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# Is Meaningful Peer Review Headed Back to Florida?

Brendan A. Sorg

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## IS MEANINGFUL PEER REVIEW HEADED BACK TO FLORIDA?

*Brendan A. Sorg\**

I.	Introduction .....	799
II.	Background.....	801
	A. Medical Peer Review & its Role Improving Patient Care .....	801
	B. Why Many Physicians Dislike Peer Review .....	804
	C. Peer Review Immunity, Confidentiality & Privilege..	806
	D. Congress Responds with HCQIA .....	809
	E. Medical Peer Review in Florida .....	811
III.	Statement of the Issue.....	818
	A. Hospitals Search for Amendment 7 Protection.....	818
	B. Patient Safety and Quality Improvement Act (“PSQIA”).....	821
IV.	Analysis .....	824
	A. Framework of the PSQIA .....	824
	B. The PSQIA Statutory Privilege and Impact on Amendment 7.....	827
	C. Overview of Common Law Privilege .....	829
	D. An Expanded Peer Review Privilege in Federal Court .....	831
	E. The United States Supreme Court Should Provide a Common Law Privilege to Medical Peer Review.....	833
V.	Conclusion .....	834

### I. INTRODUCTION

Current litigation challenging the constitutionality of Article X,

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Section 25 of the Florida Constitution, entitled “Patients’ Right to Know About Adverse Medical Incidents” and more commonly known as Amendment 7 (“Amendment 7”), will have a significant practical impact on patient care and medical peer review in Florida.<sup>1</sup> Legally, Amendment 7 contributed to the need for a federal statutory peer review privilege, which Congress recognized by enacting the Patient Safety and Quality Improvement Act of 2005 (“PSQIA”).<sup>2</sup> Now, in addition to the PSQIA, some federal courts appear ready to consider an expanded common law privilege.<sup>3</sup> This comment addresses the current applicability of Amendment 7 in the wake of the PSQIA and the foundation that has been set to undo Amendment 7, and establish an expanded common law privilege in the name of promoting patient safety and encouraging meaningful medical peer review.<sup>4</sup>

This comment lays the foundation to evaluate the sustainability of Amendment 7 post-PSQIA in Part II by first examining medical peer review, its origin, its evolution and why peer review remains important to patient safety.<sup>5</sup> Although many physicians dislike peer review,<sup>6</sup>

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1. Amendment 7 was passed by a vote of 81.2 % in favor and 18.8 % against. *November 2, 2004 General Election: Official Results*, FLA. DEP’T OF STATE, DIV. OF ELECTIONS, <http://election.dos.state.fl.us/elections/resultsarchive/> (select “2004 General” election from dropdown menu; then select “Const. Amendments” from dropdown menu) (last visited Mar. 2, 2013) (cited in *Florida Hospital Waterman, Inc. v. Buster*, 984 So. 2d 478 n.1 (Fla. 2008)). Amendment 7’s proposed statement and purpose was presented as follows:

The Legislature has enacted provisions relating to a patient’s bill of rights and responsibilities, including provisions relating to information about practitioners’ qualifications, treatment and financial aspects of patient care. The Legislature has, however, restricted public access to information concerning a particular health care provider’s or facility’s investigations, incidents or history of acts, neglects, or defaults that have injured patients or had the potential to injure patients. This information may be important to a patient. The purpose of this amendment is to create a constitutional right for a patient or potential patient to know and have access to records of a health care facility’s or provider’s adverse medical incidents, including medical malpractice and other acts which have caused or have the potential to cause injury or death. This right to know is to be balanced against an individual patient’s rights to privacy and dignity, so that the information available relates to the practitioner or facility as opposed to individuals who may have been or are patients.

Advisory Op. re: Patients’ Right to Know About Adverse Med. Incidents, 880 So. 2d 617, 618 (Fla. 2004).

2. Patient Safety and Quality Improvement Act of 2005 (“PSQIA”), Pub. L. No. 109-41, 119 Stat. 424 (2005) (codified as amended at 42 U.S.C. §§ 299b-21 to -26 (2006)). The stated purpose of the PSQIA was: “[t]o amend title IX of the Public Health Service Act to provide for the improvement of patient safety and to reduce the incidence of events that adversely effect patient safety.” PSQIA

3. See cases discussed *infra* notes 159-167.

4. See *infra* notes 136-143, 169-179 and accompanying text.

5. See *infra* notes 15-29 and accompanying text.

6. See *infra* notes 32-38 and accompanying text.

Congress has acknowledged its importance by making peer review mandatory and by providing the statutory protections to ensure peer review remains meaningful.<sup>7</sup> States have followed suit, passing their own laws that provide for the protection of peer review materials.<sup>8</sup> Part II also addresses how Amendment 7 reversed Florida's historical approach providing broad peer review protection and how this erosion of peer review protection served as a foundation for the federal statutory protections provided by the PSQIA.<sup>9</sup>

Part III, the Statement of the Issue, describes the losing arguments that hospitals<sup>10</sup> attempted to employ to protect against Amendment 7 requests, and why, in lieu of a new PSQIA argument, Amendment 7 is ripe for new round of litigation.<sup>11</sup> Part IV provides an overview of PSQIA's framework and explains how the practical implementation of the PSQIA's statutory protection limits Amendment 7.<sup>12</sup> Furthermore, this analysis section explores the likelihood of a common law medical peer review privilege, and why the trend in federal courts and the analytical framework applied by the United States Supreme Court suggests an expanded common law peer review privilege may become a reality.<sup>13</sup> In closing, this comment discusses why the benefits of an expanded medical peer review privilege outweigh the risks, and identifies current Florida litigation that may undo Amendment 7 and completely restore meaningful peer review in Florida.<sup>14</sup>

## II. BACKGROUND

### A. *Medical Peer Review & its Role Improving Patient Care*

The beginning of medical peer review dates back to 1918 when the American College of Surgeons ("ACS") established the first peer review program in the United States as a review body charged with improving the quality of patient care.<sup>15</sup> The ACS ultimately evolved into the Joint

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7. See *infra* notes 54-62, 110-117 and accompanying text.

8. See *infra* notes 50-51, 175 and accompanying text.

9. See *infra* notes 63-93 and accompanying text.

10. While the term "hospital" is used throughout this comment, the PSQIA and peer review discussion within applies broadly to any healthcare organization or healthcare facility.

11. See *infra* notes 94-123 and accompanying text.

12. See *infra* notes 123-143 and accompanying text.

13. See *infra* notes 145-166 and accompanying text.

14. See *infra* notes 180-191 and accompanying text.

15. Alissa Marie Bassler, *Federal Law Should Keep Pace with States and Recognize a Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 691 (2003). This first program, known as the Hospital Accreditation Program, was formed with the intent to improve the quality of hospital

Commission on Accreditation of Health Care Organizations (“JCAHO”),<sup>16</sup> which requires hospitals and healthcare organizations to conduct peer review of staff members in order to receive JCAHO’s accreditation.<sup>17</sup>

Peer review is a process in which the actions of health care providers are reviewed to determine the appropriateness of care that was provided.<sup>18</sup> Peer review is predominately performed by physicians and other health care professionals who are members of a hospital’s medical staff.<sup>19</sup> The medical staff members are selected by hospital leadership

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care. *Id.*

16. The Joint Commission is a national non-profit accrediting body and standards-setting organization for health care providers. Frederick Levy, Darren Mareniss, Corianne Iacovelli & Jeffrey Howard, *The Patient Safety and Quality Improvement Act of 2005*, 31 J. OF LEGAL MED. 4: 397, 406 (2010). JCAHO has been in operation since 1951 and is governed by a Board of Commissioners that is composed of health care professionals, policy experts, ethicists, and stakeholders’ representatives. *Facts about The Joint Commission*, THE JOINT COMMISSION (Jan. 3, 2013), [http://www.jointcommission.org/facts\\_about\\_the\\_joint\\_commission/](http://www.jointcommission.org/facts_about_the_joint_commission/). JCAHO’s primary function is to audit and accredit hospitals, hospice services, nursing homes, rehabilitation centers, and laboratories to ensure compliance with regulatory standards. *Id.*

17. George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 725 (2001). JCAHO is considered the foremost hospital accreditation authority and participation plays a critical role in the economic sustainability of a hospital because eligibility for federal funds, such as Medicare, depends on successfully achieving accreditation. See Murray G. Sagsveen & Jennifer L. Thompson, *The Evolution of Medical Peer Review in North Dakota*, 73 N.D. L. REV. 477, 478 n.6 (1997); Talia Storch, Note and Comment, *Medical Peer Review in Florida: Is the Privilege Under Attack?*, 32 NOVA L. REV. 269, 273 (2007); 42 C.F.R. § 482.22 (2011).

18. Eric Scott Bell, Comment, *Make Way: Why Arkansas and the States Should Narrow Health Care Peer Review Privileges for the Patient Safety and Quality Improvement Act of 2005*, 62 ARK. L. REV. 745, 749 (2009). For example, hospitals often review specific care to determine appropriate treatment, correctness of billing, quality assurance and utilization of care. *Id.* at 749-750. Peer review committees participate in intra-committee discussion focused on evaluating the specific and general performance of the hospital in an effort to identify, isolate and remedy incidents of medical error. *Id.* There are three premises that underline traditional peer review:

The first premise is that due to their unique and specialized training, only physicians can properly evaluate and judge other physicians’ medical practices and detect when colleagues pose a risk to patient care. The second premise is that a milieu supporting candid communication is most likely to foster recognition of both exemplary and substandard care. The third premise is that peer review participants are motivated to maintain high standards of care in their group or institution and act in good faith.

Ilene N. Moore, et al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1177 (2006).

19. As an example, Lee Memorial Hospital, part of Lee Memorial Health System, defines the term “medical staff” in its Medical Staff Bylaws as “those practitioners who are authorized by the Board to exercise privileges at one or more of the System’s hospitals, and, on a component basis, those practitioners who are authorized by the Board to exercise privileges at a particular system hospital.” *Lee Memorial Hospital Medical Staff Bylaws*, LEE MEM’L HEALTH SYS. 6 (June 16, 2011), <http://www.leememorial.org/physicianpub/pdf/BYLAWS/LMHBYLAWS06-16-11.pdf>. The Bylaws go onto describe the nature of medical staff membership as:

and organized as a peer review committee.<sup>20</sup> This committee is tasked to both review the qualifications and training of new applicants as well as to critique the services rendered by physicians already practicing at the hospital.<sup>21</sup> Functionally, peer review leads to efficient evaluation because practicing physicians have the expertise to evaluate peers' work and are best positioned to review the competence of other practicing physicians they regularly observe.<sup>22</sup>

Peer review is important to improving health care quality because of the role it plays in identifying best practices and reducing medical error.<sup>23</sup> Historically, civil medical malpractice claims were the cornerstone vehicle used to regulate patient safety in the United States.<sup>24</sup>

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[A] privilege that shall be extended only to professionally competent physicians (M.D. or D.O.), dentists, podiatrists and/or psychologists who continuously meet the qualifications, standards, and requirements set forth in these Bylaws . . . Medical Staff membership is a privilege and not a right of any practitioner or other person. Medical Staff membership and the exercise of privileges in connection therewith shall be extended only to practitioners who continuously meet the requirements of these Bylaws.

*Id.* at 7.

20. Susan O. Scheutzow & Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined than Real*, 7 J.L. & HEALTH 169, 173 (1992/1993). Since the hospital's board and administration is generally made up of individuals without the qualifications to evaluate medical care, evaluation and review tasks are delegated to members of the medical staff. *Id.* at 173-174. Ultimately, however, the hospital's board is responsible for any harm or risk of injury to patients. Ronald G. Spaeth, Kelly C. Pickering & Shannon M. Webb, *Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures*, 12 ANNALS HEALTH L. 235, 237 (2003). Because hospitals believe the level of quality care depends on effective peer review, governing boards work diligently to eliminate the barriers to effective peer review. *Id.*

21. Newton, *supra* note 17, at 725. In order to ensure impartiality, committee members are generally composed of unbiased practicing physicians who are not in direct competition with the physician under review. *Id.* Although ultimate decisions on any disciplinary actions taken against the reviewed physician are made by the hospital's governing board, the peer review committee makes a recommendation that is highly influential. *Id.* For initial applicants, the process involves the review of the applicant's training and overall clinical experience; a review process referred to as credentialing because it is based primarily on the physicians' credentials, such as training, certification and demonstrated ability. 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).

22. Newton, *supra* note 17, at 724. The peer review system, along with state licensing board disciplinary action and the medical malpractice system, serve as the three primary tools to monitor the quality of care provided by physicians. *Id.* Despite the existence of alternatives, peer review is widely accepted as the primary means to weed out low quality physicians and identify physicians whose skills require improvement. Scheutzow, *supra* note 21, at, 14-15.

23. See Patricia A. Sullivan & Jon M. Anderson, *The Health Care Debate: If Lack of Tort Reform is Part of the Problem, Federalized Protection for Peer Review Needs to be Part of the Solution*, 15 ROGER WILLIAMS U. L. REV. 41 (2010). Unlike the tort system, peer review is capable of "maximizing efficient health care outcomes." *Id.* at 46.

24. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 400. The primary purpose of medical malpractice cases is to assign financial responsibility for the harm caused; however, this retroactive approach focusing on a single incident does little to address systematic problems of the

Civil medical malpractice, however, fails to accomplish many patient-focused goals because it only addresses negligent care that actually causes damage; thus care that falls below quality standards but does not cause damage goes unaddressed.<sup>25</sup> Peer review protects future patients from medical error by ensuring that affiliated practitioners practice properly and have the qualifications, training and experience necessary to provide quality care.<sup>26</sup> When peer review committees engage in meaningful peer review, the process accomplishes three important purposes: (1) it leads to higher quality health care by rooting out incompetence and error; (2) it reassures patients that they are receiving quality care; and (3) it leads to a reduction in health care costs by allowing hospitals to self-regulate and increase efficiencies.<sup>27</sup> Achieving these important purposes requires more than just peer review for peer review's sake—it requires that peer review is meaningful and effective at uncovering and remedying substandard care.<sup>28</sup> Consequently, meaningful peer review requires candid communication between committee members that detects and identifies both exemplary and substandard care, and motivates all medical staff members to maintain excellent skills and professional standards.<sup>29</sup>

#### B. *Why Many Physicians Dislike Peer Review*

Overall, peer review is considered a public good.<sup>30</sup> It offers incentives for similarly trained physicians working in the same hospital to identify colleagues with knowledge gaps or skill deficiencies,

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health care industry and fails to prevent future errors. *Id.*

25. *Id.* The author argues for a more proactive approach to regulating patient safety in the United States, primarily through the mechanism of peer review. *Id.*

26. *Id.* (citing Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 543 (2003)). Hospitals and advocacy groups often characterize peer review as a risk management tool because of its aim to reduce medical errors. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 401.

