinary body established or specifically authorized under State law.
>
> ***
>
> Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c) . . . , patient safety work product shall be confidential and shall not be disclosed.[186]

Finally, and most significantly, the PSQIA expressly sets forth certain rules of construction:

> Nothing in this section shall be construed—
>
> (1) to limit the application of other Federal, State, or local laws that provide greater privilege or confidentiality protections than the privilege and confidentiality protections provided for in this section;
>
> (2) to limit, alter, or affect the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under this section;
>
> (3) except as provided in subsection (i) of this section, to alter or affect the implementations of any provision of the HIPAA confidentiality regulations or section 1320d-5 of this title (or regulations promulgated under such section);
>
> (4) to limit the authority of any provider, patient safety organization, or other entity to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with this section;

186. *Id.* §§ 299b-22(a), (b). The exceptions in subsection (c) address criminal proceedings, to enforce the act itself, and where the provider has authorized release, for example.

> *(5) as preempting or otherwise affecting any State law requiring a provider to report information that is not patient safety work product;* or
>
> (6) to limit, alter, or affect any requirement for reporting to the Food and Drug Administration information regarding the safety of a product or activity regulated by the Food and Drug Administration.[187]

On January 11, 2009, the Department of Health and Human Services promulgated regulations implementing the PSQIA.[188]

The flaw with the peer review protection in the PSQIA is buried in the provision that posits that nothing in the PSQIA shall affect any state reporting requirement regarding information that is not patient safety work product.[189] By definition, "patient safety work product" does not include "information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system."[190] Information "collected" for state officials such as the root cause analyses required to be sent to the Rhode Island Department of Health[191] "exist[s] separately . . . from a patient safety evaluation system."[192] Indeed, the legislative history of the PSQIA posits that information already reported under state statutes like the New York incident reporting statute is not patient safety work product because it is not collected or created to report to a patient safety organization.[193] Consequently, these materials fall outside the definition of patient safety work product and are still not protected under the PSQIA even though the PSQIA purports to

187. *Id.* § 299b-22(g) (emphasis added).

188. Patient Safety and Quality Improvement, 73 Fed. Reg. 70,732 (Nov. 21, 2008) (codified at 42 C.F.R. pt. 3 (2009)).

189. *See* Mikk, *supra* note 104, at 143-44 (citing 73 Fed. Reg. 8112, 8123 (proposed Feb. 12, 2008) (to be codified at 42 C.F.R. pt. 3).

190. 42 U.S.C. § 299b-21(7)(B)(ii) (2006).

191. R.I. GEN. LAWS §§ 23-17-40(c), (d) (2008).

192. 42 U.S.C. § 299b-21(7)(B)(ii).

193. S. Rep. No. 108-196, at 9 (2003); *cf.* Med. Soc'y of N.J. v. Mottola, 320 F. Supp. 2d 254, 269-71 (D.N.J. 2004) (information submitted to state Medical Practitioner Review Board was not subject to confidentiality requirements under HCQIA; nothing in the HCQIA precluded dissemination of information independently obtained by the state agency).

protect those very same documents.

One commentator concedes that mandatory reporting to state and federal organizations falls outside the protection of the PSQIA but contends that this reporting is already outside the peer review process because it is made to these agencies by some entity other than the peer review committee.[194] While it is true that information reported to the National Practitioner Data Bank is always confidential under the HCQIA,[195] her argument that there is a substantive difference between a report to a patient safety organization prepared by a peer review committee within a hospital and a report to the state Department of Health prepared by Board of Trustees seems to be, in practice, a distinction without a difference. Both involve the same incident with the same root cause analysis. To the extent that a hospital is mandated by state law to send the root cause analysis of the incident to the state, that report is not patient safety work product under the PSQIA, and its protection is left to the vagaries of state law. By leaving this door open, Congress has invited more legal wrangling and cast another shadow over the efficacy of peer review.[196]

IV. WHY THE PSQIA DOES NOT PREEMPT STATE LAW REGULATING PEER REVIEW

Health care providers may still argue that the PSQIA preempts state law to the contrary, and that cases like *Moretti* and *Samson* should be consigned to the ash heap so long as the health care provider submits its peer review materials to a patient safety organization. These arguments, however, are likely to fail given the limitation in the pre-emption clause in the PSQIA.

Article VI of the Constitution, the Supremacy Clause, provides that federal law preempts state law to the contrary.[197] Thus, state law that conflicts with federal law is without effect.[198]

194. Leaman, *supra* note 179, at 192.

195. 42 U.S.C. § 11137(b)(1) (2006); *see also* Pagano v. Oroville Hosp., 145 F.R.D. 683, 692 (E.D. Cal. 1993).

