

The Medical Peer Review Privilege in Massachusetts: A Necessary Quality Control Measure or an Ineffective Obstruction of Equitable Redress?

“Except as otherwise provided in this section, the proceedings, reports and records of a medical peer review committee shall be confidential and shall be exempt from the disclosure of public records under section 10 of chapter 66 but shall not be subject to subpoena or discovery or introduced into evidence, in any judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work, or psychology or by the department of public health pursuant to chapter 111C, and no person who was in attendance at a meeting of a medical peer review committee shall be permitted or required to testify in any such judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work or psychology or by the department of public health pursuant to chapter 111C, as to the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, deliberations or other actions of such committee or any members thereof.”¹

I. INTRODUCTION

Human fallibility has long necessitated quality control measures in most professions.² In the sensitized health care context, such measures bear heavy scrutiny and conjure up zealous advocacy.³ Medical error seized a national spotlight in the 1970s and 1980s as medical malpractice claims increased exponentially, grabbing the attention of health care professionals and lawmakers, and increasing efforts to improve the quality of health care along with the legislation and regulation surrounding medical treatment.⁴ Internally

1. MASS. GEN. LAWS ch. 111, § 204(a) (2003).

2. PAUL BARACH & MICHAEL J. KELLY, ISSUE BRIEF OF THE MASSACHUSETTS HEALTH POLICY FORUM, MEDICAL ERRORS AND PATIENT SAFETY IN MASSACHUSETTS: WHAT IS THE ROLE OF THE COMMONWEALTH? 2 (Sept. 28, 2000) (stressing all human beings make decisions involving some measure of risk); *see also* Sinaltrainal v. Coca-Cola Co., 256 F. Supp. 2d 1345, 1354 (S.D. Fla. 2003) (noting quality control necessary to protect product in marketplace); *State v. Sercey*, 825 So. 2d 959, 965 (Fla. Dist. Ct. App. 2002) (highlighting necessity of quality control procedures in accurate drug testing).

3. *See Carr v. Howard*, 689 N.E.2d 1304, 1306 (Mass. 1998) (addressing history of internal regulation proceedings in medicine designed to remedy substandard care); *Beth Israel Hosp. Ass'n v. Bd. of Registration in Med.*, 515 N.E.2d 574, 575 (Mass. 1987) (reinforcing censure of medical care concerns “life, health, comfort and convenience” of state’s citizens).

4. *See* Kathy Kendall, *Latent Medical Errors and Maine’s Statute of Limitations for Medical Malpractice: A Discussion of the Issues*, 53 ME. L. REV. 589, 602-03 (2001) (noting malpractice crisis in

conducted reporting mechanisms within the medical community emerged as a common means of improving service quality and reducing medical error.⁵ Hospitals and other health care providers increasingly utilized peer review reporting as a method of reducing medical error, while state legislatures almost unanimously enacted statutory protections strengthening the efficacy of peer review committees.⁶

The medical peer review process consists of institutional employees meeting internally to debate recent mishaps in the hopes that such roundtable-type discussions will lead to an uninhibited expression of professional opinion, thereby improving the quality of future care.⁷ The threat of future litigation, however, emerged as a steadfast obstacle keeping these peer review groups from meeting their objectives because the participants were hesitant to voice concerns that could subsequently become the subject of a legal proceeding.⁸ To alleviate this obstacle, most states, including Massachusetts, enacted statutes protecting peer review participants and documents from potential liability.⁹ In 1986, the Massachusetts Legislature passed chapter 111, section 204 of the General Laws, which provided that peer review “proceedings, reports or records” shall be confidential and therefore exempt from discovery.¹⁰

1970s and 1980s led to litigation reform); Jason Leo, *Torts—Medical Malpractice: The Legislature’s Attempt to Prevent Cases Without Merit Denies Valid Claims*, 27 WM. MITCHELL L. REV. 1399, 1402-03 (2000) (describing chaos ensuing from sudden jump in medical malpractice claims).

5. See *Carr*, 689 N.E.2d at 1306 (highlighting medical practitioners’ tendency to rely on internal disciplinary proceedings to remedy substandard care). The *Carr* court recognized that the perceived medical malpractice crisis in the 1980s prompted health care facilities to popularize internal reporting systems such as peer review. *Id.*

6. See Kenneth R. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 MASS. L. REV. 157, 157 (2002) (noting prevalence of statutes purporting to protect peer review programs); see also Barry B. Cepelewicz et al., *Recent Developments in Medicine and Law*, 33 TORT & INS. L.J. 583, 588-91 (1998) (describing statutory response and subsequent case law); Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 YALE J. ON REG. 383, 400-01 (2001) (summarizing peer review statutes as legislative attempt to bypass threat of potential litigation).

7. See *Grande v. Lahey Clinic Hospital, Inc.*, 725 N.E.2d 1083, 1085 (Mass. App. Ct. 2000) (reiterating purpose of peer review). Peer review aims to encourage candid examination and representation of professional opinion. *Id.* By enacting the peer review statute, the legislature intended for hospitals and other health care facilities to engage in vigorous self-analysis to improve overall quality of care. *Id.* at 1085-86; see also JAMES R. JENSEN, *MEDICAL STAFF PEER REVIEW—A PEEK BEHIND THE VEIL* 1 (May 17, 1988), available at <http://www.riskmanco.com/Reports6.htm> (recognizing health care providers’ capacity to determine their colleagues’ competence levels); Christina A. Graham, *Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges*, 30 CUMB. L. REV. 111, 112-15 (2000) (highlighting policy rationales behind peer review privileges); Kohlberg, *supra* note 6, at 157-58 (describing peer review process).

8. Chiang, *supra* note 6, at 396-97 (noting fear of liability acts as disincentive for physicians to report); Kelley C. Pickering et al., *Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures*, 12 ANNALS HEALTH L. 235, 243 (2003) (describing “chilling effect” threat of future litigation has on peer review committee members).

9. See *Beth Israel Hosp. Ass’n v. Bd. of Registration in Med.*, 515 N.E.2d 574, 580 (Mass. 1987) (setting forth purpose of medical peer review committees). The Supreme Judicial Court determined that the overriding rationale behind creating the peer review system was to “foster aggressive critiquing of medical care by the provider’s peers.” *Id.*

10. MASS. GEN. LAWS ch. 111, § 204(a) (2003). The statute provides in pertinent part that “the

Currently, all but two states have enacted some form of statutory protection for medical peer review committees.¹¹ Although federal courts have yet to unequivocally recognize this peer review privilege, Congress has indicated its support.¹²

While on their face these statutes appear to assume the laudable task of improving the overall quality of health care, the current systems, laden by several problems, largely fail to accomplish their stated goals.¹³ First, both a blanket privilege from discovery and immunity from liability undermine the equitable redress that should be available to patients injured by medical error.¹⁴ Society can no longer accept medical error as trivial or inevitable.¹⁵ According

proceedings, reports and records of a medical peer review committee shall be confidential and . . . shall not be subject to subpoena or discovery.” *Id.*; see also MASS. R. CIV. P. 26(b)(1) (defining scope of discovery process). The parties to a lawsuit “may obtain discovery regarding any matter, not privileged, which is relevant to the subject matter involved in the pending action.” MASS. R. CIV. P. 26(b)(1); *Carr v. Howard*, 689 N.E.2d 1304, 1307 (Mass. 1998) (expounding purpose of statute to promote “uninhibited expression of professional opinions”).

11. Alissa Marie Bassler, *Federal Law Should Keep Pace With States and Recognize a Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 690 (2003); see also *Carr*, 689 N.E.2d at 1307 (pointing to overwhelming majority of states currently protecting work of medical peer review committees).

