MAINTAINING THE BALANCE: RECONCILING THE SOCIAL AND JUDICIAL COSTS OF MEDICAL PEER REVIEW PROTECTION

> 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.[1]

I. INTRODUCTION

Medical peer review is a process by which physicians evaluate the quality of work performed by their colleagues for the purpose of determining compliance with appropriate standards of health care.[2] This procedure is a self-regulatory tool of quality assurance for the medical community.[3] The fundamental rationale behind the peer review process is efficiency—practicing physicians are in the best position to determine the competence of other practicing physicians as they regularly observe one another's work and have the expertise to effectively evaluate that work.[4]

In response to the increasing problem of medical malpractice, many state and private organizations have offered certain incentives to health care providers in order to encourage the use of peer review as a tool to promote quality health care.[5] These incentives have primarily taken the form of state mandates, prerequisites for funding, and prerequisites for accreditation.[6] Most importantly, every state legislature and Congress provide protection to the participants and work product of peer review committees in the form of statutory privilege, confidentiality requirements, and limited immunity from legal liability or some combination of these.[7] These protections are based upon the logical

---

1. Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 17 (Tex. 1996).
2. William G. Kopit, *Commentary: Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1170, 1172 (1986).
3. *Id.*
4. Robert S. Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 696 (1991).
5. Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 179 (1988).
6. *Id.*
7. *See, e.g.*, ALA. CODE § 34-24-58 (1997); MO. ANN. STAT § 537.035(3) (West 2000);

premise that physicians would be reluctant to otherwise participate in the process for fear of potential liability arising out of claims for malpractice, defamation, discrimination, or antitrust.[8]

Designed to encourage frank and effective peer review and ultimately improve the standard of health care given in hospitals and other health care institutions, these privileges and immunities unquestionably limit the scope of the discovery process and impede a plaintiff's ability to develop his or her case. This Comment will examine how legislatures have drawn the line between the competing policy interests of ensuring confidentiality within the peer review process and maintaining the integrity of the fact-finding function of discovery. Ultimately, this Comment will illustrate the importance of strict judicial adherence to the statutory privileges and immunities, despite the detriment to open discovery. Section II of the Comment will generally examine the actual process and function of medical peer review. Section III will consider the laws protecting peer review and the policy rationales behind them. Section IV will explain the circumstances in which these laws typically apply and the need for maintaining the balance of policy interests in ensuring the integrity of medical peer review statutes.

II. THE MEDICAL PEER REVIEW PROCESS

The peer review system, along with state licensing board disciplinary action and tort law's medical malpractice system, is one of three primary tools to monitor the quality of a physician's work.[9] The design of peer review is to decrease instances of medical malpractice and improve the condition of health care by allowing practicing physicians to recognize inadequacies in their peers' performances and discipline accordingly.[10] Physicians, courts, and commentators frequently laud the medical review process as the most effective and efficient method of professional self-regulation in the field.[11] Support for peer review is generally based upon the logical premise that only a physician's colleague or peer would have the expertise required to appropriately

---

63 PA. CONS. STAT. ANN. §§ 425.3-.4 (West 1996); 42 U.S.C. §§ 11101-11152 (1994).

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

9. Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 14 (1999).

10. Murray G. Sagsveen & Jennifer L. Thompson, *The Evolution of Medical Peer Review in North Dakota*, 73 N.D. L. REV. 477, 477 (1997).

11. *See, e.g.*, Scheutzow, *supra* note 9, at 15 ("[P]eer review has become widely accepted as the primary means to weed out low quality physicians and to identify and offer assistance to physicians whose skills need to be enhanced in certain areas."); David Orentlicher, *The Influence of a Professional Organization on Physician Behavior*, 57 ALB. L. REV. 583, 590 (1994) (arguing that professional medical societies are better equipped to authorize and regulate practice guidelines than are external organizations due to the professional expertise of the members).

evaluate that physician's work.[12] Consequently, peer review has become an important element in determining not only a physician's right to practice within a health care institution, but in determining the parameters of that physician's practice.[13]

The strength of the peer review process is based upon the decisions and recommendations of a committee made up of physicians from a hospital's staff. In order to ensure impartiality, committees are generally composed of an unbiased hearing officer and practicing physicians who are not in direct economic competition with the individual physician under review.[14] Although the ultimate decision to grant, suspend, or revoke a physician's staff privileges lies with the hospital's governing body, the peer review process directs the committee's recommendation to that governing body.[15]

This committee's job is both to review the qualifications and training of new applicants as well as to critique the services rendered by practicing physicians already within the institution.[16] When a physician applies for staff privileges at a hospital, the committee reviews the physician's credentials and recommends whether or not to grant privileges based on this review.[17] This initial process, known as credentialing, involves review of a physician's training, certifications, and demonstrated competence.[18] Once a physician is granted staff privileges, the committee regularly reviews quality assurance data and other information related to the physician's work product within the hospital.[19] This process occurs every two years or whenever the committee has reason to believe that a physician's conduct warrants immediate review.[20] The peer review committee's recommendation regarding staff privilege status forms the basis of the hospital's governing body's ultimate decision.[21]

Since the introduction of peer review into the medical community, various statutory and regulatory requirements have developed to man-

---

12. Sagsveen & Thompson, *supra* note 10, at 477; Young v. Western Penn. Hosp., 722 A.2d 153, 156 (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), *affirmed* 654 A.2d 547 (Pa. 1995)).

13. Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1117 (1988).

14. *See* 42 U.S.C. § 11112(b)(3)(A) (1994).

15. Scheutzow, *supra* note 9, at 13.

16. *Id.* at 13-14.

17. *Id.* at 14.

18. *Id.*

19. *Id.* No distinction is drawn between the application of medical peer review statutes to credentialing and continued staff privilege review. Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 16 (Tex. 1996).