196. *See e.g.*, Mikk, *supra* note 104, at 144; Charles M. Key, *A Review of the Patient Safety and Quality Improvement Act of 2005*, 18 HEALTH LAW. 20, 22 (2005).

197. U.S. CONST. art. VI, cl. 2.

198. Maryland v. Louisiana, 451 U.S. 725, 746 (1981) (citing McCulloch v. Maryland, 17 U.S. (4 Wheat.) 316, 427 (1819)); *see, e.g.*, Prot. & Advocacy for Persons with Disabilities v. Mental Health & Addiction Servs., 448 F.3d 119,

Principals of federalism dictate, however, that "'the federal-state balance' will not be disturbed unintentionally by Congress or unnecessarily by the courts."[199] While Congress can exercise its powers under Article I of the Constitution to upend state statutes, the presumption is that Congress generally does not.[200] Preemption is particularly disfavored "where federal law is said to bar state action in fields of traditional state regulation."[201] Preemption language involving areas of health and safety, therefore, is read narrowly.[202]

There are three ways that Congress can demonstrate that intent to preempt state law. First, Congress can explicitly define the extent to which the enacted statute preempts state law. Second, federal law can preempt state law when state law actually conflicts with federal law. Third, state law is preempted if it attempts to regulate a field that Congress determined should be occupied exclusively by the federal government.[203] Field preemption is in actuality merely a species of conflict preemption.[204]

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129 (2d Cir. 2006) (Protection and Advocacy for Mentally Ill Individuals Act, 42 U.S.C. § 10805(a)(4)(A) [PAMII], preempts Connecticut peer review statute regarding release of records to protection and advocacy systems for the mentally ill); Mo. Prot. & Advocacy Servs. v. Missouri Dep't of Mental Health, 447 F.3d 1021, 1024 (8th Cir. 2006) (to the extent PAMII conflicts with state law, it preempts Missouri law); Center for Legal Advocacy v. Hammons, 323 F.3d 1262, 1272 (10th Cir. 2003) (PAMII preempts Colorado peer review statute); Pa. Prot. & Advocacy, Inc. v. Houstoun, 228 F.3d 423, 428 (3d Cir. 2000) (PAMII preempts Pennsylvania peer review statute); *see also* Quinn v. Kent Gen'l Hosp., 617 F. Supp. 1226, 1240 n.11 (D. Del. 1985) (Sherman Act preempts discovery limitation in Delaware peer review statute). *But see* Disabilities Rights Ctr., Inc. v. Comm'r, 732 A.2d 1021, 1024 (N.H. 1999) (widely criticized decision that PAMII does not preempt New Hampshire quality assurance statute).

199. Jones v. Rath Packing Co., 430 U.S. 519, 525 (1977) (quoting United States v. Bass, 404 U.S. 336, 349 (1971)).

200. *See, e.g.*, Riegel v. Medtronic, Inc., 128 S. Ct. 999, 1011 (2008) (state and federal laws can provide parallel damage remedies).

201. N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 655 (1995).

202. *See* Medtronic, Inc. v. Lohr, 518 U.S. 470, 485 (1976) (citing Cipollone v. Liggett Group, Inc., 505 U.S. 504, 518 (1992)).

203. English v. Gen. Elec. Co., 496 U.S. 72, 78-79 (1990).

204. *Id.* at 79-80 n.5.

A. The Express Preemption in the PSQIA Does Not Extend to State Peer Review Activities

"Congress may pre-empt state authority by so stating in express terms."[205] If Congress includes a preemption clause in a particular statute, then ordinary principles of statutory construction apply, and "'there is no need to infer congressional intent to preempt state laws from the substantive provisions' of the legislation."[206] When the language is explicit, the task is easy.[207]

1. Nothing in the Text of the PSQIA Preempts State Laws Governing the Administration of Peer Review Programs

The explicit use of the phrase, "[n]otwithstanding any other provision of Federal, State or local law"[208] indicates that Congress intended that the PSQIA trump state law to the contrary when it comes to the discoverability or admissibility of "patient safety work product," but it says nothing about information generated pursuant to any state reporting requirement.[209] For example, in Rhode Island, health care providers are required by statute to file

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205. Pacific Gas & Elec. Co. v. State Energy Res. Conservation & Develop. Comm'n, 461 U.S. 190, 203 (1983). *See, e.g.*, 42 U.S.C. § 1320d-7(a)(1) (2000) (HIPAA "shall supersede any contrary provision of State law").

206. *Cipollone*, 505 U.S. at 517 (quoting Cal. Fed. Savs. & Loan Ass'n v. Guerra, 479 U.S. 272, 282 (1987) (Marshall, J.)).

