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When Revoking Privilege Leads to Invoking Privilege: Whether There Is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in Virmani v. Novant Health Inc.

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WHEN REVOKING PRIVILEGE LEADS TO INVOKING PRIVILEGE: WHETHER THERE IS A NEED TO RECOGNIZE A CLEARLY DEFINED MEDICAL PEER REVIEW PRIVILEGE IN *VIRMANI V. NOVANT HEALTH INC.*

I. INTRODUCTION

An obstetrician-gynecologist in a dark operating room performs surgery through several small incisions in the patient's abdomen with a device known as a laparoscope.[1] The surgeon inadvertently punctures an artery, creating an emergent situation, but is able to repair it and the patient recovers.[2] This scenario will often trigger a peer review investigation, where members of a committee will review an incident to determine whether a surgeon's skills and judgment met the standards of care in his or her practice area.[3] Peer review committees generally comprise selected members of the medical staff who volunteer to evaluate their peers according to hospital bylaws.[4]

Medical peer review began in earnest after 1952, when the Joint Commission on Accreditation of Hospitals (JCAH) imposed the requirement on hospitals as a means to obtain accreditation.[5] Although the peer review process identified physicians who were not practicing in accordance with the standards of care, there was no vehicle to disseminate this infor-

1. *See* MedicineNet, *Procedures & Tests*, *at* http://www.focusoncancer.com/script/main/art.asp?articlekey=944 (last visited Oct. 13, 2001) (describing laparoscopic procedure, history and advantages). Laparoscopic surgery is a technique to view the inner abdominal cavity with an instrument fitted with a tiny camera. *See id.* (describing procedure). This device allows the surgeon to perform the surgery while viewing the patient's internal organs on a television screen. *See id.* (describing device used).

2. *See, e.g.*, Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001) (citing facts of case).

3. *See* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J. L. & MED. 7, 7 (1999) (defining peer review); *see also* Craig W. Dallon, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 611 (2000) (outlining hospital and medical staff responsibility for reviewing quality of care issues by physician staff members). Privileges, in the context of staff or clinical privileges allow the physician to provide patient care services in the granting institution, within well defined limits, according to the individual's professional license, education, experience, competence, ability and judgment. *See* Dallon, *supra*, at 605-08 (defining "privileges" in scope of physician practice).

4. *See* Scheutzow, *supra* note 3, at 12 (describing composition of peer review boards).

5. *See id.* at 13 (stating that peer review has become primary method for evaluating physician competence). In order for hospitals to remain accredited the Joint Commission on Accreditation of Healthcare Organizations (JCAHO), formerly JCAH, still requires hospitals to participate in a peer review process. *See id.* (explaining function of JCAHO).

mation to other providers.[6] This missing link permitted a hospital to revoke a physician's privileges, but allowed the same physician to practice in another state where no one would be notified of his or her previous misconduct.[7]

Before 1986, regulation and reporting of information obtained as a result of peer review processes was a function of the states' boards of medicine.[8] These boards had different standards depending on the state and often did not share the information that was available to them with other states or hospital providers.[9] In 1986, Congress passed the Health Care Quality Improvement Act (HCQIA) in response to what was then known as the medical malpractice crisis.[10] The purpose of the HCQIA was

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6. *See* Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J. L. & MED. 455, 464 (1990) (stating that control of incompetence was responsibility of State Medical Boards); *see also* H.R. REP. NO. 99-903 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384-86 (explaining need for dissemination of adverse findings in peer review proceedings).

7. For a discussion of legislative intent in passing HCQIA, see *infra* notes 33-41 and accompanying text.

8. *See* Horner, *supra* note 6, at 464 (discussing traditional treatment of incompetent physician). There were many reasons why this reporting system failed, including budget and personnel limitations, increased responsibility for licensure of non-physician professionals and increased numbers of consumer complaints. *See id.* at 464-65 (providing explanation for failures in reporting). One major flaw that allowed incompetent physicians to continue their practice was the lack of uniformity among the states in requiring hospitals to report disciplinary actions to their respective state boards. *See id.* (citing failure of system). Additionally, there was a lack of an adequate central reporting system where hospitals could obtain information about physicians' qualifications. *See id.* (citing system's failure).

9. *See* H.R. REP. NO. 99-903 (stating that both Federation of State Medical Boards (FSMB) and American Medical Association (AMA) have similar data bases). Not all state medical boards required hospitals to report adverse peer review decisions. *See* Horner, *supra* note 6, at 464 (explaining lack of cooperation between state boards and FSMB). This resulted in data tracking for only the states that required such reporting. *See id.* (reporting incomplete investigation of staff qualifications).

10. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (1994) [hereinafter HCQUIA] (stating provisions of Act). The HCQIA, 42 U.S.C. § 11101, specifically states:

> (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 of discovery of the physician's previous damaging or incompetent performance.
>
> (3) This nationwide problem can be remedied through effective professional peer review.
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> (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 review.
>
> (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

to identify incompetent physicians and to report them to a central data bank where this information could be disseminated to other providers.[11] The primary method for identification of these physicians was, and continues to be, the medical peer review committee.[12]

There are many disincentives for serving on medical peer review committees, including the discomfort of evaluating one's own colleagues.[13] To alleviate some concerns and protect peer review physicians, states have created varying degrees of privileges and immunities.[14] These protections differ widely from state to state, but generally include some form of immunity from damages in a civil action to members of the peer review committee.[15] Immunities offered under the federal HCQIA differ from these

Id.; see also Horner, *supra* note 6, at 455 (stating that HCQIA was signed on November 14, 1986 and became fully operational on September 1, 1990).

11. *See* Horner, *supra* note 6, at 456 (stating that HCQIA "addresses the problem health care professional by assisting employers in identifying incompetence and unprofessionalism"); *see also* 42 U.S.C. §§ 11101-11152 (stating provisions of Act).

12. *See* Scheutzow, *supra* note 3, at 13 (discussing peer review as method of evaluating "quality of physician services" in hospitals in second half of twentieth century).

13. For a discussion of disincentives for participating in peer review, see *infra* notes 51-54 and accompanying text.

14. For a discussion of protections for peer review participants, see *infra* notes 55-69 and accompanying text.

15. *See, e.g.*, 735 ILL. COMP. STAT. 5/8-2101-2102 (1999) (providing that all information obtained "shall be privileged, strictly confidential and shall be used . . . [for] evaluation and improvement of quality care, or granting, limiting or revoking staff privileges . . . [and] shall not be admissible as evidence, nor discoverable in any action of any kind"); LA. REV. STAT. ANN. § 13:3715.3 (West 2001) (providing confidentiality and privilege of peer review committee records, except when requested by physician whose staff privileges are affected); MD. CODE ANN., HEALTH OCC. § 14-501(d) (2000) (providing statutory exception for actions initiated by physicians aggrieved by committee decision to obtain records for use in that physician's challenge to peer review conclusions); N.Y. EDUC. LAW § 6527(3) (McKinney 2001) (providing similar exemption for discovery); N.C. GEN. STAT. § 131E-95(b) (1999) (granting civil immunity to members of medical review committee and privilege from discovery or introduction into evidence of any records and material committee produces provided that process is performed without "malice or fraud"); PA. STAT. ANN. tit. 63, § 425.4 (West 1999) (stating that "proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee"); TEX. REV. CIV. STAT. ANN. art. 4495 § 5.06 (Vernon 1999) (allowing physician who is denied privileges to obtain copy of final decision and "except as otherwise provided . . . all communications made to a medical peer review committee are privileged"); VA. CODE ANN. § 8.01-581.17 (Michie 2000) (providing privilege and freedom from discovery with respect to all "proceedings, minutes, records or reports" of any "medical staff committee, utilization review committee, or other committee . . . that provides a centralized credentialing service, together with all communications, both oral and written, originating in or provided to such committees or entities"); *see also* Scheutzow, *supra* note 3, at 28 ("[M]ost states offer peer review participants immunity from civil liability.").

state protections.[16] In addition, for cases arising in federal court, peer review protections may be subject to different evidentiary standards and privileges.[17]

In *Virmani v. Novant Health Inc.*,[18] the United States Court of Appeals for the Fourth Circuit examined the standards of privilege in a medical peer review setting when a physician subject to peer review alleged discrimination in the peer review process. In reviewing this issue, the Fourth Circuit refused to recognize a federal peer review privilege.[19] This Note analyzes the medical peer review process in light of the *Virmani* decision and its relevance in the context of future peer review challenges when the legal issue involves alleged discrimination. Part II discusses the history of peer review and the privileges afforded under the HCQIA, the Federal Rules of Evidence (FRE) and the split in state and federal court decisions in applying the peer review privilege.[20] Part III examines the facts of the *Virmani* case.[21] Part IV analyzes the court's reasoning for not recognizing the privilege in the facts of this case.[22] Part V provides a critical analysis of the *Virmani* court's conclusions based on the applications of law to these facts.[23] Part VI focuses on the impact that the lack of privileges will have on the peer review process and its effect on future members of peer review committees.[24]

16. For a discussion of the protections HCQIA provides to peer review members, see *supra* notes 55-59 and accompanying text.

17. *See* FED. R. EVID. 501 (providing rule of decision that privileges are to be determined in accordance with principles of common law and based on "reason and experience").

18. 259 F.3d 284, 285 (4th Cir. 2001).