12. See Bassler, *supra* note 11, at 690-712 (advocating uniform recognition of peer review privilege in federal courts); Graham, *supra* note 7, at 115-16 (2000) (noting federal courts’ refusal to recognize existence of federal peer review privilege); see also 42 U.S.C. § 11101 (2003) (finding overriding national need to create incentive for physicians to participate in peer review proceedings); The Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, Title IV, § 402, 100 Stat. 3784 (codified as amended at 42 U.S.C. § 11101 (2003)). Congress acknowledged the increasing occurrence of medical malpractice claims across the nation, and that the health care industry should utilize peer review as an effective means to curtail the surge. The Health Care Quality Improvement Act of 1986 § 402. Congress also noted an “overriding national need” to present health care providers with sufficient incentives to participate in peer review programs. *Id.* Additionally, the federal legislation provides that medical professionals use the information imparted in the course of peer review exclusively in connection with the pursuit of improving the quality of health care. *Id.*

13. See JENSEN, *supra* note 7 (listing items weakening peer review and limiting its ability to achieve its objectives). In addition to personal agendas interfering with participants’ decision-making abilities, there exist additional obstacles. *Id.* Reviewers and reviewees may be friends or colleagues, resulting in biased evaluations. *Id.* The friendship provides incentive to use “verbal white-wash” to downplay the incidents of medical error. *Id.* Additionally, physicians may be inclined to overlook certain errors because they themselves were once inexperienced or had made similar mistakes. *Id.* Finally, physicians generally have a negative attitude towards peer review because they consider it presumptuous of their employer to compel participation in a process that puts them in such a precarious position. *Id.*; Susan O. Scheutzow, *State Medical Peer Review: High Cost but No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 12 (1999) (noting peer review protection and reporting statutes ineffective in promoting stated goals); see also *Patrick v. Burget*, 486 U.S. 94, 100-05 (1988) (holding peer review problematic because individuals tend to act in their own interest). In a case involving antitrust laws, the Court found that peer review amounted to little more than individuals making largely unregulated decisions in which they stood to benefit financially from those decisions. *Id.* at 101-03.

14. See *Carr*, 689 N.E.2d at 1315 (recognizing peer review privilege imposes some hardship on litigants); see also Graham, *supra* note 7, at 113 (suggesting peer review statutes problematic because they hinder plaintiff access in tort actions). By restricting a litigant’s ability to access certain health care records, the peer review privilege has perpetuated a “conspiracy of silence.” Graham, *supra* note 7, at 113; Pickering, *supra* note 8, at 244 (pointing out patients’ interest in having access to privileged material); Scheutzow, *supra* note 13, at 8 (acknowledging peer review laws keep information privileged despite relevance and probative value to judicial proceeding).

15. See INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *TO ERR IS HUMAN: BUILDING A SAFER*

to the Massachusetts Health Policy Forum, between 44,000 and 98,000 Americans die annually as a result of medical error, while a great number more are left injured in some capacity.¹⁶ In Massachusetts alone there are between one and two thousand preventable deaths in health care every year.¹⁷

Furthermore, no official body has conducted an exhaustive study indicating whether peer review actually lowers instances of medical error.¹⁸ To justify the existence of statutory privileges that benefit one party over another, those who are benefiting, or those who implement and enforce the policy, should demonstrate that the entity receiving the benefit effectually achieves its stated objectives.¹⁹ Accordingly, if the cost of limiting the rights of malpractice plaintiffs and aggrieved physicians outweighs the benefit conferred on the public in reducing medical error, peer review should be either overhauled or eliminated entirely.²⁰

The lack of uniformity among peer review programs and the statutes regulating them presents another problem.²¹ This inconsistency leads to confusion over whether such protections exist, and to what extent they exist, in

HEALTH SYSTEM 26-48 (2000) (detailing evidence of vast increase in medical error and its wide-reaching effect). Two studies, conducted in 1984 and 1992, found that 2.9% and 3.7% of hospital admissions, respectively, wound up with adverse complications caused by medical mismanagement. *Id.* at 26. A 1997 study determined that deaths caused by medical error over a given length of time exceeded those caused by motor vehicle accidents, breast cancer, and AIDS. *Id.* Moreover, the exponential increase in the number of adverse events has forced hospitals and other health care providers into paying exceedingly high costs in an attempt to remedy the problem. *Id.* at 27. The total national costs were estimated to be up to \$50 billion per year for adverse events, and up to \$29 billion per year for preventable adverse events. *Id.*

16. BARACH & KELLY, *supra* note 2, at 1 (noting medical error deaths).

17. BARACH & KELLY, *supra* note 2, at 1 (citing Massachusetts statistics).

18. *See* Scheutzow, *supra* note 13, at 9-12 (noting lack of studies confirming ability of peer review to actually lower error rate).

19. *See* Univ. of Pa. v. EEOC, 493 U.S. 182, 189 (1990) (quoting Trammel v. United States, 445 U.S. 40, 49-50 (1980)) (rejecting petitioners' request to establish federal common law peer review privilege). Justice Blackmun expressed the Court's hesitation to implement any privilege that may prevent a party from accessing certain materials within the judicial context. *Id.* He further noted the Court's hesitancy to craft an evidentiary privilege unless it "promotes sufficiently important interests to outweigh the need for probative evidence." *Id.* The Court held that "testimonial exclusionary rules and privileges contravene the fundamental principle that the public . . . has a right to every man's evidence." *Id.* In its decision, the Court, therefore, adopted a standard of strict scrutiny in reviewing such privileges. *Id.*

20. *See supra* note 19 and accompanying text (declaring peer review statutes largely ineffective and unfair); *see also* George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 723-42 (2001) (describing haphazard approach to enforcing peer review laws). When lawmakers enforce certain privileges arbitrarily, "the primary benefit of the statutes is wholly lost while the primary detriment remains." Newton, *supra*, at 742.

21. Scheutzow, *supra* note 13, at 27-36 (delineating different types of peer review statutes and their prevalence among states). Statutes that protect those participating in peer review programs generally appear in the form of immunity statutes, privilege statutes, or confidentiality statutes. *Id.* at 27; *see infra* notes 60-64 and accompanying text (summarizing three peer review statute types). While some states limit the privilege significantly by excluding lawsuits brought by providers who are the subject of the peer review inquiry, other states allow for expansive privilege protections. Scheutzow, *supra* note 13, at 33-34. In 1999, sixteen states had heightened restrictions in place, while twenty-one states had medium restrictions, and three states had either no privilege statute or one that could be so easily bypassed it was rendered pointless. *Id.*

any given situation.²² For example, there are no guidelines to help federal courts in determining whether to apply state peer review laws, leading to conflicting and often enigmatic results.²³

This Note will analyze the efficacy of peer review protection statutes in Massachusetts, particularly focusing on statutes that create an evidentiary privilege for peer review material. It will explore the judicial ramifications of the privilege, peer review decisions, and the effect such rulings have on patients injured by medical error. Finally, the Note will suggest alternative and more effective measures to achieve the same objectives without promulgating the inequity that plagues the current system.

II. HISTORY

A. *The Origin of the Medical Peer Review Committee*

In the legal context, the word “tort” essentially encapsulates the broad notion of distinguishing right from wrong.²⁴ Legal experts and scholars created modern tort law in the late nineteenth century to establish uniform standards of conduct through which injured persons could assess the wrong done to them and the potential for redress.²⁵ When a tortfeasor holds him or herself out to the public as professionally competent, the expectations regarding his or her standard of care escalates accordingly.²⁶ The public expects superior

22. See *Carr v. Howard*, 689 N.E.2d 1304, 1308 (Mass. 1998) (highlighting ongoing debate regarding scope of peer review privilege). The *Carr* court pointed to proposed legislation to expand the peer review privilege from information and records “generated pursuant to” such programs to include information and records “which relate also to the functions of” the programs. *Id.* (quoting H.R. DOC. NO. 2749 (1987); H.R. DOC. NO. 5624 (1987)); H.R. DOC. NO. 5930 (1987); see also MASS. GEN. LAWS ch. 111, § 205(b) (2003) (altering scope of peer review privilege). The legislature intended to expand the privilege to include any material “necessary” to assure that the quality assurance programs could achieve their goals unimpeded by threats of future liability. *Carr*, 689 N.E.2d at 1308.

