Odd Man Out? The Medical Peer Review Privilege

Every state has enacted some form of medical peer review privilege, while federal statutes extend confidentiality to the medical quality assurance records of certain agencies. Outside of specially designated "patient safety work product," however, federal law does not widely recognize a medical peer review privilege. This gap in coverage undermines the value of the available safeguards if physicians cannot accurately predict whether their appraisals and deliberations will be subject to disclosure. To encourage realistic expectations for participants in the peer review process, counsel must recognize both the prospects and limits of protection in federal court.

By Charles G. Kels

in Federal Litigation

Preventable medical errors claim upwards of 98,000 lives in U.S. hospitals annually—roughly the equivalent of one large jetliner crash every day. To enhance safety and save lives, healthcare professionals and institutions must detect, analyze, and mitigate the causes of these preventable errors.[1] Complete candor and exacting scrutiny of clinical practices are integral to this process and constitute "a sine qua non of adequate hospital care." But clinicians may be reluctant to engage in frank appraisals and blunt critiques if their comments can be used as evidence in lawsuits or disseminated and interpreted as a denunciation of their colleagues.[2]

There is a strong public interest in fostering safer healthcare. All 50 states and the District of Columbia have enacted some degree of statutory protection for the materials generated or maintained as part of the process of medical peer review.[3] Federal law extends confidentiality to the medical quality assurance activities of some government agencies.[4] Medical quality assurance is the "continuous review of the delivery of healthcare services" to assess and improve their safety. Peer review—the evaluation of the clinical performance of physicians and other healthcare providers by their professional counterparts—constitutes the heart of that endeavor.[5]

Yet the legal landscape of protections for medical peer review is inconsistent and uncertain. State protections vary widely, and courts tend to construe them narrowly.[6] The more robust protections enacted by Congress—which act as a prohibition against disclosure in addition to an evidentiary privilege[7]—only apply to a handful of specified agencies. A clear majority of federal courts have declined to recognize a wider common law privilege for medical peer review materials.[8]

The limited application of protections in federal litigation, along with the variations in state law, indicate the inherent conflict between the strong public policies of patient safety, on the one hand, and full disclosure, on the other. Together, the various schisms among jurisdictions raise important questions: Where does the gap in federal coverage leave other healthcare institutions that may be subject to federal suit, particularly government agencies that conduct quality assurance programs but lack a protective statute of their own? To what extent can their healthcare personnel engage in the peer review process with the assurance that the resulting work product will be shielded from discovery in civil actions, and how should counsel help to frame their expectations? This article reviews the federal protections for peer review materials, analyzes recent trends with respect to the relevance of state privileges in federal proceedings, and explores how the underlying policy rationale for peer review safeguards could be better served by a more predictable legal framework and stronger prohibitions on disclosure.

Congressional Quality Initiatives

In response to concerns about the prevalence of medical malpractice in the 1970s and 1980s, Congress enacted the Healthcare Quality Improvement Act (HCQIA) of 1986 to encourage honest peer review and prevent incompetent practitioners from moving from state to state without a record of prior negative performance.[9] In furtherance of the first aim, the HCQIA provides qualified tort immunity to participants in the peer review process.[10] However, it does not protect peer review materials from discovery in litigation. The sole confidentiality provision of the HCQIA pertains to information transmitted pursuant to the law's requirements, such as reports of malpractice payments or adverse clinical privileging actions to the National Practitioner Data Bank (NPDB), which can only be accessed by specific entities.[11]

Courts have often treated the silence of the HCQIA on a federal peer review privilege as evidence of Congress's intent to

exclude such protection.[12] Congress could have provided a privilege for peer review materials, but did not; some courts reason that congressional forbearance is equivalent to rejection.[13] The HCQIA, however, "no longer represents Congress's final word on this issue of medical peer review."[14] The Patient Safety and Quality Improvement Act (PSQIA) of 2005 created a voluntary reporting mechanism for healthcare providers to share data on adverse medical incidents to enhance the quality assurance enterprise.[15] To encourage participation in this process, the PSQIA grants broad privilege and confidentiality protections to information generated as part of the cooperative analysis of patient safety events.[16]

To merit such protection, however, the information must qualify as "patient safety work product." This characterization is inextricably linked to a new type of entity created by the PSQIA: the patient safety organization (PSO). Patient safety work product is information reported to a PSO, developed by a PSO, or analyzed as part of a system for reporting to or by a PSO.[17] As the external experts responsible for reviewing the patient safety information shared by healthcare providers, PSOs must be certified and listed by the Secretary of the Department of Health and Human Services (HHS).[18] The secretary has delegated this function to the Agency for Healthcare Research and Quality (AHRQ), which maintains an online listing of the 78 currently approved organizations.[19] The structure of the PSQIA renders its privilege and confidentiality protections of limited utility to federal healthcare facilities, whose medical quality assurance activities are typically internal to the relevant agency rather than vetted with an outside entity.