207. *English*, 496 U.S. at 79.

208. 42 U.S.C. § 299b-22(a) (2006).

209. An almost identical provision was incorporated in the Food Security Act of 1986, 7 U.S.C. § 1631 (2006). Various federal and state courts have consequently held that the Food Services Act trumps the farm products rule in the Uniform Commercial Code, UCC § 9-307(1) (2000). *See, e.g., In re* McDonald v. Ocilla Cotton Warehouse, Inc., 224 B.R. 862, 866-67 (Bankr. S.D. Ga. 1998); Tallahatchie County Bank v. Marlow *(In re The Julien Co.)*, 141 Bankr. 384, 388-89 (Bankr. W.D. Tenn. 1992); Fin Ag, Inc. v. Hufnagle, Inc., 720 N.W.2d 579, 582 (Minn. 2006). The preemptive power of the same phrase in the Food Security Act, however, has been limited to the narrow subject of the statute. *Fin Ag*, 720 N.W.2d at 582 ("[S]ection 1631 did not provide that the buyer would take free of all security interests, but instead only established a notice system that provided a mechanism for buyers to protect themselves from some, but not all, security interests."). While the Food Security Act preempted the farm products rule, it did not, for example, preempt the UCC's four-month rule for reperfecting security interests in collateral which is removed to another state. *Julien*, 141 Bankr. at 389 (referring to legislative history). The preemptive effect of the Food Security Act on the Uniform Commercial Code, thus, only went so far.

root cause analyses with the state Department of Health.[210] Pursuant to the familiar principle of *expressio unius est exclusio alterius,*[211] this silence is fatal to any argument that a "provider"[212] could comfortably rely on the PSQIA in any jurisdiction that mandates the generation of peer review information.

While it is true that definition of "patient safety work product" includes "data reports, records, memoranda, [or] analyses (such as root cause analyses),"[213] which seems to be by definition, peer review information,[214] the "patient safety work product" must be "reported to a patient safety organization" pursuant to the PSQIA to qualify as "patient safety work product," not a state peer review system.[215] Sending the same information collected for peer review purpose to a patient safety organization does not ipso facto immunize that information for the purpose of mandatory state peer review purposes. In fact, the PSQIA expressly states that information that is "collected, maintained, or developed separately or exists separately, from a patient safety evaluation system" that is copied to a patient safety organization "shall not by reason of its reporting be considered patient safety work product."[216] Thus, it is not possible to secure the protection of the privilege afforded by the PQSIA for state mandated peer-review information because state law mandates that it exists independent of the voluntary requirement of the PSQIA.

This narrow reading of the protection afforded by the privilege in the PSQIA is consistent with the rules of construction provided for in the PSQIA. The rules of construction state that nothing in the PSQIA shall be construed "to limit, alter, or affect

210. *See* R.I. GEN. LAWS §§ 23-17-40(c), (d) (2008).

211. "A cannon of construction holding that to express or include implies the exclusion of the other, or of the alternative." BLACK'S LAW DICTIONARY 265 (2d pocket ed. 2001).

212. The term "provider" includes a "pharmacy . . . or health center[,]" as well as a "physician, physician assistant, nurse practitioner, clinical nurse specialist, . . . pharmacist, or other individual health care practitioner[.]" 42 U.S.C. § 299b-21(8)(A).

213. *Id.* § 299(b)-21(7)(A).

214. *See, e.g.,* CONN. GEN. STAT. ANN. § 19a-17b(d) (West 2003); KAN. STAT. ANN. § 65-1695(b) (Supp. 2008).

215. 42 U.S.C. § 299b-21(7)(A)(i)(I).

216. *Id.* § 299b-21(7)(B)(ii).

the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under" the PSQIA.[217] The rules of construction also posit that nothing in the PSQIA preempts or otherwise affects "any State law requiring a provider to report information that is not patient safety work product. "[218]

By definition, information reported to a state health care regulator is not patient safety work product when it is "separate information or a copy thereof."[219] Since information that is reported to a state health care regulator is not patient safety work product, it is not afforded the protection of the privilege under the PSQIA.[220]

Likewise, the section on limitations of actions in the PSQIA undermines any argument that the PSQIA preempts state peer review statutes. That section of the PSQIA expressly provides that a patient safety organization may not be compelled to produce information collected or developed under the PSQIA.[221] It also provides that "[a]n accrediting body shall not take an accrediting action against a provider based on the good faith participation of the provider in the collection, development, reporting, or maintenance of patient safety work product."[222] The section on limitation of actions in the PSQIA says nothing, however, about limiting claims by patients.[223]