27. Bassler, *supra* note 15, at 691-692. “When hospital conditions and patient care improve and the rates of death and disease decline, the number of medical malpractice lawsuits should decline. Peer review thus seeks to identify and eliminate these systematic ‘accidents waiting to happen,’ thereby maximizing efficient health care outcomes.” Sullivan & Anderson, *supra* note 23, at 46 (citing *Pastore v. Samson*, 900 A.2d 1067, 1074-76 (R.I. 2006); Bryan A. Liang & LiLan Ren, *Medical Liability Insurance and Damage Caps: Getting Beyond Band Aids to Substantive Systems Treatment to Improve Quality and Safety in Healthcare*, 30 AM. J.L. & MED. 501, 530 (2004)).

28. Brief of the Idaho Hosp. Ass’ns as Amicus Curiae Supporting Respondents, *Montalbano v. Saint Alphonsus Reg’l Med. Ctr.*, 264 P.3d 944 (Idaho 2011) No. 37573-2010, 2010 WL 5497832, at \*8 (discussing why peer review merely for the sake of compliance with Joint Commission standards is not the goal).

29. Bell, *supra* note 18, at 753.

30. Sullivan & Anderson, *supra* note 23, at 51.

facilitate their improvement, and monitor progress and future performance.<sup>31</sup> Regardless of its many benefits, not all physicians are enamored with peer review.<sup>32</sup> First, peer review committee members are often direct colleagues or friends with the reviewed physician and understand that a disciplinary recommendation that leads to a termination of clinical privileges may have a devastating effect on the reviewed physician's career, while also ending any friendship.<sup>33</sup> Second, committee members may be reluctant to participate in the peer review process because they do not want their evaluations and appraisals of a fellow physician's competence later disclosed.<sup>34</sup> Third, committee members may have concerns over retaliation in the form of a lawsuit against the peer review committee.<sup>35</sup> Finally, peer review may be time consuming and lead to less billable time or loss of referrals.<sup>36</sup> Thus, in the face of abounding disincentives, physicians are often reluctant to voluntarily participate in the peer review process, and when they do there is little incentive to participate aggressively and meaningfully.<sup>37</sup> In recognition of the need for meaningful peer review, state and federal

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31. Storch, *supra* note 17, at 278. This internal committee is generally preferred to external parties assuming review responsibility because when serious problems are identified, the hospital can take proactive steps to limit the doctor's further interaction with patients before government agencies get involved. *Id.*

32. Sullivan & Anderson, *supra* note 23, at 50. One of the reasons physicians dislike peer review is because fundamentally peer review entails acknowledging error and doctors are not supposed to make mistakes, let alone admit and apologize for them. *Id.*

33. Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1118 (1988). The negative repercussions that follow a substandard review may have lasting effects that include, but are not limited to, damaged reputation, loss of income, patients and malpractice insurance, the stigma associated with a negative review and potential difficulty finding future employment elsewhere. Storch, *supra* note 17, at 275.

34. Scheutzow, *supra* note 21, at 18. Especially in cases where the reviewing physician knows or considers the reviewed physician a friend, the reviewing physician may only be willing to testify as part of a confidential peer review process where the testimony will not be revealed during a malpractice or other legal action. *Id.*

35. Some physician's disciplined through the peer review process have brought successful suits against peer review participants and the hospital under an antitrust theory, arguing the peer review activity was undertaken to decrease the number of competing physician's in the reviewing physician's practice area. Spaeth, Pickering & Webb, *supra* note 20, at 241 (citing *Patrick v. Burget*, 486 U.S. 94, 105 (1988) (finding that peer review activities were not protected from application of federal antitrust laws where a surgeon alleged violations of the Sherman Act against reviewing physicians)).

36. Morter, *supra* note 33, at 1140.

37. Newton, *supra* note 17, at 727. Weighing against the disincentives discussed within this paragraph are the possible ethical concerns for quality of patient care or concerns for reputation and accreditation status of a reviewer's hospital that may motivate a physician's voluntary involvement in the peer review process. *Id.* at 726.

immunity, confidentiality and privilege protections must work together to facilitate the existence of a functional peer review system.<sup>38</sup>

### C. Peer Review Immunity, Confidentiality & Privilege

Federal and state laws generally grant protection to the peer review process in one or more of three ways: (1) providing immunity from lawsuits to peer review committee members; (2) requiring individuals participating in peer review to keep information about the process and conclusions confidential; and (3) making peer review information privileged.<sup>39</sup> Immunity is an exemption from liability against a suit brought by a plaintiff.<sup>40</sup> “Congress and practically every state legislature have enacted statutes that immunize those persons participating in the peer review process.”<sup>41</sup>

Confidentiality protection focuses on the obligation to refrain from disclosing information to third parties outside of the judicial process.<sup>42</sup>

38. See *id.* at 735.

39. Scheutzow, *supra* note 21, at 9.

40. Sullivan & Anderson, *supra* note 23, at 55 (citing *St. Louis, Iron Mountain & S. Ry. Co. v. McWhirter*, 229 U.S. 265, 287 (1913)). Because immunity deprives a plaintiff of a potential remedy, courts typically construe immunity provisions narrowly. Sullivan & Anderson, *supra* note 23, at 55 (citing *Weissman v. Nat'l Ass'n of Secs. Dealers, Inc.*, 500 F.3d 1293, 1297 (11th Cir. 2007)).

41. Sullivan & Anderson, *supra* note 23, at 55. Specifically, the Health Care Quality Improvement Act immunity provided by Congress is a qualified immunity and does not extend to other forms of relief. *Id.* at 52. The Health Care Quality Improvement Act will be discussed in greater detail later in this comment. See *infra* notes 56-61 and accompanying text. For language from state immunity statutes, see, e.g., OHIO REV. CODE ANN. § 2305.251 (West 2012) (“No individual who is a member of or works for or on behalf of a peer review committee of a health care entity shall be liable in damages to any person for any acts, omissions, decisions, or other conduct within the scope of the functions of the peer review committee.”); IND. CODE ANN. § 16-21-2-6 (West 2011) (“The governing board and the governing board’s employees, agents, consultants, and attorneys have absolute immunity from civil liability for communications, discussions, actions taken, and reports made concerning disciplinary action or investigation taken or contemplated if the reports or actions are made in good faith and without malice.”); MINN. STAT. § 145.63 (West 2012). (“No review organization and no person who is a member [of] . . . a review organization shall be liable for damages or other relief in any action brought by a person or persons whose activities have been or are being scrutinized or reviewed by a review organization . . .”).

42. Scheutzow, *supra* note 21, at 35. Confidentiality may be imposed by law or contract; thus, from a practical perspective, all hospitals should contractually require that peer review participants keep peer review information confidential. Scheutzow & Gillis, *supra* note 20, at 196-197. Furthermore, hospital bylaws should require medical staff members participating in peer review to keep all information confidential and as part of the appointment process to any peer review committee, the hospital should require that each participant sign an agreement to keep the information confidential. *Id.* at 196. “This gives rise to a contractual claim for breach of contract should any participant breach the confidentiality and voluntarily testify or divulge peer review information.” *Id.*

To achieve meaningful peer review, confidentiality is a must:

Confidentiality is essential to the proper functioning of peer review. First, confidentiality promotes the candid, free flow of information between physicians who are part of the peer review committee. Second, and probably most importantly to the physicians on the committee, confidentiality protects reviewing members of the committee from being forced to disclose documents and statements made during the peer review process if they are later sued by the physicians they review.<sup>43</sup>

Confidentiality concerns impact peer review participants' willingness to participate meaningfully in the peer review process, thus lack, or any perceived lack, of confidentiality may lead to the obliteration of meaningful peer review.<sup>44</sup> Historically, Florida courts had repeatedly articulated the significance of confidentiality to peer review and improved healthcare quality, going as far as stating that lack of confidentiality will terminate meaningful peer review.<sup>45</sup>

Lastly, privilege protection is the right to keep information from being used as evidence.<sup>46</sup> Generally, privilege ascribed to peer review

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43. Bassler, *supra* note 15, at 703-704. Commentators have stated that voluntary disclosure of peer review findings may be particularly damaging to the process. Scheutzow & Gillis, *supra* note 20, at 192. *See, e.g.*, West Covina Hosp. v. Superior Court, 718 P.2d 119 (Cal. 1986) (holding California's privilege statute did not prohibit a peer review participant from voluntarily testifying as to the proceedings reasoning). "Obviously, interpretations such as West Covina would render absolutely meaningless any corresponding peer review privilege protection that exists as physicians would always be concerned that one of the participants would choose voluntarily to disclose the proceedings." Scheutzow & Gillis, *supra* note 20, at 191. *See also, e.g.*, Babcock v. Bridgeport Hosp., 742 A.2d 322, 344 (Conn. 1999) (quoting Claypool v. Mladineo, 724 So. 2d 373, 388 (Miss. 1998) ("Only where . . . peer review committees . . . are assured of confidentiality [will they] feel free to enter into uninhibited discussions of their peers.")); Young v. Western Pa. Hosp., 722 A.2d 153, 156 (Pa. Super. Ct. 1998) ("The need for confidentiality in the peer review process stems from the need for comprehensive, honest, and sometimes critical evaluations of medical providers by their peers in the profession."); Sun Health Corp. v. Myers, 70 P.3d 444, 447 (Ariz. Ct. App. 2003) ("The confidentiality of peer review committee proceedings is essential to achieve complete investigation and review of medical care."); Konrady v. Oesterling, 149 F.R.D. 592, 597 ("The theory is that a confidential environment will encourage physician candor and participation in the process. This, the theory goes, will result in better doctors and ultimately better health care.").

44. Morter, *supra* note 33, at 1130-1131.

45. James C. Sawran & Robert C. Weill, *Amendment 7: Will the Patient's Right to Know Come at Too High a Price?*, 24 No. 2 TRIAL ADVOC. Q. 7, 9 (2005). "Confidentiality is essential to . . . [medical review committee] meetings; and these meetings are essential to the continued improvement in the care and treatment of patients . . . . To subject these discussions and deliberations to the discovery process, without a showing of exceptional necessity, would result in terminating such deliberations." *Id.* (citing Dade County Med. Ass'n v. Hlis, 372 So. 2d 117, 120 (Fla. 3d D.C.A. 1979)).

46. Scheutzow & Gillis, *supra* note 20, at 179. "The recognition of a privilege with respect to communications between parties or with respect to an institution's self-examination of its

has been a legislative creation utilized to achieve open and effective peer review.<sup>47</sup> Thus, this privilege is institutional in nature, created not to aid the individual peer review participants, but to protect the institution of peer review, and indirectly the public who rely on peer review to increase the quality of healthcare.<sup>48</sup> Said another way, if peer review privilege is compromised, the net result will lessen efforts to improve healthcare and the patient outcomes will suffer as a result.<sup>49</sup> In recognition of the need for meaningful peer review and the importance of privilege protection, “all fifty states and the District of Columbia have created an evidentiary privilege for peer review information.”<sup>50</sup> However, despite this near universal recognition of peer review privilege, the scope of privileges granted by the states varies.<sup>51</sup> Therefore, physicians may have to speculate about the scope of the applicable statutory privilege, thus discouraging aggressive and meaningful peer review participation.<sup>52</sup> To achieve meaningful and effective peer review, protections must be consistent, a principle recognized by Congress and the United States Supreme Court.<sup>53</sup>

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activities represents ‘an exception to the general liability of every person to give testimony upon all facts inquired in a court of justice.’” *Id.*

47. Scheutzow & Gillis, *supra* note 20, at 181. The primary justification for privilege is that protecting peer review participants from having to testify against reviewed physicians promotes candor during peer review proceedings. B. Abbott Goldberg, *The Peer Review Privilege: A Law in Search of a Valid Policy*, 10 AM. J.L. & MED. 151, 154 (1984).

48. Scheutzow & Gillis, *supra* note 20, at 181 (“Clearly the peer review privilege was created to encourage peer review and thus protect the institutions performing peer review and not to protect the individuals who were subject to review.”).

49. Brief of the Idaho Hosp. Ass’ns as Amicus Curiae Supporting Respondents, *supra* note 28, at \*13-14 (citing *Bredice v. Doctors Hosp.*, 50 F.R.D. 249, 250 (D.D.C. 1970) (concluding the value of the peer review process would be destroyed if the meetings and the names of those participating were to be opened to the discovery process)).

50. Brief of the Idaho Hosp. Ass’ns as Amicus Curiae Supporting Respondents, *supra* note 28, at \*8 (citing *KD v. United States*, 715 F. Supp. 2d 587, 594 (D. Del. 2010) (citing Ghazal Sharifi, *Is the Door Open or Closed? Evaluating the Future of the Federal Medical Peer-Review Privilege*, 42 J. MARSHALL L. REV. 561, 564 (2009)).

51. Scheutzow & Gillis, *supra* note 20, at 188. As one author opined, peer review laws are: [A] crazy quilt of statutes that pertain to a variety of committees and afford often incomplete or incomprehensible protection to committee members and/or staff, witnesses, documents, spectators, and so forth, but are seldom clear with respect to the exact nature of the protection that is provided to whom, what, or under what circumstances.

Morter, *supra* note 33, at 1132.