Federal Claims Invoke Federal Privileges

Except for patient safety work product, federal law does not widely recognize a medical peer review privilege. Although all states provide some level of protection, in varying degree, there is no certainty that such safeguards will apply in federal litigation. Generally, federal privileges govern claims arising under federal law, along with state law claims subject to pendent jurisdiction in federal court.[20] Peer review materials may be discoverable in connection with many federal causes of action, including employment discrimination, antitrust violations, breaches of the Emergency Medical Treatment and Active Labor Act (EMTALA), and in the medical malpractice context, claims under the Federal Tort Claims Act (FTCA).[21]

As the mechanism by which the federal government waives sovereign immunity and renders itself subject to certain tort claims, the FTCA incorporates state substantive law based upon where the allegedly tortious act or omission occurred.[22] Thus, in medical malpractice cases against the United States, state law determines the standard of care. Rule 501 of the Federal Rules of Evidence provides that "in a civil case, state law governs privilege regarding a claim or defense for which state law supplies the rule of decision."[23] Yet unlike diversity suits, in which state law is "operative of its own force," the FTCA merely absorbs state law as federal law.[24] Although state law is applicable in adjudicating liability, its function is to "to fill interstices or gaps" in federal law. Where state law is assimilated rather than self-operative, it does not provide the rule of decision for purposes of Rule 501.[25] "In non-diversity jurisdiction civil cases," therefore, "federal privilege law will generally apply."[26]

Federal Courts Disfavor New Privileges

The Federal Rules of Civil Procedure direct that in civil actions brought in federal court, "parties may obtain discovery regarding any nonprivileged matter that is relevant to any party's claim or defense."[27] The existence of a privilege is governed by Federal Rule of Evidence 501, which instructs federal courts, in the absence of more specific authority, to interpret common law privileges "in the light of reason and experience."[28] Federal courts have historically been reluctant to recognize new common law privileges, as contravening "the fundamental principle that 'the public…has a right to every man's evidence.'"[29] Privileges "are not lightly created nor expansively construed, for they are in derogation of the search for truth."[30]

In the 1990 case *University of Pennsylvania v. Equal Employment Opportunity Commission (EEOC)*, the Supreme Court definitively rejected a nonmedical, academic peer review privilege applicable to tenure decisions in higher education.[31] The EEOC investigated allegations of discrimination made by a Wharton professor who had been denied promotion. The University of Pennsylvania sought to limit disclosure to "protect the integrity of the peer review process" but was met with the Court's unanimous refusal to fashion a new privilege. Professing a disinclination to exercise its Rule 501 authority expansively, the Court emphasized that "the balancing of conflicting interests" between confidentiality and disclosure "is particularly a legislative function." In establishing the EEOC's enforcement responsibilities, Congress had exercised its legislative discretion and placed more importance on nondiscrimination than academic autonomy.[32]

In the 1996 case *Jaffee v. Redmond*, the Court recognized a psychotherapist–patient privilege under Rule 501.[33] The seven-member majority acknowledged the high bar for derogating from the general rule disfavoring discovery limitations but determined its appropriateness in this instance because the therapeutic relationship at the heart of mental health counseling is based on a presumption of confidentiality. As a result, "the psychotherapist privilege serves the public interest by facilitating the provision of appropriate treatment for individuals suffering the effects of a mental or emotional problem." In the Court's analysis, this transcendent public good outweighed the evidentiary harm caused by the privilege.[34]

Of potential relevance to future federal protection of medical peer review, the *Jaffee* court assigned considerable import to "the uniform judgment of the states," all of which had "enacted into law some form of psychotherapist privilege." The majority reasoned that because disclosure of statements made during counseling sessions could discourage mentally ill patients from seeking treatment, "denial of the federal privilege would therefore frustrate the purposes of state legislation that was enacted to foster these confidential communications."[35] In dissent, Justice Scalia ridiculed this reasoning as "inverse preemption," whereby "the truth-seeking functions of federal courts must be adjusted so as not to conflict with the policies of the states." Much like the medical peer review privilege, the state versions of the psychotherapist privilege "vary considerably from state to state," and "no uniform federal policy can possibly honor most of them."[36]