19. *See Virmani*, 259 F.3d at 285 (stating plaintiff's claim of discrimination because hospital treated non-Indian physicians less harshly than physicians of Indian origin). In affirming the district court's decision the United States Court of Appeals for the Fourth Circuit declined to recognize a privilege for medical peer review materials. *See id.* at 293 (holding that plaintiff's need for evidence outweighed interest in recognizing privilege for peer review proceeding). The Fourth Circuit's decision and an earlier Seventh Circuit decision are the only two decisions to have addressed the privilege issue in a medical peer review setting when the doctor subject to review alleges impermissible discrimination in the process. *See id.* ("The Seventh Circuit has squarely addressed the issue of whether peer review documents should be privileged in federal courts . . . . We, too, decline to recognize such a privilege here."). In denying a privilege in *Virmani*, the Fourth Circuit also compelled records of peer reviews of all obstetrician-gynecologists from 1982 through 1997. *See id.* (discussing affirmance of district court order to limit scope of Virmani's requests for all peer reviews for any reason).

20. For a discussion of this history and background information, see *infra* notes 25-93 and accompanying text.

21. For a discussion of the facts of the *Virmani* case, see *infra* notes 94-108 and accompanying text.

22. For a discussion of the court's reasoning, see *infra* notes 109-43 and accompanying text.

23. For further discussion of the analysis, see *infra* notes 144-86 and accompanying text.

24. For a discussion of the impact this case will have, see *infra* notes 187-204 and accompanying text.

II. BACKGROUND

A. *The Peer Review Process*

Medical peer review is a gatekeeping function that is performed by members of a medical staff to further quality of care.[25] Members of the medical staff can request peer review for quality care issues, such as an adverse incident similar to the one described in the Introduction.[26] Peer review is also performed when a physician seeks prospective staff privileges at a hospital.[27] In such instances, the medical peer review committee evaluates the applicant's qualifications, references, licensure, training and professional conduct.[28] Finally, a peer review committee will generally meet to review current staff members for renewal of medical privileges.[29]

25. *See* Dallon, *supra* note 3, at 608-09 (discussing credentialing process). Dallon distinguishes the differences between obtaining medical staff membership and obtaining clinical privileges. *See id.* ("[S]taff membership does not assure the grant of any particular requested clinical privileges."). As a member of the medical staff, a physician has "a voice in the operation of the hospital" and is also expected to "supervise, direct and perform" patient services. *See id.* (describing advantages of membership to include ability to admit patients and to utilize services provided by hospital). Staff privileges, in contrast, authorize the services that the physician can provide. *See id.* (differentiating types of services requested). Peer review is provided by members of the medical staff as part of their role in supervising the quality of patient care. *See id.* (stating bylaws delineate role of medical staff to include "'mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges'"). The governing body of the hospital has the final decision in granting or limiting staff privileges, but allows the medical staff broad discretion and usually follows their recommendations. *See id.* at 610 (citing JCAHO Manual MS.5.1). Credentialing responsibilities arise from this organizational structure to ensure that practitioners are qualified to provide those services for which they applied. *See id.* (stating that process "entails obtaining, verifying, and assessing" qualifications of health care practitioner). Privileges, used in the context of staff or clinical privileges, include the "permission to provide medical or other patient care services in the granting institution . . . based on the individual's professional license and his/her experience, competence, ability, and judgment." *See* Joint Commission on Accreditation of Healthcare Organizations, Comprehensive Accreditation Manual for Hospitals: The Official Handbook Manual MS-7, MS.5.1 (1999) (defining credentialing process).

26. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 285 (stating that peer review followed adverse incident–puncture of patient artery); *see also* Dallon, *supra* note 3, at 611-12 (describing medical staff investigation of physician's privileges when hospital staff identifies problems such as quality of care provided).

27. *See* Dallon, *supra* note 3, at 610-11 (explaining differences in functions of peer review in distinct contexts).

28. *See id.* at 611 (discussing application for staff privileges). Staff privileges are a limitation of the permissions granted to physicians in that they can only perform those services for which they have been credentialed. *See id.* (stating method for credentialing). An anesthesiologist for example, would not be credentialed for performing surgery and conversely, a surgeon would not be credentialed for providing anesthesia. *See id.* at 608 (discussing limits of staff privileges); *see also* Scheutzow, *supra* note 3, at 13-14 (providing examples of limitations of privileges).

29. *See* Scheutzow, *supra* note 3, at 14 (defining peer review process for existing members of staff).

When a peer review committee meets to review a quality concern incident, the findings are not always adverse to the physician who is subject to the review.[30] If the physician is found to have used proper judgment and maintained the required level of care, but has nonetheless had a bad outcome, it is unlikely that the committee will sanction the physician.[31] Conversely, if a committee finds that the physician has performed contrary to the standards of care required by the physician's specialty, the committee can recommend to the medical board that the physician's privileges be limited, suspended pending further investigation or retraining, or revoked.[32]

B. *The Health Care Quality Improvement Act*

In 1986 Congress responded to a perceived medical malpractice crisis by passing the HCQIA.[33] In an effort to improve the quality of health care, Congress called for a national effort to identify incompetent physicians and to limit their continued practice.[34] Groups that had assumed responsibility for licensure, such as the various State Boards of Examiners, had not established sufficient methods to require hospitals to report adverse actions to the boards.[35] In its study prior to approving HCQIA, Congress found:

> [G]roups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it all too easy to

30. *See id.* at 16 (stating case of physician negligence "would not necessarily result in adverse peer review action").

31. *See id.* (stating peer review process is designed to monitor individual physician's trends rather than single acts).

32. *See* Dallon, *supra* note 3, at 612 (discussing actions taken when quality of care issues are questioned); *see also* Scheutzow, *supra* note 3, at 14 (stating that "physician[s] may be denied the privilege to provide . . . service if quality concerns have been raised").

33. *See generally* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11151 (1994); *see also* Horner, *supra* note 6, at 457 (discussing history of HCQIA). The existence of a "'medical malpractice crisis'" has been disputed and may be a result of increased numbers of claims and sizes of awards. *See id.* at 457-58 (describing factors influencing these increases, including: high public expectation, overestimation of results by physicians and increased insurance rates in high risk specialties and in certain geographic areas). For further discussion of HCQIA, see *infra* notes 39-54 and accompanying text.

34. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (2) (1994) (discussing congressional findings concerning need to restrict movement of incompetent physicians); *see also* H.R. REP. No. 99-903, at 3-4 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384 (explaining need to improve quality of health care).

35. *See* H.R. REP. No. 99-903 (stating that even when state licensing boards act, it is not enough to prevent continued practice in other locations).

move to different hospitals or states and continue their practices in these new locations.[36]

According to congressional testimony, even if a state board revoked a physician's license, the physician would apply for licensure in another state.[37] The physicians could then continue to practice in the other state, and cause unsuspecting patients a higher risk of injury and possibly even death.[38]

C. *Impact of the Health Care Quality Improvement Act*

HCQIA's mandate was "to encourage good faith professional review activities of health care entities, [and] to require collection and dissemination to hospitals . . . of information concerning certain payments in medical malpractice claims and certain adverse decisions . . . ."[39] Congress determined that the peer review setting would be the method of identifying and collecting information on incompetent medical professionals.[40] To encourage physicians to cooperate in this process, Congress believed it was "essential to provide [physicians with] some legal immunity."[41]

As a second prong of its attempt to address incompetent physician care, Congress provided for the "dissemination" of gathered information.[42] Under HCQIA, dissemination is mandatory rather than discretionary and "requires" hospitals to report to their state medical board peer review that results in specific disciplinary action.[43] Both hospitals and state boards are further "required" to forward the information to the Sec-

36. *Id.*

37. *See* Horner, *supra* note 6, at 464 (discussing twelve witnesses who testified at hearings); *see also* H.R. REP. No. 99-903 (stating that "[o]ne witness was a medical director who had hired numerous physicians without being able to discover even well documented problems–sometimes with tragic consequences").

38. *See* H.R. REP. No. 99-903 (explaining that continued incompetence by small group of physicians has led to death and injury); *see also* Horner, *supra* note 6, at 464 (discussing plea bargains made by some physicians to voluntarily relinquish their license or privileges instead of hospital or state licensing board proceeding with formal disciplinary actions).

39. *See* H.R. REP. No. 99-903 (defining intent of HCQIA).

40. *See id.* (stating that purpose of legislation is to improve quality of health care through physician identification).

41. *See id.* (explaining that in exchange for participating in process peer review members would receive protection "from damages in suits by physicians who lose their hospital privileges").

42. *See id.* at 2 (describing process of tracking disciplinary action). The Act generally requires disciplinary bodies to report actions to a central location and for hospitals to request this information before hiring physicians. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11131-11135 (1994) (detailing procedures of reporting and requesting information).

43. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11131 (1994) (requiring reporting of adverse actions); *see also* Horner, *supra* note 6, at 472 (stating that any professional review actions affecting clinical privileges for more than thirty days or entities making payment in medical malpractice claims are reportable).

retary of the United States Department of Health and Human Services or its designee.[44] As a means to strengthen data collection, Congress designated the National Practitioner Data Bank (NPDB) as a repository for collecting information on adverse actions against physicians and other healthcare practitioners.[45] The NPDB provides a system for nationally tracking physicians who have been identified under the reporting regulations.[46]

The peer review committee serves an important function in the wake of HCQIA because adverse actions taken upon a physician in the course of the peer review evaluation ultimately are reported to the NPDB.[47] Physicians whose privileges have been revoked and who have been reported to the NPDB suffer many losses, including loss of staff privileges.[48] Loss of privileges prevents a physician from treating current patients, and may impact on a physician's sources for future referrals. Furthermore, it impairs self confidence and damages a physician's reputation in the community.[49] Ultimately, this loss of privilege could severely limit a physician's capacity for present and future earnings.[50]

Equally important to ensuring quality of care are the peer reviews themselves; peer reviews can become the last line of defense for the patient who is the recipient of a physician's incompetent care, which might otherwise go unchecked.[51] The peer review committee faces, however, an

44. *See* 42 U.S.C. § 11131 (requiring reports of any paid malpractice claims over certain amount); *see also* Horner, *supra* note 6, at 472 (same).

45. *See* Horner, *supra* note 6, at 472-73 (stating that National Practitioner Data Bank (NPDB) collects all reported information regarding medical malpractice payments and adverse actions and makes information available to state licensing boards, other physician employers and hospitals). In addition to its reporting duties, the peer review committee has a concomitant duty to request information when physicians first apply for privileges and every two years when they renew them. *See id.* at 475 (citing 42 U.S.C. § 11135). Despite these collection and reporting duties, "[c]onsumers will have no access to the information." *Id.* at 475-76.

46. *See id.* at 471 (discussing NPDB's development with cooperation of Unisys Corporation, American Hospital Association and American Medical Association). The NPDB became operational on September 1, 1990. *See id.*

47. *See id.* (explaining provisions on reporting under Part B of HCQIA).

48. *See* Dallon, *supra* note 3, at 613 (describing physician's interest in access to hospital privileges).

49. *See id.* at 612-13 (listing negative implications of denial of privileges).

50. *See id.* at 615-16 (describing how loss of clinical privileges has profound economic impact on practitioner).

51. *See* Horner, *supra* note 6, at 458 (stating that patients rely on hospitals to monitor quality of care). Horner emphasizes that charitable immunity has been replaced by the doctrine of corporate liability as the basis for hospital concern regarding physician competence. *See id.* at 459. Horner cites numerous cases where hospitals were found liable in negligence for a failure to ascertain physicians' qualifications before granting privileges. *See id.* at 459 n.18 (citing cases). She claims that, as a result, hospitals "[a]nxious to shield themselves from corporate liability . . . delegated physician review responsibilities to peer review committees . . . ." *See id.* at 460 (discussing model standards for bylaws). Another commentator theorizes that hospitals are motivated by patient welfare and that this motivation arises from the hospital's desire to: (1) fulfill its mission, (2) maintain

awesome and often conflicting task.[52] Participants have a duty to maintain the highest level of healthcare through the evaluative process, but the subject of the evaluation may be a colleague, referral source, friend or partner.[53] Participants also fear reprisal in the form of a lawsuit by the physician who is adversely affected by the evaluation.[54]

D. *Protections Afforded to Peer Review Members*

1. *Immunity Under HCQIA*

Based on the House Energy and Commerce Committee (the Committee) hearings in anticipation of HCQIA's passage, Congress was advised that physicians facing revocation of their licenses based on peer review recommendations would respond with civil lawsuits.[55] Fearing that doctors would not perform meaningful peer reviews, Congress decided to provide limited immunity to doctors and hospitals that acted in accordance with due process during peer review proceedings.[56]

Although Congress discussed whether to attach broader protections to members involved in the peer review process, the Committee ultimately decided to grant immunity only from "damages against professional review

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reputation in the community, (3) discharge a legal duty or (4) fear of liability. *See* Dallon, *supra* note 3, at 616-17 (explaining hospital's interest in patient welfare).

52. *See* Scheutzow, *supra* note 3, at 18 (discussing reluctance of physicians to evaluate their colleagues).

53. *See id.* (assessing disincentives for physicians who participate in peer review).

54. *See id.* (demonstrating non-legal repercussions of sanctioned physician in addition to retaliatory litigation); *see also* Horner, *supra* note 6, at 461 (stating that physicians retaliatory measures included suits for defamation, antitrust violations, interference with business advantage and violations of civil rights or due process); Thomas C. Riney, *Hippocrates Enters the New Millennium-Texas Medical Privileges in the Year 2000*, 41 S. TEX. L. REV. 315, 345 (2000) (theorizing that physicians "who have had hospital privileges curtailed . . . will often add a civil rights violation . . . to a lawsuit . . . ." to assure disclosure of peer review records).

55. *See* H.R. REP. No. 99-903, at 3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384 (stating that physicians sanctioned by peer review often file antitrust lawsuits). Before 1986 there was an increase in civil antitrust actions against peer review groups. *See* Horner, *supra* note 6, at 461-62 (discussing holding in *Patrick v. Burget*, which awarded treble damages of more than $2 million to physician whose privileges were terminated). States offered immunity for peer review members in state actions, but this did not adequately prevent federal antitrust litigation. *See id.* at 462-63 (discussing HCQIA's purpose to protect, in part, against antitrust litigation provided that peer reviewers meet procedural safeguards and are not in economic competition with subject of review).

56. *See* H.R. REP. No. 99-903 (discussing scope of immunity). In discussing the protections afforded to peer review actions, the House Energy and Commerce Committee [hereinafter Committee] Report continues by noting:

> For a professional review action to qualify for protection from damages it must be taken: in the reasonable belief that it is in furtherance of quality care; after a reasonable effort to obtain facts; after adequate due process; in the reasonable belief that the action was warranted by facts known.

Id.

bodies" and "for persons providing information to professional review bodies."[57] The bill thus provides qualified immunity if the peer review is properly conducted according to the established criteria.[58] Immunity is not available where the peer review committee fails to provide the minimum procedural safeguards outlined by HCQIA.[59]

2. *Privilege Under State Statutes*

Unlike the limited immunity afforded under HCQIA, all fifty states and the District of Columbia have enacted a peer review privilege.[60] The protections offered are not uniform throughout the states but generally offer immunity from damages in a civil action to those members participating in the peer review.[61] Additionally, the majority of states extends

57. *Id.* The Committee Report further states:

> [T]he Committee considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review[.]

Id.

58. *See* 42 U.S.C. § 11112 (1994) (listing guidelines for review to trigger immunity).

59. *See id.* (specifying standard of review for immunity to attach). These procedural safeguards include that the professional review action is taken to further enhance quality health care, necessary facts are obtained and the subject of the review has had adequate notice and a hearing and there is a reasonable belief that the facts warranted the action. *See id.* (explaining standards for review actions).

60. *See* Appellant's Brief at 24, Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001) (No. 00-2423) (discussing legislative recognition of privilege in all fifty states); *see also* Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1061 (7th Cir. 1981) (discussing in dicta that comity compels recognition of state privileges when there is no substantial cost of federal policies, but holding that in antitrust action where evidence can only be obtained by documents themselves, court did not extend privilege); Weekoty v. United States, 30 F. Supp. 2d 1343, 1346 (D.N.M. 1998) (noting significance in fact that forty-six states have statutes that protect work of medical review committees).

The North Carolina peer review privilege statute, which was at issue in *Virmani*, is N.C. GEN. STAT. § 131E-95 (1999). It states:

> (a) A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability for damages in any civil action on account of any act, statement or proceeding undertaken, made, or performed within the scope of the functions of the committee.
>
> (b) The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential and not considered public records . . . and shall not be subject to discovery or introduction into evidence in any civil action against a hospital or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee. . . .

Id.

61. *See* Scheutzow, *supra* note 3, at 28 (stating statutes vary as to entities protected and type of protections granted); *see also* Christina A. Graham, Comment,

this privilege to discovery of documents and provides for confidentiality of the information obtained from the peer review process.[62]

3. *Privilege Under Armed Services Law*

Military physicians who participate in peer review are given a broader range of privileges and immunities by the Department of Defense than that provided under HCQIA.[63] Specifically, the statute provides that the records are "confidential and privileged."[64] Subsection (c) allows disclosure and testimony under a limited set of circumstances.[65] When a provider, however, has initiated a proceeding following an action restricting clinical privileges, disclosure is permitted for an administrative or judicial proceeding.[66]

Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges, 30 CUMB. L. REV. 111, 125-26 (2000) (explaining existence of state statutes providing varying degree of privilege for peer review documents). The author asserts that the North Carolina state courts "adopted an expansive approach to peer review privilege" favoring privilege over discovery. *See id.* at 126 (discussing outer limits under state peer review statute). She also proposes that if "hospitals and peer review committee members become too accustomed to expansive privileges, and . . . a federal question pulls them into federal court, they will likely be ill-equipped to protect the integrity of their review process." *Id.* at 130-31.

62. *See id.* (discussing impact of peer review protection laws). State and federal courts are confronted with the issue of privilege when the plaintiff requests peer review documents, usually in discovery, and the defendant health care entity denies the request based on peer review privilege. *See, e.g., Virmani*, 259 F.3d at 286 (describing motion for compelling peer review documents after hospital invoked privilege). Under some state statutes, immunity will protect peer review documents while other statutes will allow the physician who has been adversely affected to discover documents. *See, e.g.*, Scheutzow, *supra* note 3, at 28-29 (describing varying degrees of immunity offered by state statutes).