52. Morter, *supra* note 33, at 1137. In contrast, the author argues that the application of peer review privilege in a consistent manner will encourage meaningful and effective peer review. *Id.*

53. See Brief of the Idaho Hosp. Ass’ns as Amicus Curiae Supporting Respondents, *supra* note 28, at \*20. The Brief acknowledges that privileges are generally only effective when individuals whose communications are being protected know, at the time of communication, that the communication will be kept private. *Id.* “The United States Supreme Court, among others, has

#### D. *Congress Responds with HCQIA*

Prior to the healthcare reform initiatives and importance placed on peer review discussed herein, Congress recognized the importance of peer review by requiring that hospitals participating in Medicare implement peer review programs.<sup>54</sup> Also, Congress statutorily provided peer review protections of medical programs offered by the Department of Defense and the Department of Veteran Affairs.<sup>55</sup> In 1986, attempting to extend state peer review immunities on a federal level, Congress passed the federal Health Care Quality Improvement Act of 1986 (“HCQIA”).<sup>56</sup>

In short, the HCQIA drafters felt that by improving the peer review process, the quality of healthcare across the country would improve.<sup>57</sup>

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recognized this principle, stating that if the purpose of a privilege is to be served, ‘the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected.’” *Id.* (quoting *Jaffe v. Redmond*, 518 U.S. 1, 18 (1996) (discussing the expansion of the psychotherapist-patient privilege).

54. See Sullivan & Anderson, *supra* note 23, at 51. This recognition originally manifested itself pursuant to Congress’ spending power, when Congress mandated that hospitals have peer review programs to participate in Medicare. See 42 U.S.C.A. § 1320c-3(a) (West 2013).

55. See Sullivan & Anderson, *supra* note 23, at 51-52. Congress has afforded peer review protection for medical programs offered by the Department of Defense and the Department of Veteran Affairs. See 10 U.S.C.A. § 1102(a) (West 2013) (“Medical quality assurance records created by the Department of Defense as part of a medical quality assurance program are confidential and privileged.”). See also 38 U.S.C.A. § 5705(a) (West 2013) (“Records and documents created by the Department [of Veteran Affairs] as part of a medical assurance program . . . are confidential and privileged [absent an exception].”).

56. 42 U.S.C.A. §§ 11101-11152 (West 2013). The HCQIA was an attempt to address the national health care quality assurance problem that was resulting from local peer review committees’ inability to report medical error findings because of the confidentiality requirement of state peer review statutes. Newton, *supra* note 17, at 732. “Consequently, a physician whose privileges were revoked could simply relocate with little fear of having his or her previous incompetence discovered. 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.” *Id.* Responding to this problem, the HCQIA established a framework requiring notification to the National Practitioner Data Bank (“NPDB”) when a hospital board’s decision adversely affects a physician’s privileges for longer than thirty days. *Id.* The reporting requirements are a mandatory provision of the HCQIA and failure to comply may result in the loss of HCQIA immunity. *Id.*

57. 42 U.S.C.A. § 11101. The statute provides an overview of the HCQIA by stating that: Congress finds the following: (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State; (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance; (3) This nationwide problem can be remedied through effective professional peer review; (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer

Congress believed it could improve the peer review process by providing further protection to physicians serving in review capacities by assuring immunity from civil litigation.<sup>58</sup> The HCQIA was designed to shield participants in professional review actions by providing immunity from liability so long as the appropriate procedural requirements were met.<sup>59</sup> Under the HCQIA, the immunity afforded is qualified; requiring that the peer review activity has been conducted:

(1) in the reasonable belief that the action was in furtherance of quality of care (2) after a reasonable effort to obtain the facts of the matter (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts.<sup>60</sup>

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review; and (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

*Id.* “Under this bill, hospitals and physicians that conduct peer review will be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions meet the due process and other standards established in the bill.” H.R. REP. NO. 99-903, at 2 (1986), reprinted in 1986 U.S.C.C.A.N. 6384, 6385. Hospitals and physicians that discipline doctors are required to report these disciplinary actions to the state medical boards, who will forward this information to the Department of Health and Human Services. *Id.* The bill further requires hospitals to query the NPDB before hiring doctors or other licensed health care practitioners. *Id.*

58. Christina A. Graham, Comment, *Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges*, 30 CUMB. L. REV. 111, 113 (1999-2000) (citing 42 U.S.C.A. § 11101 (West 1995)).

59. Lu Ann Trevino, *The Health Care Quality Improvement Act: Sword or Shield?*, 22 T. MARSHALL L. REV. 315, 331 (1997). “Peer reviewers who improperly use the process lose their immunity from liability and discovery.” *Id.* at 328. “Congress meant to prevent peer review committees from using their power and immunity as swords against innocent practitioners.” *Id.* (citing *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322 (1991) (finding that a hospital boycott of a physician and publication of false disciplinary actions were restraint of trade); *Patrick v. Burget*, 486 U.S. 94 (1988) (holding that state-action doctrine did not protect Oregon physicians from federal antitrust liability for their activities on hospital peer review committee actions)).

60. 42 U.S.C.A. §§ 11112(a)(1)-(4). The statute goes onto say that “a professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.” *Id.* Some critics claim the existence of immunity for peer review activities is unnecessary to protect hospitals from damage arising from negligent peer review suits:

According to these critics, if Congress were to repeal the HCQIA tomorrow, and all the state legislatures were to follow suit, hospitals would still have the oft-cited incentive of improving patient care as an impetus to continuing their peer review activities. The flaw in that argument is that the cost of those improvements would increase dramatically, and as the price went up, less health care would be available. To the extent that physicians declined to participate in peer review activities, hospitals could easily rectify that problem by indemnifying them or procuring insurance. In doing so, the cost of peer

Ultimately, while the HCQIA provided the individual peer review committee members immunity from damages liability, it did not extend necessary protections to peer review documents and activities.<sup>61</sup> Thus, as discussed herein, Florida hospitals relying on the HCQIA to protect peer review documents found that Congress did not provide such protection in the HCQIA.<sup>62</sup>

#### *E. Medical Peer Review in Florida*

Prior to Amendment 7, Florida statutes provided expansive peer review protection.<sup>63</sup> Florida restricted patients' access to information regarding adverse medical incidents through a collection of statutes that provided hospitals great latitude to regulate themselves through private action.<sup>64</sup> Often cited Florida case law states that these statutes were enacted to control the escalating cost of health care by encouraging self-regulation by the medical profession through peer review and evaluation.<sup>65</sup> As the Florida Supreme Court acknowledged, "[t]he privilege afforded to peer review committees is intended to prohibit the chilling effect of the potential public disclosure of statements made to or information prepared for and used by the committee in carrying out its peer review function."<sup>66</sup> The Florida legislature made meaningful peer

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review would be borne by hospitals, not patients. Even if that were true, however, the issue would be whether the total cost to society still increased.

Sullivan & Anderson, *supra* note 23, at 58.

61. See, e.g., *West Florida Reg'l Med.Ctr., Inc. v. See*, 18 So. 3d 676 (Fla. 1d D.C.A. 2009) (holding that Congress did not provide for confidentiality or privilege of peer review records or communications, but did provide peer review participants with immunity from liability).

62. See *infra* notes 94-105 and accompanying text.

63. Graham, *supra* note 58, at 125.

64. See, e.g., FLA. STAT. §395.0193(7) (West 2013) and §766.101(5) (West 2013) (establishing confidentiality of proceedings and reports in peer review proceedings); FLA. STAT. §395.0191(8) (West 2013) (granting immunity from discovery to investigations, records, and reports regarding credentialing); FLA. STAT. §395.0193 (West 2013) and §766.101(5) (West 2013) (granting immunity from discovery to peer review investigations, records, and reports); FLA. STAT. §395.0197(6)(c) and (7) (West 2013) (providing confidentiality and privilege protection for annual risk management reports of adverse incidents); FLA. STAT. §766.1016(2) (West 2013) ("Patient safety data shall not be subject to discovery or introduction into evidence in any civil or administrative action."); FLA. STAT. §395.0193(8) (West 2013) (providing testimonial and discovery immunity for investigations, proceedings, and records of the peer review body); FLA. STAT. §395.0193(1) (West 2013) (granting immunity from retaliatory tort suits to physicians participating in the peer review process in good faith).

65. *Cruger v. Love*, 599 So. 2d 111, 113 (1992) (citing *Holly v. Auld*, 450 So.2d 217, 219-20 (1984) (interpreting former section 768.40(4), Florida Statutes, the predecessor to section 766.101)).

66. *Cruger*, 599 So.2d at 114-115. Expanding on the reasons stated above for why many physicians dislike peer review, the *Cruger* court stated that this chilling effect is attributable to several factors; specifically, doctors are reluctant to engage in peer review because they fear "loss of

review possible by providing a guarantee of confidentiality for the peer review process, most explicitly in Florida Statute, Section 766.101(5).<sup>67</sup> Florida courts, relying on the collection of statutes referenced above, consistently upheld a liberal interpretation of Florida's peer review confidentiality and privilege laws.<sup>68</sup>

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referrals, respect, and friends, possible retaliations, vulnerability to torts, and fear of malpractice actions in which the records of the peer review proceedings might be used." *Id.* at 115 (citing Gregory G. Gosfield, *Medical Peer Review Protection in the Health Care Industry*, 52 TEMP. L. Q. 552, 558 (1979)).

67. See *Cruger*, 599 So.2d at 113. Florida Statutes Section 766.101(5) reads:

The investigations, proceedings, and records of a [medical review] committee . . . shall not be subject to discovery or introduction into evidence in any civil action against a provider of professional health services arising out of the matters which are the subject of evaluation and review by such committee, and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, or other actions of such committee or any members thereof.

FLA. STAT. §766.101(5) (West 2013). For examples of other State statutes accomplishing similar purposes, see, e.g., ALA. CODE §22-21-8 (West 2012) ("Written reports, records, correspondence . . . shall be held in confidence and shall not be subject to discovery or introduction in evidence in any civil action against a health care professional or institution arising out of matters which are the subject of evaluation and review . . ."); ARIZ. REV. STAT. ANN. §36-445.01 (West 2013) ("All proceedings, records and materials prepared in connection with [peer] reviews . . . including all peer reviews of individual health care providers practicing in and applying to practice in hospitals or outpatient surgical centers and the records of such reviews, are confidential and are not subject to discovery."); CONN. GEN. STAT. §19a-17b(d) (West 2013) ("The proceedings of a medical review committee conducting a peer review shall not be subject to discovery or introduction into evidence in any civil action for or against a health care provider arising out of the matters which are subject to evaluation and review by such committee . . ."); D.C. CODE §44-805(a)(1) (West 2012) ("The files, records, findings, opinions, recommendations, evaluations, and reports of a peer review body . . . shall be confidential and shall be neither discoverable nor admissible into evidence in any civil, criminal, legislative, or administrative proceeding."); GA. CODE ANN. §31-7-133(a) (West 2013) ("The proceedings and records of a review organization shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action . . ."); N.C. GEN. STAT. §90-21.22(e)(f) (West 2013) ("No person participating in good faith in the peer review [program] . . . shall be required in a civil case to disclose any information acquired or opinions, recommendations, or evaluations acquired or developed solely in the course of participating in [peer review].").

68. See *Monroe Reg'l Med. Ctr., Inc. v. Roundtree*, 721 So. 2d 1220 (Fla. Dist. Ct. App. 1998) (holding that a defendant doctor is not required to disclose matters which were the subject of evaluation and review by a medical peer review committee regarding the doctor's staff privileges that were taken during an oral deposition because the information concerning the actions taken by the committee are protected by the peer review statute); *Cruger*, 599 So.2d at 111 (holding that mother's request for copies of physician's applications for hospital privileges after physician's alleged negligent treatment of her son's fractured thumb were protected because statutory privilege protects any document considered by medical review committee or hospital board as part of its decision-making process); *Holly v. Auld*, 450 So.2d 217 (Fla. 1984) (holding that discovery privilege is not limited to medical malpractice actions and, in fact, includes defamation actions arising out of the matters which are the subject of evaluation and review by hospital credentials

The paradigm shift from expansive protection to Amendment 7 resulted from a decades-long battle between doctors, insurance companies, and tort reformers on one side, and trial lawyers, patients' rights advocates, and civil justice proponents on the other.<sup>69</sup> Many defense lawyers believe that Amendment 7 was proposed by plaintiff lawyers as a direct response to Article I, Section 26 of the Florida Constitution, entitled "Claimant's Right to Fair Compensation," commonly known as Amendment 3 ("Amendment 3").<sup>70</sup> Amendment 3 was another 2004 Florida initiative championed by the Florida Medical Association that sought tort reform by delineating attorney caps on non-economic damages in medical malpractice negligence actions, essentially ensuring a greater percentage of the damage award to the claimant.<sup>71</sup>

Due to a well-coordinated effort launched by Floridians for Patient Protection<sup>72</sup> over 480,000 signatures were secured to put the Amendment 7 initiative on the ballot.<sup>73</sup> Amendment 7 was approved by

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committees).

69. J.B. Harris, *Riding the Red Rocket: Amendment 7 and the End to Discovery Immunity of Adverse Medical Incidents in the State of Florida*, 83-MAR FLA. B. J. 20 (2009) (citing Mary Ellen Klas, Doctors, *Lawyers Wage Fierce Battle on State Ballot*, MIAMI HERALD, Oct. 28, 2004, available at <http://www.highbeam.com/doc/1G1-123718964.html>).

70. Amendment 3 states:

In any medical liability claim involving a contingency fee, the claimant is entitled to receive no less than 70% of the first \$250,000.00 in all damages received by the claimant, exclusive of reasonable and customary costs, whether received by judgment, settlement, or otherwise, and regardless of the number of defendants. The claimant is entitled to 90% of all damages in excess of \$250,000.00, exclusive of reasonable and customary costs and regardless of the number of defendants. This provision is self-executing and does not require implementing legislation.

FLA. CONT. art I, § 26.