Federal Circuits Have Declined to Recognize a Medical Peer Review Privilege

Consistent with the longstanding judicial aversion to erecting testimonial barriers, all three circuit courts that have directly addressed the issue of medical peer review have declined to recog-

nize an applicable privilege.[37] The Fourth Circuit determined that its decision was "more properly guided" by the Supreme Court's rejection of an academic peer review privilege in *University of Pennsylvania* than by its recognition of a psychotherapist–patient privilege in *Jaffee*.[38] The Eleventh Circuit looked to *Jaffee* for "useful guidance on how to determine whether an evidentiary privilege should be created" but ultimately found that the public good produced by a medical peer review privilege would not sufficiently outweigh its evidentiary impact so as to override the presumption of liberal discovery.[39]

These cases are not necessarily dispositive, however, because in each of them the dispute involved the propriety and fairness of the medical peer review process *itself*. The Seventh Circuit went to some length to differentiate this context from a malpractice action, in which holding hospital committee minutes privileged "will generally have little impact upon the plaintiff's ability to prove a meritorious claim."[40] While the internal critiques of a medical facility could no doubt be of great strategic value to malpractice plaintiffs, the underlying claim in a malpractice suit concerns "actions that occurred independently of the review proceedings"—namely, the alleged inadequacy of the care rendered by the named healthcare providers.[41] Where the plaintiff is a physician who asserts that the hospital's peer review process was conducted discriminatorily on the basis of race or in restraint of trade, recognizing a privilege could potentially "prevent the plaintiff from asserting his claim altogether."[42] It is perhaps instructive that the HCQIA creates an exception to immunity for peer review participants in litigation of just this type, such as in civil rights actions and antitrust prosecutions.[43]

In declining to recognize a peer review privilege, most courts nonetheless concede that it "would serve important interests" if available. As an alternative to the privilege, federal courts are generally more willing to protect hospitals' interests "through other established means such as protective orders, confidentiality agreements, and when appropriate, by disclosure only after an in-camera review" of the relevant documents.

Most District Courts Have Declined to Recognize a Medical Peer Review Privilege

Despite the apparent opening provided by the circuit opinions to recognize a common law peer review privilege in the medical malpractice context, most district courts have extended the federal policy against evidentiary exclusion and denied the privilege even in such cases.[44] In one FTCA case stemming from a Department of Veterans Affairs (VA) medical center in New York, the claimant sought peer review documents from other nonparty hospitals that had employed the involved VA physician. Since the VA quality assurance statute did not apply to these nonfederal facilities, the court had to decide whether to afford comity to New York's peer review law or recognize a federal common law privilege; ultimately, it declined to do either. The court concluded that the state peer review statute was "not conclusive in an action brought in federal court under federal law," and that finding such a federal privilege was "more appropriate for Congress than for the courts."[45]

In a later case alleging the negligent performance of a hysterectomy, the involved gynecologist was a deemed federal employee for FTCA purposes because he worked in a rural community health clinic.[46] When the plaintiff sought to compel discovery of the clinic's medical staff documentation, both the clinic and the United States invoked West Virginia's peer review statute. The court found that federal privilege rules trumped the state legislation, and that no common law peer review privilege existed or should be recognized. In light of the HCQIA's failure to couple confidentiality with immunity, and the general disfavor of privileges in federal practice, the court was "especially hesitant" to chart a new course.[47]

Federal courts express a clear preference for protective orders as a superior mechanism over privileges for resolving disputes over discovery or disclosure.[48] For good cause, courts may "issue an order to protect a party or person from annoyance, embarrassment, oppression, or undue burden or expense."[49] In declining to recognize a peer review privilege, most courts nonetheless concede that it "would serve important interests" if available. As an alternative to the privilege, federal courts are generally more willing to protect hospitals' interests "through other established means such as protective orders, confidentiality agreements, and when appropriate, by disclosure only after an in-camera review" of the relevant documents.[50] Such mechanisms, while mitigating against widespread exposure of peer review deliberations, do not address the underlying premise that their very availability in litigation may deter full and frank participation by healthcare providers at the outset.

Some District Courts Hold Peer Review Documents Qualifiedly Privileged

A minority of district courts have been bolder in making qualitative distinctions between discrimination and malpractice cases, and finding peer review materials privileged in the latter. These courts typically acknowledge that "the numerical majority" of cases have been decided otherwise, but elect to recognize a qualified privilege anyway.[51] In one 2010 case alleging medical malpractice by the National Institutes of Health (NIH), the minor plaintiff and his family sought safety monitoring documents related to the clinical trial in which the minor had been enrolled. The court recognized that even though Maryland negligence law was incorporated by the FTCA based upon where treatment had occurred, the state's peer review statute yielded to federal common law due to the federal question presented. Despite the longstanding tradition of broad discovery, the court in this case granted the government's motion to deny production regarding confidential and evaluative materials generated during the NIH's review of its research protocols.[52]