20. Scheutzow, *supra* note 9, at 14.

21. *Id.* at 13.

age its use in hospitals. Early in the twentieth century, the American College of Surgeons ("ACS") established the first peer review program in the United States.[22] In 1952, the ACS joined with the American Medical Association, the American Hospital Association, and the American College of Physicians to form the Joint Commission on the Accreditation of Hospitals, an organization devoted to ensuring the professional work of hospitals by establishing peer review standards and guidelines.[23] This organization, currently known as the Joint Commission on Accreditation of Health Care Organizations ("JCAHO"), requires hospitals and other health care organizations to conduct regular peer review of staff members in order to qualify for accreditation.[24]

Additionally, states and the federal government have done their part to encourage the peer review process. All states have adopted statutory provisions requiring minimum standards of monitoring in order for hospitals to qualify for state licensure.[25] The federal government additionally requires the credentialing of new applicants and regular evaluations of staff members in order for a hospital to qualify for participation in the Medicare program.[26] In 1972, Congress established Professional Standard Review Organizations in order to independently review the quality of medical care rendered at hospitals.[27] These organizations, currently known as Peer Review Organizations, although independent of the hospital staff, work closely with a hospital's peer review process in reviewing the appropriateness of care given to Medicare beneficiaries.[28]

Despite these incentives and mandates, individual physicians are often hesitant to participate in the peer review process.[29] Possible ethical concerns for the quality of patient health care or concerns for the reputation and accreditation status of a hospital might motivate a physician's voluntary involvement in the process.[30] Besides these abstract considerations, however, few material incentives that might encourage effective peer review exist.[31] On the other hand, disincentives abound.

---

22. ANNE R. SOMERS, HOSPITAL REGULATION: THE DILEMMA OF PUBLIC POLICY 104 (1969).

23. Darricades, *supra* note 8, at 269.

24. JOINT COMMISSION ON ACCREDITATION OF HEALTHCARE ORGANIZATIONS, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS MS.5.11 (1996). The JCAHO is considered the foremost hospital accreditation authority and participation serves as the basis for certain federal funding programs. Sagsveen & Thompson, *supra* note 10, at 478 n.6.

25. Darricades, *supra* note 8, at 268.

26. 42 C.F.R. § 482.22 (1991).

27. *Id.*

28. 42 U.S.C. § 1320(c) (1994).

29. Darricades, *supra* note 8, at 270.

30. *Id.* at 270-271.

31. Morter, *supra* note 13, at 1119-20.

Typically, an aversion to criticizing one's peers, loss of pay for time spent participating, or the fear of reprisal in the form of loss of patient referrals discourages participation by physicians.[32] Most importantly, however, the fear of possible legal repercussions from adverse decisions, particularly the discovery and liability implications associated with lawsuits, tends to chill frank and effective participation in the process.[33]

Consequently, in the face of these obvious disincentives, physicians are often reluctant to voluntarily participate in the peer review process; and when they do, they have little reason to participate aggressively and meaningfully.[34] The fear of legal repercussions potentially stifles the "[f]ree, uninhibited communication of information to and within the peer review committee" that is "imperative to the professed goal of critical analysis of professional conduct."[35]

III. THE LAW OF PEER REVIEW PROTECTION

In response to the reluctance of physicians to participate in this system of self-regulation stand the laws of peer review protection. Contrary to the fundamental principal that "'the public . . . has a right to every man's evidence,'"[36] and despite the movement towards the abrogation of privileges and immunities generally,[37] state legislatures and Congress have enacted laws to protect both peer review committee members from liability and their work product from discovery.[38] As mentioned, these protections stand in contrast to the general broad evidentiary rule of discovery that parties "may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action."[39] Legislatures and courts have chosen to

---

32. *See id.* at 1120.

33. Richard L. Griffith & Jordan M. Parker, *With Malice Toward None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation*, 22 TEX. TECH. L. REV. 157, 160 (1991); Burney v. East Ala. Med. Ctr., 939 F. Supp. 1514, 1521 (M.D. Ala. 1996) ("Congressional findings in the text of the [Health Care Quality Improvement Act] note that 'The threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.'") (quoting Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318, 1321 (11th Cir. 1994) (quoting 42 U.S.C.A.§ 11101(4) (West 1995)), *cert. denied*, 514 U.S. 1019 (1995)).

34. Morter, *supra* note 13, at 1119-20.

35. Griffith & Parker, *supra* note 33, at 159.

36. Donald P. Vandegrift, Jr., *The Privilege of Self-critical Analysis: A Survey of the Law*, 60 ALB. L. REV. 171, 174 (1996) (quoting United States v. Bryan, 339 U.S. 323, 331 (1950) (quoting J. WIGMORE, EVIDENCE § 2139 (3d ed. 1940))).

37. Scheutzow, *supra* note 9, at 17.

38. *See, e.g.*, ALA. CODE § 34-24-58 (1997); MO. ANN. STAT § 537.035(3) (West 2000); 63 PA. CONS. STAT. ANN. §§ 425.3-.4 (West 1996); 42 U.S.C. §§ 11101-11152 (1994).

39. FED. R. CIV. P. 26(b)(1). *See also* United States v. Nixon, 418 U.S. 683, 710 (1974) ("[E]xceptions to the demand for every man's evidence are not lightly created nor expansively

strike a balance between the need for open and effective discovery and their belief in the peer review process as a tool for improving health care.[40]

In this struggle between open litigation and peer review as tools of health care regulation, the statutory immunities and privileges are generally regarded with a preferred status. When faced with this collision of policy interests in an action for malpractice, the Connecticut Supreme Court explained, "Should a conflict between access to such evidence and peer review confidentiality arise, it was the legislature's judgment in enacting the peer review privilege that the strong public policy favoring open peer review would outweigh any incidental burden on discovery."[41] As will be discussed, despite the burden on discovery, this legal shield afforded peer review is ultimately to the benefit of both the health care system and the civil litigation system.