71. Eric S. Matthew, *A New Prescription: How a Thorough Diagnosis of the "Medical Malpractice" Amendments Reveals Potential Cures for Florida's Ailing Citizen Initiative Process*, 14 U. MIAMI BUS. L. REV. 331, 350-351 (2006). The Florida Medical Association was dissatisfied with the caps on noneconomic damages it achieved in 2003 and decided to ask voters to place a drastic cap on contingency fees for plaintiff lawyers in malpractice cases. *Fla. Physicians, Plaintiffs Lawyers Battle Over Med-Mal Discovery*, INJURYBOARD.COM (Oct. 28, 2005, 10:56 AM), <http://orlando.injuryboard.com/medical-malpractice/fla-physicians-plaintiffs-lawyers-battle-over-med-mal-discovery.aspx?googleid=200192>. When the Academy of Florida Trial Lawyers counterattacked with Amendment 7, hospitals, businesses, and insurance groups tried unsuccessfully to convince the Florida Medical Association doctors to drop their initiative in exchange for getting the plaintiffs lawyers to drop their initiative. *Id.*

72. *Floridians for Patient Protection* was affiliated with the Academy of Florida Trail Lawyers and the Florida Lawyers Action Group. Sawran & Weill, *supra* note 45, at n. 3.

73. Laura V. Yaeger, *Amendment 7: Medical Tradition v. The Will of the People: Has Florida's Peer Review Privilege Vanished*, 13 MICH. ST. U. J. MED & L. 123, 127 (2009). Interest in Amendment 7 was heightened due to Amendment 3, which passed in 2004 and severely restricted attorney contingency fees in malpractice suits. See Mary Coombs, *How Not to do Medical*

the Florida electorate on November 2, 2004 with over eighty-one percent of affirmative votes.<sup>74</sup> Amendment 7's passage came to symbolize the public's long-standing frustration over a perceived "protect our own" mentality that shielded from public scrutiny even the most dangerous doctors and hospitals.<sup>75</sup>

Amendment 7 states that "patients have a right to access any records made or received in the course of business by a health care facility or provider relating to any adverse medical incident."<sup>76</sup> Amendment 7 significantly eroded longstanding privileges and immunities surrounding Florida's peer review, credentialing, investigations, quality assurance, and risk assessments as they applied to hospitals.<sup>77</sup> For example, courts found that Florida Statutes, Sections 395.0191(8) and 766.101(5), once utilized to protect medical peer review records, were preempted by Amendment 7.<sup>78</sup> By granting access

*Malpractice Reform: A Florida Case Study*, 18 HEALTH MATRIX 373, 386 (2008).

74. See *supra* note 1 and accompanying text. As an indication of Amendment 7's popularity, 5,849,125 citizens voted for it, while only 1,358,183 voted against it. *Id.*

75. Harris, *supra* note 69, at 20 ("In the public's view, allowing the medical profession to continue to monitor itself, while hiding behind the veil of secrecy, had over time become like the proverbial fox guarding the hen house.").

76. FLA. CONST. art. X, §25. The statute provides that the following terms have the following meaning:

- (1) The phrases "health care facility" and "health care provider" have the meaning given in general law related to a patient's rights and responsibilities.
- (2) The term "patient" means an individual who has sought, is seeking, is undergoing, or has undergone care or treatment in a health care facility or by a health care provider.
- (3) The phrase "adverse medical incident" means medical negligence, intentional misconduct, and any other act, neglect, or default of a health care facility or health care provider that caused or could have caused injury to or death of a patient, including, but not limited to, those incidents that are required by state or federal law to be reported to any governmental agency or body, and incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials, or similar committee, or any representative of any such committees.
- (4) The phrase "have access to any records" means, in addition to any other procedure for producing such records provided by general law, making the records available for inspection and copying upon formal or informal request by the patient or a representative of the patient, provided that current records which have been made publicly available by publication or on the Internet may be "provided" by reference to the location at which the records are publicly available.

*Id.* (cited in Florida Eye Clinic, P.A. v. Gmach, 14 So. 3d 1044, 1045 (Fla. Dist. Ct. App. 2009).

77. Harris, *supra* note 69, at 20. The rationale for such protections had been that by ensuring full, frank, and open peer review and self-evaluation, the quality of patient care improves. Holly v. Auld, 450 So. 2d 217, 220 (Fla. 1984); see also Cruger v. Love, 599 So.2d 111, 114 (Fla. 1992).

78. See West Florida Reg'l Med. Ctr. Inc. v. See, No. SC09-1997, 2012 WL 87282 (Fla. Jan. 12, 2012) (finding that even if the document in question is considered to be within the protections of sections 766.101(5) and 395.0191(8), Amendment 7 mandates its disclosure because the document is a record of an adverse medical incident). Here, a blank application form upon which information was placed to generate a medical staff application was an adverse medical incident record because it

to such documents, not only were hospitals exposed to new potential liabilities and increased financial burdens, but peer review in Florida was changed forever by new disincentives for both hospitals and its peer review committee members.<sup>79</sup>

Evidently concerned by the initiative's outcome, which essentially allowed Amendment 7 implementation to bypass all three branches of government, Florida's legislature passed an enabling statute ("Enabling Statute")<sup>80</sup> during the 2005 regular sessions which restricted Amendment 7.<sup>81</sup> Many argue that the legislature's response was a clear statement they believed the pendulum had swung too far and that the benefit to current and future patients of having easy access to adverse medical incident information is attenuated, while the harmful effect on physicians' willingness to participate in peer review is far more direct.<sup>82</sup> "Metaphorically speaking, the electorate inadvertently supported Amendment 7 which treats the disease (tort reform hindering plaintiff attorneys) instead of the patient (health care as a whole)."<sup>83</sup>

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was pertinent to the process and procedure that led to the alleged negligent grant of medical staff privileges. *Id.*

79. Yaeger, *supra* note 73, at 148 (predicting the potential costs involved in responding to Amendment 7 document requests will be enormous with hospitals unequipped with the staff to respond timely).

80. See FLA. STAT. ANN. §381.028 (West 2013). Significantly, § 381.028(6)(a) and (b) provided that Amendment 7 neither repealed restrictions on the admissibility of records to adverse medical incidents, nor made them discoverable or admissible into evidence for any purpose, including impeachment, in any civil or administrative action against a health care facility or health care provider. *Id.* The intent of these provisions was to keep intact the long standing privileges and immunities surrounding peer review, credentialing, investigations of adverse medical incidents, quality assurance, and risk assessment set forth under § 395.0191, 395.0193, 395.0197, 766.101, and 766.1016, the very statutes Amendment 7 aimed to modernize. See Florida Hosp. Waterman, Inc. v. Buster, 984 So. 2d 478 (Fla. 2008)).

81. Matthew, *supra* note 71, at 332.

82. Coombs, *supra* note 73, at 424. "Perhaps the most lacking element of the Florida initiative process is that no law requires disseminating information about potential long-term ancillary effects of passing individual or multiple initiative . . . . Unfortunately, most citizens were unaware of the potential downsides of enacting these initiatives . . ." Matthew, *supra* note 71, at 346. See Holly v. Auld, 450 So. 2d 217, 220 (1984) (noting the court's assumption that the legislature balanced the potential benefit to providing broad disclosure of evidence against the potential for health care cost containment offered by effective self-regulation, finding the latter to be of greater weight; this careful balancing is exactly the kind of policy judgment which is exclusively the responsibility of the legislature rather than the courts). The Holly court's statement furthers the argument against Florida's citizen initiative process which allows laws to bypass all branches of government and the requisite policy judgment checks and balances. See Matthew, *supra* note 71, at 332.

83. Matthew, *supra* note 71, at 350-351. While on its surface Amendment 7 helps patients acquire important information, the fact that Amendment 7 advocates so easily downplayed the obvious importance of privilege in the medical setting demonstrates the shortcomings of Florida's initiative process. *Id.* at 351. As one author states:

A frenzy of litigation followed the Enabling Statute that resulted in conflicting and opposing outcomes.<sup>84</sup> In March 2008, in *Florida Hospital Waterman, Inc. v. Buster*, (“*Buster II*”),<sup>85</sup> which was appealed from a Florida District Court, (“*Buster III*”),<sup>86</sup> the Florida Supreme Court weighed in and invalidated several provisions of the Enabling Statute, finding that they were in conflict with Amendment 7.<sup>87</sup> Specifically, the Florida Supreme Court held that Amendment 7 was self-executing, applied retroactively to existing records and its retroactive application does not violate a hospital’s due process rights.<sup>88</sup>

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The ancillary effects of the medical malpractice amendments reveal that Florida’s citizen initiative process is in a quandary: special interest groups propose self-serving amendments; initiatives are presented to Florida voters without sufficient deliberation; the summarizing text of an initiative can understate its wide-ranging socioeconomic effects; there is no substantive review of the initiatives.

*Id.* at 351.

84. Yaeger, *supra* note 73, at 132. The divergent outcomes included several Florida court cases including the following decisions: *Florida Hosp. Waterman, Inc. v. Buster*, 932 So. 2d 344 (Fla. Dist. Ct. App. 2006) (“*Buster I*”) (holding that Amendment 7 is self-executing); *Notami Hosp. of Fla., Inc. v. Bowen*, 927 So. 2d 139 (Fla. Dist. Ct. App. 2006) (holding that Amendment 7 is self-executing, applies retroactively, and that the statute purporting to implement Amendment 7 is unconstitutional); *Bayfront Med. Ctr. v. Neavins*, 920 So.2d 185, 186-87 (Fla. Dist. Ct. App. 2006) (dismissing petition for writ of certiorari as mooted by passage of the Patients’ Right-to-Know About Adverse Medical Incidents Act); *Rusiecki v. Jackson-Curtis*, No. 03-008570-CI-21, 2005 WL 408133, at \*1 (Fla. Cir. Ct. Jan. 31, 2005) (holding that Amendment 7 was not self-executing and cannot be applied retroactively to impair vested privacy and privilege rights); *Richardson v. Nath*, No. 04-006970-01-21, 2005 WL 408132, at \*1 (Fla. Cir. Ct. Jan. 18, 2005) (holding that Amendment 7 was not self-executing and cannot be retroactively applied to impair the hospital’s vested rights).

85. 984 So.2d 478 (Fla. 2008).

86. 932 So. 2d 344 (Fla. 5d D.C.A. 2006)

87. *Id.*

88. *Id.* at 481. In concluding that Amendment 7 is self-executing, the *Buster II* Court applied the standard set forth in *Gray v. Bryant*, 125 So. 2d 846, 851 (Fla. 1960), stating that a constitutional provision should be self-executing if it “lays down a sufficient rule by means of which the right or purpose which it gives or is intended to accomplish may be determined, enjoyed, or protected without the aid of legislative enactment.” *Buster II*, 984 So. 2d at 485. Applying *Gray’s* standard, the *Buster II* Court held that Amendment 7 provides a sufficient rule by which patients can gain access to records of a health care provider’s adverse medical incidents. *Id.* at 486. The court supports its conclusion by stating that Amendment 7 expressly declares that it will be effective on passage, indicating that its effectiveness in overriding prior statutory law was not to be dependent upon the enactment of implementing legislation. *Id.*

In deciding that Amendment 7 applied retroactively, the *Buster II* Court relied on its two-prong analysis articulated in *Metro. Dade Cnty v. Chase Fed. Hous. Corp.*, 737 So. 2d 494 (Fla. 1999). *Buster II*, 984 So. 2d at 487. The first prong analyzes whether there is clear legislative intent to apply the statute retroactively, and the second prong focuses on whether retroactive application is constitutionally permissible. *Buster II*, 948 So. 2d at 486-487 (citing *Chase Fed.*, 737 So. 2d at 499). *Buster II* focused on the plain language of the Amendment to satisfy the first prong, and concluded that the guarantee of confidentiality previously afforded adverse medical incident reports and peer review committees did not create a vested right, and thus, the retroactive application is not

Based on this holding several provisions of the Enabling Statute that limited access to information granted by Amendment 7 were invalidated.<sup>89</sup> Specifically, the *Buster II* court identified five conflict provisions between Amendment 7 and the Enabling Statute, and concluded the following language should be severed from the statute: (1) language stating that only final reports were discoverable; (2) language providing for disclosure of only final reports relating to the same or substantially similar condition, treatment or diagnosis with that of the patient requesting access; (3) limitations to produce only those records generated after November 2, 2004; (4) language stating that that Amendment 7 will have no effect on existing privilege statutes; and (5) language providing that patients can only access the records of a facility or provider in which they are a patient.<sup>90</sup> Consequently, *Buster II*'s ruling preserved the broad interpretation of Amendment 7, eroding completely any peer review protections in Florida.<sup>91</sup> Hospital insiders believe that since Amendment 7 passed, meaningful peer review has come to a screeching halt, stating further that it was already difficult to get physicians to engage in peer review prior to Amendment 7 and that it will now be impossible.<sup>92</sup> Physician resistance to peer review participation appeared warranted as hospitals began to see an influx of Amendment 7 motions to compel peer review documents after the

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unconstitutional. *Buster II*, 984 So. 2d at 490. The Court then used language from Div. of Workers' Comp. v. Brevda, 420 So. 2d 887 (Fla. Dist. Ct. App. 1982) which read: "to be vested, a right must be more than a mere expectation based on an anticipation of the continuance of an existing law; it must have become a title, legal or equitable, to the present or future enforcement of a demand . . ." *Brevda*, 420 So.2d at 891 (cited in *Buster II*, 984 So. 2d at 491). Based on this language, the *Buster II* Court found that the hospital's claim rests on a mere expectation of the continuance of the legislative policy of limited access to the proceedings of peer review committees. *Buster II*, 984 So. 2d at 490. In concluding that Amendment 7 applied to existing records, the *Buster II* Court agreed with the succinct analysis from *Notami Hosp.* which stated:

Here, the plain language of the amendment permits patients to access any record relating to any adverse medical incident, and defines 'patient' to include individuals who had previously undergone treatment. The use of the word "any" to define the scope of discoverable records relating to adverse medical incidents, and the broad definition of 'patient' to include those who 'previously' received treatment expresses a clear intent that the records subject to disclosure include those created prior to the effective date of the amendment. The effective date merely sets forth the date patients obtained the right to receive the records requested. Because the plain language of the amendment expresses a clear intent that it be applied to include records created prior to its effective date, doing so is not an unconstitutional retroactive application.