In sum, neither the text nor the structure of the PSQIA

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217. *Id.* § 299b-22(g)(2) (2006).
218. *Id.* § 299b-22(g)(5) (2006).
219. *Id.* § 299b-21(7)(B)(ii) (2006).
220. The Report of the Senate Committee on Health, Education, Labor and Pensions on the Patient Safety and Quality Improvement Act of 2003, S. REP. NO. 108-196 (2003), the precursor of the PSQIA, explicitly states that "[i]nformation that must be reported under Federal, State or local reporting requirements (such as New York's incident reporting statute 10 NYCRR § 405.8)—even when those laws or regulations require the reporting of the same or similar information regarding the type of events also reported through the system contemplated by this legislation—is not within the definition of patient safety data because it is not 'collected or developed . . . for reporting to a patient safety organization . . . . ' Conversely, information covered under state reporting laws fall outside the definition of patient safety data because such information is 'collected or developed separately from and that exists separately from patient safety data . . . . '"*Id.* at 9.
221. 42 U.S.C. § 299b-22(d)(4)(A)(i).
222. *Id.* § 299b-22(d)(4)(B).
223. *See id.* § 299b-22(d)(4).

suggests that the PSQIA preempts any state reporting requirement.[224]

2. Nothing in the Regulations Implementing the PSQIA Preempts State Laws Governing the Administration of Peer Review Programs

Statutes are not the only source of law. Congress may delegate rulemaking to administrative agencies.[225] The power to make rules with the force of law extends to the power to preempt conflicting state requirements.[226] Thus, there are two questions that must be answered: (1) whether Congress intended to delegate to the administrative agency the power to make rules preempting conflicting state statutes, and (2) whether the administrative agency exercised that power.[227]

There is nothing explicit in the PSQIA that authorizes the Secretary of Health and Human Services to adopt regulations that preempt state peer review laws. The Secretary has issued regulations implementing the PSQIA, none of which purports to preempt state law.[228] In fact, the commentary from the Agency for Healthcare Research and Quality, Office for Civil Rights, Department of Health and Human Services, expressly states that the "fact that information is collected, developed, or analyzed

224. Where the text is clear, the analysis is over. *See* Pa. Prot. & Advocacy v. Houstoun, 228 F.3d 423, 427-28 (3d Cir. 2000) (rejecting use of contrary legislative history where the text was unambiguous). Unlike *Houstoun*, where the legislative history seemed at odds with the text of the statute, the legislative history of the PSQIA and its text are in accord. During the floor debate on the PQSIA, Congressman Bilirakis, the original sponsor of the legislation stated: "The bill does not shield other information outside the patient safety work product from use in court cases." Cong. Rec. H6673 (July 27, 2005). Similarly, Senator Enzi, the chairman of the Health, Education, and Pensions Committee stated, "[I]nformation which is currently available to plaintiffs' attorneys or others will remain available just as it is today." Cong Rec. S8741 (July 22, 2005); *see also* Cong. Rec. S8743-44 (July 22, 2005) (statement of Sen. Jeffords) ("This legislation does nothing to reduce or affect other Federal, State or local legal requirements pertaining to health related information.").

225. ICC v. Cincinnati, New Orleans & Tex. Pac. R.R. Co., 167 U.S. 479, 494-95 (1897).

226. Wyeth v. Levine, 129 S. Ct. 1187, 1200 (2009) (collecting authorities).

227. *See In re* Cajun Elec. Power Co-op., Inc., 109 F.3d 248, 255 (5th Cir. 1997).

228. *See* 42 C.F.R. pt. 3 (2009).

under the protections of the Patient Safety Act does not shield a provider from needing to undertake similar activities, if applicable, outside the ambit of the statute so that the provider can meet its obligations with nonpatient safety work product."[229]

Like the PSQIA itself, the regulations actually exclude from the definition of patient safety work product information "that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system."[230] Information that is gathered for other purposes, even if reported by way of a copy to the patient safety organization, does not become patient safety work product by reason of its reporting.[231] Information that is not patient safety work product is subject to discovery and, depending on the jurisdiction, must be reported to state regulators without the protection of the PSQIA.[232]

The regulations implementing the PSQIA thus afford providers no protection from their failure to comply with mandatory state peer review requirements. To the contrary, "the original records underlying patient safety work product remain available in most instances for the providers to meet these *other* reporting requirements."[233] A provider, therefore, should not expect that any information that it voluntarily provides to a patient safety organization will be inviolate from civil discovery or inadmissible at trial where provision of the same information is mandated under state law.