63. *See* 10 U.S.C. § 1102 (1994) (providing confidentiality of medical quality assurance records and qualified immunity for participants).

64. *See id.* The statute reads in part:

> (a) Confidentiality of records.—Medical quality assurance records created by or for the Department of Defense as part of a medical quality assurance program are confidential and privileged. Such records may not be disclosed to any person or entity, except as provided in subsection (c).
>
> (b) Prohibition on disclosure and testimony.—(1) No part of any medical quality assurance record described in subsection (a) may be subject to discovery or admitted into evidence in any judicial or administrative proceeding, except as provided in subsection (c).
>
> (2) A person who reviews or creates medical quality assurance records for the Department of Defense or who participates in any proceeding that reviews or creates such records may not be permitted or required to testify in any judicial or administrative proceeding with respect to such records . . . .

Id.

65. *See id.* at (c) (listing A through G exceptions where disclosure is allowed).

66. *See id.* (describing section (c)(1)(B) and section (G) exceptions to privilege of documents).

4. *Privilege Under the Veterans Administration*

Physicians who participate in peer review for the Veterans Administration are granted privileges and immunities that are also broader than those granted under HCQIA.[67] Disclosure is permitted when information is sought for licensing and accreditation functions and for protection of health and safety.[68] The privilege, however, is not excepted even to those who are the subject of the peer review.[69]

E. *Application of Privilege*

When a plaintiff brings a state law action implicating privilege of peer review records, the state court will base its decision on an interpretation of the state law of privilege.[70] If, however, a suit implicating the peer review process is brought in federal court on a federal question, the federal law of privilege will apply.[71] For purposes of jurisdiction, when there is a federal question together with pendent state claims, courts must decide whether to apply federal or state law to the claims.[72] Courts, however, will not apply different rules of evidence for each count.[73] If federal law applies, then the court will follow federal common law of privilege under the

67. *See* 38 U.S.C. § 5705 (1994) (discussing confidentiality of medical quality-assurance records). The statute reads in part:

> (a) Records and documents created by the Department as part of a medical quality-assurance program (other than reports submitted pursuant to section 7311 (g) of this title) are confidential and privileged and may not be disclosed to any person or entity except as provided in subsection (b) of this section.
>
> (b) The name of and other identifying information regarding any individual patient or employee of the Department, . . . shall be deleted from any record or document before any disclosure [is] made.

Id. For a further discussion of the HCQIA, see *supra* notes 55-59 and accompanying text.

68. *See* 38 U.S.C. § 5705 (b)(1) (citing limited exclusions for disclosure).

69. *See id.* at (a) (providing all rules pertaining to confidentiality of records).

70. *See generally* Virmani v. Presbyterian Health Servs. Corp., 515 S.E.2d 675 (N.C. 1999) (basing decision on state law of privilege); HCA Health Serv. of VA v. Levin, 530 S.E.2d 417 (Va. 2000) (deciding case based on state privilege statute).

71. *See* FED. R. EVID. 501 (stating that "the privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience"); *see also* Marshall v. Spectrum Med. Group, 198 F.R.D. 1, 2 (D. Me. 2000) (citing FRE 501).

72. *See Marshall*, 198 F.R.D. at 2 (stating that FRE 501 does not preclude court from applying state law to federal actions); *see also* FED. R. EVID. 501 (providing, "[h]owever, in civil actions and proceedings, with respect to an element of a claim or defense as to which State law supplies the rule of decision, the privilege of a witness, person, government, State, or political subdivision thereof shall be determined in accordance with State law").

73. *See Marshall*, 198 F.R.D. at 2-3 (explaining that in cases where both state and federal claims exist, law is not provided based upon number of counts); *see also* LeMasters v. Christ Hosp., 791 F. Supp. 188, 189 (S.D. Ohio 1991) (stating courts in federal question cases can apply state privilege law by analogy or for comity).

FRE.[74] Nevertheless, federal courts facing questions of privilege in a peer review setting have the discretion to follow state law of privilege where it "can be applied with no substantial cost to federal substantive and procedural policies."[75] Rather than listing a structured set of privileges, FRE 501 mandates that the court define privilege by applying "common law . . . in the light of reason and experience."[76]

There is no federal common law privilege covering the peer review process.[77] The United States Supreme Court has approved testimonial privileges under FRE 501 in contexts relevant to the establishment of a peer review privilege. In *Jaffee v. Redmond*,[78] the Supreme Court upheld a decision to create a privilege in a patient-psychotherapist relationship despite the Court's disfavor of testimonial privileges.[79] The *Jaffee* Court started with the premise that there is always a duty to give testimony when one is capable of doing so.[80] The Court, however, recognized the need to protect confidential communications between a therapist and her patient to further the open and frank disclosure necessary for successful psychiatric treatment.[81] Similarly in the medical peer review process, there is a

74. *See* FED. R. EVID. 501 (stating that privileges will be determined by common law); *see also* 6 JAMES WM. MOORE ET AL., MOORE'S FEDERAL PRACTICE ¶ 26.47 (3d ed. 1997) (citing scope of discovery).

75. *See* MOORE ET AL., *supra* note 74, at ¶ 26.47[3-4] (explaining that court has discretion to look to state laws for privilege when balancing interest in need for evidence against equally compelling interest in protecting confidentiality); *see also* Trammel v. United States, 445 U.S. 40, 48 (1980) (discussing impact of state laws of spousal privilege in developing testimonial privilege law).

76. *See* H.R. REP. NO. 93-650, at 8 (1975), *reprinted in* 1974 U.S.C.C.A.N. 7075-82 (stating thirteen rules submitted with nine strictly defined non-constitutional privileges outlined but committee amended to current rule to allow privileges to be developed by courts).

77. *See* Scheutzow, *supra* note 3, at 50 (stating that "no federal common law peer review privilege presently exists").

78. 518 U.S. 1 (1996).

79. *See Jaffee*, 518 U.S. at 9 (stating that privileges may be justified by stronger public good). In approving the privilege, the Court emphasized an overriding duty to ascertain the truth as being vital to patient treatment. *See id.* at 10 (explaining importance of patient-therapist relationship as factor to consider). *Jaffee* decided that the evidentiary benefit, if the privilege were denied, was modest in comparison to the chilling effect that might occur if the trust relationship was not held as confidential. *See id.* at 12-13 (concluding that policy decisions of states bear on federal decisions concerning privilege). The Court has drawn on a public policy argument when approving other privileges as well. *See* United States v. Nixon, 418 U.S. 683, 709-10 (1974) (explaining implication of privileges as "derogation of the search for truth"); Upjohn Co. v. United States, 449 U.S. 383, 389 (1981) (stating that privilege must serve public policy).

80. *See Jaffee*, 518 U.S. at 9 (discussing justification of privileges). The Court emphasized its reluctance to create additional privileges based on three centuries of belief that "the public . . . has a right to every man's evidence." *See id.* (citing United States v. Bryan, 339 U.S. 323, 331 (1950)(quoting 8 J. WIGMORE, EVIDENCE § 2192, at 64 (3d ed. 1940))).

81. *See id.* at 10 (discussing psychotherapist privilege as one of thirteen privileges proposed by Judicial Conference Advisory Committee to Congress as part of Proposed Federal Rules of Evidence).

strong public need for physicians to evaluate their peers without the fear of litigation based on their candid assessments.[82]

The Court's creation of the *Jaffee* privilege was a result of a balancing test where the apparent need to preserve a communication outweighed the need for probative evidence.[83] The Court's balancing test for privileges flows from *Trammel v. United States*.[84] In *Trammel*, the Court used a similar balancing test to weigh the need for evidence against the competing interests of spousal privilege.[85] Again, in *University of Pennsylvania v. EEOC*,[86] the Court relied on the balance test to show that the need to protect privilege was outweighed by the need for probative evidence.[87]

Federal courts have considered the question of peer review privilege in a variety of ways using the basis of the claim to decide whether privileges are recognized.[88] For example, the United States Court of Appeals for the

82. *See* Appellant's Brief at 7-8, Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001) (No. 00-2423) (supporting need for privilege). Novant described the work of medical review committees as "life saving" because it is one of the few ways that clinical practice is evaluated and improved. *See id.* at 8 (quoting Weekoty v. United States, 30 F. Supp. 2d 1343, 1344 (D.N.M. 1998)). Novant added credence to this argument by indicating that every state has responded to this important public need by enacting statutes to privilege the information shared in the peer review process. *See id.* (adding that Congress also established privilege provision for Veterans Administration and Defense Department hospitals).

83. *See id.* at 8-9 (stating balance of competing interests of privilege over evidence).

84. 445 U.S. 40 (1980).

85. *See Trammel*, 445 U.S. at 49-50 (deciding issue of adverse spousal testimony).

86. 493 U.S. 182 (1990).

87. *See Univ. of Pa.*, 493 U.S. at 193 (asserting that cost of disclosure is "only one side of the balance"). The Court quoted a Third Circuit case stating that "peer review material itself must be investigated to determine whether the evaluations are based in discrimination[.]" *See* EEOC v. Franklin & Marshall Coll., 775 F.2d 110, 116 (3d. Cir. 1985), *cert. denied*, 476 U.S. 1163 (1986) (stating that "an alleged perpetrator of discrimination cannot be allowed to pick and choose the evidence").