In consciously deviating from the majority rule, the court emphasized two main factors. First, it echoed the circuit opinions in differentiating civil rights and antitrust cases from malpractice claims. In the former, there is a strong federal interest in eradicating certain invidious practices through enforcement. In the latter, "no such

federal policy is at stake" that makes recognition of a privilege inherently harmful to the public interest. Unlike cases alleging abuse of the review process itself, privileging peer review materials in a malpractice action would not preclude plaintiffs from presenting evidence of wrongdoing to support their claim.[53] Second, the court noted that while the HCQIA neglected to protect peer review materials from disclosure, the subsequently enacted PSQIA evidenced a congressional intent to promote a culture of safety by erecting confidentiality safeguards. Even though the NIH review committees were not designated as PSOs, "they clearly perform the same review functions Congress intended the PSQIA to encourage."[54]

In another recent case, a patient underwent a hysterectomy at Chicago's Mount Sinai Hospital and died from a post-operative infection. The patient's estate sued the United States under the FTCA because one of the significantly involved surgeons was employed by a federally funded health clinic. When the plaintiff sought discovery of statements made at the hospital peer review meeting regarding the surgery, both Mount Sinai and the government looked to withhold the materials based on the Illinois Medical Studies Act. The court here exercised its prerogative under Rule 501 and determined that the criteria established by *Jaffee* for recognizing a privilege "are satisfied by application of a peer review privilege in FTCA cases." The opinion reiterated the "decisive distinction" between malpractice claims, where "recognition of a privilege merely precludes the discovery of otherwise relevant, but not indispensable information," from cases in which the peer review proceedings act as the alleged vehicle for discrimination. The court offered a full-throated defense of the value of such a privilege in the malpractice context, finding that it "furthers the national interest in the protection of the health of its citizenry" by enabling "the candor that is essential to effective peer review."[55]

These notable exceptions indicate that the preclusion of protections for peer review materials in federal question litigation may not be an entirely settled matter. However, even the minority of courts that have recognized a peer review privilege in FTCA cases have not been sufficiently clear about whether they are applying the relevant state statute as a matter of comity within the court's discretion or whether they view the widespread availability of state protections as a persuasive factor in finding a federal common law privilege available. These decisions have sometimes discussed "the considerations of comity between state and federal sovereigns," but they have not stated outright whether they are merely utilizing the state privilege or recognizing a federal one as in *Jaffee*.[56] The *Jaffee* decision illustrated that "the case for recognizing a particular federal privilege is stronger…where the information sought is protected by a state privilege," but it did not adopt any particular state privilege wholesale.[57] The distinction between creating a federal privilege and applying a state doctrine is potentially significant, because it implicates the wide variability among state peer review laws that could ultimately undermine evidentiary consistency across federal jurisdictions. It also invokes a larger, unsettled question about whether comity is even an appropriate mechanism regarding privileges in a federal subject-matter case.[58]

Some Authority Exists for a "Self-Critical Analysis" Privilege

Absent a widely recognized federal peer review privilege, defendant hospitals have pursued a more limited privilege for self-evaluative materials as an alternative. In the formative case of *Bredice v. Doctor's Hospital*, the plaintiff in a malpractice suit from the District of Columbia sought minutes from a hospital mortality conference. The court was sympathetic to the "undeniable" value of the hospital's retrospective review, the purpose of which was "the improvement, through self-analysis, of the efficiency of medical procedures and techniques." Given the overwhelming public interest in keeping such meetings confidential "so that the flow of ideas and advice can continue unimpeded," the court denied discovery of the peer review materials. However, the court also indicated that "a showing of exceptional necessity" could override this calculation, subjecting discoverability determinations to a case-by-case balancing test.[59]

Prior to enactment of the agency-specific quality assurance statutes, federal agencies such as the Department of Defense (DoD) relied on this qualified privilege to protect peer review materials from disclosure.[60] The privilege of self-critical analysis, although finding its quintessential expression in hospital committee reports, is not unique to the medical setting. Courts have also applied it to internal investigations conducted by police departments and railroads and to self-reporting of equal employment compliance by government contractors, in which the free flow of information would be curtailed by the anticipation of disclosure. Implicit in such a privilege is "an acknowledgment of the self-defeating nature of allowing discovery of frank self-analyses: in the long run, denying protection will stifle more information than applying the privilege."[61]

Given the case-by-case approach established by *Bredice*, however, the self-critical analysis privilege is not absolute. Reliance on the privilege in the peer review context is an inherently uncertain venture, since the court's determination on each occasion entails "balancing the public's interest in protecting the confidentiality of the peer review process against the needs of the particular party seeking discovery."[62] This moving target provides little solace to peer review participants, whose candor and criticism are predicated on an expectation of confidentiality before the process even begins. The variability in the self-evaluative privilege undercuts its rationale, because each qualification erodes the consistency necessary to make the privilege useful. Federal courts have simultaneously fashioned a common law protection for self-evaluative materials and "failed to give the privilege sufficiently broad application to effectuate the important policies underlying it."[63]