B. Nothing in the PSQIA Suggests that Congress Intended to Preempt the Field of Peer Review

Given the extremely limited expression of preemption in the PSQIA, the next question is whether field preemption is present. Field preemption occurs when Congress impliedly intended to occupy the field so fully that it "left no room for the States to supplement it."[234] Congress can manifest this intent through (1) pervasive federal regulation, (2) the presence of a dominant federal interest, and (3) by evidence that shows that the object

229. 73 Fed. Reg. 70732 (Nov. 21, 2008).
230. 42 U.S.C. § 299b-21(7)(B)(ii) (2006).
231. 42 C.F.R. § 3.20 (2006).
232. *Id.*
233. *Id.* (emphasis added).
234. Rice v. Santa Fe Elevator Corp., 331 U.S. 218, 230 (1947).

sought to be obtained by federal law and the character of the obligations imposed by it reveal a Congressional intent to fully occupy the field.[235] Given that health and safety are traditionally areas of state concern, courts "will seldom infer, solely from the comprehensiveness of federal regulations, an intent to pre-empt in its entirety a field related to health and safety."[236]

For example, in *Gade v. National Solid Wastes Management Association,* the Supreme Court considered a preemption challenge to Illinois licensing statutes involving the handling of solid waste to promote job safety.[237] While the Illinois statute was consistent with federal law, Congress had determined that the Occupational Safety and Health Act ("OSHA") of 1970[238] would occupy the field of workplace safety unless a state expressly assumed responsibility for all work place safety issues.[239] Illinois had not taken on those responsibilities.[240] Consequently, its licensing statutes fell to the field preemption of OSHA.[241]

Nothing in the PSQIA suggests that Congress intended to deal with anything other than the discoverability and admissibility of "patient safety work product," issue as opposed to protecting all peer review as defined by state law. Consequently, there is no case to be made that the PSQIA generally preempts the historically state-driven field of peer review.

C. Nothing in the PSQIA Actually Conflicts with any Peer Review Statutes

The only issue remaining is whether any of the state peer review statutes actually conflict with the PSQIA.[242] "[A] conflict will be found . . . where the state 'law stands as an obstacle to the

235. *Id.*; *see, e.g.,* Hines v. Davidowitz, 312 U.S. 52, 63 (1941) (recognizing field preemption in the area of foreign relations).

236. Hillsborough County v. Automated Med. Labs, Inc., 471 U.S. 707, 718 (1985).

237. 505 U.S. 88, 91 (1997).

238. 29 U.S.C. §§ 651-678 (2006) (OSHA).

239. Gade v. Nat'l Solid Wastes Mgmt. Ass'n, 505 U.S. 88, 97 (1992) (citing 29 U.S.C. § 667(b)).

240. *Id.*

241. *See id.* at 103-04.

242. *Cf.* Prot. & Advocacy for Persons with Disabilities v. Mental Health & Addiction Servs., 448 F.3d 119, 129 (2d Cir. 2006) (to the extent that PAIMI and the Connecticut peer review statute actually conflict, PAIMI governs).

accomplishment and execution of the full purposes and objectives of Congress.'"[243] A conflict thus exists when it is impossible to comply with a state law without violating federal law.[244]

In this case, by definition, there can be no actual conflict between the PSQIA and any peer review statute, since the protection afforded by the PSQIA is limited to information sent to a patient safety organization, not a state agency. The two systems operate in "parallel."[245] Thus, all mandatory state law reporting obligations remain in full force and effect despite enactment of the PSQIA. As a result, all peer review materials mandated by those statutes are not patient safety work product. To the extent that the respective state laws do not adequately protect peer review materials, nothing has changed.

V. A PROPOSAL FOR REFORM

As the foregoing discussion of peer review in Rhode Island, and the rest of the country amply demonstrate, the law governing the peer review privilege is in chaos. While the PSQIA was intended to remedy this problem, it falls short to the extent that states still mandate the generation of peer review materials outside patient safety organizations. In the continued absence of bright-line rules, health care providers are likely to limit peer review activities, thereby frustrating the use of peer review to reduce preventable adverse events.[246] Given the inadequacy of the PSQIA and the need for a better return on America's investment in health care reform, it is time to recognize a uniform

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243. Edgar v. Mite Corp., 457 U.S. 624, 631 (1982).

244. Fidelity Fed. Sav. & Loan Ass'n v. de la Cuesta, 458 U.S. 141, 153 (1982); *see, e.g.*, Shilling v. Moore, 545 N.W.2d 442, 447 (Neb. 1996) (HCQIA provides more protection than Nebraska peer review statute).

245. *Cf.* 151 Cong. Rec. S8744 (2005) (statement of Sen. Jeffords) ("[T]he legislation before us creates a new, parallel system of information collection and analysis.").