*Buster II*, 984 So. 2d at 487 (quoting *Notami Hosp.*, 927 So. 2d at 145).

89. *Buster II*, 984 So. 2d at 492.

90. *Id.* at 492-493.

91. See Yaeger, *supra* note 73, at 147.

92. *Id.* at 148 (citing an interview with a member of a Florida hospital's executive staff).

*Buster II* decision.<sup>93</sup>

### III. STATEMENT OF THE ISSUE

#### A. *Hospitals Search for Amendment 7 Protection*

As Florida hospitals scrambled to protect peer review documents, a primary argument was that the HCQIA serves as a definitive expression of policy favoring a statutory peer review privilege.<sup>94</sup> Courts arriving at the opposite conclusion concede that the HCQIA placed importance on maintaining immunity for participants of the peer review process, but believe that Congress “spoke loudly with its silence in not including a privilege against discovery of peer review material in the HCQIA.”<sup>95</sup>

Several federal courts recognized the lack of an explicit medical peer review privilege in the HCQIA and deemed this a policy choice by Congress.<sup>96</sup> As one federal court in Ohio stated:

Far from creating a broad privilege, Congress, in enacting the HCQIA, carefully crafted a very specific privilege, applicable to peer review material submitted to the Secretary [of Health and Human Services] pursuant to the dictates of the mandatory reporting provisions of that statute. That is as far as Congress went, and that is as far as this Court should apply the privilege contained therein.<sup>97</sup>

Two Florida court of appeals cases have similarly held that no federal statutory peer review privilege was created by the HCQIA. *West*

93. *e.g.*, *Florida Hosp. Assoc. v. Viamonte*, No. 4:08cv312-RH/WCS, 2008 WL 5101755, at \*2 (N.D. Fla. Nov. 26, 2008) (finding that the Florida Hospital Association had received 400 demands for information under Amendment 7). Prior to Amendment 7, the Florida Hospital Association would have refused many of the requests for information and would have been within their right under Florida statutes to do so. *Id.* However, post-Amendment 7, they now must either provide the information against their wishes or risk fine or enforcement action. *Id.*

94. *Bassler*, *supra* note 15, at 703-704. Specifically, advocates point to the way in which HCQIA alleviates physicians’ fear of participating in peer review by reducing potential liability, establishing detailed reporting requirements for reporting settlements, judgments and arbitration awards, and setting forth requirements for peer review immunity. *Id.*

95. *Id.* at 704 (quoting *United States v. QHG of Ind., Inc.*, No. 1:97-CV-174, 1998 WL 1756728, at \*7 (N.D. Ind. Oct. 8, 1998)).

96. *See, e.g.*, *In re Admin. Subpoena Blue Cross Blue Shield of Mass., Inc.*, 400 F.Supp.2d 386, 391-92 (D. Mass. 2005); *Nilavar v. Mercy Health Sys.-W. Ohio*, 210 F.R.D. 597 (S.D. Ohio 2002); *Teasdale v. Marin Gen. Hosp.*, 138 F.R.D. 691, 694 (N.D. Cal. 1991); *Mattice v. Mem’l Hosp. of S. Bend*, 203 F.R.D. 381, 386-87 (N.D. Ind. 2001) (concluding that the HCQIA does not privilege peer review materials and that these materials are therefore discoverable).

97. *Nilavar*, 210 F.R.D. at 602 (holding that physician peer review privilege was nonexistent within federal common law, and extensive authority, as well as “reason and experience,” prevented against adopting it in action).

*Florida Regional Medical Center, Inc. v. See*<sup>98</sup> involved a petitioner's argument that Amendment 7 violates the Supremacy Clause of the United States Constitution because it is impliedly preempted by the federal HCQIA.<sup>99</sup> In arriving at its conclusion, the court stated that in enacting the HCQIA, Congress did not provide for confidentiality or privilege of peer review records or communications, but did provide peer review participants with immunity from liability for damages with respect to their participation in such actions.<sup>100</sup> The court continued by stating that the HCQIA further provides the following instruction:

Except as specifically provided in this subchapter, nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter.<sup>101</sup>

The court concluded its analysis that the HCQIA did not preempt Amendment 7 by stating, "Congress expressly dealt with the issue of immunity from liability for communications related to peer review and with the issue of preemption of laws concerning such protections."<sup>102</sup> In *Columbia Hosp. Corp. of South Broward v. Fain*,<sup>103</sup> the Florida court of appeals used a parallel argument to *See* to reject the hospital organization's argument that Amendment 7 is impliedly preempted by the HCQIA by concluding that "the abolition of peer review discovery protections is contrary to the Act's intent to foster 'effective peer review.'"<sup>104</sup>

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98. 18 So. 3d 676 (Fla. 1d D.C.A. 2009).

99. *Id.* at 684.

100. *Id.* at 685.

101. *Id.*

102. *West Florida Reg'l Med. Ctr., Inc. v. See*, 18 So. 3d at 685. The court continued by quoting the HCQIA, saying that Congress further expressed the following intent:

Nothing in this chapter shall be construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity, or as limiting any defenses or immunities available to any physician, health care practitioner, or health care entity.

*Id.* at 685-686 (citing 42 U.S.C.A. §11115 (West 2013)). The *See* court found that Congress again fell short of addressing the confidentiality or privileged status of records generated in peer review processes, but did express its intent not to undermine the ability of patients to seek redress for medical malpractice. *See*, 18 So. 3d at 686.

103. 16 So. 3d 236, 242 (Fla. Dist. Ct. App. 2009).

104. *Id.* at 242. Here, the Florida court of appeals uses language from subchapters I and II of the HCQIA to conclude that under the HCQIA, Florida's statutes, which had provided greater protection and incentives by providing discovery protections for peer review proceedings, were

Impacted significantly because of the absence of explicit protection for peer review, and despite its legislative history focusing on encouraging meaningful peer review through appropriate protection, the HCQIA alone was not enough to defeat Amendment 7.<sup>105</sup> Left to alternate arguments, hospitals unsuccessfully argued for protection under work-product privilege,<sup>106</sup> impairment of contracts,<sup>107</sup> and that certain Amendment 7 requests were irrelevant, overbroad and/or unduly

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expressly not preempted. *Id.* HCQIA Subchapter I contains provisions regarding how it is to be construed with state law and provides: “nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting . . . any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter.” 42 U.S.C.A. § 11115(a) (West 2013). Subchapter II of the HCQIA provides for limited confidentiality of certain reports which must be submitted for inclusion in a national database. 42 U.S.C.A. § 11137(b)(1) (West 2013). *Fain* contended that the provisions of Subchapter I and II of the HCQIA work in tandem and that peer review cannot be “effective” if the discovery protections previously afforded by Florida’s statutes are abrogated by Amendment 7. *Fain*, 16 So. 3d at 242-243. However, in *Buster II*, the Florida Supreme Court made clear that the limited discovery protections previously afforded by Florida’s statutes were effectively abolished by the passage of Amendment 7. *Id.* at 243 (citing *Buster II*, 984 So. 2d at 488-89). “These discovery protections were not mandated by the HCQIA, and while they may have contributed to effective peer review in Florida, the people of the State of Florida are not preempted from abolishing these statutory protections by constitutional amendment.” *Fain*, 16 So. 3d at 243. The *Fain* court concluded that Columbia’s disagreement with Amendment 7 is not sufficient to overcome the presumption of its constitutionality or to demonstrate a departure from the essential requirements of law. *Id.*

105. See *supra* notes 94-104 and accompanying text.

106. See *Lakeland Reg’l Med. Ctr. v. Neely ex rel. Neely*, 8 So. 3d 1268 (Fla. Dist. Ct. App. 2009) (finding that while records prepared in anticipation of litigation are prepared by clients, at least in part, to assist lawyers, this line of reasoning was insufficient to override the broad right of access to adverse medical incident reports guaranteed under Amendment 7 which was intended to provide a clear path to access medical incident records); *Florida Eye Clinic v. Gmach*, 14 So. 3d 1044 (Fla. Dist. Ct. App. 2009) (finding that Amendment 7 supersedes any fact work-product privilege because Amendment 7 expresses a clear intent that patient have a right to access any record made or received in the course of business that relates to an adverse medical incident). Notably, the *Gmach* court went on to note a distinction between “fact” work-product and “opinion” work-product, noting that it did not read Amendment 7 as “evinced an intent from the voters to eliminate the privilege of opinion work product.” *Id.* at 1050. Thus, the *Gmach* court held that there was a distinction between opinion work-product and fact work-product, bringing to light the necessity of understanding precisely which documents a medical provider is attempting to shield using the work-product privilege. *Id.*

107. See *Fain*, 16 So. 3d at 236 (holding that Amendment 7 does not violate the Contracts Clause on the basis that the amendment impaired contracts between the hospital and its doctors providing for confidentiality of peer review proceedings because the impairment was not severe and the public’s interest in providing for broad discoverability of adverse medical incident reports met the constitutional hurdle); *West Florida Reg’l Med. Ctr. v. See*, 18 So. 3d 676 (Fla. Dist. Ct. App. 2009) (holding that Amendment 7 does not operate as a substantial impairment of the contractual relationship between a hospital and its staff by preventing the hospital from honoring confidentiality provisions in its medical staff bylaws, and therefore, Amendment 7 does not violate the Federal Contracts Clause; additionally, the plain language of the bylaws expressly limited guarantee of confidentiality to the extent permitted by law).

burdensome.<sup>108</sup> Seemingly left without a defense to Amendment 7 motions, Florida hospitals received its strongest defense yet in the form of new federal legislation.<sup>109</sup>

*B. Patient Safety and Quality Improvement Act (“PSQIA”)*

Faced with plaintiffs’ attorneys circumventing state laws with strong peer review protections and other states, like Florida, eroding away peer review protections, Congress was forced to reconsider the federal statutory protections afforded peer review to ensure a meaningful process.<sup>110</sup> Congress responded with the PSQIA, stating in its legislative history that: “[c]urrently, the State peer review protections are inadequate to allow the sharing of information to promote patient safety.”<sup>111</sup> This conclusion was supported with a 1999 Institute of Medicine (IOM) report, entitled *To Err is Human*,<sup>112</sup> which estimated that as many as 98,000 Americans die each year from preventable medical errors.<sup>113</sup> Differentiating from the HCQIA’s catalyst which

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108. See *Fain*, 16 So. 3d at 240 (holding that a request for Amendment 7 materials is not an ordinary discovery request that may be subjected to overbreadth, irrelevance, or burdensomeness objections because pursuant to Amendment 7, a patient has the absolute right to discover records relating to any adverse medical incident and that right is not conditioned on the discovery being relevant to a pending claim); *Amisub North Ridge Hosp., Inc. v. Sonaglia*, 995 So. 2d 999 (Fla. Dist. Ct. App. 2008) (finding that Amendment 7 does not limit the definition of a patient to one seeking the information for any type of proper purpose; thus Amendment 7 does not require the information that a patient seeks to be relevant to a pending medical malpractice action or to a medical care decision); *Morton Plant Hosp. Ass’n, Inc. v. Shahbas ex rel. Shahbas*, 960 So. 2d 820 (Fla. Dist. Ct. App. 2007) (holding that whether a request is overly burdensome is not a relevant consideration for an Amendment 7 request).

109. See *infra* notes 111, 118-123 and accompanying text.

110. Brief of the Idaho Hosp. Ass’ns as Amicus Curiae Supporting Respondents, *supra* note 28, at \*9 (discussing the PSQIA’s broad approval of the medical peer review process and more sweeping evidentiary protections that are now afforded peer review individuals and documents).

111. S. REP. NO. 109-544, at 3 (2005).

112. COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM* (Linda T. Kohn et. al. eds., 2000).

113. *Id.* “The report emphasizes the need to make system improvements and advises that health care information reporting systems must develop and implement processes through which medical error information can be identified, analyzed and utilized to prevent further medical errors.” S. REP. NO. 108-196, at 2 (2003) (discussing *To Err Is Human*, *supra* note 112)). Unfortunately, society’s long-standing reliance on the threat of malpractice litigation discourages health care professionals and organizations from disclosing, sharing, and discussing information about medical errors. S. REP. NO. 108-196, at 2 (2003). Unlike civil actions, the IOM’s systems-based approach focuses on prospective systematic safety remedies, rather than on retrospectively applying blame, thus working to prevent future error. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 399.

In *To Err is Human* and subsequent reports, the IOM recommends a tiered approach to improve the quality of care: federal protections for a voluntary error reporting system

focused on the need “to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance,”<sup>114</sup> the PSQIA addressed the broader problem of systematic failures in the delivery of health care that resulted in preventable adverse events. Specifically, the PSQIA stated, “One of the main conclusions was that the majority of medical errors do not result from individual recklessness or the actions of a particular group; rather, most errors are caused by faulty systems, processes, and conditions that lead people to make mistakes or fail to prevent adverse events.”<sup>115</sup>

In a 2003 report on the PSQIA, the Senate declared its intent to remedy this situation by “promoting a learning environment . . . to move beyond the existing culture of blame and punishment . . . to a ‘culture of safety’ that focuses on . . . the prevention of future medical errors” in an effort to increase patient safety.<sup>116</sup> With its mission clear, on July 29, 2005, the PSQIA was signed into law.<sup>117</sup>

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(which is the focus of this bill); a narrowly focused mandatory reporting system to collect standardized information by State governments about adverse events that result in death or serious harm . . . increased investment in information technology; establishing a national focus to create leadership and enhance the knowledge base about safety; raising standards and expectations for improvements in safety; and creating safety systems inside health care organizations through the implementation of safe practices at the delivery level. Enactment of [the PSQIA] is a significant step in an ongoing effort to improve the quality of care provided to all Americans.

S. REP. NO. 108-196, at 2 (2003).

114. *KD ex. rel. Dieffenbach v. United States*, 715 F.Supp. 2d 587, 595 (2010) (citing 42 U.S.C.A. § 11101(2) (West 2013)).