The need for certainty was precisely what prompted the *Jaffee* court to reject case-by-case balancing in favor of a clear privilege. The mental health patient is entitled to know *before* establishing a relationship with his psychotherapist that confidential communications will not be broadcast outside the confines of the therapeutic setting. In this sense, "making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege."[64] While every privilege has its limits—notably imminent threats of harm—the protections it affords must be predictable to remain viable. "An uncertain privilege," as the Court explained in the context of attorney–client communications, "is little better than no privilege at all."[65]

Filling the Gap in Peer Review Protections

In the current environment, parties seeking to protect peer review documents in federal question litigation can be expected

to take a tripartite approach, invoking the geographically relevant state peer review statute, a tenuous federal common law privilege, and the qualified privilege of self-critical analysis.[66] Hoping that one of these evidentiary safeguards will "stick" may represent the best litigation approach, but it is not especially useful in enabling medical professionals to undertake their peer review responsibilities with the assurance of nondisclosure. Hence, a significant void in the legal architecture of peer review protections exists. Federal agencies without specific statutory coverage cannot accurately forecast the discovery risk posed by analyzing and critiquing their own medical functions. Even nonfederal healthcare entities must know that "attachment of a federal claim to a suit involving, for example, a sentinel or similar event will vitiate any peer review privilege of materials" not designated as patient safety work product.[67]

A Comprehensive Statutory Framework?

The predicament faced by federal agencies could be alleviated by legislation that extends protection for medical quality assurance records beyond the select group benefiting from targeted statutes. This is especially important because the current piecemeal structure can sometimes work directly against unprotected agencies and other defendants seeking to assert a peer review privilege in federal litigation. When healthcare entities have pointed to the agency-specific laws as evidence that "Congress favors a medical peer review privilege," they have often been rebuffed. Courts more often draw the opposite conclusion, finding such laws "demonstrate that Congress will create a medical peer review privilege when it is so inclined."[68] Courts take note of these legislative examples more for their carefully drawn scope than for a larger message indicating congressional approval of peer review protections.[69]

There is precedent for a change in legislative approach. Throughout the 1960s and 1970s, Congress immunized the medical personnel of executive agencies from personal tort liability through agency-specific statutes.[70] In 1988, however, Congress opted for comprehensive legislation, making the remedy against the United States under the FTCA exclusive for torts committed by "any employee of the government while acting within the scope of his office or employment."[71] This government-wide immunity provision, known as the Westfall Act, left the targeted statutes in place while simultaneously "shielding all federal employees from personal liability without regard to agency affiliation or line of work."[72]

While civil discovery privileges are available in the Freedom of Information Act context, the tenuous nature of the self-evaluative privilege introduces another element of doubt regarding the susceptibility of peer review documents into public release.

A similar shift to expand quality assurance protection for other federal agencies could remove much of the uncertainty that hangs over their efforts to monitor healthcare operations. Congressional enactments for individual agencies, although not entirely uniform in scope, have typically been more comprehensive than state peer review laws. The extant federal statutes not only erect a testimonial privilege, but also classify medical quality assurance records as confidential. Unlike a privilege, this confidentiality is not subject to waiver and acts as a prohibition against disclosure, with attendant penalties for unauthorized release.[73]

Case law interpreting the DoD quality assurance statute has indicated that an FTCA action "should proceed as if a quality assurance review had never occurred."[74] This framework contrasts sharply with the situation faced by noncovered agencies, such as the NIH, seeking to shield peer review reports from discovery. In such cases, the government first must hope that the court recognizes a peer review privilege against the majority of precedent. Even when the court has done so, it still ordered the United States to produce "all nonconfidential or nonevaluative documents relating to the NIH peer review process," which were considered exempt from the qualified privilege.[75] Even a favorable outcome in litigation arguably undermines the underlying purpose to promote candor and deliberation in the quality assurance endeavor, because NIH professionals are left guessing which portion of their work product is ultimately discoverable.

The Freedom of Information Act (FOIA) places federal medical facilities in a unique position.[76] Statutory language rendering their quality assurance materials prohibited from release can produce the added benefit of barring them from disclosure under Exemption 3 of the FOIA.[77] Without this option, peer review documents may be no more protected than regular medical files in FOIA litigation unless courts recognize the self-critical analysis privilege for that purpose.[78] While civil discovery privileges are available in the FOIA context, the tenuous nature of the self-evaluative privilege introduces another element of doubt regarding the susceptibility of peer review documents to public release.[79]

A Common Law Peer Review Privilege?