23. See *Romero v. Cohen*, 679 N.Y.S.2d 264, 266 (1998) (noting split authority in New York and nationwide regarding enforcing peer review privilege statutes); Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 553-56 (2003) (describing choice of law dilemma).

24. See generally BLACK’S LAW DICTIONARY 1489 (6th ed. 2001). A “tort” is defined as a “civil wrong for which a remedy may be obtained, usu[ally] in the form of damages; a breach of a duty that the law imposes on everyone in the same relation to another as those involved in a given transaction.” *Id.*

25. See RESTATEMENT (SECOND) OF TORTS § 283 (1965) (highlighting rationale underlying tort system and reasonableness standard). The Restatement provides “the standard is one which is fixed for the protection of persons other than the defendant.” *Id.*; see also G. EDWARD WRIGHT, TORT LAW IN AMERICA: AN INTELLECTUAL HISTORY 3-19 (2003) (outlining origin of tort system).

26. See generally Elizabeth L.B. Greene, et al., *Massachusetts Superior Court Civil Practice Jury Instructions: Medical Malpractice*, in MASSACHUSETTS SUPERIOR COURT CIVIL PRACTICE JURY INSTRUCTIONS ch. 4 (2003) (defining medical malpractice).

Negligence of a physician who practices a specialty consists of a failure to exercise the degree of care and skill of the average qualified physician practicing that specialty, taking into account the advances in the profession at the time of the alleged negligent act and the medical resources available to the physician.

knowledge and capability from the professional in the particular field, and subsequently, that the service provided will match the advertised level of expertise.²⁷ The public benefits from a tort system that embraces equity by holding professionals, such as medical providers, to a universally accepted standard which will return an injured party to the status quo while simultaneously mitigating future mistakes and resulting harm.²⁸

Medical malpractice claims increased drastically in recent decades, purportedly leading to higher costs, defensive medical practice, and ultimately, decreased quality of care.²⁹ The medical establishment maintains that increased regulation of, and insulation from, these claims is necessary to prevent a dramatic decline in overall quality of care.³⁰ This type of regulation and absolute insulation from malpractice claims, however, conflicts directly with the interests of those left injured by the alleged incidents.³¹ In response to the emergence of medical error as a chief concern among those in the medical community, reporting systems surfaced as a commonly used mechanism to quell the decrease in quality of care, and, in turn, medical malpractice claims.³²

Using reporting systems as a means of quality control is not unique to health care facilities.³³ Such reporting systems subsist in various forms and in a

Id. § 4.1.

27. See *P.T. v. Richard Hall Cmty. Mental Health Care Ctr.*, 837 A.2d 436, 445 (N.J. Super. Ct. Law Div. 2002) (discussing public policy rationale behind medical malpractice litigation). The court held that authorities must charge professionals with certain duties in order to safeguard the public from certain harmful excesses. *Id.*; *Moses v. McWilliams*, 549 A.2d 950, 964-65 (Pa. Super. Ct. 1988) (maintaining duty of medical care encompasses total duty to patient).

28. See *supra* notes 24-27 and accompanying text (summarizing benefit of current tort and malpractice system).

29. See W. John Thomas, *The Medical Malpractice "Crisis": A Critical Examination of a Public Debate*, 65 TEMP. L. REV. 459, 476-503 (1992) (summarizing cost-benefit analysis relative to medical malpractice claims).

30. *Id.* at 462-63 (noting physician response to supposed malpractice crisis). The majority of physicians today concentrate on limiting malpractice claims in lieu of decreasing the number of medical errors that lead to such claims. *Id.* at 462. To accomplish this goal, the medical community has utilized such tactics as lobbying lawmakers to adopt measures preventing certain claims, limiting potential recovery and increasing plaintiffs' financial burdens. *Id.* at 462-63.

31. See *supra* notes 24-27 and accompanying text (evaluating malpractice process and injured patients' rights).

32. See generally INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 86-108 (discussing creation of and rationale for error reporting systems in healthcare).

33. See Larry Keller, *Evaluating the Evaluations, Employee Reviews: Do They Work?* (Jan. 23, 2001), at <http://www.cnn.com/2001/CAREER/trends/01/22/appraisals/index.html> (comparing success rate of existing internal reviewing systems). Approximately eighty percent of all United States companies engage in some form of employee evaluation program. *Id.* Among those firms, however, approximately eighty-five percent are dissatisfied with the appraisal system. *Id.* As a byproduct of this dissatisfaction, companies tend to restructure their programs every three to five years in hopes of making them more effective. *Id.* In addition to continual discontent among those implementing the programs, there are other problems. *Id.* First, managers, or those in supervisory positions, tend to rate employees more highly in an effort to motivate them as workers and increase productivity. *Id.* Also, while the employees subjected to negative reviews will inherently question the reviewer's credibility, the system offers no occasion for the accused to face his or her accuser. *Id.* This becomes problematic because the decisions made by these committees significantly affect that individual's

number of industries.³⁴ For example, aviation, space, road and rail travel, as well as nuclear power and chemical processing each employ forms of standardized reporting.³⁵ Although these systems all operate with an eye towards improving the quality of their respective product or service, they vary significantly in both form and procedure.³⁶ Some of the systems mandate reporting, while others are entirely voluntary.³⁷ Some require individual reports, whereas others receive reports only from the organization as a whole.³⁸ The distinctions lie not only across industry lines, but also within the health care context itself.³⁹ In addition to physical discrepancies, reporting systems differ considerably in scope.⁴⁰ While health care reporting systems tend to be narrower in focus, many programs seek a more expansive reach.⁴¹

Reporting systems in health care facilities typically serve two core functions:

future pay and employment opportunities. *Id.*

34. See BARACH & KELLEY, *supra* note 2, at 4 (noting multitude of occupational fields which have implemented internal regulatory processes). See generally Amtrak Customer Advisory Committee at <http://www.amtrak.com/about/acac.html> (last visited Feb. 19, 2005) (describing quality control measures implemented by company). The National Railroad Passenger Corporation (Amtrak) established the Customer Advisory Committee (ACAC) to facilitate communication lines with its customers and to improve the quality of the service provided. *Id.* The ACAC, comprised of customers from all over the United States, meets several times a year with senior management to exchange concerns and suggestions with an eye toward achieving informed feedback in the areas of representing passenger interests and increasing overall safety. *Id.*; see also United States Department of Agriculture, Grain Inspection, Packers and Stockyards Administration, Federal Grain Inspection Service, *Quality Handbook*, 1-83 (Oct. 1996) (setting forth general quality control initiatives). The Department of Agriculture implements a multi-tiered system of review to regulate the quality of domestic grain production. United States Department of Agriculture, *supra*, at 9. A Federal Grain Inspection Service ensures that the regionalized quality control systems in place help to meet and even exceed customer expectations. *Id.* An ad hoc fact-finding team makes an annual report on the effectiveness of the national quality assurance system. *Id.* at 10. Moreover, a “Special Purpose Inspection Quality Review” team is summoned to investigate findings of unusual grain quality in the marketplace. *Id.* at 77. The handbook stresses personal commitment at all levels of quality assurance processes. *Id.* at 3. Without such commitment, such programs become “just more paper” with little effect on daily operations. *Id.*

35. BARACH & KELLEY, *supra* note 2, at 4 (listing industries that utilize standardized reporting).

36. See INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 86-109 (describing variety in physical structure and operational form of reporting systems).

37. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 86-90. Mandatory reporting systems tend to focus on holding providers who have committed medical error accountable for their mistakes. *Id.* at 86. The incidents reviewed are typically larger in scale, such as errors that result in death or serious injury. *Id.* State regulatory boards generally enforce these mandatory systems by threat of penalties or fines for wrongdoing. *Id.* Systems that focus on improving overall safety, rather than mitigating and punishing specific incidents are typically voluntary in nature. *Id.* at 87. These systems concentrate more on identifying and remedying “near misses” before any significant harm actually results. *Id.*

38. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 90. Institutionally produced reports often indicate their facility’s overall dedication to improving its quality of care. *Id.* Conversely, reports from individual practitioners who are actually providing the treatment arguably accords the information increased validity because it comes from a more direct source. *Id.*

39. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 90.

40. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 90.

41. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 90. The author cites reporting systems focusing on medication error as an example of the specificity typical of health care reporting systems. *Id.*

to hold providers accountable for their performance and, alternatively, to impart certain information that will increase general safety in connection with medical care.⁴² While theoretically compatible, these goals are often difficult to implement at the same time.⁴³ To alleviate some of these difficulties, most states either mandate some form of reporting system explicitly by statute or make certain licensing and funding contingent on the existence of these programs such that hospitals and other health care providers cannot function without their existence.⁴⁴

Medical peer review committees, the preferred reporting method among health care providers, focus primarily on improving patient injury rates, but typically also discuss any other issue its participants deem worthy of deliberation.⁴⁵ The reports are generally submitted by hospitals or nursing homes, but are also provided by other licensed facilities such as ambulatory care centers.⁴⁶ Many health care experts designate the peer review process and the protective statutes as among the “most promising” sources for collecting data on medical errors.⁴⁷

The scope and reach of peer review programs fluctuate tremendously because the statutory definitions, guidelines and protections vary considerably.⁴⁸ These discrepancies render peer review statutes a problematic source of legal security in the collection of medical error data.⁴⁹ For example,

42. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 86 (articulating functions of internal reporting systems within health care institutions).

43. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 86.

44. *See* MASS. GEN. LAWS ch. 111, § 203(d) (2003) (making licensure contingent on hospitals' participation in risk management programs). The statute provides that the board of medicine should make sure that certain risk management processes are in place in hospitals throughout Massachusetts. *Id.* In order to assure compliance with this order, the statute mandates that hospital licensure be conditional upon the creation of such committees. *Id.*

45. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 91 (describing mandatory reporting systems utilized in several jurisdictions).

46. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 91. The type of health care facility from which the Board requires mandating varies considerably from state to state. *Id.* For example, in 1996, Connecticut determined that of the 15,000 total reports it received from health care providers, 14,000 of those came from nursing homes. *Id.*

47. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 119.

48. *See* Charles D. Creech, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 182-89 (1988) (elucidating scope of privileges). Most of the statutory language is similarly themed, though the precise language may differ. *Id.* at 182. Generally, the statutes define the medical peer review committee, some providing greater detail as to specific characteristics needed to qualify as a committee. *Id.* at 182-83. The specificity of the definition varies enormously from state to state. *Id.* Most of the statutes list what types of materials shall be protected. *Id.* at 183-84. While most of the statutes protect documents created within the committee proceeding, variations arise relative to documents produced indirectly as a result of activities surrounding the committee. *Id.* In this regard, the statutes create an implicit ambiguity by neglecting to specifically designate which records or reports are privileged and which are not. *Id.* at 183-85.

49. *See* Graham, *supra* note 7, at 138 (concluding scope of peer review privileges often complicated and not easily attainable); *see also* Creech, *supra* note 48, at 182 (criticizing inconsistency with which courts enforce peer review statutes). No one benefits from a “half-hearted” privilege. Creech, *supra* note 48, at 182. When a privilege is enforced with ambivalence, the result is “a game of semantics that leaves parties twisting in

while some peer review statutes only protect documents created by the committees, other statutes protect any document produced within or given to that committee.⁵⁰ Moreover, the statutory definitions of a qualifying peer review committee also differ considerably from state to state.⁵¹

Peer review committees are most always comprised of employees from within the institution, so despite their effectual discrepancies, structurally they are often quite similar.⁵² The committee's members participate in a roundtable type forum in which they discuss either specific mistakes or general performances of their fellow staff members, with an eye toward improving the overall quality of care.⁵³ Although specific state legislative mandates vary, peer review committees typically identify, isolate, and remedy incidents of medical error.⁵⁴

Medical professionals describe medical error as an "inadvertent or an unintended occurrence in the course of a health care delivery" that may cause an injury to the patient.⁵⁵ The medical community utilizes a number of mechanisms as part of a systematic process that works to alleviate such medical error, including disciplinary action from licensing boards, malpractice lawsuits, and peer review.⁵⁶ Both health care providers and legislators acknowledge that peer review is crucial to achieving the requisite reporting of medical error needed to adequately improve the overall quality of care.⁵⁷ While in theory peer review created an avenue by which physicians could thoroughly and precisely weed out sources of medical error, disincentives to accurate reporting, such as potential future liability, emerged as considerable obstacles.⁵⁸

the wind while lawyers determine its scope." *Id.*

50. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 120-21 (summarizing general structure of peer review systems).

51. INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 120-21.

52. Scheutzow, *supra* note 13, at 12-13 (outlining physical structure of peer review committees).

53. Scheutzow, *supra* note 13, at 12 (detailing types of action peer review committees generally utilize to fulfill their purpose). These committees decide whether the staff member they are critiquing should continue to provide health care services at that institution given the quality of service he or she has provided to date. *Id.*

54. Scheutzow, *supra* note 13, at 13-14 (identifying peer review purposes). Peer review groups analyze and critique quality of care rendered by the medical staff. *Id.* at 13. On the occasion the group identifies an incident of inadequate care, their objective then becomes to either prevent the care from continuing or cause the physician to improve the care that is provided. *Id.*

55. Bryan A. Liang, *Promoting Patient Safety Through Reducing Medical Error: A Paradigm of Cooperation Between Patient, Physician, and Attorney*, 24 S. ILL. U. L.J. 541, 542 (2000) (defining medical error for purposes of peer review analysis).

56. See Scheutzow, *supra* note 13, at 14-15 (delineating potential quality control measures available to health care providers). Licensing boards tend to focus their inquiries on physicians in private practice, while peer review committees tend to evaluate physicians at hospitals. *Id.* at 14. Medical malpractice actions, in theory, achieve the same end via the threat of civil liability and financial punishment. *Id.* at 15.

57. See Scheutzow, *supra* note 13, at 7-8 (noting legislatures have tendency to value effective peer review).

58. See Graham, *supra* note 7, at 112-13 (summarizing disincentives to reporting which historically stymied participation in peer review committees). The author notes fear of personal rejection by one's peers, financial loss via diminution of potential referrals, and civil liability as reasons for discouraging physician

Consequently, nearly every state enacted laws protecting the peer review procedure in order to facilitate the reduction in medical error and improve the quality of care.⁵⁹

B. Medical Peer Review Statutes

Peer review statutes generally appear in one of three forms, though they all operate to promote the free exchange of ideas by removing disincentives to participation.⁶⁰ The first type grants full immunity from future litigation for all peer review participants.⁶¹ Other states have enacted statutes making materials connected with the peer review proceedings entirely privileged from the discovery process.⁶² Finally, there are statutes that make peer review material confidential, thereby precluding any disclosure to third parties even outside of the judicial process.⁶³ Most statutes contain at least one, if not all, of these provisions in some form.⁶⁴ These peer review statutes came about in the 1980s largely in response to congressional findings that both the increasing occurrence of medical malpractice lawsuits and the need to improve the quality of medical care had become national problems.⁶⁵

participation in peer review. *Id.* These disincentives posed enough of an obstacle to effectively chill the quality management and assurance programs. *Id.*

59. Kohlberg, *supra* note 6, at 157 (acknowledging almost every state has peer review statute). *But see* Scheutzow, *supra* note 13, at 11 (admonishing peer review statutes for not providing ample protection). While peer review laws provided satisfactory protection against legal retribution, disincentives still existed in the form of non-legal risks such as contemptuous reaction from fellow employees and loss of referrals. *Id.*

60. *See Swatch v. Treat*, 671 N.E.2d 1004, 1007 (Mass. App. Ct. 1996) (identifying importance of confidentiality in peer review process). The *Swatch* court noted that peer review committee members require the security of knowing their words and actions related to the peer review will not bear negatively on them in the future. *Id.*; *see also* Scheutzow, *supra* note 13, at 9 (addressing three ways by which states encourage peer review). While protective statutes are the norm, some states additionally require hospitals to report peer review findings to state authorities and threaten penalties for failure to do so. Scheutzow, *supra* note 13, at 9.