115. *Dieffenbach*, 715 F.Supp. 2d at 595 (quoting Patient Safety and Quality Improvement, 73 Fed. Reg. 8112, 8112-13 (Feb. 12, 2008)). *Dieffenbach* also quoted the same PSQIA Federal Register content by citing that:

Much of the impetus for this legislation can be traced to the publication of the landmark report, ‘To Err is Human,’ by the Institute of Medicine in 1999 [which] cited studies that found that at least 44,000 people and potentially as many as 98,000 people die in U.S. hospitals each year as a result of preventable medical errors. Based on these studies and others, the Report estimated that the total national costs of preventable adverse events . . . to be between \$17 billion and \$29 billion, of which health care costs represent one-half.

*Dieffenbach*, 715 F.Supp. 2d at 595 (quoting Patient Safety and Quality Improvement, 73 Fed. Reg. 8112, 8112-13 (Feb. 12, 2008)).

116. *Dieffenbach*, 715 F. Supp.2d at 595 (quoting S. REP. NO. 108-196, at 2 (2003)).

117. Patient and Safety Quality Improvement Act of 2005, Pub. L. No. 109-41, 119 Stat. 424 (2005) (codified at 42 U.S.C. §§ 299b-21 to -26 (2013)). In remarks made at the time the PSQIA was signed into law, President George W. Bush stated that the PSQIA is a “commonsense law” designed to allow others to learn from the collective experiences of physicians and nurses by protecting providers who report critical patient safety information. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 407 (citing *Remarks on Signing the Patient Safety and Quality Improvement Act of 2005*, 41 WEEKLY COMP. OF PRESIDENTIAL DOCUMENTS 1227 (July 29, 2005)).

In short, the PSQIA guarantees confidentiality and provides a privilege to patient safety work product (“PSWP”) that is voluntarily submitted to a patient safety organization (“PSO”).<sup>118</sup> The PSQIA was drafted “to ensure that this legislation strikes the appropriate balance between plaintiff rights and creating a new culture in the health care industry that provides incentives to identify and learn from errors.”<sup>119</sup> The PSQIA extends state peer review protections to patient safety and quality improvement materials that are collected and analyzed by hospitals for internal use or shared for the purposes of improving patient safety and quality of care.<sup>120</sup>

Testimony received by Congress made it clear that a “safe harbor” must be created for the reporting of medical error information, or no provider would gather and report such data because the risk of liability was too great.<sup>121</sup> Thus, while the PSQIA fails to mention peer review explicitly, its extensive discussion of broad federal protection in its legislative history makes it clear that Congress intended that the PSQIA protect the peer review process.<sup>122</sup>

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118. 42 U.S.C.A. § 299b-22 (West 2013).

119. S. REP. NO. 108-196, at 3 (2003). This Senate Report stated that the PSQIA recognizes that patient safety can best be improved by fostering efforts to identify and fix errors while ensuring that providers remain accountable. *Id.*

120. *Id.* at 2. The PSQIA privilege encompasses not only the report to the PSO but also: [A]ll aspects of the analysis of, and subsequent corrective actions related to, adverse events, medical errors, and ‘near misses’ reported as patient safety data. It covers all deliberations, including oral and written communications, and work products that meet the requirements for patient safety data. This legislation also establishes confidentiality protections for this written and oral patient safety data to promote the reporting of medical errors. As a result, health care providers will be able to report and analyze medical errors, without fear that these reports will become public or be used in litigation. This nonpunitive environment will foster the sharing of medical error information that is a significant step in a process to improve the safety, quality, and outcomes of medical care.

*Id.* at 4. *See also Dieffenbach*, 715 F.Supp. 2d at 595-96.

121. S. REP. NO. 108-196, at 1 (2003). While the PSQIA’s confidentiality and privilege protections are broad, limited disclosures are allowed under certain conditions. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 412. The most significant exception involves the disclosure of patient PSWP during criminal proceedings. *Id.* PSWP may be disclosed if the court determines that the information contains material evidence that cannot be reasonably obtained from another source. *Id.* (citing 42 U.S.C.A. § 299b-22(c)(1)(A) (West 2013)). Disclosures are also permitted to law enforcement officials if a provider reasonably believes PSWP is necessary to facilitate criminal law enforcement activity and between authorized entities. *See* 42 U.S.C.A. § 299b-22(c)(2)(G); 42 U.S.C.A. § 299b-22(c)(2).

122. *See* Kathryn Leaman, *Let’s Give Them Something to Talk About: How the PSQIA may Provide Federal Privilege and Confidentiality Protections to the medical Peer Review Process*, 11 MICH. ST. U. J. MED & L. 177, 193 (2007). “[A] possible benefit from omitting the term ‘peer review’ from the [PSQIA] is that it allowed Congress to expand the class of activities generating protected patient safety information beyond the limited scope of peer review.” Levy, Mareniss,

In lieu of the PSQIA, Amendment 7 is ripe for a new round of litigation, with the statutory privilege created by the PSQIA serving as a potential precursor to a supplementary common law peer review privilege.<sup>123</sup>

#### IV. ANALYSIS

##### A. *Framework of the PSQIA*

Understanding the practical impact of PSQIA implementation begins with understanding the mechanics behind the law. The PSQIA provides federal privilege and confidentiality protection to PSWP<sup>124</sup> that

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Iacovelli & Howard, *supra* note 16, at 414.

123. See, e.g., Complaint, Lee Mem'l Health Sys. v. Guillermo *et al.*, No. 2:10-cv-00700, 2011 WL 5826672 (Nov. 18, 2011) (2:10-cv-00700-CEH-DNF), 2010 WL 5809357 (arguing that Amendment 7 is preempted by the PSQIA).

124. The PSQIA defines "patient safety work product" as:

Except as provided in subparagraph (B), the term "patient safety work product" means any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements—

(i) which—

(I) are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization; or

(II) are developed by a patient safety organization for the conduct of patient safety activities;

and which could result in improved patient safety, health care quality, or health care outcomes; or

(ii) which identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.

42 U.S.C.A. § 299b-21(7)(a) (West 2013).

The PSQIA expressly clarifies that definition, such that:

(i) Information described in subparagraph (A) does not include a patient's medical record, billing and discharge information, or any other original patient or provider record.

(ii) Information described in subparagraph (A) does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system. Such separate information or a copy thereof reported to a patient safety organization shall not by reason of its reporting be considered patient safety work product.

(iii) Nothing in this part shall be construed to limit—

(I) the discovery of or admissibility of information described in this subparagraph in a criminal, civil, or administrative proceeding;

(II) the reporting of information described in this subparagraph to a Federal, State, or local governmental agency for public health surveillance, investigation, or other public health purposes or health oversight purposes; or

(III) a provider's recordkeeping obligation with respect to information described in this subparagraph under Federal, State, or local law.

42 U.S.C.A. § 299b-21(7)(b).

Congress indicated that not all traditional healthcare operations, record keeping

is assembled for reporting to a PSO<sup>125</sup> within a patient safety evaluation system (“PSES”).<sup>126</sup> Because the reporting of medical errors is voluntary under the PSQIA, the legal protections that are provided to hospitals act as an incentive to encourage reporting.<sup>127</sup> PSOs are organizations that collect and analyze PSWP.<sup>128</sup> Once the PSO collects

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documents, or communications fall under the patient safety work product definition . . . . The key distinction between the traditional healthcare operations that Congress intended to exclude and the peer review process is that peer review materials submitted to the PSO as patient safety work product originated from the peer review process itself, rather than from the actual delivery of healthcare . . . . Therefore, anything created during the peer review process by relying on non-patient safety work product, such as medical records, physician notes, operations logs, billing records, records of drug deliveries, et. falls under the patient safety work product definition and the protections granted by the PSQIA because it does not originate during initial healthcare delivery.

Leaman, *supra* note 122, at 191-192.

125. A PSO is defined in the PSQIA as: “a private or public entity or component thereof that is listed by the Secretary of Health and Human Services pursuant to section 299b-24(d) of this title.” 42 U.S.C.A. § 299b-21(4). The PSQIA requires the Secretary to compile and maintain a listing of entities with respect to which there is an acceptance of a certification as a PSO. 42 U.S.C.A. § 299b-24(d) (West 2013). The process for certification and listings of PSOs is implemented and overseen by the Agency for Healthcare Research and Quality (“AHRQ”), while compliance with the confidentiality provisions is handled by the Office of Civil Rights. Patient Safety and Quality Improvement Final Rule, 73 Fed. Reg. 70732 (Nov. 21, 2008). This PSO listing can be found online at: *Listed Patient Safety Organizations*, AGENCY FOR HEALTHCARE RESEARCH AND QUALITY, <http://www.pso.ahrq.gov/listing/psolist.htm> (last visited Mar. 15, 2012).

126. The term “patient safety evaluation system” means the collection, management, or analysis of information for reporting to or by a patient safety organization. 42 U.S.C.A. §299b-21(6). Documentation of PSES clearly establishes when information is PSWP, thus although healthcare organization are not required to document its PSES, the Department of Health and Human Services highly encourages it. Patient Safety and Quality Improvement Final Rule, 73 Fed. Reg. 70732, 70738-70739 (Nov. 21, 2008). PSES is defined by reference to “patient safety activities,” which include:

(1) efforts to improve patient safety and the quality of health care delivery; (2) the collection and analysis of patient safety work product; (3) the development and dissemination of information regarding patient safety, such as recommendations, protocols or information regarding best practices; (4) the utilization of patient safety work product for the purposes of encouraging a culture of safety, as well as providing feedback and assistance to effectively minimize patient risk; (5) the maintenance of procedures to preserve confidentiality with respect to patient safety work product; (6) the provision of appropriate security measures with respect to patient safety work product; (7) the utilization of qualified staff; and (8) activities related to the operation of a patient safety evaluation system and to the provision of feedback to participants in a patient safety evaluation system.

David S. Ivill & Amy Hooper Kearbey, *The Rise of Patient Safety Organizations: Reports and Sharing without Fear of Liability*, N.Y. L.J. (Nov. 2, 2009) (citing 42 U.S.C. §299b-21(5); Patient Safety and Quality Improvement Final Rule, 73 Fed. Reg. 70732, 70798 (Nov. 21, 2008) (to be codified at 42 C.F.R. §3.20)).

127. Bell, *supra* note 18, at 747.

128. *KD ex. rel. Dieffenbach v. United States*, 715 F.Supp.2d 587, 596 (D. Del. 2010) (citing S. REP. NO. 108-196, at 5 (2003)).

PSWP, it evaluates the documented medical errors and recommends ways that the hospital can prevent similar medical errors from happening again, thus improving patient safety and quality of care.<sup>129</sup> The hospital's PSES must promptly submit PSWP to the hospital's PSO because PSQIA privilege will not apply if the PSO fails to receive the PSWP.<sup>130</sup>

With limited exceptions,<sup>131</sup> to encourage PSWP reporting and create a non-punitive environment for evaluating medical errors, the PSQIA provides that PSWP shall be privileged and confidential:

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

(b) Confidentiality of patient safety work product: Notwithstanding any other provision of Federal, State, or local law, and subject to subsection (c) of this section, patient safety work product shall be confidential and shall not be disclosed.<sup>132</sup>

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129. Leaman, *supra* note 122, at 185-186. PSOs, in turn, voluntarily report non-identifiable PSWP to AHRQ which maintains a network of databases to analyze PSWP reporting. *Id.* at 186.

130. See S. REP. NO. 108-196, at 7 (2003) (emphasizing that while the PSQIA remains silent on the required reporting timeframe, hospitals must report patient safety work product to the PSO within two months from the time the event being evaluated occurred to be eligible for PSQIA protections).

131. 42 U.S.C.A. §299b-22(a)(3) (West 2013) (noting that PSQIA privilege and confidentiality protections do not apply to disclosures made in criminal proceedings, disclosures that are expressly permitted, non-identifiable disclosures, disclosures to the Food and Drug Administration, or any other exceptions that the Agency for Healthcare Research and Quality determines at a later date).

132. 42 U.S.C.A. § 299b-22(a)-(b). Patient safety information can become PSWP through three distinct paths: (1) information created for and reported to a PSO; (2) information and analysis

On January 11, 2009, the Department of Health and Human Services promulgated regulations implementing the PSQIA.<sup>133</sup> The protections afforded by the PSQIA enable all hospitals and health care providers to share data within a protected legal environment without the threat that the information will be used against it.<sup>134</sup> The result of the PSQIA is a statutory solution that encourages meaningful peer review and improved quality of care, while also serving as the impetus to an expanded federal common law peer review privilege.<sup>135</sup>

#### B. *The PSQIA Statutory Privilege and Impact on Amendment 7*

The PSQIA creates federal statutory privilege and confidentiality protections that shield providers from the unauthorized use and disclosure of specific quality and safety information as described above.<sup>136</sup> The PSQIA comprehensively addresses the following three problems in the state peer review protection system: “(1) it creates a uniform national system of protections that protects a wide array of health care institutions; (2) it encourages sharing information with other parties; and (3) it cannot be avoided by filing a claim in federal court.”<sup>137</sup>

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generated by a PSO in the process of generating patient safety activities; and (3) documentation of deliberations or analysis of, or the fact of reporting pursuant to, a PSES. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 409. The language of the PSQIA continues by stating that:

Nothing in this section shall be construed—(1) to limit the application of other Federal, State, or local laws that provide greater privilege or confidentiality protections than the privilege and confidentiality protections provided for in this section; (2) to limit, alter, or affect the requirements of Federal, State, or local law pertaining to information that is not privileged or confidential under this section; (3) except as provided in subsection (i) of this section, to alter or affect the implementations of any provision of the HIPAA confidentiality regulations or section 1320d-5 of this title (or regulations promulgated under such section); (4) to limit the authority of any provider, patient safety organization, or other entity to enter into a contract requiring greater confidentiality or delegating authority to make a disclosure or use in accordance with this section; (5) as preempting or otherwise affecting any State law requiring a provider to report information that is not patient safety work product; or (6) to limit, alter, or affect any requirement for reporting to the Food and Drug Administration information regarding the safety of a product or activity regulated by the Food and Drug Administration.