246. *See* Chiang, *supra* note 22, at 405; *see also* Upjohn Co. v. United States, 449 U.S. 383,393 (1981) ("An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all."); Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 17 (Tex. 1996) ("Nothing is worse than a half-hearted privilege; it becomes a game of semantics that leaves parties twisting in the wind while lawyers determine its scope." (quoting Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 182 (1988))).

and predictable peer review privilege. Congress, not the states or the courts, is in the best position to do so.

A. There Will Not Be a Judicial Solution

The Supreme Court can recognize "by reason and experience" the existence of a federal common law privilege where such a privilege has been widely recognized by the states.[247] "The Rule [501 of the Federal Rules of Evidence] . . . did not freeze the law governing the privileges of witnesses in federal trials at a particular point in our history, but rather directed federal courts to 'continue the evolutionary development of testimonial privileges.'"[248] For example, in *Jaffee v. Redmond*, the Supreme Court recognized the widespread adoption of a psychotherapist-patient privilege to invoke the "reason and experience" provision in Rule 501 to justify the recognition of that privilege.[249] It has been suggested that following the logic of *Jaffee*, the Supreme Court should recognize a federal common law peer review privilege.[250]

The Supreme Court, however, is unlikely to do so. As an initial matter, the Supreme Court has never viewed privileges expansively.[251] Moreover, *Jaffee* militates against the recognition of a privilege. The "reason and experience" provision is "not a privilege popularity contest."[252] Here, given that state peer review statutes vary in terms of what is and is not protected, it is unlikely that a judicial fix is in the offing.[253]

Jaffee also directs courts to balance a host of other factors. On one side is whether the privilege furthers a public good, and whether it is rooted in the imperative need for confidence and

247. Jaffee v. Redmond, 518 U.S. 1, 11-12 (1996) (recognizing federal privilege for communications between psychoanalysts and patients based on widespread acceptance at the state level).

248. *Id.* at 8-9 (quoting Trammel v. United States, 445 U.S. 40, 47 (1980)).

249. *Id.* at 10.

250. Alissa M. Bassler, Comment, *Federal Law Should Keep Pace with States and Recognize a Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 707-12 (2003).

251. United States v. Nixon, 418 U.S. 683, 710 (1974).

252. Jenkins v. DeKalb County, 242 F.R.D. 652, 661 (N.D. Ga. 2007).

253. Syposs v. United States, 63 F. Supp. 2d 301, 308 (W.D.N.Y. 1999); Johnson v. Nyack Hosp., 169 F.R.D. 550, 559 (S.D.N.Y. 1996).

trust.[254] On the other side is the evidentiary benefit of denying the privilege.[255] While a peer review privilege furthers a public good to the extent it fosters medical practices, the plaintiffs' bar will say that society can reach the same end through damage awards.

The Supreme Court has yet to weigh these criteria, but in 2001, in *Virmani v. Novant Health Inc.*, the Court of Appeals for the Fourth Circuit considered *Jaffee,* and declined to recognize a peer review privilege, albeit in the context of an employment discrimination case, not a medical malpractice claim.[256] Likewise, in *Adkins v. Christie,* the Court of Appeals for the Eleventh Circuit reached the same result in 2007 in another discrimination suit, again relying on *Jaffee.*[257] In the older decision of *Memorial Hospital for McHenry County v. Shadur,* an antitrust case, the Court of Appeals for the Seventh Circuit came to the same conclusion.[258] In all cases, the cause of action arose out of the peer review process itself, obviating the privilege.[259] When these three decisions are read along with the wave of lower court decisions,[260] the weight of authority runs heavily against judicial relief.

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254. *Jaffee,* 518 U.S. at 9-12.

255. *Id.*

256. 259 F.3d 284, 291; *see also* Ghazal Sharifi, Comment, *Is the Door Open or Closed? Evaluating the Future of the Federal Medical Peer-Review Privilege,* 42. J. MARSHALL L. REV. 561, 579-80 (2009) (*Virmani* court adhered to *Jaffee*). *But see* Teresa L. Salamon, *When Revoking Privilege Leads to Invoking Privilege: Whether There Is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in Virmani v. Novant Health, Inc.*, 47 VILL. L. REV. 643, 670 (2002) (*Virmani* court deviated from *Jaffee* in failing to follow state trends).

257. Adkins v. Christie, 488 F.3d 1324, 1330 (11th Cir. 2007); *see also* Sharifi, *supra* note 256, at 579-80 (*Adkins* court adhered to *Jaffee*).

258. 664 F.2d 1058, 1062-63 (7th Cir. 1981); *see also* Sharifi, *supra* note 256 at 579-80 (*Shadur* and *Jaffee* are consistent).

259. *Adkins,* 488 F.3d at 1329; *Virmani,* 259 F.3d at 284; *Shadur,* 664 F.2d at 1062.