88. *See* Marshall v. Spectrum Med. Group, 198 F.R.D. 1, 5 (D. Me. 2000) (finding no federal privilege in suit "which alleges abuse of the peer review process"); Patt v. Family Health Sys., Inc., 189 F.R.D. 518, 524-25 (E.D. Wis. 1999) (granting discovery of peer review documents in gender based discrimination case); Holland v. Muscatine Gen. Hosp., 971 F. Supp. 385, 389 (S.D. Iowa 1997) (stating that no privilege recognized under federal or Iowa law in investigation of employment discrimination); Robertson v. Neuromedical Ctr., 169 F.R.D. 80, 84 (M.D. La. 1996) (refusing to adopt state law of privilege in Americans with Disabilities Act discrimination case); Johnson v. Nyack Hosp., 169 F.R.D. 550, 561 (S.D.N.Y. 1996) (allowing disclosure of peer review documents of other physicians in plaintiff's claim of racial discrimination); LeMasters v. Christ Hosp., 791 F. Supp. 188, 191 (S.D. Ohio 1991) (holding that "peer review proceedings are [not] *always* discoverable in every case" but allowing discovery in discrimination case); Teasdale v. Marin Gen. Hosp., 138 F.R.D. 691, 695 (N.D. Cal. 1991) (holding that plaintiff was entitled to discover record even if applying state statute rather than HCQIA protections); *cf.* Pamintuan v. Nanticoke Mem'l. Hosp., 192 F.3d 378, 390 (3d Cir. 1999) (affirming summary judgment in favor of defendant when plaintiff could not rebut presumption of immunity under HCQIA); Weekoty v. United States, 30 F. Supp.

Seventh Circuit in *Memorial Hospital v. Shadur*[89] declined to follow state laws of privilege, stating that the need for evidence is particularly important in an antitrust suit.[90] Three years later, the Seventh Circuit, in *Marrese v. American Academy of Orthopedic Surgeons*,[91] used the same claim-based approach, but the weight of the evidence in the facts of the case was not enough to allow the court to approve disclosure of documents.[92] State courts, in contrast, have consistently answered the question of peer review based on the state statutes and have recognized the privilege.[93]

2d 1343, 1348 (D.N.M. 1998) (finding in favor of recognizing privilege in self-critical analysis process). *Compare* United States v. Harris Methodist Fort Worth, 970 F.2d 94, 100 (5th Cir. 1992) (balancing test was not for disclosure of evidence but for Fourth Amendment), *with* Marrese v. Am. Acad. of Orthopedic Surgeons, 726 F.2d 1150, 1160-61 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985) (discussing means of reconciling competing interest such as in camera inspection or redaction), *and* Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1063 (7th Cir. 1981) (refusing to extend privilege in antitrust case where evidence is contained in proceedings themselves). *But see* Burrows v. Redbud Cmty. Hosp. Dist., 187 F.R.D. 606, 613 (N.D. Cal. 1998) (allowing discovery of peer review documents subject to protective order in malpractice action); Brem v. Decarlo, 162 F.R.D. 94, 102 (D. Md. 1995) (holding public interest of confidentiality is greater than need for evidence in defamation suit).

89. 664 F.2d 1058 (7th Cir. 1981).

90. *See Shadur*, 664 F.2d at 1061-62 (endorsing balancing approach weighing "need for the truth" against policy furthered by privilege). The court, recognizing state privilege and need for comity when consistent with federal practice, distinguished this case from cases in which the plaintiff in a malpractice action would be able to proceed with the claim. *See id.* at 1062 (citing Bredice v. Doctors Hosp., 50 F.R.D. 249, 250 (D.D.C. 1970)). The court further explained that by applying privilege without regard to the need for disclosure, the result would be to provide absolute immunity to the participants. *See id.* at 1063 (discussing effect of holding hospital disciplinary proceedings privileged). The court concluded that even the state statute would not be construed to extend the privilege that far. *See id.* (drawing comparison to cases of conspiracy to fix prices and cases where statements were made in bad faith).

91. 726 F.2d 1150 (7th Cir. 1984), *rev'd on other grounds*, 470 U.S. 373 (1985).

92. *See Marrese*, 726 F.2d at 1160 (describing participants' reluctance to offer candid evaluations if names were used as list to be deposed). The court did not allow the plaintiff to have the membership files after plaintiff stated that he wanted to use it as a deposition list to determine why his application for membership was rejected. *See id.* (stating that "atmosphere of mutual confidence" would be eroded). The court in dicta discussed methods that the district court could have used to "reconcile the parties' competing needs," such as in camera examination. *See id.* at 1160-61 (describing method district court used as "not well designed to protect the privacy of the [defendant] Academy's members"). The discovery issue was never answered. *See id.* (noting that "files of an association of medical professionals . . . are discoverable in appropriate circumstances").

93. *See* Miami Heart Inst. v. Reis, 638 So. 2d 530, 531 (Fla. 1994) (maintaining peer review privilege in defamation action); Eubanks v. Ferrier, 267 S.E.2d 230, 233 (Ga. 1980) (upholding state peer review statute in malpractice case); Stricklin v. Becan, 689 N.E.2d 328, 331 (Ill. 1997) (remanding for in camera review to prevent discovery of privileged material in malpractice claim); Balt. Sun Co. v. Univ. of Md. Med. Sys. Corp., 584 A.2d 683, 688 (Md. 1991) (allowing previous ruling that physician could discover his peer review documents, but court could seal documents from public disclosure); Woodlands v. McCown, 927 S.W.2d 1, 12 (Tex.

III. FACTS: THE EVENTS GIVING RISE TO *VIRMANI V. NOVANT HEALTH INC.*

The *Virmani* case concerned a physician plaintiff, Dr. Virmani, whose hospital privileges were terminated after he punctured a patient's iliac artery during a laparoscope procedure.[94] Dr. Virmani's conduct created a life-threatening emergency.[95] Following this adverse event, the department chairman informed Dr. Virmani that another physician would assist him in all laparoscopic cases pending a review.[96] The hospital instituted a peer review in March 1995 and, five months later in November, terminated Dr. Virmani's medical staff privileges.[97] The committee sent a report to Dr. Virmani stating that 24 of the 102 cases they examined were problematic.[98]

In response, Dr. Virmani filed an action in state court in North Carolina asserting that the hospital had breached its bylaws.[99] The trial court ordered the hospital to conduct a second peer review using reviewers from outside the hospital staff.[100] On appeal by the defendant, however, the state appellate court allowed the peer review to remain internal.[101] The

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1996) (vacating order of trial court to produce documents privileged under peer review); HCA Health Serv. of Va. v. Levin, 530 S.E.2d 417, 420 (Va. 2000) (upholding peer review statute in defamation action). In states that have a statute protecting peer review privilege, state courts apply the privilege and withhold the documents from discovery. *See id.* at 419 (interpreting plain language of statute to refuse disclosure of documents without "extraordinary circumstances").

94. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 285-86 (4th Cir. 2001) (stating facts of case). Dr. Virmani had clinical privileges as an obstetrician-gynecologist at both Presbyterian Hospital and Presbyterian Hospital Matthews in 1990. *See id.* at 285 (citing facts).

95. *See* Plaintiff's Complaint at 4, *Virmani*, 259 F.3d 284 (stating that this was known complication of surgery, emergency surgery was performed to repair artery and patient had successful outcome).

96. *See id.* (discussing hospital's reaction and stating that "appropriately credentialed physician would assist" Dr. Virmani).

97. *See Virmani*, 259 F.3d at 285 (explaining peer review report). The committee reviewed all cases in which Dr. Virmani had been the primary care physician since August of 1993. *See id.* (explaining peer review process).

98. *See id.* (stating review was conducted by OB-GYN committee); *see also* Appellant's Brief at 3, *Virmani*, 259 F.3d 284 (stating that twenty-four problematic cases included performance of unnecessary procedures, performance of procedures without indication, missed diagnoses and delayed responding to fetal distress).

99. *See Virmani*, 259 F.3d at 285 (discussing nature of Virmani's action).

100. *See id.* (stating holding of state trial court); *see also* Plaintiff's Complaint at 7, *Virmani*, 259 F.3d 284 (noting five of six members of first committee were in economic competition with plaintiff).

101. *See* Virmani v. Presbyterian Health Servs. Corp., 488 S.E.2d 284, 289 (N.C. Ct. App. 1997) (stating that internal peer review was appropriate according to bylaws).

hospital then performed a second review and Dr. Virmani's privileges were again revoked.[102]

Doctor Virmani filed an action in federal court on January 15, 1999 against Novant, the corporation that operated the hospitals, claiming that the termination of his privileges constituted discrimination against him on the basis of his race and national origin.[103] During discovery, Virmani requested peer review records from all hospital physicians for the previous twenty years.[104] The hospital sought a protective order based on a North Carolina statute and pursuant to FRE 501, arguing that the peer review records were privileged.[105] The district court denied the motion, thus declining to recognize a privilege for peer review materials.[106] Nevertheless, because the scope of Dr. Virmani's request was "overly broad," the court limited the scope of his request to only allow OB-GYN records for the period 1982 through 1997.[107] The Fourth Circuit subsequently affirmed the trial court's decision following an interlocutory appeal.[108]

IV. NARRATIVE ANALYSIS

In upholding the district court's decision to allow Dr. Virmani to compel production of records related to peer review, the Fourth Circuit declined to recognize a federal peer review privilege.[109] First, the court addressed the standard of review under FRE 501.[110] The court, in a foot-

102. *See Virmani*, 259 F.3d at 285-86 (discussing outcome of second peer review); *see also* Plaintiff's Complaint at 21, *Virmani*, 259 F.3d 284 (claiming that committee recommended to board that plaintiff's privileges be terminated based on lack of documentation, lack of indications for procedure, poor clinical judgment and questionable surgical expertise even though plaintiff had no opportunity to respond to allegations).