The disparity between state and federal protections for peer review information could also be addressed through recognition of a common law privilege. For the Supreme Court to hear and resolve this issue would likely require a circuit split, which does not exist since no circuit court has applied the privilege as a matter of federal law.[80] However, were the question eventually to reach the Court, many of the same factors that propelled recognition of the psychotherapist–patient privilege in *Jaffee* are present in medical peer review.

There can be little doubt that the efficacy of the peer review process qualifies as a significant public good. Congress has explicitly acknowledged "an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review."[81] Reluctance by medical professionals to engage in candid and continuous evaluations of healthcare services may indirectly result in lower quality of care overall.[82] The American Medical Association advocates confidentiality in the peer review process as integral to its foremost objective of promoting "the highest quality of medical care as well as patient safety."[83] Likewise, the American College of Medical Quality's professional policies dictate confidentiality of peer review deliberations to enable "frank, open,

and complete" discussions.[84]

There is widespread consensus among the states that peer review materials are worthy of protection. While state privileges do not bind federal courts, "the uniform judgment of the states" is relevant to the judicial exercise of reason and experience under Rule 501.[85] The legislatures in every state "have concluded that without a peer review privilege, physicians will be discouraged from participating in the full and frank expression of opinion that is essential if peer review is to fulfill its vital role in advancing the quality of medical care."[86] Although these statutes, much like the state psychotherapist privileges discussed in *Jaffee*, are far from identical, they "share a common purpose in encouraging physician candidness by eliminating the fear that peer review information will be used against them in subsequent litigation."[87]

Conclusion

Privileges can impose a hardship on litigants, excluding potentially relevant information from discovery. But they reflect a determination by legislatures and courts that sometimes this necessary evil is justified by a greater public good. The societal benefit advanced by medical peer review is the prevention of medical error and the concomitant reduction in morbidity and mortality. The justification for protecting peer review records is that compelling their disclosure would discourage their creation, sacrificing the social utility of patient safety to the needs of individual litigants. Physicians will be disinclined to assertively critique their peers if their statements entangle them in litigation and expose them to professional rifts.

Every state has already concluded, albeit in varying degree, that subjecting peer review files to disclosure would produce an unacceptable chilling effect on the self-policing activities of healthcare entities. Congress has made the same finding regarding the quality assurance programs of specified federal agencies and information classified as patient safety work product under the PSQIA. However, the remainder of the federal healthcare sector, together with nonfederal medical institutions faced with federal question litigation, is left in a state of limbo regarding the status of peer review activities not involving external PSOs. Peer review is assured of protection under federal law only if it falls under the purview of the PSQIA or is performed in a specified agency's quality assurance program.

This situation is counterproductive, because each time that a court either fails to recognize or pierces the privilege, it erodes the certitude of physicians and other medical professionals who must participate wholeheartedly in the peer review process to render it effective. In this way, exceptions to the privilege subvert the basic policy justifications that support its overall hindrance to full and open discovery.[88] Ideally, this gap in coverage will eventually be bridged by a uniform federal privilege that enables healthcare entities to undertake peer review activities with a reliable prediction of what federal courts protect, and in what circumstances.

Until then, counsel representing healthcare institutions in federal litigation should recognize the limitations and uncertainties in current law. They should continue to press for recognition of the peer review privilege or invoke the self-critical analysis privilege in response to discovery requests, but must also caution their clients that peer review materials may not be protected in federal court. ⊙

Major Charles G. Kels is an attorney for the Department of Homeland Security and a judge advocate in the Air Force Reserve. Opinions expressed in this article are those of the author alone and do not necessarily reflect those of the Departments of Homeland Security, Air Force, or Defense.

Endnotes

[1] Inst. of Med., To Err Is Human: Building a Safer Health System (Linda T. Kohn et al. eds., 2000).

[2] *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970), *aff'd* 479 F.2d 1920 (D.C. Cir. 1973).

[3] *Virmani v. Novant Health, Inc.*, 259 F.3d 284, 290 (4th Cir. 2001).

[4] These include the Department of Defense (DoD), 10 U.S.C. § 1102 (2012); Coast Guard (USCG), 14 U.S.C. § 645 (2012); Department of Veterans Affairs (VA), 38 U.S.C. § 5705 (2012); and certain programs supported by the Indian Health Service (IHS), 25 U.S.C. § 1675 (2012).

[5] *See* S. Rep. No. 331, 99th Cong., 2d Sess. 245 (1986).

[6] *See* Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. Legal Med. 541, 547-550 (2003).

[7] *See, e.g.*, Gill P. Beck, *The Confidentiality of Department of Defense Medical Quality Assurance Records: Developments Under 10 U.S.C. § 1102*, U.S. Attorneys' Bull., July 2009, at 20, 21; William A. Woodruff, *The Confidentiality of Medical Quality Assurance Records*, Army Law., May 1987, at 5, 9.