42 U.S.C.A. §299b-22(g).

133. Patient Safety and Quality Improvement Final Rule, 73 Fed. Reg. 70732 (Nov. 21, 2008) (codified at 42 C.F.R. part 3). The summary of the final rules states that the PSQIA “establishes a framework by which hospitals, doctors, and other health care providers may voluntarily report information to Patient Safety Organizations (PSOs), on a privileged and confidential basis, for the aggregation and analysis of patient safety events.” *Id.*

134. *Id.*

135. *See id.*

136. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 414.

137. *Id.* at 415. Prior to the PSQIA, the lack of federal peer review privilege enabled plaintiffs’ attorneys to circumvent state peer review protections by joining a state claim to a federal

Federal courts have recognized that the PSQIA created tightly crafted federal privilege and confidentiality protection for PSWP.<sup>138</sup> In doing so, the PSQIA expressly preempts any state law or constitutional provision that is contrary to its provisions, including Amendment 7.<sup>139</sup>

Almost all patient safety information reported by hospitals to PSOs will come from traditional peer review activities, meaning PSQIA protection will shield traditional peer review activities within hospitals.<sup>140</sup> Thus, Florida hospitals that report peer review materials appropriately through a PSO will attain protection for the type of documents that Amendment 7 desired to make discoverable. Consequently, as Florida courts continue to identify peer review documents as public records, more and more hospitals are partnering with PSOs and following the PSQIA's statutory framework to protect these documents.<sup>141</sup> From a practical perspective, many Florida plaintiffs' attorneys and PSQIA critics opine that hospitals are only partnering with PSOs in order to block the public from peer review materials.<sup>142</sup> While it is too early to have aggregate data on what the

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claim filed in federal court. *Id.* at 404. This procedural strategy was employed in *Burrows v. Redbud Community Hospital*, 187 F.R.D. 606 (N.D. Cal. 1998), when the parents of an eleven-month-old boy, who died after being transferred from the emergency department at Redbud Community Hospital to another hospital ninety minutes away, filed an EMTALA action in federal court that included state claims of wrongful death and medical malpractice. Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 404 (citing *Redbud Cmty. Hosp. v. Burrows*, 188 F.R.D. 356, 358 (N.D. Cal. 1997)). When the parents sought discovery of peer review documents related to the attending physician's decision to transfer, the hospital refused to disclose the information citing California's peer review statute for support. *Redbud*, 187 F.R.D. at 612. In an unpublished opinion, the Northern District of California determined that California's peer review statute did not apply in this matter because the EMTALA action raised a federal question, and under federal law at the time, there was no protection or these materials. *Id.* (discussed in Levy, Mareniss, Iacovelli & Howard, *supra* note 16, at 404).

138. *Lee Med. v. Beecher*, 312 S.W.3d 515, 534-35 (Tenn. 2010). The court stated that the Institute of Medicine's 2000 report prompted additional congressional debate over medical error and provided momentum that served as a catalyst for Congress to enact the PSQIA. *Id.*

139. See PSQIA privilege and confidentiality language *supra* note 132 and accompanying text. See also *Fancher v. Shields*, No. 10-CI-4219 (Jefferson Cir. Ct, Ky. Aug. 16, 2011) (holding that there is a clear statement of a Congressional intent that such patient safety communications be protected in order to foster openness in the interest of improved patient safety, and thus, the area has been preempted by the federal law).

140. Bell, *supra* note 18, at 772.

141. Christine Jordan Sexton, *Fighting to Keep Peer Review Private*, FLA. MED. BUS., July 2009, at 6. The author states that because the PSQIA trumps Florida state law and the *Buster II* ruling, and because PSOs are specifically designed to allow doctors to share information about medical errors without fear of legal discovery, she sees PSOs building momentum in Florida. *Id.*

142. *Id.* The author quotes medical malpractice attorney Sean Cronin who says, "I'm concerned that [hospitals] are setting up legal entities [in the form of PSOs] for the sole purpose of keeping information from the public." *Id.*

PSQIA has meant to peer review in Florida, the fact that Florida has more listed PSOs than any other state suggests that Florida hospitals recognize the statutory framework of the PSQIA as a means to re-introduce meaningful peer review in an effort to improve patient safety and quality of care.<sup>143</sup>

### C. *Overview of Common Law Privilege*

While the PSQIA's federal statutory protection cloaks qualified peer review activities with privilege and confidentiality protection, it falls short of protecting peer review activities that fail to satisfy its statutory requirements.<sup>144</sup> In these instances, protection depends on federal common law principles.<sup>145</sup> Under Federal Rule of Civil Procedure 26(b)(1), information that is not privileged is discoverable if relevant or reasonably calculated to lead to admissible evidence.<sup>146</sup> Assuming a federal question exists, "Federal Rules of Evidence 501 directs that . . . privileges 'shall be governed by the principles of

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143. Florida leads the nation in the number of PSOs, with eight listed on AHRQ's webpage. In total, seventy-seven PSOs in thirty states and the District of Columbia are currently listed by AHRQ. *Geographical Director of Patient Safety Organizations*, AGENCY FOR HEALTH CARE RESEARCH AND QUALITY, <http://www.pso.ahrq.gov/listing/geolist.htm> (last visited Mar. 3, 2013). As an example, Medical Peer Review Resource, LLC ("MPRR") is a listed PSO in the state of Florida. *Id.* Although a national PSO, MPRR's website has a section devoted to its "Florida Focus" which reads:

Due to the fast growth and interest in the need to improve quality, by finding a way to protect peer review, we are particularly working with Florida healthcare providers who face a unique issue, Amendment 7, also known as the Patient's Right to Know Amendment. Amendment 7 raises a serious challenge for Florida hospitals and physicians, as previously protected peer review information is subject to greater discovery in litigation. Amendment 7 confers broad rights to obtain records of adverse medical incidents. MPRR's efforts focus on how hospitals and physicians can protect this information through our PSO, as instituted by the Patient Safety and Quality Improvement Act of 2005 (PSQIA).

*Florida Focus*, MED. PEER REVIEW RES., LLC, <http://medicalpeerreviewresource.com/florida.php> (last visited Feb. 10, 2012).

144. *See, e.g.,* Schlegel v. Kaiser Foundation Health Plan, No. CIV 07-0520 MCE KJM, 2008 WL 4570619 (E.D. Cal. Oct. 14, 2008) (declining to afford PSQIA federal statutory protection when there was no indication that the applicable investigations conducted were prepared for and reported to a PSO); *Massi v. Walgreen Co.*, No. 3:05-CV-425, 2006 U.S. Dist. LEXIS 77893, at \*14-16 (E.D. Tenn. Oct. 25, 2006) (recognizing the federal privilege, but ruling that there was inadequate showing by the defendant that the information was assembled for purposes of reporting to a PSO).

145. *See, e.g.,* *Schlegel*, 2008 WL 4570619, at \*3; *Francis v. United States*, No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509, at \*6 (S.D. N.Y. May 31, 2011); *K.D. ex rel. Dieffenbach v. United States*, 715 F. Supp.2d 587, 595 (D. Del. 2010).

146. *Dieffenbach*, 715 F. Supp.2d at 591. Generally, any party asserting privilege bears the responsibility of proving the availability of privilege and its applicability. *Id.*

common law as they may be interpreted by the courts of the United States in light of reason and experience.”<sup>147</sup> This rule is intended to afford district courts the “flexibility to develop rules of privilege on a case-by-case basis.”<sup>148</sup>

The United States Supreme Court decision in *Jaffee v. Redmond*<sup>149</sup> established the psychotherapist—patient privilege as the most recently recognized federal privilege.<sup>150</sup> Here, the *Jaffee* Court concluded that the “reason and experience” clause of Federal Evidence Rule 501 required the psychotherapist—patient privilege be recognized.<sup>151</sup> Articulating its rationale, the Court stated that: “Reason tells us that psychotherapists and patients share a unique relationship in which the ability to communicate freely without the fear of public disclosure is the key to successful treatment.”<sup>152</sup> The court continued, stating that “in the absence of absolute confidentiality, the practice of psychotherapeutic counseling would fail to serve the purpose it is intended for: the treatment of patients.”<sup>153</sup> Here, it was determined that the sheer possibility of disclosure may impede the development of trust and confidence essential to successful treatment.<sup>154</sup>

In satisfying the “experience” prong, *Jaffee* noted that all fifty states had adopted some form of psychotherapist—patient privilege.<sup>155</sup> Stating that “it is appropriate to treat a consistent body of policy determinations by state legislatures as reflecting both ‘reason’ and ‘experience,’” the *Jaffee* Court concluded the vast recognition of psychotherapist-patient privilege by state legislatures evidenced

147. *Id.* at 591 (citing FED. R. EVID. 501); *see also Francis*, 2011 WL 2224509, at \*5 (quoting *Jaffee v. Redmond*, 518 U.S. 1, 8 (1996) (recognizing a psychotherapist-patient privilege)).

148. *Francis*, 2011 WL 2224509, at \*5 (quoting *Univ. of Pa. v. E.E.O.C.*, 493 U.S. 182, 189 (1990)).

149. 518 U.S. 1 (1996).

150. *Id.* at 1. In *Jaffee*, the defendant police officer shot the decedent when the officer believed the decedent was about to stab another man. *Id.* Post-incident, the defendant sought counseling. *Id.* Survivors of the decedent brought a federal suit claiming the decedent’s constitutional rights were violated because the officer allegedly used excessive force during the encounter. *Id.* at 5. The privilege issue focused on whether the plaintiffs were able to obtain notes and statements taken by the officer’s therapist during counseling sessions, or whether the statements and notes were protected from compelled disclosure by recognition of a new federal common law psychotherapist-patient privilege. *Id.* at 5.

151. *Id.* at 2.

152. *Id.* at 6.

153. Bassler, *supra* note 15, at 708 (citing *Jaffee*, 518 U.S. at 10).

154. Bassler, *supra* note 15, at 708 (citing *Jaffee*, 518 U.S. at 10). Here, the author compares the importance of privilege in the psychotherapist-patient relationship to the importance of privilege in a successful attorney-client relationship. Bassler, *supra* note 15, at 708.

155. *Jaffee*, 518 U.S. at 2

overwhelming support for expanding the privilege.<sup>156</sup> Further, the Court noted that a uniform recognition of the privilege is important because the participants in the confidential conversation must be able to predict with some degree of certainty whether particular discussions will be protected; noting that an uncertain privilege is little better than no privilege at all.<sup>157</sup>

#### D. *An Expanded Peer Review Privilege in Federal Court*

Federal courts have recognized that medical peer review privilege furthers federal policy.<sup>158</sup> Historically, however, courts have declined to recognize a medical peer review privilege for two primary reasons: reliance on an inapplicable United States Supreme Court ruling<sup>159</sup> and Congress' failure to create a medical peer review privilege when it enacted the HCQIA.<sup>160</sup>

Focusing on the second rationale, as the Court in *KD ex rel. Dieffenbach v. U.S.*<sup>161</sup> correctly recognized, the HCQIA no longer represents Congress' final word on medical peer review protection.<sup>162</sup> In

156. *Id.* at 14.

157. *Id.* (citing *Upjohn Co. v. U.S.*, 101 S. Ct. 677, 684 (1923) (“An uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”)).

158. *See, e.g.*, *Francis v. United States*, No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509, at \*6 (S.D. N.Y. May 31, 2011) (articulating the primary purpose of privilege is to encourage candor among medical staff by shielding the information from disclosure in medical malpractice suits).

159. *See Univ. of Pa. v. E.E.O.C.*, 110 S. Ct. 577 (1990) (holding common-law privilege would not be recognized to protect peer review materials from disclosure and insisting that courts narrowly construe statutes providing privileges). This case, however, pertained to a professor's tenure peer review file in an employment discrimination action and does not, and should not, extend to peer review documents in medical malpractice actions. *Francis*, 2011 WL 2224509, at \*6. “The interests at issue in a discrimination claim . . . are different from [those] of a medical malpractice case, and merit a different analysis.” *Adkins v. Christie*, 488 F.3d 1324, 1330 (11th Cir. 2007). “Moreover, recognizing a medical peer review privilege in a civil rights case would not further the primary purpose of such a privilege: ‘to encourage candor among medical staff by shielding the information from disclosure in medical malpractice suits.’” *Francis*, 2011 WL 2224509, at \*6 (quoting *Singh v. Pocono Med. Ctr.*, No. 3:09-0439, 2010 WL 2521039, at \*3 (M.D. Pa. June 15, 2010)).

160. *See Virmani v. Novant Health Inc.*, 259 F.3d 284, 292 (4th Cir. 2001) (relying heavily on the fact that the legislative history of the HCQIA was silent as to whether Congress considered and rejected a federal privilege the court concluded that Congress will create a peer review privilege when it is so inclined and did not do so in the HCQIA); *Agster v. Maricopa Cnty*, 422 F.3d 836, 839 (9th Cir. 2005) (concluding that Congress had occasion and opportunity to consider the privilege and decided not to grant it either explicitly or by implication; therefore the court found a general objection for providing a privilege itself).

161. 715 F.Supp.2d 587, 595 (D. Del. 2010).

162. *Id.* (cited in *Francis*, 2011 WL 2224509, at \*6). Differentiating the PSQIA and HCQIA further, unlike HCQIA's legislative history, “the PSQIA's legislative history contains frequent

its analysis, *Dieffenbach* stated that the PSQIA “announces a more general approval of the medical peer review process and more sweeping evidentiary protections for materials used therein.”<sup>163</sup>

Furthermore, because the PSQIA promoted a learning environment intended to create a “culture of safety” that focuses on information sharing, improved patient safety and quality and the prevention of future medical care, the *Dieffenbach* court felt its decision to recognize a qualified privilege for confidential and evaluative materials produced in the applicable review process was aligned with PSQIA’s intent.<sup>164</sup>

Similarly, in *Francis v. United States*<sup>165</sup> the court recognized a privilege for medical peer review materials after stating that “in light of the broad protection afforded by the PSQIA” the relevant inquiry is whether medical peer review privilege would advance Congress’ goal of promoting peer review to improve quality care.<sup>166</sup> Here, the defendant demonstrated to the Court’s satisfaction that private and public interests would be served by recognizing a medical peer review privilege because “the success of a hospital’s quality assurance review process ‘depends upon an atmosphere of confidence.’”<sup>167</sup>

These two United States District Court decisions demonstrate that the PSQIA has changed courts’ historical position on medical peer review privilege and suggests that the United States Supreme Court may

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references to expanding peer review protections so that healthcare providers can report medical errors without fear of being sued.” Leaman, *supra* note 119, at 195 (citing S. REP. NO. 108-196, at 1-3 (2003) (recognizing that medical errors must be reported, analyzed and corrected in order to improve patient safety and the quality of healthcare in the United States). While a court may decline federal peer review confidentiality and privilege protection because Congress failed to expressly provide for them in the PSQIA’s statutory language, this is unlikely because Congress has expressly stated that even though the words “peer review” do not appear in the PSQIA, the purpose of the legislation was to provide peer review protections. Leaman, *supra* note 122, at 195-196 (citing H.R. REP. NO. 109-197, at 11(2005) (emphasizing that the PSQIA provides peer review protection of PSWP reported to a PSO).