Whether by state or federal statute, the protection afforded the peer review process is composed of three distinct, but closely related, types of laws: (1) those granting immunity from lawsuits to the individuals and institutions involved in the peer review process;[42] (2) those declaring peer review work product to be privileged and inadmissible in court;[43] and (3) those providing that information related to the process remain confidential.[44] Consequently, the sanctity of the peer review process is protected on three fronts by immunity, privilege, and a confidentiality requirement.[45] This sort of protected status seemingly surpasses even the most revered and shielded relationships at law, such as the attorney-client relationship.[46]

Although the statutes do not maintain complete consistency across state lines, the scope of protection shrouding peer review generally insulates the process in three different ways.[47] As an initial matter, many of these statutes immunize the individuals and institutions participating in the peer review process.[48] Considering an action brought by a physician for wrongful suspension of staff privileges, an Arizona appellate court explained the rationale behind the legislation as follows:

---

construed, for they are in derogation of the search for truth.").

40. Creech, *supra* note 5, at 180.

41. Babcock v. Bridgeport Hosp., 742 A.2d 322, 344 (Conn. 1999).

42. *See, e.g.*, ALA. CODE §§ 34-24-58(a), 6-5-333(a).

43. *See, e.g., id.* §§ 22-21-8(b), 6-5-333(d), 34-24-58(a).

44. *See, e.g., id.* §§ 22-21-8, 6-5-333(d).

45. Scheutzow, *supra* note 9, at 17

46. *See* Creech, *supra* note 5, at 186 note 36 ("This stands in sharp contrast to . . . the attorney-client privilege, where the presence of a third party may be deemed to destroy the communication's privileged status.").

47. Scheutzow, *supra* note 9, at 17.

48. *See, e.g.*, ALA. CODE § 34-24-58(a) (1991); *id.* § 6-5-333(a) (1997).

> Review by one's peers within a hospital is not only time-consuming, unpaid work, it is also likely to generate bad feelings and result in unpopularity. If lawsuits by unhappy reviewees can easily follow any decision, even a temporary one followed by a due process hearing such as here, then the peer review demanded by [the Arizona peer review statute] will become an empty formality, if undertaken at all.[49]

This immunity, then, is largely designed to remove an individual's fear of facing damages in cases likely to involve defamation, antitrust, or negligent credentialing claims.[50]

Secondly, the work product privilege protects the information associated with the peer review process from discovery.[51] The rationale behind this protection is that physicians would be reluctant to frankly participate in a peer review proceeding discussing the shortcomings of a colleague, and perhaps a friend, if they believed those statements could later be discovered in a judicial or administrative proceeding.[52] In a recent decision, the Alabama Supreme Court expressed this reasoning that "the purpose of a peer-review statute is to encourage full candor in peer review proceedings and that . . . policy is advanced only if all documents considered by the committee or board during the peer-review or credentialing process are protected."[53]

The confidentiality requirement creates an affirmative duty on the part of committee members to keep information related to the peer review within the process.[54] In doing so, the atmosphere of candor essential to the effective functioning of the committee is ensured by protecting peer review information even outside of the context of a legal proceeding.[55] This is an important element, as information relating to the peer review process might be valuable to many individuals and groups other than the medical community and litigants.[56]

The District of Columbia and all states have some form of peer review protection statute.[57] As the same fundamental justification forms the basis of peer review statutes across the country, these laws share

---

49. Scappatura v. Baptist Hosp. of Phoenix, 584 P.2d 1195, 1201 (Ariz. Ct. App. 1978).

50. Bryan v. James Holmes Reg'l Med. Ctr., 33 F.3d 1318, 1321 (11th Cir. 1994), *cert. denied*, 514 U.S. 1019 (1995).

51. *See, e.g.*, ALA. CODE § 22-21-8.

52. Sagsveen & Thompson, *supra* note 10, at 480

53. *Ex parte* Krothapalli, 762 So. 2d 836, 839 (Ala. 2000).

54. *E.g.*, ALA. CODE § 34-24-58.

55. Scheutzow, *supra* note 9, at 17.

56. Sagvensen & Thompson, *supra* note 10, at 481-82 ("Beyond the medical community, litigants, and the Secretary [of the Department of Health and Human Resources], 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.").

57. Scheutzow, *supra* note 9, at 9.

common fundamental attributes.[58] Peer review statutes generally define what constitutes a protected medical review committee.[59] Frequently these reflect those committees recommended by the JCAHO such as credentialing committees, departmental committees, and committees dedicated to reviewing more specialized procedures.[60] Logically, the privileges and immunities provided by the statutes are not available if the review in question does not fall within the statutes' definitions of protected "peer review."[61]

The immunization of committee members and affiliated institutions from liability for their actions or statements performed within the scope and function of a peer review committee is an important strength of medical review statutes. Most states offer peer review participants immunity from civil liability.[62] The strongest of these statutes offer immunity to committee members, institutions, and individuals providing information to the committee.[63] On the other side of the spectrum, the weaker of the statutes grant immunity for few or specific individuals in the process.[64]

The qualified immunity, however, is not absolute. In a majority of cases immunity only applies when the investigation is conducted in good faith, without malice, and based upon the reasonable belief that the committee's action is warranted.[65] Few statutes, however, provide parameters for the good faith and without malice standard.[66]

In terms of the discovery privilege, the typical peer review statute protects all documents related to the proceeding of committee meet-

---

58. Creech, *supra* note 5, at 182.

59. *Id.* at 183.

60. *Id.*; *see, e.g.*, ALA. CODE § 6-5-333(b) (1993); *id.* § 34-24-58(b).