103. *See Virmani*, 259 F.3d at 285-86 n.1 (citing claim). Doctor Virmani asserted that his civil rights had been violated because he is a member of a racial minority and the hospital discriminated against him based on race and national origin through the peer review process. *See* Plaintiff's Complaint at 31, *Virmani*, 259 F.3d 284 (discussing violation of 42 U.S.C. §§ 1981, 1985). Novant is a nonprofit corporation operating hospitals in Charlotte and in Matthews and was formerly known as Presbyterian Health Services Corp. *See Virmani*, 259 F.3d at 285 (stating that Presbyterian Hospital and Presbyterian Hospital Matthews are known collectively as "Presbyterian").

104. *See Virmani*, 259 F.3d at 286 (discussing Virmani's request for records).

105. *See id.* (stating Novant's argument). For a further discussion of N.C. GEN. STAT. § 131E-95(b) (1999), see *supra* note 60 and accompanying text. For a further discussion of FRE 501, see *supra* notes 72, 74 and accompanying text.

106. *See Virmani*, 259 F.3d at 286 (discussing outcome of district court).

107. *See id.* (agreeing with Novant that scope of request was overly broad).

108. *See id.* at 293 (declining to recognize privilege).

109. *See id.* at 292-93 (summarizing conclusion of court in *Memorial Hospital v. Shadur*, 664 F.2d 1058 (7th Cir. 1981), as only other circuit to squarely address issue of peer review documents in federal court, refusing to recognize a federal peer review privilege). The *Virmani* court stated that "[we], too, decline to recognize such a privilege here." *Id.* at 293.

110. *See id.* at 286-87 (discussing review of case). The court explained that the recognition "of a privilege under Federal Rule of Evidence 501 is a mixed question

note, stated that the outcome of this case would have been different if North Carolina state law applied.[111] Because this case involved a federal question together with a pendent state claim, the Fourth Circuit followed its "sister circuits" and applied the federal law of privilege.[112] The court then stated the rule of evidentiary privileges using the high standard promulgated by the Supreme Court first in *United States v. Nixon*[113] and again reiterated in *University of Pennsylvania.*[114] The Fourth Circuit had not answered the question of privilege for peer review before,[115] and was reluctant to create or apply a new privilege.[116] Specifically, in addressing whether to approve a privilege, the court had to answer the question "whether the interest in promoting candor in medical peer review proceedings outweighs the need for probative evidence in a discrimination suit."[117]

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of law and fact, which we review *de novo.*" *See id.* at 286-87 (citing Carman v. McDonnell Douglas Corp., 114 F.3d 790, 793 n.2 (8th Cir. 1997)). For a further explanation of FRE 501, see *supra* notes 72-74, 76-77 and accompanying text.

111. *See id.* at 286 (quoting FRE 501 when state law supplies the rule of decision). The court compared the rules with the N.C. GEN. STAT. § 131E-95(b) and determined that "if North Carolina law supplied the rule of decision, the materials would be privileged." *Id.* at 287 n.3. For a further discussion of the North Carolina statute, see *supra* note 60 and accompanying text.

112. *See id.* (explaining that case contains federal question together with pendent state law claim). The court stated that since the Supreme Court has not addressed this issue it looked to other circuits for authority. *See id.* (citing Jaffee v. Redmond, 518 U.S. 1, 16 n.15 (1996)). The Fourth Circuit followed other circuit courts and applied federal law. *See id.* (citing Pearson v. Miller, 211 F.3d 57, 66 (3d Cir. 2000); Hancock v. Dodson, 958 F.2d 1367, 1373 (6th Cir. 1992); von Bulow v. von Bulow, 811 F.2d 136, 141 (2d Cir. 1987); *Mem'l Hosp.*, 664 F.2d at 1061).

113. 418 U.S. 683 (1974).

114. *See Virmani*, 259 F.3d at 287 (articulating importance of disclosing evidence). The court started with the presumption that privileges "are not lightly created." *See id.* (citing United States v. Nixon, 418 U.S. 683, 710 (1974)). The court also stated that evidentiary privileges refute the "fundamental principle that the public . . . has a right to every man's evidence." *See id.* (citing Univ. of Pa. v. EEOC, 493 U.S. 182, 189 (1990)).

115. *See id.* at 286-88 (discussing de novo review). Following *Jaffee*, the Court recognized "a general duty to give what testimony one is capable of giving, and that any exemptions which may exist are distinctly exceptional, being so many derogations from a positive general rule." *See id.* at 287 (citing Jaffee v. Redmond, 518 U.S. 1, 9 (1996)).

116. *See id.* (discussing Supreme Court's admonition not to create or recognize new privilege). The court, in finding an answer to the issue, refused to recognize a peer review privilege in the absence of "sufficiently important interests [that] outweigh the need for probative evidence." *See id.* (citing *Univ. of Pa.*, 493 U.S. at 189 (quoting Trammel v. United States, 445 U.S. 40, 51 (1980)).

117. *See id.* (describing issue to be determined).

A. *The Fourth Circuit's Analysis of Supreme Court Privilege Jurisprudence*

The court first addressed the petitioner's reliance on *Jaffee* to uphold a peer review privilege because it served a "compelling public end."[118] The court in *Jaffee* had concluded that the benefits of a psychotherapist-patient privilege outweighed the evidentiary benefits that would be gained if the communication were not protected.[119] The Fourth Circuit agreed with the *Jaffee* court's assessment that only modest evidentiary value would be lost in recognition of the psychotherapist-patient privilege.[120] Nevertheless, the court distinguished *Jaffee* for two reasons. First, Dr. Virmani's claim related to discrimination in the peer review process itself and evidence would be lost if the court recognized a peer review privilege.[121] Second, the evidence requested in *Jaffee* consisted of a therapist's notes recorded while counseling a patient about a prior incident, which formed the basis of the case.[122] The court ultimately determined that Dr. Virmani's evidence could only be substantiated by the peer review documents, which addressed the reason why the hospital revoked his privileges.[123]

The court next analyzed the similarities between *University of Pennsylvania* and *Virmani*, noting that both cases involved an issue of alleged discrimination in the peer review process.[124] Influenced in large part by the Supreme Court's reasoning in *University of Pennsylvania*, the *Virmani* court concluded that the interests in providing evidence that might eradi-

118. *See id.* at 288 (discussing Novant's argument that peer review privilege advances same principles upheld in *Jaffee*).

119. *See id.* (stating that most evidence would not exist if psychotherapist-patient communication were not privileged) (citing *Jaffee*, 518 U.S. at 11).

120. *See id.* (discussing loss of evidence in recognition of privilege).

121. *See id.* (noting that best evidence to make determination of discrimination can be found in peer review records). The court here distinguished the *Jaffee* reasoning because, in *Jaffee*, the evidence existed not only in the notes from the counseling sessions between the patient and therapist, but could also be gained from the actual event, the shooting. *See id.* (explaining events in *Jaffee*). In Dr. Virmani's circumstances, the court concluded that the actual event was the peer review process itself; this process was the only source of evidence available for Dr. Virmani to make his claim. *See id.* (explaining process provides best evidence to determine if suspension was properly reached).

122. *See id.* (discussing petitioner's misplaced reliance on *Jaffee*).

123. *See id.* ("The best evidence regarding whether Virmani was properly suspended for his medical actions, rather than improperly suspended due to his race and national origin, is to be found in the process by which the decision to suspend him was reached.").

124. *See id.* at 288-89 (noting that decision is "more properly guided by *University of Pennsylvania*"). In *University of Pennsylvania*, a professor was denied tenure and subsequently claimed the decision was based on impermissible race and sex discrimination. *See id.* (discussing facts of case). The court employed the Supreme Court's balancing test and concluded that "the costs associated with discrimination outweighed the costs that would ensue from the disclosure of peer review materials." *See id.* (citing *Univ. of Pa.*, 493 U.S. at 193).

cate possible discrimination outweighed the important interest of "promoting candor" in the peer review process.[125]

B. *The Fourth Circuit's Analysis of State Privilege Jurisprudence*

In answer to the split between state and federal courts, the *Virmani* court first analyzed the decisional basis for many of the state court holdings.[126] Notably, the court referred to the *Jaffee* principle that "existence of a consensus among the States indicates that 'reason and experience' support recognition of the privilege."[127] Many of the cases cited by *Virmani* granted privilege status to peer review documents based on the balance of more divergent interests than that posed in a discrimination case.[128] The court agreed with the holdings in the cases reviewed, but distinguished the competing interests involved.[129] The *Virmani* court concluded that many of the state statutes and cases cited were not applicable in a discrimination suit.[130] The court culminated this analysis with the reverberating theme of advancing public interests if a discrimination claim were to be successful.[131]

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125. *See id.* at 289 (discussing balance of interests in *University of Pennsylvania*).