260. *See, e.g., In re* Admin. Subpoena Blue Cross Blue Shield, 400 F. Supp. 2d 386, 392-93 (D. Mass. 2005); Weiss v. Chester, 231 F.R.D. 202, 206 (E.D. Pa. 2005); Braswell v. Haywood Reg'l Med. Ctr., 352 F. Supp. 2d 639, 650 (W.D.N.C. 2005); Sonnino v. Univ. of Kan., 220 F.R.D. 633, 645 (D. Kan. 2004); Nilavar v. Mercy Health Sys.-W. Ohio, 210 F.R.D. 597, 609 (S.D. Ohio 2002).

B. There Can and Should Be a Legislative Solution

By contrast, Congress is in a position to fix this problem as part of its debate on health care. The Constitution affords Congress the power to regulate interstate commerce as well as the power to create inferior courts, and the procedural rules governing them.[261] Since the provision of health care affects a myriad of interstate interests, and Congress has the power to create privileges, there is "no doubt concerning the power of Congress to regulate a peer review process."[262] Indeed, the HCQIA was ostensibly enacted, in large part, in response to the nationwide problem of incompetent physicians moving from state to state.[263]

A federal peer review privilege would also reflect the changing ways by which medicine is practiced.[264] The tort system, with its focus on specific incidents had utility in the halcyon days when patients had a single doctor, and most health care was delivered in the home.[265] In the unusual instance that patient did go to the local hospital, it had charitable immunity from liability.[266]

Today, the solitary doctor ministering to his patients is practically gone. Patients are typically treated by teams of health care providers, "some of whom never actually come in contact with the patient but whose expertise is nevertheless vital to the treatment and recovery of patients."[267] These health care providers work in major medical centers that may well do

261. U.S. CONST. art. I, § 8, cl. 3.

262. Summit Health, Ltd. v. Pinhas, 500 U.S. 322, 332 (1991); *see also* Univ. of Pa. v. EEOC, 493 U.S. 182, 183 (1990) (Congress retains the power to create evidentiary privileges); Freilich v. Bd. of Dirs., 142 F. Supp. 2d 679, 694-97 (D. Md. 2001), *aff'd,* 313 F.3d 295 (4th Cir. 2002) (HCQIA does not impinge on the Tenth Amendment).

263. H.R. REP. NO. 99-903, at 2, (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6385.

264. Furrow, *supra* note 180, at 34-35.

265. Eleanor D. Kinney, *Private Accreditation as a Substitute for Direct Government Regulation in Public Health Programs: When Is It Appropriate?,* 57 LAW & CONTEMP. PROBS. 47, 50 (Autumn 1994).

266. *See* Freiman, *supra* note 34, at 723-32 (reviewing the wide discrepancies in the corporate practice of medicine doctrine among the southeastern states and the problems created thereby).

267. Mozingo v. Pitt County Mem'l Hosp., 415 S.E.2d 341, 345 (N.C. 1992); *see also* Ybarra v. Spangard, 154 P.2d 687, 690 (Cal. 1944) (recognizing the doctrine of res ipsa loquitur given the multiplicity of actors in the hospital setting).

business in more than one jurisdiction.[268] When patients bring suit, they look to the hospital, not just to the last doctor who saw them.[269] Accordingly, the law has followed the practice; in many states, the doctrine of charitable immunity has been widely abrogated.[270]

Given this new economic paradigm, a uniform peer review privilege would lower transaction costs to these health care providers, thereby reducing, *ceteris paribus,* the cost of health care to patients. A federal fix to the peer review problem is not just permissible; it is necessary.

There is no doubt that, as is the case with all privileges, adoption of the peer review privilege will come with a price. The Massachusetts Supreme Judicial Court has broadly analogized the peer review privilege to the attorney-client privilege. The fact that it may suppress the search for the truth "'is the price that society must pay.'"[271] Congress, however, has gone out of its way to limit that price to patients. The definition of "patient safety work product" expressly excludes "a patient's medical record."[272] Given that, in most states, there are penalties for falsifying a medical record,[273] the plaintiffs' bar still has what it needs to

268. *See, e.g.,* Banner Health Sys. v. Long, 663 N.W.2d 242, 246 (S.D. 2003) (litigation over the departure of an Arizona hospital and nursing home chain from South Dakota); *see also* Jeffrey F. Chase-Lubitz, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 447 (1987) (describing the contemporary interstate practice of corporate medicine); Mello et al., *supra* note 7, at 409.

269. *See, e.g.,* Long v. Women & Infants Hosp., No. C.A. PC/03-0589, 2006 WL 2666198, at *1 (R.I. Super. Ct. Sept. 11, 2006); Tucson Med. Ctr. v. Misevch, 545 P.2d 958, 958 (Ariz. 1976); Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253, 258 (W.V. 1965).