61. *See, e.g.*, *Ex parte* St. Vincent's Hosp., 652 So. 2d 225, 230 (Ala. 1994) (holding review documents to be discoverable as the committee's function was not accreditation or quality assurance).

62. ALA. CODE § 34-24-58(a) ("[N]o member [of a medical review committee] shall be liable for such decision, opinion, action or proceeding."); Scheutzow, *supra* note 9, at 28.

63. CAL. CIV. CODE § 43.7(a)-(b) (West Supp. 2000); ME. REV. STAT. ANN. tit. 24, § 2511 (West 2000); W. VA. CODE § 30-3-14(m) (1998); *see also* Scheutzow, *supra* note 9, at 28.

64. *See, e.g.*, ALA. CODE § 22-21-8(b); GA. CODE ANN. § 31-7-133 (1996); *see also* Scheutzow, *supra* note 9, at 28-29. Under many states' peer review statutes, committee members are additionally not subject to subpoena for testimony at trial concerning the committee proceedings or subpoena for discovery in most cases. *But cf.* Arnett v. Dal Cielo, 56 Cal. Rptr. 2d 706 (Cal. 1996) (holding that investigative subpoena issued by State Medical Board did not constitute "discovery" for purposes of medical peer review statute).

65. Smith v. Our Lady of the Lake Hosp., Inc., 639 So. 2d 730, 742 (La. 1994) ("The majority of states have qualified the immunity, imposing as statutory hurdles the threshold requirement that the peer review actions be taken without malice, in good faith or reasonably in order to invoke the immunity . . . .").

66. *See* Crabtree v. Dodd, No. 01A01-9807-CH-00370, 1999 WL 617619, at *10 (Tenn. Ct. App. Aug. 17, 1999) ("Malice is not defined under the Peer Review Law or elsewhere in Title 63 of the Tennessee Code Annotated."); *see also* Scheutzow, *supra* note 9, at 29.

ings.[67] Like the immunity provisions, however, the privileges are not completely absolute. Many statutes explicitly provide that documents are not protected simply because they constitute part of the peer review process.[68] In other words, documents otherwise discoverable are not protected because a medical review committee may have made use of them.[69] A plaintiff capable of obtaining information from its "original source," therefore, is not precluded from doing so simply because a peer review committee made use of the information.[70] The Alabama Supreme Court explained that "a plaintiff seeking discovery cannot obtain directly from a hospital review committee documents that are available from the original source, but may seek such documents from the original source."[71]

Unlike those provisions granting immunity from liability, the malice exception does not generally apply to discovery privileges.[72] Courts have struggled with this argument in response to plaintiff's attempts to discover certain protected information by simply alleging malice.[73] In *Irving Healthcare System v. Brooks*, the Texas Supreme Court held that an allegation of malice was insufficient to warrant production of documents otherwise protected under the Texas peer review privilege.[74] In so doing, the court recognized the distinction between two forms of protection offered to the peer review process—protection from discovery and qualified immunity from liability.[75] The court went on to explain that the malice exception is unique to the immunity provision under Texas law.[76] As such, "it does not follow that an allegation or even proof of malice that would negate a qualified immunity negates

---

67. *E.g.*, ALA. CODE § 22-21-8(b) ("All accreditation, quality assurance credentialing and similar materials shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action."); *id.* § 6-5-333(d) ("All information, interviews, reports, statements, or memoranda furnished to any committee . . . are declared to be privileged.").

68. *See, e.g.*, ALA. CODE § 22-21-8(b) ("Information, documents, or records otherwise available from original sources are not to be construed as being unavailable for discovery or for use in any civil action merely because they were presented or used in preparation of accreditation, quality assurance or similar materials . . . ."); Creech, *supra* note 5, at 184.

69. *Id.*; *see also* Babcock v. Bridgeport Hosp., 742 A.2d 322, 343 (Conn. 1999) ("The legislative history surrounding the [peer review] statute further indicates that the privilege applies to the peer review committee's self-generated analysis, but not to the underlying facts that provide the basis for that analysis when such facts have been collected by an independent source.").

70. Monroe Reg'l Med. Ctr., Inc. 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.")

71. *Ex parte* Krothapalli, 762 So. 2d 836, 839 (Ala. 2000).

72. Freeman v. Piedmont Hosp., 444 S.E.2d 796, 798 (Ga. 1994).

73. *Id.*; Patton v. St. Francis Hosp., No. A00A1672, 2000 WL 1300449, *2 (Ga. App. Sept. 14, 2000); Irving Healthcare System v. Brooks, 927 S.W.2d 12, 16 (Tex. 1996).

74. *Irving*, 927 S.W.2d at 16.

75. *Id.*

76. *Id.*

the separate discovery exemption under the statute."[77] Although the extension of immunity and the exemption of matters from discovery are commensurate protections, with regard to malice the two are distinct.[78]

In addition to the peer review protection statutes drafted by state legislatures, Congress has granted its own form of protection to medical review members and their work product in the Health Care Quality Improvement Act ("HCQIA") of 1986.[79] HCQIA grants immunity to professional review committees, individual members of those committees, individuals under contract with those committees, and any individuals that assist those committees in their peer review function.[80] This legislation was an attempt to address the specific national component of the health care quality assurance problem.[81] Local committees that evaluate incompetent physicians and revoke staff privileges are precluded from reporting their findings due to the confidentiality requirements of peer review statutes.[82] Consequently, a physician whose privileges were revoked could simply relocate with little fear of having his or her previous incompetence discovered.[83] Additionally, hospitals were often willing to accept the voluntary resignation of incompetent physicians in exchange for silence regarding the events leading up to the resignation.[84] The very system designed to promote quality health care, therefore, was stifling it on a national scale by facilitating this migratory practice of incompetent physicians.