[8] Nijm, *supra* note 6, at n. 92; *see also KD ex rel. Dieffenbach v. United States*, 715 F.Supp.2d 587, 592 (D. Del. 2010) ("the balance of authority weighs against recognition" of a privilege for medical peer review materials).

[9] 42 U.S.C. §§ 11101-11152 (2012).

[10] 42 U.S.C. § 11111 (2012).

[11] 42 U.S.C. § 11137 (2012); 45 C.F.R. § 60.15 (2012).

[12] *See, e.g., Syposs v. United States*, 179 F.R.D. 406, 410 (W.D.N.Y. 1998); *Teasdale v. Marin General Hosp.*, 138 F.R.D. 691, 694 (N.D. Cal. 1991) ("Congress spoke loudly with its silence.").

[13] *Weiss v. County of Chester*, 231 F.R.D. 202, 207 (E.D. Pa. 2005).

[14] *Dieffenbach*, 715 F.Supp.2d at 595.

[15] 42 U.S.C. §§ 299b-21-26 (2012).

[16] 42 U.S.C. § 299b-22 (2012).

[17] 42 U.S.C. § 299b-21(7)(A) (2012).

[18] 42 U.S.C. § 299b-24 (2012).

[19] 42 C.F.R. § 3.112 (2012) (referencing AHRQ's PSO website at www.pso.ahrq.gov).

[20] *Pearson v. Miller*, 211 F.3d 57, 66 (3rd Cir. 2000).

[21] Bryan A. Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, 24 S. Ill. U. L.J. 541, n. 53 (2000).

[22] 28 U.S.C. §§ 1346(b), 2671-2680 (2012).

[23] Fed. R. Evid. 501.

[24] *Menses v. U.S. Postal Serv.*, 942 F.Supp. 1320, 1322-1323 (D. Nev. 1996); Woodruff, *supra* note 7, at n. 11.

[25] *Dieffenbach*, 715 F.Supp.2d at 590.

[26] Conf. Rep. No. 1597, 93rd Cong., 2d Sess. (1974), *reprinted in*

1974 U.S.C.C.A.N. 7098, 7101.

[27]Fed. R. Civ. P. 26(b)(1).

[28]Fed. R. Evid. 501.

[29]*Trammel v. United States*, 445 U.S. 40, 51 (1980), *quoting United States v. Bryan*, 339 U.S. 323, 331 (1950).

[30]*United States v. Nixon*, 418 U.S. 683, 710 (1974).

[31]*University of Pa. v. EEOC*, 493 U.S. 182 (1990).

[32]*Id*. at 189-190.

[33]*Jaffee v. Redmond*, 518 U.S. 1 (1996).

[34]*Id*. at 11.

[35]*Id*. at 12-14.

[36]*Id*. at 24-25 (Scalia, J., dissenting).

[37]*See Mem'l Hosp. v. Shadur*, 664 F.2d 1058 (7th Cir. 1981); *Virmani*, 259 F.3d 284; *Adkins v. Christie*, 488 F.3d 1324 (11th Cir. 2007).

[38]*Virmani*, 259 F.3d at 288-289.

[39]*Adkins*, 488 F.3d at 1328-1329.

[40]*Shadur*, 664 F.2d at 1062.

[41]*Virmani*, 259 F.3d at 290-291.

[42]*Adkins*, 488 F.3d at 1329.

[43]42 U.S.C. § 11111(a) (2012); Nijm, *supra* note 6, at 553.

[44]*Nilavar v. Mercy Health Sys.*, 210 F.R.D. 597, 609 (S.D. Ohio 2002)("the federal common law has never adopted a physician peer review privilege…cases reaching the contrary conclusion are, simply stated, anomalies in the corpus of federal case law.").

[45]*Syposs v. United States*, 179 F.R.D. 406, 409-412 (W.D.N.Y. 1998).

[46]42 U.S.C. § 233(g) (2012).

[47]*Tucker v. United States*, 143 F.Supp.2d 619, 626 (S.D.W.V. 2001).

[48]*Pearson*, 211 F.3d at 73.

[49]Fed. R. Civ. P. 26(c)(1).

[50]*Adkins*, 488 F.3d at 1328-1329.

[51]*Sevilla v. United States*, 852 F.Supp.2d 1057, 1058 (N.D. Ill. 2012).

[52]*Dieffenbach*, 715 F.Supp.2d at 598.

[53]*Id*. at 597.

[54]*Id*. at 595-596.

[55]*Sevilla*, 852 F.Supp.2d at 1059, 1062.

[56]*Id*. at 1061.

[57]*Pearson*, 211 F.3d at 67.