61. Susan O. Scheutzow & Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined than Real*, 7 J.L. & HEALTH 169, 175-79 (1993) (expounding upon peer review immunity statutes).

62. *Id.* at 179-90 (examining peer review privilege statutes). *But see* *Univ. of Pa. v. EEOC*, 493 U.S. 182, 189 (1990) (cautioning recognition of new privilege against disclosure of peer review materials); *Graham*, *supra* note 7, at 114-15 (discussing courts' preference for liberal discovery and tendency towards heavy scrutiny of new privileges). Courts agree in large part that privileges to discovery pose as obstacles impeding the fact-finding process, and as such must be scrutinized closely and limited in application in order to balance the interests of the parties involved. *See, e.g.*, *Greater Newburyport Clamshell Alliance v. Pub. Serv. Co. of N.H.*, 838 F.2d 13, 20 (1st Cir. 1988) (highlighting need to implement balancing test to determine materiality of potentially privileged information); *Mello v. Hingham Mut. Fire Ins. Co.*, 656 N.E.2d 1247, 1250-51 (Mass. 1995) (rejecting plaintiff's attempt to escape certain obligations by claiming privilege); *Wojcik v. Boston Herald, Inc.*, 803 N.E.2d 1261, 1264-65 (Mass. App. Ct. 2004) (acknowledging plaintiff's need for requested discovery outweighed defendant's interest in withholding same).

63. Scheutzow & Gillis, *supra* note 61, at 192-95 (summarizing peer review confidentiality statutes).

64. *See* Scheutzow, *supra* note 13, at 58-62 (listing state peer review statutes).

65. The Health Care Quality Improvement Act of 1986, Pub. L. No. 99-660, Title IV, § 402, 100 Stat. 3784 (codified as amended at 42 U.S.C. § 11101 (2003)) (itemizing various congressional rationales for implementing federal measures protecting professional review systems). Congress determined that the states

In 1986, the public perceived a medical malpractice crisis and Congress reacted by enacting the Health Care Quality Improvement Act (HCQIA) to achieve two objectives: to grant immunity to peer review committee members, and to require hospitals to consult a national data bank when granting or removing staff privileges, thereby preventing physicians with quality care problems from simply moving from one hospital to another with impunity.⁶⁶ Though the HCQIA did not specifically create a peer review privilege, it clearly indicated that Congress believed that the medical malpractice crisis had become a national crisis that necessitated immediate remedial action.⁶⁷ The vast majority of states, including Massachusetts, followed suit by codifying various degrees of confidentiality pertaining to peer review committees and their work product.⁶⁸

Massachusetts General Law chapter 111, section 204, enacted in 1986, provides in pertinent part that “the proceedings, reports and records of a medical peer review committee . . . shall not be subject to subpoena or discovery.”⁶⁹ Approximately one year later, the legislature enacted Massachusetts General Law chapter 111, section 205 to elucidate some ambiguities in the language of the first peer review statute.⁷⁰ The new version expanded the scope of privileged materials to include any materials “necessary” to comply with requirements set forth by the board of registration in medicine, and “necessary” to the committee’s work product.⁷¹

alone were not capable of dealing with the increasing number of medical malpractice lawsuits. *Id.* There existed an “overriding national need” to incentivize participation in professional peer review by protecting contributors from potential private money damages stemming from their participation in the review. *Id.*

66. Scheutzow, *supra* note 13, at 9-10, 17-18 (examining purposes for and policy rationales behind enacting HCQIA).

67. *See supra* notes 65-66 and accompanying text (outlining congressional findings).

68. Graham, *supra* note 7, at 112 (finding states responded to HCQIA by enacting peer review statutes); *see also* Carr v. Howard, 689 N.E.2d 1304, 1306-07 (Mass. 1998) (highlighting history and rationale behind codification of peer review privilege).

69. *See* MASS. GEN. LAWS, ch. 111, § 204 (2003) (addressing confidentiality of peer review records). Subsections (b), (c) and (d) expound upon the parameters of the privilege. *Id.* Subsection (b) provides that documents such as incident reports, created outside of the peer review forum, are not privileged. *Id.* Section (c) states that the protection does not apply to testimony of matters known independent of the peer review proceeding. *Id.* Finally, subsection (d) allows for courts and other administrative bodies to use sound judgment to protect the confidentiality of the peer review process. *Id.*

70. *See* Grande v. Lahey Clinic Hosp., Inc., 725 N.E.2d 1083, 1085 (Mass. App. Ct. 2000) (detailing procedural history of Massachusetts’ peer review statutes).

71. MASS. GEN. LAWS, ch. 111, § 205 (2003). Subsection (b) of the statute provides that:

[i]nformation and records which are necessary to comply with risk management and quality assurance programs established by the board of registration in medicine and which are necessary to the work product of medical peer review committees . . . shall be deemed to be proceedings, reports or records of a medical peer review committee.

Id. Subsection (a) defines the applicable facilities and programs that the statute effects. *Id.* “Health care facility” includes any entity that the Board of Registration in Medicine mandates be required to partake in risk management and quality assurance programs. *Id.* Likewise, “programs” include “[r]isk management and quality assurance programs established by the board of registration in medicine, programs and activities undertaken pursuant to regulations promulgated by the board of registration in medicine.” *Id.*

Nearly every state enacted statutes similar in form to the Massachusetts version, affording protection from liability for peer review participants.⁷² Those negatively effected by these new privileges, including physicians fired pursuant to peer review committee findings and litigants in medical malpractice actions challenged the statutes soon after their inception.⁷³ Several reviewing courts found the statutory language in question ambiguous on its face and thus subject to judicial interpretation as to legislative intent.⁷⁴

C. Judicial Review of Medical Peer Review Statutes

Most courts construe discovery rules in a liberal manner to facilitate their truth-seeking purpose.⁷⁵ Privileges to the discovery process act as mechanisms that keep certain information from being used as evidence.⁷⁶ In light of the general sentiment favoring unimpeded and liberal discovery, courts have typically applied heightened scrutiny when adjudicating a challenge to such a privilege to ensure that the costs of enforcing it did not outweigh the benefits.⁷⁷ This near universal hesitancy to enforce overreaching privileges that weaken the discovery process has prompted federal courts, as well as a number of state courts, including Massachusetts, to refuse to create a common law privilege for

72. See *supra* note 11 and accompanying text (noting peer review statutes exist in nearly every state).

73. See *infra* notes 81-97 and accompanying text (outlining lawsuits brought in Massachusetts subsequent to passage of peer review statute).