In response to this macro-quality assurance problem, HCQIA established a framework for a national reporting system for the decisions of medical review bodies.[85] This framework requires notification to the National Practitioner Data Bank ("NPDB") when a board's decision adversely affects a physician's privileges for longer than thirty days.[86] The NPDB is also notified of all settlements in medical malpractice claims.[87] In order to ensure compliance, Congress included conditional

---

77. *Id.*

78. *Id.*; *see also Patton*, 2000 WL 1300449, at *2 ("Since neither the peer review or [sic] medical review statutes pertaining to the discovery privilege mention malice, it is doubtful that the legislature intended to expand the malice exception to the code sections affording a discovery privilege to peer review proceedings.").

79. 42 U.S.C. §§ 11101-11152 (1994).

80. *Id.* § 11111(a).

81. *See* Charity Scott, *Medical Peer Review, Antitrust, and the Effect of Statutory Reform*, 50 MD. L. REV. 316, 325 (1991).

82. *Id.* ("[E]ven if those in the new locale did try to investigate the newcomer, the state medical board or medical providers in the old locale frequently were reluctant to provide complete and accurate reports about the doctor because of fear of being sued.").

83. *Id.*

84. *Id.* at 326.

85. 42 U.S.C. §§ 11131-34 (1994).

86. *Id.* § 111133.

87. *Id.* § 111131.

immunity and privilege provisions in the statute—a carrot instead of a stick.[88] The reporting requirements are a mandatory provision of HCQIA and failure to comply can potentially result in revocation of the Act's immunity provisions.[89]

The statute protects those bodies that qualify as "a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity."[90] The statute insulates activities designed "(A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity, (B) to determine the scope or conditions of such privileges or membership, or (C) to change or modify such privileges or membership."[91]

HCQIA provides four standards that must be met in order for the statutory privileges and immunities to apply.[92] First, the review activity must be undertaken "in the reasonable belief that the action was in the furtherance of quality health care."[93] Second, the action must commence only "after a reasonable effort to obtain the facts of the matter."[94] Third, the review must provide that "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."[95] Finally, the review must be made "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain [the] facts."[96] Consequently, HCQIA applies to those peer review activities reasonably believed to further the quality of health care and those that meet the requisite due process provisions.[97] HCQIA does not, however, provide protection in the form of a confidentiality requirement for the proceedings and records of medical review committees, as do many state statutes.[98]

---

88. Scott, *supra* note 81, at 327; Darricades, *supra* note 8, at 275; 42 U.S.C. § 11111.
89. 42 U.S.C. § 11111(b).
90. *Id.* § 11151(11).
91. *Id.* § 11151(10).
92. *Id.* § 11112(a). For a detailed application of these four factors, see *Rogers v. Columbia*, 971 F. Supp. 229, 234-37 (W.D. La. 1997).
93. 42 U.S.C. § 11112(a)(1).
94. *Id.* § 11112(a)(2).
95. *Id.* § 11112(a)(3).
96. *Id.* § 11112(a)(4).
97. Scheutzow, *supra* note 9, at 31.
98. Morter, *supra* note 13, at 1130.

IV. THE PEER REVIEW PLAINTIFF

The protections afforded the peer review process operate to exclude relevant evidence.[99] After all, a fundamental premise of the American civil litigation system is that the truth-finding function of the judicial system is best served by allowing all interested parties the most open possible access to evidence.[100] While unquestionably serving a laudable social end by promoting the interest of healthcare, these protections simultaneously exact "a social cost" in impeding access to relevant evidence.[101] This is the conflict of the competing policy interest inherent in the debate over peer review legislation.

The laws of peer review protection, therefore, represent a legislative choice between these competing public concerns. Legislatures and courts recognize the importance of peer review for effective health care[102] and have weighed "the need for truth against the importance of the relationship or policy sought to be furthered by the privilege."[103] In so doing, although the line has been drawn at different points along the spectrum depending on the jurisdiction, they have chosen a balance between open discovery and confidentiality in the peer review process.[104] Ultimately, then, peer review statutes embrace the objective of medical review candor at the expense of impairing access to evidence.

Despite the movement towards the rescission of privileges and immunities within the judicial system generally,[105] the protection of the peer review process and the maintenance of these laws is necessary for effective medical self-regulation. Although some scholars argue that the protections of the peer review laws do not actively encourage frank and effective review, an absence of these statutes would unquestionably hinder, if not destroy, the self-policing nature of medicine in the United States.[106] Due to the inability of peer review to operate effectively without the veil of confidentiality, and the ability of injured plaintiffs to recover in tort despite the burden on discovery, this legal

---

99. Esdale v. American Community Mutual Ins. Co., No. 94 C 4600, 1995 WL 263479, *3 (N.D. Ill. May 3, 1995).

100. *See* FED. R. CIV. P. 26(b)(1).

101. *See* Matchett v. Superior Court, 115 Cal. Rptr. 317, 320-21 (Cal. Ct. App. 1974) (stating that peer review confidentiality "embraces the goal of medical staff candor at the cost of impairing plaintiff's access to evidence").

102. Creech, *supra* note 5, at 180.

103. *Esdale*, 1995 WL 263479, at *3.

104. Creech, *supra* note 5, at 180.

105. Scheutzow, *supra* note 9, at 17.

106. In 1998, Susan O. Scheutzow published a study analyzing the effectiveness of peer review statutes nationwide in promoting physicians' meaningful participation in the peer review process. Scheutzow, *supra* note 9. As a result of her research, the author concluded simply that "neither the state peer review immunity statutes nor the privilege statutes encourage peer review." *Id.* at 55.

shield is ultimately to the benefit of both the healthcare and the civil litigation systems.