163. *Francis*, 2011 WL 2224509, at \*6 (quoting *Dieffenbach*, 715 F. Supp.2d at 595).

164. *Dieffenbach*, 715 F.Supp.2d at 595. The court’s recognition of a qualified privilege for confidential evaluative materials produced by the pertinent review process was heavily influenced by public policy evident in Maryland privilege law and Congress’ intent in passing the PSQIA. *Id.* at 592. Although the review body at issue here was not technically a PSO, the court felt it clearly performed the same functions that Congress intended the PSQIA to encourage such as monitoring, oversight and performing periodic assessments of data quality. *Id.* at 596. Because the pertinent review process collected the same kind of safety data enumerated in the PSQIA, within the same organizational structure, to accomplish the same goal, the court concluded that it was “confident that protecting otherwise confidential and evaluative materials resulting from this process would not substantially offend the federal policy announced in the PSQIA.” *Id.* at 597.

165. No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509 (S.D. N.Y. May 31, 2011).

166. *Id.* at \*6

167. *Francis*, 2011 WL 2224509, at \*5 (quoting *Jaffee v. Redmond*, 518 U.S. 1, 10 (1996)).

consider a new expanded common law medical peer review privilege.<sup>168</sup>

*E. The United States Supreme Court Should Provide a Common Law Privilege to Medical Peer Review*

Influenced by the recent United States District Court decisions referenced above, the United States Supreme Court should establish a common law peer review privilege. *Jaffee* provides an analytical framework that supports extending a federally recognized privilege to medical peer review.<sup>169</sup>

First, the absolute confidentiality that the *Jaffee* Court reasoned was imperative to establishing successful psychotherapist–patient relationships, is equally important to encouraging meaningful medical peer review.<sup>170</sup> The *Jaffee* Court further opined that without protection, statements that might have otherwise been relevant to a civil action would never have been made by the patient, leaving nothing to discover because of fear that disclosures would not be kept confidential.<sup>171</sup> Likewise, if physicians fear that statements made during the peer review process are discoverable, it is unlikely that they will participate in peer review.<sup>172</sup> If physicians do not participate in peer review, the ability to accomplish Congress’ goals of significantly reducing medical error is compromised.<sup>173</sup>

Second, *Jaffee* noted that recognizing an expanded privilege may be appropriate when there is uniform recognition of the privilege among the states.<sup>174</sup> *Dieffenbach* and *Francis* recognized that all fifty States and

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168. Michael Cassidy, *Patient Safety and Quality Improvement Act (PSQIA) May Change Federal Common Law Privilege*, TUCKER ARENSBERG ATTORNEYS MED. LAW BLOG (June 14, 2010), <http://www.medlawblog.com/articles/credentialing-and-peer-review/patient-safety-and-quality-improvement-act-psqia-may-change-federal-common-law-privilege>.

169. See Bassler, *supra* note 15, at 707.

170. See *supra* notes 154-154 and accompanying text.

171. See Bassler, *supra* note 15, at 708. In support of this point, the court stated:

In contrast to the significant public and private interests supporting recognition of the privilege, the likely evidentiary benefit that would result from the denial of the privilege is modest. If the privilege were rejected, confidential conversations between psychotherapists and their patients would surely be chilled, particularly when it is obvious that the circumstances that give rise to the need for treatment will probably result in litigation. Without a privilege, much of the desirable evidence to which litigants such as petitioner seek access—for example, admissions against interest by a party—is unlikely to come into being. This unspoken ‘evidence’ will therefore serve no greater truth-seeking function than if it had been spoken and privileged.

*Jaffee*, 518 U.S. at 11-12.

172. See Bassler, *supra* note 15, at 711.

173. See *supra* notes 58, 116, 122 and accompanying text.

174. See *Jaffee*, 518 U.S. at 12. As the Supreme Court has noted, “any State’s promise of

the District of Columbia recognize some form of medical peer review privilege.<sup>175</sup> Such overwhelming state support was an important factor in satisfying *Jaffee's* “experience” test, thus providing support that the United States Supreme Court will find it appropriate to recognize a corresponding federal common law medical peer review privilege.<sup>176</sup>

Finally, like the psychotherapist-patient privilege in *Jaffee*, both reason and experience conclude that a medical peer review privilege promotes sufficiently important interests that overshadow the need for obtaining evidence.<sup>177</sup> This fact is solidified by *To Err is Human*, discussed above, which suggests meaningful peer review will help prevent as many as 98,000 preventable errors annually, resulting in annual savings of as much as \$29 billion in national healthcare costs.<sup>178</sup> In light of its role in improving patient safety and quality of care, the public interest in promoting peer review continues to be “overwhelming.”<sup>179</sup>

## V. CONCLUSION

There is a general recognition and acceptance at both the local and national level that “(1) meaningful peer review is essential to improving healthcare outcomes; (2) that meaningful and effective peer review requires candid participation by physicians; and (3) that physician participation will be candid only where the details of peer review are kept confidential and privileged.”<sup>180</sup>

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confidentiality would have little value if . . . the privilege would not be honored in a federal court. Denial of the federal privilege therefore would frustrate the purposes of the state legislation that was enacted to foster these confidential communications.” *Id.* at 13.

175. *K.D. ex rel. Dieffenbach v. United States*, 715 F.Supp.2d 587, 592-594 (D. Del. 2010); *Francis v. United States*, No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509, at \*5-6 (S.D. N.Y. May 31, 2011). “These statutes share a common purpose in encouraging physician candidness by eliminating the fear that peer review information will be used against them in subsequent litigation.” *Dieffenbach*, 715 F.Supp. 2d at 594. Although Florida no longer provides peer review protection after Amendment 7, the “experience” test is further supported in this case because Congress has explicitly recognized the importance of peer review in the PSQIA. *See Bassler, supra* note 15, at 711.

176. *See Francis*, 2011 WL 2224509, at \*5-6. Furthermore, while all states provide for certain peer review protection, subtle differences in the language of each state’s peer review statutes and the underlying public policy associated with each respective statute have led to varying interpretations on the scope of state medical peer review protection. *Graham, supra* note 58, at 138.

177. *See Jaffee*, 518 U.S. at 9-10; *see also supra* notes 115-115 and accompanying text.

178. *See supra* note 113 and accompanying text.

179. Brief of the Idaho Hosp. Ass’n as Amicus Curiae Supporting Respondents, *supra* note 28, at \*8 (quoting *Bredice v. Doctors Hosp., Inc.* 50 F.R.D. 249, 251 (D.D.C. 1970))

180. Brief of the Idaho Hosp. Ass’n as Amicus Curiae Supporting Respondents, *supra* note 28, at \*9. These principles have been recognized in state courts across the country. *Id.* at \*10 (citing as

The introduction of the PSQIA re-established the foundation for meaningful peer review by providing federal statutory privilege and confidentiality protection for peer review materials submitted to a PSO.<sup>181</sup> Furthermore, multiple federal courts have focused on the intent of the PSQIA to recognize an expanded federal peer review privilege, decisions that may help serve as the catalyst for the United States Supreme Court to consider an expanded federal common law privilege for medical peer review.<sup>182</sup>

Although potential plaintiffs may feel a greater burden establishing medical malpractice claims, the burden is not undue as plaintiffs may still obtain necessary records and documents from their own medical records to give rise to appropriate actions.<sup>183</sup> In scenarios where privilege applies, while patients may not have access to adverse medical incidents when considering which physician choose, the reductions in medical error presumed associated with peer review protection should increase the patient's confidence that treatment will be performed without error.<sup>184</sup> Therefore, considering the constituents most directly affected by federal peer review privilege and confidentiality protection, it appears clear that benefits of protection outweigh the risks.<sup>185</sup> In addition to quality of care improvements, a uniform federal peer review privilege would lower transactions costs to hospitals, thereby reducing patients' cost of health care, a critical issue in the United States.<sup>186</sup>

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examples, *Konrady v. Oesterling*, 149 F.R.D. 592, 595 (D. Minn. 1993) (the goal of peer review is the improvement of patient care); *Ardisana v. Northwest Cmty. Hosp., Inc.*, 795 N.E.2d 964, 969 (Ill. App. Ct. 1st Dist. 2003) (purpose of statute privileging peer review materials is to advance the quality of health care by ensuring that peer review committee members effectively engage in the peer-review process); *State ex rel. St. Johns Reg'l Med. Ctr. v. Dally*, 90 S.W.3d 209, 214 (Mo. Ct. App. 2002) ("Peer review, the process by which physicians and hospitals evaluate and discipline staff doctors, has become an integral component of the health care system in the United States.").

181. See *supra* notes 124-135 and accompanying text.

182. See cases discussed *supra* notes 159-164.

183. Leaman, *supra* note 124, at 200-201. PSQIA advocates believe that it strikes an important balance "because the PSQIA protections will ease peer review participants' fears of being sued for honestly evaluating their colleagues, while at the same time giving plaintiffs who wish to sue for medical malpractice access to the information created at the time of the alleged malpractice." *Id.* at 188. Specifically, the definition of PSWP expressly excludes a patient's medical record. See *Sullivan & Anderson, supra* note 23, at 90.

184. See *supra* notes 26-27 and accompanying text.

185. Leaman, *supra* note 122, at 200-201. The author identifies the three primary parties influenced by PSQIA federal privilege and confidentiality protections as (1) the physicians that participate in peer review; (2) potential plaintiffs who may bring a medical malpractice action; and (3) individuals seeking medical care. *Id.* at 200.

186. *Sullivan & Anderson, supra* note 23, at 90. "Peer review encourages practices that seek to avoid preventable adverse events in the first place, thereby reducing costs." *Id.* at 51. Additionally, the author argues that a uniform privilege will lead to a uniform body of law which

In Florida, the effects of the PSQIA will be uniquely felt because of its impact on Amendment 7.<sup>187</sup> Hospitals are already restructuring internal processes and partnering with PSOs to obtain the available statutory PSQIA protections, and a new wave of litigation is now ripe for hospitals to challenge Amendment 7 requests utilizing a PSQIA defense.<sup>188</sup> Florida may not have to look far for the case that will set this new direction, as one Florida hospital system is already litigating with PSQIA as its principal argument.<sup>189</sup> While a federal district court in Florida recently agreed to abstain from exercising jurisdiction over the hospital's challenge to Amendment 7, this decision will likely only delay, not deter, a case destined for federal court review.<sup>190</sup> With determined parties and the sustainability of Amendment 7 in the balance post-PSQIA, this case and the role it plays in further re-establishing meaningful peer review and improving the quality of patient care in Florida will be important to watch.<sup>191</sup>

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will lower costs associated with attorney fees and insurances premiums, while also reducing the overall cost of collecting peer review materials. *Id.* at 41, 91.

187. *See supra* notes 141-143 and accompanying text.

188. *See supra* notes 123, 140 and accompanying text. Florida hospitals should be encouraged by recent state court decisions in Illinois and Kentucky that have upheld PSQIA protections for hospitals that restructured their internal processes to comply with the PSQIA and its PSES guidelines. *See The Dep't of Fin. and Prof'l Regulation v. Walgreen Co.*, 970 N.E. 2d 552, 557-558 (Ill. App. 2d, 2012) (finding that the quality improvement reports created by the pharmacy under its tracking and reporting system were privileged under the PSQIA when Walgreen's vice-president stated in her affidavit that the pharmacy did not create, maintain, or otherwise have in its possession any incident reports other than those quality improvement reports in question that were transmitted to its federally certified PSO); *Fancher v. Shields*, No. 10-CI-4219, (Jefferson Cir. Ct, Ky. Aug. 16, 2011) (holding that Congress provided for broad confidentiality and legal protections of information collected and reported voluntarily to a PSO for the purposes of improving the quality of medical care and patient safety). *But see Morgan v. Cmty. Med. Ctr.*, No. 08 CV 4850, (Pa. D & C.3d, June 14, 2011) (finding that the hospital failed to meet its burden that the PSQIA protected the incident report being sought because it could have been prepared principally for purposes other than those that the PSQIA protects).

189. *See Complaint, Lee Mem'l Health Sys. v. Guillermo et. al*, No. 2:10-cv-00700-CEH-DNF, 2010 WL 5809357 (M.D. Fla. Nov. 19, 2010). Stating that the Florida courts have failed to conclusively establish the constitutionality of Amendment 7 and its relationship to Florida statutes and federal laws, LMHS' motion seeks a declaration clarifying its rights and obligations under Amendment 7 and a determination on the constitutionality of Amendment 7 in relation to the PSQIA. *Id.* at \*5. In order to meet the statutory requirements of peer review protection afforded by the PSQIA, LMHS executed a Patient Safety Organization Professional Services Agreement with Medical Peer Review Resource, LLC ("MPRR") on September 2, 2009 and implemented the LMHS Patient Safety Evaluation System to identify, collect, and analyze PSWP for purposes of reporting such PSWP to MPRR. *Id.* at \*15-16.

190. *U.S. Court in Florida Will Abstain From Considering Challenge to Florida's Patients Right to Know Amendment*, IX HEALTH LAW. WKLY. 47 (Dec. 9, 2011).

191. *See id.*