74. See *Reid v. Lockheed Martin Aeronautics Co.*, 199 F.R.D. 379, 382-88 (N.D. Ga. 2001) (recognizing inconsistent holdings among jurisdictions with respect to peer review statutes). The *Reid* court acknowledged that in the thirty years since peer review privileges emerged, the judicial response in cases challenging those privileges had been inconsistent at best. *Id.* at 382. “The Supreme Court and the circuit courts have neither definitively denied the existence of such a privilege, nor accepted it and defined its scope.” *Id.* (quoting *Dowling v. Am. Haw. Cruises, Inc.*, 971 F.2d 423, 425 n.1 (9th Cir. 1992)); see also *Commonwealth v. Choate-Symmes Health Servs., Inc.*, 545 N.E.2d 1167, 1167 (Mass. 1989) (commenting on court’s role in construing ambiguous statutory language); *Graham, supra* note 7, at 125-38 (describing interpretive variations utilized by state courts when faced with challenges to peer review statutes). The manner of interpretation typically hinges on balancing the policy of improved health care with that of maintaining liberal discovery for litigants. *Graham, supra* note 7, at 125. In some states, such as Florida and North Carolina, the state courts adopted an expansive approach to interpreting peer review statutes, embracing medical staff candor even at the cost of impairing plaintiffs’ ability to retrieve certain evidence. *Id.* at 125-31. Other states toe a delicate line, carefully acknowledging the incompatibility between peer review statutes and unhindered access to all relevant information. *Id.* at 131-35. Still other states, such as Illinois and Rhode Island, espouse a system that adheres as much as possible to the truth-seeking goals characterizing liberal discovery rules. *Id.* at 135-38.

75. See *United States v. Nixon*, 418 U.S. 683, 709-10 (1974) (stressing necessity for free flow of information to facilitate search for truth).

76. See *United States v. Bryan*, 339 U.S. 323, 331-32 (1950) (explaining rationale for retarding factual exchange process in favor of protecting certain real interests). The public generally has the right to “every man’s evidence,” except for that evidence subject to some constitutional, common law or statutory privilege. *Id.* at 331.

77. *Nixon*, 418 U.S. at 709-10 (addressing negative impact of privileges and importance of careful assessment and critique of their effect). The Court acknowledged that privileges such as attorney-client and priest-parishioner protected legitimate interests. *Id.* It warned, however, that “these exceptions to the demand for every man’s evidence are not lightly created nor expansively construed, for they are in derogation of the search for truth.” *Id.*

medical peer review work product.⁷⁸ As such, reviewing courts are left to make sense of this ambiguous statutory language.⁷⁹

Soon after the legislature enacted chapter 111, section 204, Massachusetts courts regularly upheld the medical peer review privilege against challenges to its validity.⁸⁰ In 1987, the Massachusetts Supreme Judicial Court (SJC), in *Beth Israel Hospital Ass'n v. Board of Registration in Medicine*,⁸¹ invalidated a regulation requiring hospitals to permit certain board members access to patient care assessment information, to the extent that such information consisted of medical peer review proceedings, reports and records.⁸² The court concluded that it would make little sense for the legislature to make peer review records privileged without intending that such privilege be enforced when challenged.⁸³

Approximately two years later, the SJC again confronted the task of construing this ambiguous statutory language.⁸⁴ In *Commonwealth v. Choate-Symmes Health Services, Inc.*,⁸⁵ the court reinforced its support for the privilege.⁸⁶ The Board of Registration in Medicine sought to obtain peer review committee records in its preliminary investigation of a physician, but the court deferred to its position in *Beth Israel Hospital Ass'n*.⁸⁷

In 1998, the SJC decided *Carr v. Howard*,⁸⁸ considered by many to be the seminal decision regarding medical peer review in Massachusetts.⁸⁹ In *Carr*,

78. See *Carr v. Howard*, 689 N.E.2d 1304, 1306 (Mass. 1998) (noting lack of common law privilege for medical peer review committee materials in Massachusetts). *But see* *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970) (holding confidentiality essential to meaningful deliberation in staff meetings). The *Bredice* court found that staff meetings required a degree of confidentiality to realize the goal of continued improvement in patient care and treatment. *Id.*; Creech, *supra* note 48, at 140. Subsequent opinions have cited *Bredice* with mixed reaction in determining whether such a common law privilege exists in the peer review forum. Creech, *supra* note 48, at 190.

79. See *supra* notes 75-78 and accompanying text (summarizing why and how courts tend to interpret peer review statutes).

80. See *infra* notes 81-92 and accompanying text (summarizing Massachusetts case law upholding peer review statutory privilege).

81. 515 N.E.2d 574 (Mass. 1987).

82. *Id.* at 579 (invalidating defendant's interpretation of existing statutory privilege). Following a legislative order requiring the Board of Medicine to become proactive in identifying medical error and to improve the quality of patient care, the Board adopted certain regulations which called for the creation of risk management programs in Massachusetts hospitals. *Id.* at 576. Numerous hospitals joined in an action challenging the regulations, arguing that at least part of the regulations directly violated the existing statutory privilege protecting "proceedings, records and reports" of peer review committees. *Id.* at 579.

83. *Id.* at 579-80 (finding Board's argument unpersuasive and reinforcing peer review privilege).

84. *Commonwealth v. Choate-Symmes Health Servs., Inc.*, 545 N.E.2d 1167, 1167 (Mass. 1989) (citing *Beth Israel Hospital Ass'n* in which court examined similar issue).

85. 545 N.E.2d 1167 (Mass. 1989).

86. *Id.* at 1168 (finding documents associated with peer review not accessible). The SJC re-affirmed its determination that the legislature intended the peer review process remain privileged, noting the Board of Registration should petition the legislature to alter the statute if it wanted preliminary access to the records. *Id.*

87. *Id.* (adhering to precedent).

88. 689 N.E.2d 1304 (Mass. 1998).

89. *Id.* at 1305-06 (setting forth factual premise of case). A psychiatric patient broke away from hospital employees on the fifth floor of a parking garage and jumped to his death, landing on the plaintiff. *Id.* at 1305.

the court held that an incident report utilized by, but not created within the peer review committee, was nonetheless privileged and therefore not discoverable because the report was necessary to comply with the established risk management program, and to the committee's work product.⁹⁰ The court also denied the plaintiff's motion for an in camera review.⁹¹ *Carr* expanded the peer review privilege to any material utilized by a committee necessary to achieve improved quality of care, and further narrowed potential access to this information by rejecting in camera review of the privilege's applicability.⁹²

While *Carr* signified the apex of judicial deference to the medical peer review privilege in Massachusetts, the courts have more recently indicated that such deference may be dissipating.⁹³ In *Miller v. Milton Hospital & Medical Center, Inc.*,⁹⁴ the Massachusetts Appeals Court held that a letter from the chief of surgery to the hospital president was not covered by the medical peer review privilege because, if admitted, it would present material issues of fact that otherwise would not exist.⁹⁵ The court explained that its analytic focus in determining whether a particular document constitutes a peer review proceeding, record or report should include inquiry into the document's purpose in addition to the manner in which it was created.⁹⁶ The *Miller* court

The plaintiff filed suit against the administratrix of the decedent's estate, who then filed a third-party action against the hospital for indemnification. *Id.* The plaintiff subpoenaed certain records related to the patient's death. *Id.* The hospital refused to produce the incident reports on the grounds that the records were privileged pursuant to Massachusetts General Law chapter 111, sections 204 and 205. *Id.* at 1305.

90. *Id.* at 1310 (holding incident report privileged provided hospital created document in accordance with proper facility protocol). In reaching its holding, the court noted the word "necessary" as it appears in chapter 111, section 205(b) does not imply that a peer review committee must exhaust every potential alternative means of procuring information before utilizing the actual record. *Id.* Incident reports, by virtue of their importance to the peer review process, are necessary to the committee accomplishing its goals and to its work product. *Id.*

91. *Id.* at 1314 (holding in camera review not warranted). The court rejected an in camera review to determine whether certain incident reports should be discoverable on the premise that such review should be relegated to a last resort in the medical peer review process. *Id.* at 1313. The party asserting the privilege merely has the burden of showing the material it seeks to protect is necessary to the committee's general work product, and is complying with the mandated risk management program. *Id.* In this case, the hospital satisfied that burden by providing affidavits reinforcing the existence of such necessity. *Id.* at 1313.