In order to understand the implications of those laws protecting peer review, the importance of peer review as a process should be understood. Essentially, peer review committees serve two important functions.[107] First, they provide an efficient method of self-regulation.[108] The process ensures the standardization of the most effective and appropriate medical procedures at a minimal administrative cost.[109] Second, and most apparent, the system serves the interest of public health by effectively policing those procedures, institutions, and healthcare providers that might pose a risk to patients.[110] As such, peer review serves an important public policy role for healthcare on a national level.[111]

The protections afforded the peer review process are a necessary component for the survival of meaningful peer review in the medical profession. As mentioned *supra*, a number of disincentives to participation exist relating to the legal implications of the peer review process.[112] The threat of potential liability for comments made within proceedings or actions taken by committees would stifle candid participation.[113] Additionally, the threat of dealing with the burden of answering discovery, or testifying as to what transpired within a committee proceeding, would discourage meaningful service on a committee.[114] After all, "the evidentiary burdens could consume large portions of the doctors' time to the prejudice of their medical practices or personal endeavors."[115] Ensuring meaningful participation safeguards the important public policy interests served by the peer review process. As confidentiality, immunity, and privilege ensure meaningful participation, these statutes are critical to the existence of a functional peer review system.

In addition to the benefits afforded healthcare, the peer review protections serve to further the interest of judicial efficiency in the litigation of medical malpractice claims. As a matter of evidence and trial procedure, if the discovery privileges were not in place and plaintiffs

---

107. People v. Superior Court, 286 Cal. Rptr. 478, 483 (Cal. Ct. App. 1991).
108. *Id.*
109. *Id.*
110. *Id.*
111. Fox v. Kramer, 82 Cal. Rptr. 2d 513, 521 (Cal. Ct. App. 1999) ("There is therefore no question that peer review committees play an important role in serving public welfare.").
112. *Id.* at 520.
113. California Eye Inst. v. Superior Court, 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.").
114. *Fox*, 82 Cal. Rptr. 2d at 520.
115. West Covina Hosp. v. Superior Court, 718 P.2d 119, 122 (Cal. 1986).

were allowed access to such evidence, the results would be devastating in terms of litigation cost. As discussed *supra*, a typical physician is subject to peer review every two years at each hospital that he or she has staff privileges, including the initial credentialing process.[116] Not only would production of such voluminous information be burdensome, but if such extrinsic evidence were eventually offered into evidence, a defendant's efforts to rebut would be unduly oppressive. Potentially, a defendant physician could be forced to defend against dozens of past charges of negligence, thus requiring all of the accompanying evidence, witnesses, cost, and trial time associated with such an effort.

The privileges afforded by these statutes serve another important judicial function in impeding peer review committee work product from facilitating the prosecution of malpractice cases. If peer review material were readily discoverable, the process, in effect, would become little more than a source of highly prejudicial evidence of a physician's past instances of negligence and impropriety for use by a plaintiff in developing his or her case. In addition, the peer review committee would provide a pool of extremely valuable witnesses—experts in the field that have probably worked alongside the defendant and whose testimony is not tainted by the high fee accompanying typical expert witness testimony. As a result of access to such material and testimony, hospitals and health care professionals would quickly realize that their efforts to ensure quality care were creating a paper trail of the most valuable sort of evidence for plaintiffs. The collapse of meaningful self-policing within the medical community would follow shortly thereafter.

Although peer review protection "impedes the truth-seeking function of the adjudicative process,"[117] a plaintiff is far from precluded from bringing a cause of action with fair access to evidence. As discussed *supra*, peer review statutes protect the work product of a review proceeding, not the underlying substantive evidence.[118] Consequently, plaintiffs are not precluded from obtaining any evidence of malpractice from the original source.[119]

In developing his case, a malpractice plaintiff has full access to his own records, may depose those involved in his treatment, and may employ an expert to examine this evidence in order to give opinion and

---

116. Scheutzow, *supra* note 9, at 13-14.

117. Babcock v. Bridgeport Hosp., 742 A.2d 322, 341 (Conn. 1999).

118. *See, e.g.*, ALA. CODE § 22-21-8(b) (1997); *Babcock*, 742 A.2d at 342 ("[T]he privilege applies only to those documents that reflect the "proceedings" of a peer review, or that were created primarily for the purpose of being utilized during the course of peer review.").

119. *Ex parte* Krothapalli, 762 So. 2d 836, 839 (Ala. 2000); *Babcock*, 742 A.2d at 342-43 ("[T]he privilege does not apply to those documents that were independently 'recorded' or 'acquired.'").

testimony as to the quality of care he received.[120] As such, "denial of the privileged documents should have little impact on any patient's ability to maintain a cause of action for medical malpractice . . . ."[121] In fact, allowing access to the records of peer review proceedings would provide an unfair advantage to a plaintiff attempting to recover for an action in medical malpractice—the peer review committee would effectively be charged with the responsibility of building the plaintiff's case. In this sense, the protections simply level the judicial playing field.

Certain problems associated with the malice exception to qualified immunity from liability accompany particular types of claims that encounter the laws of peer review protection. As a general matter, the protections afforded the peer review process are typically implicated by only a few types of legal claims.[122] For purposes of this Comment, cases involving the peer review immunity statutes fall into two categories: the physician-plaintiff and the patient-plaintiff. The physician-plaintiff will typically implicate the peer review statutes in actions to recover against an individual, committee, or hospital in a case involving due process, antitrust, defamation, or tortious interference with a business relationship.[123] The patient-plaintiff, on the other hand, will typically implicate the peer review statutes in actions against a physician for malpractice[124] or against a hospital under a theory of corporate liability such as negligent credentialing.[125]

The doctrine of negligent credentialing is an important theory of corporate liability for an injured patient-plaintiff who feels that a health care institution is responsible for his or her injuries. Physicians have classically held the status of an independent contractor because their actions and decisions are typically their own and not controlled by the hospital in which they practice.[126] Consequently, hospitals and health care institutions have traditionally been liable only for the acts of their employees, and not the acts of physicians that have access to their facilities.[127] Nevertheless, courts have been imposing corporate liability

120. Doe v. Illinois Masonic Med. Ctr., 696 N.E.2d 707, 711 (Ill. App. Ct. 1998).

121. *Id.*

122. Although typically applied in medical malpractice and other common health care liability causes of action, peer review statutes are not necessarily limited to specific causes of action. *See In re* Osteopathic Med., 16 S.W.3d 881, 885 (Tex. Ct. App. 2000) (holding that the medical peer review privilege may be applicable to a cause of action based on premises liability).