126. *See id.* at 290 (discussing state court decisions). For a further discussion of the contrasting decisions in state and federal courts, see *supra* notes 88-93 and accompanying text.

127. *See id.* (citing Jaffee v. Redmond, 518 U.S. 1, 12-13 (1996)).

128. *See id.* at 290-91 (discussing rulings in *Memorial Hospital v. Shadur*, 664 F.2d 1058 (7th Cir. 1981) (per curiam); *Eubanks v. Ferrier*, 267 S.E.2d 230 (Ga. 1980); *Baltimore Sun Co. v. University of Maryland Medical System Corp.*, 584 A.2d 683 (Md. 1991); *HCA Health Service of Virginia, Inc. v. Levin*, 530 S.E.2d 417 (Va. 2000)).

129. *See id.* at 291 (stating that reviewed decisions were based on different concerns). In a discrimination case, the court stated, the claim arises from within the peer review proceedings. *See id.* (establishing need in discrimination case for plaintiff's access to peer review records). In a malpractice action, the claim occurs from events outside of the proceedings. Therefore, preventing the plaintiff's access to peer review records will not impact greatly on his or her ability to obtain necessary evidence. *See id.* at 290-91 (contrasting these types of cases).

130. *See id.* at 291 (contrasting medical malpractice or defamation actions with discrimination cases). The court rejected Novant's emphasis on state court decisions involving medical malpractice and defamation claims as being too dissimilar to discrimination cases. *See id.* (explaining that crucial issue differs in medical malpractice context because it "is not what occurred at the review proceeding"). Specifically, the court noted that the former cases reflect a "legislative choice between the competing public concerns" allowing for recognition of privilege, whereas the later type of case advances both public and private interests and would weigh against recognizing privilege. *See id.* at 290 ("[S]tate[s'] policy decisions . . . do not inform the judgment of this court in this case.").

131. *See id.* (citing *Shadur*, 664 F.2d at 1062). The court analogized its reluctance to recognize privilege in an antitrust case to a discrimination case where a successful plaintiff would "'vindicate not only his own right to practice medicine . . . , but also the strong public interest in open and fair competition . . . .'" *See id.* (quoting *Shadur*, 664 F.2d at 1062).

C. *The Fourth Circuit's Analysis of Congressional Intent*

Without answering the question of whether Congress considered the privilege for peer review records, the *Virmani* court established that Congress had "considered the relevant competing concerns."[132] The court agreed with Congress' assessment that physicians would be reluctant to participate in peer review and, therefore, provided limited protection to the participants.[133] The court then discussed the protections provided by Congress in sections 11101-11111 of the HCQIA.[134] Acknowledging these protections, the court noted that Congress specifically created an exception to the immunity provisions for claimed violations of civil rights.[135] The court pointed to further evidence that Congress intended to limit protection by quoting the HCQIA's sponsor, who stated that "the bill was not intended to shield acts of discrimination."[136]

Next, the court refuted Novant's attempt to show that Congress favored a privilege based on broader protections in the Department of Defense and the Department of Veterans Affairs peer review statutes.[137] The court asserted that "Congress will create a medical peer review privilege when it is so inclined."[138]

1. *The Fourth Circuit's Analysis of Inter-Circuit Case Law*

The court rejected Novant's final argument that Fifth and Seventh Circuit case law supported recognition of a peer review privilege.[139] The Fourth Circuit interpreted the Seventh Circuit's decision in *Shadur* as a

132. *See id.* (citing Univ. of Pa. v. EEOC, 493 U.S. 182, 189 (1990)). Novant had argued that Congress favored a privilege for medical peer review records under the HCQIA. *See id.* (citing lower court's rejection of Congress' intent to create privilege). The Fourth Circuit decided instead that Congress provided a limited immunity with an express exception in civil rights cases. *See id.* at 291-92 (explaining HCQIA).

133. *See id.* at 291 (citing 42 U.S.C. § 11101 (1994)). For a further discussion of this provision, see *supra* note 10 and accompanying text.

134. *See id.* (discussing provisions of Act). For a further discussion of the HCQIA, see *supra* notes 10, 55-59 and accompanying text.

135. *See id.* at 291-92 (citing 42 U.S.C. § 11111(a)(1)). This provision states that liability in damages "shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964. . ." 42 U.S.C. § 11111 (a)(1). For a further discussion of the Act, see *supra* note 10-11 and accompanying text.

136. *See Virmani*, 259 F.3d at 292 n.10 (citing Representative Henry A. Waxman in 132 CONG. REC. 33,117 (1986)).

137. *See id.* at 292 (citing 10 U.S.C.A. § 1102(a)(1998) and 38 U.S.C.A. § 5705(a) (1991)). For a further discussion of both provisions, see *supra* note 63-69 and accompanying text.

138. *See id.* (stating that provisions demonstrate what Congress intended).

139. *See id.* at 292-94 (citing United States v. Harris Methodist Fort Worth, 970 F.2d 94 (5th Cir. 1992); Marrese v. Am. Acad. of Orthopedic Surgeons, 726 F.2d 1150 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985); Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1063 (7th Cir. 1981)).

direct rejection of the peer review privilege in an antitrust action.[140] Further, considering Seventh Circuit case law, the *Virmani* court interpreted *Marrese* as not undermining *Shadur*, as Novant proposed, but rather as a narrow holding because there were other "devices that the district judge could have used to reconcile the parties' competing needs."[141] The court then dismissed Novant's reliance on the Fifth Circuit's *United States v. Harris Methodist Fort Worth*[142] decision as inapposite, because it was not a case involving the balancing of interests under FRE 501.[143]

V. CRITICAL ANALYSIS

The Fourth Circuit correctly upheld the district court's decision,[144] but for the wrong reasons. The court should have upheld a peer review privilege under the applicable state statute, thereby adopting the privilege as federal common law. The court could then examine the documents in camera and determine if there was evidence of malice or fraud; a finding of either would negate the privilege allowing Dr. Virmani discovery.[145] If

140. *See Virmani*, 259 F.3d at 292 (citing *Shadur*).

141. *See id.* at 292 n.11 (citing *Marrese*, 726 F.2d at 1160). For a further discussion of *Marrese*, see *supra* notes 88, 92 and accompanying text.

142. 970 F.2d 94 (5th Cir. 1992).

143. *See Virmani*, 259 F.3d at 292-93 (discussing search issue in *Harris Methodist Fort Worth* as Fourth Amendment issue). In *Harris Methodist Fort Worth*, a hospital received notice from the Department of Health and Human Services (HHS) that it was investigating physician staff privileges and peer review proceedings. *See Harris Methodist Fort Worth*, 970 F.2d at 96 (explaining that HHS claimed that Title VI authorized investigation). The hospital raised two issues in response: first, the search, which occurred without consent, violated the Fourth Amendment; and second, the physician peer review materials were subject to privilege against discovery. *See id.* at 100-03 (agreeing with hospital that consent was for "reasonable search" and concluding that search would chill peer review process). The district court held that HHS had conducted an unreasonable search in violation of the Constitution; the Fifth Circuit affirmed. *See id.* at 103 (concluding that because search "exceeded bounds of reasonableness, we need not define the scope of any applicable privilege").

144. *See Virmani*, 259 F.3d at 293 (stating holding).

145. *See* N.C. GEN. STAT. § 131E-95 (1999) ("A member of a duly appointed medical review committee who acts without malice or fraud shall not be subject to liability . . . ."). For a further discussion of the good faith provision, see *supra* note 60 and accompanying text. Under the circumstances, privilege under the broad state law would have precluded Dr. Virmani from discovering his peer review records as long as the peer review members acted in good faith. *See id.* The statute's good faith provision will permit in camera inspection of the proceedings to determine whether good faith was exercised. *See* Virmani v. Presbyterian Health Servs. Corp., 515 S.E.2d 675, 680 (N.C. 1999) (describing how hospital attached documents to legal memorandum sent to presiding judge, but did not file documents in order to preserve state privilege); *see also* Marrese v. Am. Acad. of Orthopedic Surgeons, 726 F.2d 1150, 1160 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985) (discussing use of in camera inspection and redaction to determine merits of case). In *Virmani*, the state court sealed the documents pursuant to state law. *See Virmani*, 515 S.E.2d at 685-86 (citing N.C. GEN. STAT. § 131E-95). The court would not be compelled to extend this immunity if it found

the process were carried out in good faith, there would be no merit to Dr. Virmani's argument.[146] In the alternative, the court could have interpreted the statute to allow disclosure of the subject in an adverse peer review, consistent with the approaches of various other states.[147]

Instead, the Fourth Circuit applied the balancing test utilized by the Supreme Court in *Jaffee* and *University of Pennsylvania* to decide whether the interest in the evidence found in the peer review process was greater than the interest in protecting confidentiality in a discrimination claim.[148] In discrimination claims the weight of authority favors the need for evidence.[149] But failure to recognize a federal peer review privilege, while upholding a state statutory privilege, will perpetuate confusion until a consensus is reached between state and federal court decisions.[150]

First, it is still unclear whether federal common law recognizes any privilege at all for the peer review process or if the privilege is non-existent only when there is an issue of discrimination.[151] Second, if the *Virmani*

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that the members conducted a peer review with "malice or fraud". *See* N.C. GEN. STAT. § 131E-95 (a).