270. *See* Dallon, *supra* note 13, at 617; Goldberg, *supra* note 3, at 162; Scheutzow, *supra* note 27, at 25-26; *see, e.g.,* President of Georgetown College v. Hughes, 130 F.2d 810, 827 (D.C. Cir. 1942); Silva v. Providence Hosp., 97 P.2d 798, 802 (Cal. 1939); Parker v. Port Huron Hosp., 105 N.W.2d 1, 14-15 (Mich. 1960).

271. Pardo v. Gen. Hosp. Corp, 841 N.E.2d 692,703 n.27 (Mass. 2006) (quoting Matter of a John Doe Grand Jury Investigation, 562 N.E.2d 69, 70 (Mass. 1990)).

272. *See* 42 U.S.C. § 299b-21(7)(B)(i) (2006).

273. *See, e.g.,* N.Y. PUB. HEALTH LAW § 230-a (1991); R.I. GEN. LAWS §§ 5-37-5.1(8), (9) (2004); *see also* Saunders v. Admin. Review Bd. for Prof'l Med. Conduct, 695 N.Y.S.2d 778, 778 (N.Y. App. Div. 1999) (upholding doctor's suspension for inadequate recordkeeping).

prosecute legitimate malpractice claims.[274]

Admittedly, a federal peer review privilege would be inconsistent with federalism. Federalism is the doctrine by which a federal court recognizes and, to the extent possible, accommodates the sovereignty and legitimate interests of the state in which the federal court sits.[275] However, the court in *Johnson v. Nyack Hospital* identified the unreality of this approach: "[P]arties similarly situated in all respects save the location of the . . . court in which they happen to be litigating would be faced with a real possibility of different outcomes based purely on that geographical happenstance."[276]

A second objection is that a uniform federal rule will stifle innovation. When Congress does not exercise its power to provide uniformity, the states cannot serve as laboratories of innovation.[277] Several states have established their own statewide patient safety organizations. The present hodgepodge, however, frustrates the analysis of peer review materials as health care providers deal with state systems that "often lack clarity and use different language to describe the reporting requirements."[278] A uniform privilege will lend itself to a uniform body of law, which will reduce the cost of collecting peer review materials and encourage more health care providers to participate.

A third criticism is that a uniform federal rule simply is not necessary; health care providers have functioned for years without a federal privilege and adding one now will not increase the amount of peer review.[279] The flaw in this argument is that experience has proved otherwise. Since enactment of the regulations implementing the PSQIA, numerous patient safety

274. Mikk, *supra* note 104, at 160-61.

275. *See* Younger v. Harris, 401 U.S. 37, 43 (1971).

276. Johnson v. Nyack Hosp., 169 F.R.D. 550, 559 (S.D.N.Y. 1996) (refusing to "make the parties' access to evidence in resolving a claim under federal statutes depend upon which bank of the Hudson River the evidence happens to be located on.").

277. New State Ice Co. v. Liebmann, 285 U.S. 262, 311 (1932) (Brandeis, J., dissenting).

278. Furrow, *supra* note 180, at 29 (citing Joel S. Weissman, et al., *Error Reporting and Disclosure Systems: View from Hospital Leaders,* 293 J. AM. MED. ASS'N 1359, 1362 (2005)).

279. *See, e.g.,* Scheutzow, *supra* note 27, at 52.

organizations have been formed.

To trump the assumption that a federal statute can coexist with "the historic presence of state law," Congress must do so by demonstrating a "clear and manifest purpose."[280] Congress needs to amend the definition of patient safety work product[281] to include all peer review materials required to be filed with a state regulatory agency, not exclude them.

CONCLUSION

The reliable predictability of uniform and effective protection is essential to unleash aggressive and unrestrained peer review as part of healthcare reform, to drive quality up and costs down. The uncertainty of the current state-by-state patchwork quilt has deterred a nationwide search for best practices, in the name of enhancing the ability of the individual malpractice plaintiff to obtain access ex post facto to the relevant incident information. These priorities need to be reversed. The mechanism to achieve this critical goal should be incorporated into healthcare reform – Congress should amend the Patient Safety and Quality Improvement Act by adding an effective peer review privilege that unambiguously and effectively eliminates any risk that peer review information can leak into the tort system. Such an amendment should make clear that peer review information may appropriately be accessed by state regulators, without risk of a waiver of the federal peer review privilege.

280. Wyeth v. Levine, 129 S. Ct. 1187, 1195 (2009).
281. *See* 42 U.S.C. § 299b-21(7)(B)(ii) (2006).