123. Pauline Martin Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 LOY. L.A. L. REV. 357, 367 (1993).

124. *See, e.g.*, *Ex parte* Burch, 730 So. 2d 143 (Ala. 1999).

125. *See, e.g.*, Kalb v. Morehead, 654 N.E.2d 1039 (Ohio Ct. App. 1995).

126. *Id.*

127. Griffith & Parker, *supra* note 33, at 161.

on hospitals for the acts of physicians since the late 1960s.[128] The theory behind this liability is based upon apparent agency—the idea that patients often view physicians as employees of the hospital.[129] Consequently, in cases of negligent credentialing, courts will treat the hospital as if it is the ultimate caregiver and hold it responsible for failure to meet its duty to properly credential physicians.[130]

The peer review protections can conceivably pose a devastating obstacle to the development of a patient-plaintiff's case against a health care institution for negligent credentialing. As discussed, peer review statutes immunize defendant health care institutions from liability while simultaneously restricting the discovery of the work product involved in the peer review process by providing a privilege and requiring confidentiality.[131] A patient-plaintiff is able to circumvent a hospital's immunity and survive summary judgment in an action for negligent credentialing only by offering proof of malice or bad faith involved in the credentialing.[132] Consequently, the development of the peer review privilege runs contrary to the development of hospital corporate liability as "courts have continued to recognize new theories of corporate liability while state legislatures have shrouded in secrecy the most obvious source of evidence against hospitals—the peer review records."[133] Inherent in this legal contradiction is the essence of the social and judicial cost of peer review protections: while serving to advance effective review by encouraging frank participation in the process, these statutes appear to hinder that goal by shielding improper review from disclosure.

This legal hurdle brought on by the simultaneous operation of the qualified immunity malice exception and the discovery privilege are apparent in the case of *St. Luke's Episcopal Hospital v. Agbor*.[134] *St. Luke's* involved a negligent credentialing action against a hospital for permanent disabilities suffered by an infant as a result of an injury sustained during birth.[135] The defendant hospital filed for summary judgment, alleging that the Texas medical review statutes immunized them from liability absent a showing of malice in the credentialing proc-

---

128. *See* Darling v. Charleston Community Mem'l Hosp., 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 383 U.S. 946 (1966).

129. Griffith & Parker, *supra* note 33, at 162.

130. *See Darling*, 211 N.E.2d at 258.

131. *See, e.g.*, ALA. CODE § 22-21-8 (1997).

132. Creech, *supra* note 5, at 200.

133. B. Abbot Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 159, 162 (1984) ("[A]s a matter of public policy it makes little sense to create a cause of action and then, by creating a privilege, destroy the means of establishing it.").

134. 952 S.W.2d 503 (Tex. 1997).

135. *St. Luke's Episcopal Hosp.*, 952 S.W.2d at 504.

ess.[136] On appeal, the Texas Supreme Court concluded that the malice provisions of the peer review statute did apply to the common law action of negligent credentialing.[137] The court reasoned that

> [t]he provisions creating peer review immunity are consistent with the rest of the statute in which they are found . . . . The Texas Act directly concerns immunity from suit for those participating in medical peer review activity. The context of the statute as a whole involves precisely the situation in this suit—regulating the practice of medicine, including "evaluation of the qualifications of professional health-care practitioners."[138]

In his dissenting opinion, Chief Justice Phillips, discussing the problem inherent in the malice and good faith requirements, pointed out that requiring a showing of malice would virtually eliminate the negligent credentialing cause of action, as the threshold requirement of malice would make plaintiff's claims almost impossible to prove.[139]

Much like the patient-plaintiff in attempting to recover in an action for negligent credentialing, the physician-plaintiff faces a similar malice exception hurdle in attempting to recover for damages resulting from the actions of a peer review committee. Physicians that have had their staff privileges revoked, suspended, or denied frequently bring individual actions against the hospital, committee, or individual members of the committee alleging that these privileges were denied wrongfully, or that members of the committee defamed his or her character and reputation.[140] As mentioned, most peer review statutes offer immunity to medical review committee members, and many also restrict the discovery of the work product involved in the process.[141] Additionally, these statutes generally include a malice exception qualifying the committee from civil liability.[142] Implicit in this situation, however, is the contradiction that faces the physician-plaintiff in this position—building a case for the actions of a review committee when evidence of the committee's actions is protected from discovery by statute.[143]

While effective in protecting the integrity of the peer review proc-

---

136. *Id.*

137. *Id.* at 506-07.

138. *Id.* at 507 (quoting TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(1)(m) (repealed 1999)).

139. *Id.* at 510.

140. *See, e.g.*, Zamanian v. Christian Health Ministry, 715 So. 2d 57 (La. Ct. App. 1998).

141. *See, e.g.*, ALA. CODE § 22-21-8 (1997).