[58]*E.g.*, *Folb v. Motion Picture Indus. Pension & Health Plans*, 16 F.Supp.2d 1164, 1170 (C.D. Cal. 1998) (concluding that the magistrate judge "erred as a matter of law in applying the California mediation privilege 'as a matter of comity'… To the extent the authority relied upon by the magistrate judge suggests federal courts should look to the law of the forum state as a matter of comity in determining the contours of federal privilege law, that authority is disapproved by *Jaffee*.").

[59]*Bredice*, 50 F.R.D. at 250-251.

[60]Woodruff, *supra* note 7, at 5-6.

[61]Note, *The Privilege of Self-Critical Analysis*, 96 Harv. L. Rev. 1083, 1086-1090 (1983).

[62]Woodruff, *supra* note 7, at 6.

[63]*Self-Critical Analysis*, *supra* note 61, at 1100.

[64]*Jaffee*, 518 U.S. at 17.

[65]*Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981).

[66]*See, e.g.*, *Dieffenbach*, 715 F.Supp.2d at 588 ("The United States asserts these documents are privileged under the Maryland medical peer review statute, the federal self-critical analysis privilege, and federal common law.").

[67]Liang, *supra* note 21, at n. 53.

[68]*Virmani*, 259 F.3d at 292.

[69]*Syposs*, 179 F.R.D. at 411.

[70]*E.g.*, 38 U.S.C. § 7316 (originally enacted 1965); 42 U.S.C. § 233 (originally enacted 1970); 10 U.S.C. § 1089 (originally enacted 1976); 51 U.S.C. § 20137 (originally enacted 1976); 22 U.S.C. § 2702 (originally enacted 1980).

[71]28 U.S.C. § 2679(b)(1) (2012).

[72]*Levin v. United States*, 133 S. Ct. 1224, 1229-1230 (2013).

[73]Woodruff, *supra* note 7, at 9-11.

[74]Beck, *supra* note 7, at 22; *see also In re United* States *of America*, 864 F.2d 1153, 1155 (5th Cir. 1989) (noting that 10 U.S.C. § 1102(c) "details the particular instances in which the disclosure of records and the giving of testimony is authorized. None of the exceptions to the general proscription…even arguably, applies to litigation under the Federal Tort Claims Act.").

[75]*Dieffenbach*, 715 F.Supp.2d at 598.

[76]5 U.S.C. § 552 (2012).

[77]5 U.S.C. § 552(b)(3) (2012); *see Goodrich v. Dep't of the Air Force*, 404 F. Supp. 2d 48 (D.D.C. 2005); *Dayton Newspapers, Inc. v. Dep't of the Air Force*, 107 F. Supp. 2d 912 (S.D. Ohio 1999) (both cases holding that the DoD medical quality assurance statute qualifies under FOIA Exemption 3). Both the DoD statute, at 10 U.S.C. § 1102(f), and the IHS statute, at 25 U.S.C. § 1675(g), specifically note that covered medical quality assurance records may not be made available to any person under the FOIA.

[78]*See Wash. Post Co. v. DOJ*, No. 84-3581, slip op. at 18-21 (D.D.C. Sept. 25, 1987) (magistrate's recommendation) (applying the critical self-evaluative privilege under FOIA Exemption 4), *adopted*, (D.D.C. Dec. 15, 1987), *rev'd in part on other grounds and remanded*, 863 F.2d 96, 99 (D.C. Cir. 1988).

[79]*See Sangre de Cristo Animal Protection, Inc. v. DOE*, No. 96-1059, slip op. at 7-9 (D.N.M. Mar. 10, 1998)(declining to apply the self-critical analysis privilege in the context of animal research).

[80]*See Jaffee*, 518 U.S. at 7-8 ("The United States Courts of Appeals do not uniformly agree that the federal courts should recognize a psychotherapist privilege under Rule 501… Because of the conflict among the Courts of Appeals and the importance of the question, we granted certiorari.").

[81]42 U.S.C. § 11101(5).

[82]S. Rep. No. 331, 99th Cong., 2d Sess. 245 (1986).

[83]Am. Med. Ass'n, Medical Peer Review, www.ama-assn.org/ama/pub/physician-resources/legal-topics/medical-peer-review.page (last visited Aug. 10, 2013).

[84]Am. Coll. Med. Quality, Policy 20: Confidentiality of Peer Review Information, www.acmq.org/policies/policies19and20.pdf (last visited Aug. 10, 2013).

[85]*Jaffee*, 518 U.S. at 14.

[86]*Sevilla*, 852 F.Supp.2d at 1060.

[87]*Dieffenbach*, 715 F.Supp.2d at 594.

[88]*See generally* Kenneth Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 Mass. L. Rev. 157 (2002).