92. See *Carr v. Howard*, 689 N.E.2d 1304, 1310 (Mass. 1998) (expanding on statutory mandate requiring privileged material be "necessary" to risk management program); see also *id.* at 1313 (holding litigants may only turn to in camera review as a last resort).

93. See Kohlberg, *supra* note 6, at 158 (noting trend among state courts to subordinate peer review privilege to competing legal interests).

94. 766 N.E.2d 107 (Mass. App. Ct. 2002).

95. *Id.* at 109 (holding evidence offered could potentially alter summary judgment decision if admitted). In *Miller*, Dr. Miller signed a contract to act as chief of emergency medicine at the Milton Hospital & Medical Center. *Id.* Soon thereafter, Dr. Miller and the chief of surgery came to a disagreement over the follow-up procedure for surgical patients in the emergency room. *Id.* at 109-10. Following this disagreement, the chief of surgery wrote a letter to the hospital president, who in turn terminated Dr. Miller's contract without renewal. *Id.* at 110. At trial, Dr. Miller attempted to admit the letter from the chief of surgery to the president but the Massachusetts Superior Court allowed a motion in limine denying such admission as per Massachusetts General Law chapter 111, section 204. *Id.* at 109. The appeals court reversed, holding that the defendants failed to sustain their burden establishing the letter as a peer review product. *Id.* at 112.

96. *Id.* at 111 (quoting *Carr v. Howard*, 689 N.E.2d, 1304 (Mass. 1998)) (stating proper analysis for

further established that the burden falls on the party claiming the privilege to meet the proper qualifications.⁹⁷

Courts in a number of jurisdictions have encountered similar obstacles in evaluating and interpreting their peer review statutes.⁹⁸ This inconsistent enforcement has raised questions as to the overall legitimacy and effectiveness of peer review statutes.⁹⁹ The lack of any conclusive studies that definitively establish the success rate of medical peer review exacerbates this doubt.¹⁰⁰ Rather than provide support for maintaining these committees, studies instead indicate that implementation of a peer review program actually has little bearing on incidents of medical error at any given health care institution.¹⁰¹ If peer review committees do not improve the quality of care by decreasing occurrences of medical error, privileges extended to such programs only serve to deprive certain litigants of proper judicial recourse.¹⁰²

III. ANALYSIS

Health care providers confer an essential and inimitable service.¹⁰³ Given the indispensable nature of the service, implementing measures that control the quality of care seems justified, if not obligatory.¹⁰⁴ Such obligations, however,

evaluating peer review privilege claims).

97. *Id.* at 112 (holding defendant failed to sustain its burden).

98. *See supra* note 74 and accompanying text (describing ambiguity among different jurisdictions in response to challenges to peer review statutes).

99. *See Creech, supra* note 48, at 179-82 (commenting on current state of peer review privilege statutes). By inconsistently limiting the scope of these statutes, courts effectively undermine the legislature's intentions. *Id.* at 181. The author maintains "[n]othing is worse than a half-hearted privilege; it becomes a game of semantics that leaves parties twisting in the wind while lawyers determine its scope." *Id.* at 182.

100. *See Scheutzow, supra* note 13, at 10 (analyzing study suggesting peer review statutes not meeting public policy objectives).

101. *See generally* Department of Health and Human Services, Office of Inspector General, *Hospital Reporting to the National Practitioner Data Bank* (1995), available at <http://oig.hhs.gov/oei/reports/oei-01-94-00050.pdf> [hereinafter *OIG Report*] (finding peer review programs do not reduce medical error). In 1986, Congress enacted the HCQIA, which established the National Practitioner Data Bank. *See supra* note 65 and accompanying text (describing context which led to congressional enactment of HCQIA). From September 1, 1990 to December 31, 1993, seventy-five of all hospitals did not report a single adverse event. *OIG Report, supra*, at 3. During that period, the approximately 6,500 hospitals nationwide reported only 3,154 incidents of medical error. *Id.* Furthermore, studies cast doubt on the legitimacy of peer-to-peer evaluation in the first place. *Scheutzow, supra* note 13, at 16. A 1992 survey found "physician agreement regarding quality of care is only slightly better than the level expected by chance." *Id.*

102. *See Scheutzow, supra* note 13, at 8-9 (suggesting peer review protection not justified if stated purpose not achieved). Peer review statutes constrain the judicial process by excluding relevant evidence. *Id.* at 8. If peer review does not enhance the quality of care, these statutes are relegated to special interest laws that protect hospitals and certain physicians at the expense of justice. *See id.* at 9.

103. *See generally* Harvard Medical School, *History*, at <http://www.hms.harvard.edu/about/history.html> (last visited Mar. 23, 2005) (outlining program's role in training future medical practitioners). "For over two centuries Harvard Medical School has been a major participant in the effort to understand life, to cure and prevent disease, and to reduce the burden of human illness." *Id.*

104. *See supra* note 15 and accompanying text (noting necessity for quality control measures because of high number of preventable deaths).

should not open the door for *carte blanche* protections that largely ignore hundreds of years worth of tort doctrine.¹⁰⁵ While peer review statutes arguably eradicate certain reticence among the members of these committees, legislatures resolved to cure one defect by creating another of equal or even greater consequence.¹⁰⁶

American jurisprudence has long regarded the free flow of information as a fundamental attribute of a legal system that values equity above all else.¹⁰⁷ Historically, courts in nearly every jurisdiction have applied heavy scrutiny upon derogations to this informational flow, such as privileges exempting certain material from discovery.¹⁰⁸ In light of recent decisions such as *Miller*, Massachusetts courts have indicated their allegiance to this philosophy of liberal discovery by limiting the range of peer review materials that may properly be exempted.¹⁰⁹ The medical peer review statutes in Massachusetts should be repealed or at least amended to conform to these general sentiments toward fairness and away from favoritism.¹¹⁰

The predicament at hand arises because two entities co-exist, each advocating conflicting agendas.¹¹¹ Hospitals and other health care providers want to maximize participation in peer review to improve their overall product and reduce medical error.¹¹² Patients injured by that medical error, and those who otherwise suffer from peer review findings, benefit from access to the information formed within or utilized by peer review committees.¹¹³ Legislatures that have enacted peer review protective statutes apparently value the former over the latter, because injured patients undoubtedly lose some ability to achieve rectification when they cannot access records concerning their medical treatment.¹¹⁴ While any legislative process inherently involves some qualities tending toward favoritism, a congressional body should ensure

105. See *supra* note 14 (discussing inequity imposed on litigants); see also *supra* notes 24-27 (expounding upon history of tort doctrine and its purposes).

106. See *supra* notes 81-97 and accompanying text (summarizing judicial interpretation of congressional intentions regarding peer review statutes).

107. See *supra* notes 75-77 and accompanying text (discussing judicial tendency to uphold discovery process against unwarranted privileges).

108. See *supra* notes 75-77 and accompanying text (describing scrutiny applied to privilege exceptions).

109. See *supra* notes 94-97 and accompanying text (addressing *Miller* and its repercussions).

110. See *supra* note 102 and accompanying text (assessing inherent unfairness in system that confers benefit upon medical providers without confirming its effectiveness).

111. Compare *supra* notes 26-27 and accompanying text (acknowledging malpractice lawsuits necessary to achieve equitable tort system), with INSTITUTE OF MEDICINE OF THE NATIONAL ACADEMIES, *supra* note 15, at 91, 119 (stressing peer review necessary to improve patient care).