142. Creech, *supra* note 5, at 200.

143. *See* Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 18 (Tex. 1996) ("There unquestionably is friction in this legislative scheme. It recognizes on the one hand that communications made to a medical peer review committee may be actionable, and on the other, forecloses some avenues of discovery of those communications.").

ess, the malice and good faith requirements of peer review immunity seem to create a "catch-22" for the physician-plaintiff attempting to recover against a review committee. Since peer review immunities statutorily protect peer review committee members from liability,[144] a plaintiff must provide some form of palpable evidence of malice or bad faith in order to circumvent the immunity and survive summary judgment in an action for defamation or anti-trust.[145] Logically, though, such evidence would be most apparent from the records, testimony, and work product of the peer review committee.

According to the plain language of most peer review statutes, an otherwise immune quality assurance committee member is vulnerable to civil liability when that member has (1) acted in bad faith or with malice or (2) acted without a reasonable belief that the action was taken or recommendation made was warranted under the known facts.[146] A determination of whether a peer review committee member is entitled to the qualified immunity of the peer review statutes, therefore, requires an examination of the subjective motive and knowledge of the committee members.[147] Consequently, courts are often left with the task of interpreting vague statutory language such as "malice" and "good faith," while plaintiffs are left with the burden of making a showing of malice and good faith with little or no access to any evidence that could meet this burden.[148]

In *Smith v. Our Lady of the Lake Hospital*,[149] the Louisiana Supreme Court faced the dilemma of interpreting the malice and good faith requirements in the context of a physician-plaintiff's suit against a hospital and members of its peer review board. In considering whether the plaintiff sufficiently made a showing of malice in order to overcome the pleading standard required by Louisiana's peer review laws, the court upheld the defendant's motion for summary judgment.[150] The court reasoned that the statutes created a presumption of good faith on

144. *See, e.g.*, ALA. CODE § 22-21-8.

145. *See, e.g., id.*

146. *See id.* § 6-5-333(a).

147. As a peer review committee's own records are protected from discovery by statute, such a determination must necessarily be based on extrinsic evidence of malice and bad faith. Even though no specific indicators definitively warrant production of privileged materials, certain factors do imply malice or bad faith in the context of medical peer review. Based on a number of decisions compelling production of peer review product, commentator Pauline Rosen concluded that a plaintiff is most likely to prevail if he or she can show that (1) the committee's review originated and was pursued outside the normal review channels, (2) he was summarily terminated before a legitimate consideration of the case, (3) he was denied procedural due process throughout the review, (4) he was treated worse than other similarly situated doctors, or (5) the committee's disciplinary action was severely harsh. Rosen, *supra* note 123, at 395-96.

148. *See, e.g.*, Smith v. Our Lady of the Lake Hosp., Inc., 639 So. 2d 730 (La. 1994).

149. 639 So. 2d 730 (La. 1994).

150. *Smith*, 639 So. 2d at 747.

the part of the peer review committee and the burden was on the plaintiff-physician to establish malice.[151] In concluding that the plaintiff had not met this burden, the court reasoned, "'[m]ere allegations of malice and bad faith, even with specifications of personal animosity and possible prior overreaching of authority, will not suffice to allow an action against hospital personnel engaging in peer review.'"[152] Consequently, this physician-plaintiff was forced to overcome a statutorily created presumption of good faith, but was not given the tools to do so.[153]

Despite the seemingly insurmountable burden faced by the patient-plaintiff in an action for negligent credentialing and the physician-plaintiff in an action against a peer review committee, this friction is an inevitable and desirable result of the balance between competing policy interest. Peer review protection statutes represent an intentional legislative scheme to protect the communications of peer review committees at the expense of barring some avenues of proof of some particular claims.[154] In practice, these statutes generally require more than a simple allegation of malice in order for the qualifying element of the immunity to be exercised.[155] Such a pleading standard is appropriate in order to effectively protect the policy interests promoted by the peer review process. If a plaintiff were simply able to allege malice within a complaint and overcome the privileges and immunities of peer review protection, the effectiveness and strength of the statutes would be emasculated.[156]

Accordingly, peer review committees and their members should only be subject to civil liability upon a showing of direct evidence of malice.[157] As "personal animosity, jealousy, anger and irritation" are intrinsic to the hospital work environment, a litigant must present more than conclusory allegations.[158] Although this evidence may be more difficult to produce without the records of the defendant peer review committee, as discussed *supra*, there are alternative avenues by which relevant information may be obtained.[159]

---

151. *Id.*

152. *Id.* (quoting Scappatura v. Baptist Hosp. of Phoenix, 584 P.2d 1195, 1201 (Ariz. Ct. App. 1978)).

153. *See id.*

154. Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 18 (Tex. 1996).

155. Creech, *supra* note 5, at 200.

156. *Irving*, 927 S.W.2d at 17.

157. Crabtree v. Dodd, No. 01A01-9807-CH-00370, 1999 WL 617619, at *11 (Tenn. Ct. App. Aug. 17, 1999).

158. Scappatura v. Baptist Hosp. of Phoenix, 584 P.2d 1195, 1201 (Ariz. Ct. App. 1978).

159. *Irving*, 927 S.W.2d at 18. In *Irving Healthcare System*, the Supreme Court of Texas addressed a case in which a physician-plaintiff sued a hospital alleging wrongful denial of staff privileges. *Id.* at 12. Although ultimately holding the evidence to be privileged, the court explained that "[t]here are several means by which confidential information may be disclosed to an affected physician." *Id.* at 18.

V. CONCLUSION

If haphazardly and inconsistently applied, the privileges and immunities of the medical peer review statutes fail to serve their purpose of ensuring candor within the process. Committee members are ultimately left unsure of the confidentiality of their participation, undermining the effectiveness of peer review. By the same token, inconsistently applied peer review statutes would continue to restrict a plaintiff's access to evidence. Consequently, when not clearly defined and strictly adhered to, the primary benefit of the statutes is wholly lost while the primary detriment remains. In order for these policy interests to mutually benefit from the existence of these laws, courts must broadly apply the privileges and immunities provided by the laws of peer review protection.

George E. Newton II