112. See *supra* notes 45-47 and accompanying text (summarizing hospitals' stance on peer review statutes).

113. See *supra* notes 26-28 and accompanying text (summarizing outlook of those injured by medical error).

114. See *supra* note 6 and accompanying text (concluding passing of protective statutes indicative of legislative intent). But see *supra* notes 73-74 and accompanying text (noting ambiguous language emblematic of peer review statutes).

that its decisions actually achieve its stated goals, thereby justifying protecting one party at the expense of another.¹¹⁵ To the contrary, the medical peer review statutes do not lower incidents of medical error, and therefore do not meet the legislature's stated goals.¹¹⁶ Admittedly, these statutes remove some apprehension of the committee participants, but decreasing committee members' reluctance to participate is separate and apart from improving the overall quality of care.¹¹⁷

Privileges from discovery operate as a means to an end.¹¹⁸ In this case, the clearly specified objective is a decrease in medical error brought about by improving the quality of care.¹¹⁹ Hence, to justify the existence of peer review protection statutes that make committee product privileged, these laws must actually and unequivocally decrease incidents of medical error.¹²⁰ To date, however, no exhaustive study has linked the imposition of medical peer review statutes of any kind with a reduction in medical error occurrences.¹²¹ While health care professionals argue that these measures remove certain reservations about contributing to peer review, that openness, in and of itself, is clearly distinct from the alleviation of medical mistakes.¹²²

Further encumbering the efficacy of peer review statutes is the manifest lack of any homogeneity among both the programs themselves and their regulations.¹²³ Although a vast majority of states have adopted a peer review law of some type, no two statutes are precisely alike.¹²⁴ These discrepancies cause confusion for individuals who receive medical treatment at one facility and are then transferred across state lines for further treatment on the same injuries.¹²⁵ Moreover, the peer review programs often vary considerably, even among

115. See *supra* notes 19-20 and accompanying text (discussing necessity for legislative action to meet its stated objectives).

116. See *supra* note 18 and accompanying text (noting inability to connect peer review statutes to reduction in medical errors).

117. See Scheutzow, *supra* note 13, at 10-12 (discussing distinction between encouraging peer review and actually improving quality of health care).

118. See *supra* note 62 and accompanying text (describing privileges generally).

119. See *supra* note 9 and accompanying text (setting forth rationale behind creating protective peer review statutes). But see *supra* note 18 and accompanying text (pointing to lack of any conclusive studies linking statutes with actual reduction in medical error).

120. See *supra* note 19 and accompanying text (suggesting discovery privilege necessitates showing such exemption actually works).

121. *Supra* notes 13, 18, 100 and accompanying text (affirming no authoritative body has conducted study correlating implementation of protective statutes with stated purpose).

122. See *supra* note 101 and accompanying text (suggesting peer review statutes actually have little or no bearing on rate of medical error).

123. See *supra* notes 21, 48-51 and accompanying text (stressing expansive, diverse range of peer review systems and resulting effect).

124. *Supra* note 48 and accompanying text (comparing statutes and concluding no two contain unerringly parallel language).

125. See *supra* notes 21-23 and accompanying text (concluding similar material may be exempt from discovery in one jurisdiction while available in another).

intrastate health care facilities.¹²⁶ The lack of any statutory characterization relating to the composition of peer review committees puts those injured by the committees' findings in the predicament of having to identify what constitutes privileged material without sufficient instruction.¹²⁷

A privilege from discovery impedes the free flow of information and undermines the equitable grounds that support our jurisprudence.¹²⁸ Any such privilege must be termed plainly and applied consistently in order to retain any intimation of procedural evenhandedness.¹²⁹ The medical peer review statutes in Massachusetts leave a wake of inequity because they contain ambiguous language and have not achieved any documented reduction in incidents of medical error.¹³⁰

Peer review has emerged as the predominant quality control method utilized by those in health care.¹³¹ The amplified advocacy and dependency on peer review directly correlates with the passage of medical peer review statutes, such as the privilege bestowed in Massachusetts.¹³² Because these statutes negatively effect so many, an inquiry into whether peer review is indeed the most suitable process becomes commonsensical, if not necessary.¹³³

Such an inquiry reveals that peer review is not the most effective means to achieving better overall health care.¹³⁴ While in theory the process may seem infallible, in practice peer review becomes an arena pitting co-employees against one another plagued by personal bias, agendas and aspirations.¹³⁵ The

126. See *supra* notes 48-51 and accompanying text (expounding upon broad scope of peer review programs).

127. See *supra* note 51 and accompanying text (highlighting uncertainty caused by lack of statutory uniformity and variation in peer review systems).

128. See *supra* notes 75, 77 and accompanying text (reaffirming general judicial disdain for privileges because they tend to block "free flow" of information).

129. See *supra* notes 48-51, 60-64, 123-127 and accompanying text (discussing inherent unfairness in current peer review system).

130. See *supra* notes 74, 100-102 (recognizing ambiguity and lack of effectiveness as problems requiring attention).

131. See *supra* note 47 and accompanying text (designating peer review as vital process in determining causes of medical errors).

132. See *supra* notes 58-59 and accompanying text (noting importance of protective statutes in supporting efficacy of peer review process). See generally *supra* notes 69-71, 74-78, 81-97 and accompanying text (focusing on Massachusetts peer review statutes and their judicial treatment).

133. See *supra* note 14 and accompanying text (exposing harmful effect on potential litigants who are negligently injured in course of medical treatment); cf. *supra* note 34 and accompanying text (comparing quality control measures in other professions which do not have similar privileges).

134. See *supra* note 34 and accompanying text (comparing health care quality control measures to those in other professions); see also *supra* notes 100-102 and accompanying text (addressing overall ineffectiveness of peer review).

135. See *supra* note 33 and accompanying text (delineating inherent problems with wholly internal workplace regulation); see also Franklin D. Cleckley & Govind Hariharan, *A Free Market Analysis of the Effects of Medical Malpractice Damages Cap Statutes: Can We Afford to Live with Inefficient Doctors?*, 94 W. VA. L. REV. 11, 66-67 (1991) (highlighting ineffectiveness of internal regulation systems). "As is too often the case in many professions, self-regulation is a license for no regulation." Cleckley & Hariharan, *supra*, at 66.

medical establishment would benefit from shifting its focus away from internal peer review committees altogether.¹³⁶ Rather, a multi-tiered process, such as that implemented by Amtrak or the United States Department of Agriculture, conducted and regulated entirely by objective third party entities, would more effectively reduce medical error while eradicating the need for statutes such as Massachusetts General Laws chapter 111, section 204.¹³⁷

IV. CONCLUSION

Medical error presents a significant problem that necessitates attention. On first glance, a process by which employees discuss incidents of medical error internally would seem to effectively alleviate such occurrences. Problems arise, however, when these employees are granted certain legislatively created protections, such as those found in Massachusetts General Laws chapter 204, section 111.

The American tort system is premised upon an ideology of free flowing information that ultimately leads to just findings in any particular case. Historically, courts have reserved privileges that derogate this process for circumstances where either a potential litigant needs protection, such as the attorney-client privilege, or where social mores dictate such protection, as with the ecclesiastic privilege. Peer review committees do not satisfy either of these prerequisites.

Moreover, there is no proof that jurisdictions with peer review statutes more effectively reduce incidents of medical error than those without. In light of this realization, one may reasonably conclude that the harm to those negatively affected by the statutes outweighs any potential public benefit.

Statutes that confer a privilege from discovery upon peer review information should be repealed or amended to comport with fundamental theories of equity. If peer review cannot function effectively without these statutes in place to protect its participants, then hospitals and other health care facilities should remove this system as a quality control process altogether. Instead these institutions should explore other avenues to improve the quality of health care provided to patients by virtue of reducing incidents of medical error.

David L. Fine

136. See *supra* note 13 and accompanying text (setting forth number of reasons why peer review does not work as quality control measure); *supra* note 14 (criticizing statutes which protect peer review material from discovery as injurious to many factions); *supra* notes 100-102 and accompanying text (concluding statutes protecting medical peer review do not achieve objectives).

137. See *supra* note 34 and accompanying text (summarizing alternative quality control processes).