146. *Cf.* Pamintuan v. Nanticoke Mem. Hosp., 192 F.3d 378, 380 (3d Cir. 1999) (stating summary of facts).

147. *See, e.g.*, LA. REV. STAT. ANN. § 13:3715.3 (West 2001) (providing confidentiality and privilege of peer review committee records, except when requested by physician whose staff privileges are affected); MD. CODE ANN., HEALTH OCC. § 14-501(e)(1) (2000) (providing statutory exception for actions initiated by physicians aggrieved by committee decision to obtain records for use in that physician's challenge to peer review conclusions); N.Y. EDUC. LAW § 6527(3) (McKinney 2001) (providing similar exemption for discovery). For a further discussion of state statutes, see *supra* note 15 and accompanying text.

148. *See Virmani*, 259 F.3d at 286-87 (discussing balance of interests). In *Jaffee v. Redmond*, the balancing question was whether "a privilege protecting confidential communications between a psychotherapist and her patient 'promotes sufficiently important interests to outweigh the need for probative evidence . . . .'" *See* 518 U.S. 1, 9-10 (1996) (quoting Trammel v. United States, 445 U.S. 40, 51 (1980)). In *University of Pennsylvania v. EEOC*, the Court weighed the costs that ensued from disclosure of confidential information in peer review against the "costs associated with racial and sexual discrimination . . . ." *See* 493 U.S. 182, 193 (1990) (discussing compelling interests of both parties).

149. *See Virmani*, 259 F.3d at 293 n.13 (citing discrimination cases rejecting privilege). Federal district courts in discrimination cases have rejected a peer review privilege. *See id.* (citing court cases). For a further discussion of discrimination cases, see *supra* notes 85-87 and accompanying text.

150. *See* Appellant's Petition for Rehearing at 1, *Virmani*, 259 F.3d 284 (discussing results of holding). Novant argued that "rejection of the privilege in federal question cases effectively eviscerates the protection of the state law privileges." *Id.*; *see, e.g.*, Graham, *supra* note 61, at 138 (concluding that "contradictory court decisions complicate the understanding of the level of privilege afforded . . . at both the state and federal level.").

151. *See Virmani*, 259 F.3d at 293 (stating that Seventh Circuit declined to recognize privilege). But the Seventh Circuit specifically stated, "[Confidential files] are discoverable in appropriate circumstances, subject to appropriate safeguards." *See* Marrese v. Am. Acad. of Orthopedic Surgeons, 726 F.2d 1150, 1161 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985); *see also* Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1062 (7th Cir. 1981) (recognizing that peer review privi-

holding is to be narrowly construed to discrimination suits, then the existence of privilege in other areas based on a balancing test will only be determined after the case is being litigated.[152] This leaves peer review committee members no notice as to whether they have the protection of privilege, as it will only be decided after the fact.[153] Finally, peer review committees are made up of different members, depending on their specialty and who is active on the committee from year to year.[154] If the process is in question, then it may not have been a fair assessment in *Virmani* to compare the committees who reviewed Dr. Virmani with committees of different members during the past twenty years.[155]

A. *Supreme Court Decisions for Privilege*

In two Supreme Court cases, one limiting and one creating a federal privilege, the Court deferred to state trends to decide important privilege issues.[156] After examining state court decisions, the Court in *Trammel* followed these trends and narrowed a federal spousal privilege.[157] In *Jaffee,*

lege in malpractice action "will have little impact upon . . . plaintiff's ability to prove a meritorious claim").

152. *See* Appellant's Petition for Rehearing at 9, *Virmani*, 259 F.3d at 287 (stating that participants cannot predict whether suit might be brought in federal or state forum). A physician's dependence on privilege is based on a belief at the time of his participation that he is immune from liability. *See Jaffee*, 518 U.S. at 17 (discussing uselessness of state privilege laws if privilege is not upheld in federal court); Upjohn Co. v. United States, 449 U.S. 383, 393 (1981) (discussing need for certainty of privilege less it be "little better than no privilege at all").

153. *See* Appellant's Petition for Rehearing at 9, *Virmani*, 259 F.3d at 287 (explaining outcome will "chill the candor" that is needed for successful peer review); *see also Jaffee*, 518 U.S. at 17 (rejecting balancing component). The Court in *Jaffee* held that "making the promise of confidentiality contingent upon a trial judge's later evaluation of the relative importance of the patient's interest in privacy and the evidentiary need for disclosure would eviscerate the effectiveness of the privilege." *Id.* The Court also stated that participants in communication must be able to predict whether it is confidential and protected. *See id.* (citing *Upjohn*, 449 U.S. at 393).

154. For a discussion of peer review committees and process, see *supra* notes 25-32.

155. *Cf.* Pamintuan v. Nanticoke Mem'l Hosp., 192 F.3d 378, 389 (3d Cir. 1999) (focusing on whether hospital made reasonable effort to obtain facts of matter in discrimination case rather than whether plaintiff is substandard to other physicians).

156. *Compare* Trammel v. United States, 445 U.S. 40, 49-53 (1980) (concluding need to narrow privilege), *with Jaffee*, 518 U.S. at 13 (creating new privilege).

157. *See Trammel*, 445 U.S. at 49-53 (concluding that spousal privilege should be modified based on "reason and experience" because of similar holdings in states). Notably, the Court also emphasized that state trends were especially relevant because laws of marriage are traditionally state mandated. *See id.* at 49-50 (citing Sosna v. Iowa, 419 U.S. 393, 404 (1975)). Similarly, the Supreme Court has stated that "general health care regulations . . . historically [have] been a matter of local concern." *See* Appellant's Petition for Rehearing at 9, Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001) (citing N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 707 (1995)).

however, the Court created a privilege in part because all fifty state legislatures favored it.[158]

In *Virmani*, although the court noted that "the existence of a consensus among the states indicated that 'reason and experience' support recognition of the privilege," it failed to follow such a line of reasoning.[159] The *Virmani* court instead balanced the need for promoting candor among peer review members against the interests for evidence in medical malpractice and defamation claims to decide whether it was appropriate to recognize a privilege.[160]

Contrary to judicial trends, many states have expanded statutes over the last thirteen years to enhance protection for peer review members.[161] Some states provide blanket protection for the medical peer review process.[162] Other states offer broad privilege, but carve out limited excep-

158. *See Jaffee*, 518 U.S. at 14 n.13 (stating that although there is range of exceptions recognized in states, that range is not enough to "undermine the force of . . . unanimous judgment"). The unanimity of the state's had an impact on the Court's decision to recognize a privilege. *See id.* (considering creation of privilege by all fifty states). Justice Scalia, in his dissent, criticized the Court's decision to create a new privilege. *See id.* at 19 (Scalia, J., dissenting) (claiming Court in past has adhered to principle rejecting new privileges). As examples of the trend to reject new privileges, Justice Scalia cited *Trammel*, 445 U.S. at 50; *United States v. Nixon*, 418 U.S. 683, 710 (1974); *University of Pennsylvania v. EEOC*, 493 U.S. 182, 201 (1990); and *United States v. Gillock*, 445 U.S. 360 (1980)). *See id.* at 19 (enumerating cases limiting privilege).

159. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 290 (4th Cir. 2001) (quoting *Jaffee* that policy decisions of states have bearing on "whether federal courts should recognize a new privilege"); *see also Jaffee*, 518 U.S. at 12-13 (same); *Trammel*, 445 U.S. at 49-50 (limiting privilege in spousal testimony based on state law trends).

160. *See Virmani*, 259 F.3d at 290 (discussing state case holdings in response to defendant's argument that states have all recognized some form of peer review privilege). The court cited *Eubanks v. Ferrier* as an example of a state statute allowing privilege when a plaintiff requested peer review documents to further a medical malpractice claim. *See id.* (citing Eubanks v. Ferrier, 267 S.E.2d 230, 232 (Ga. 1980)); *see also* HCA Health Serv. of Va., Inc. v. Levin, 530 S.E.2d 417, 420 (Va. 2000) (upholding privilege for peer review records in defamation action because intent is to promote candid discussion to improve quality of health care system).

161. *Compare* Charles David Creech, Comment, *The Medical Review Committee Privilege: A Jurisdictional Survey*, 67 N.C. L. REV. 179, 179 (Nov. 1988) (asserting that "forty-six states now have statutes" protecting peer review), *with* Scheutzow, *supra* note 3, at 28 (claiming that forty-seven states and District of Columbia have state statutes for peer review privilege in 1999), *and* Appellant's Petition for Rehearing (En Banc) at 1, *Virmani*, 259 F.3d 284 (stating that peer review privilege has been adopted by all fifty states).

162. *See, e.g.*, GA. CODE ANN. § 31-7-143 (2001) (protecting committee proceedings and records from discovery); N.C. GEN. STAT. § 131E-95 (1999) (providing broad protection from discovery); VA. CODE ANN. §.8.01-581-17 (2000) (providing privilege for communications from legal discovery "unless a circuit court, after a hearing and for good cause arising from extraordinary circumstances being shown, orders the disclosure . . . .").

tions.[163] The *Virmani* court stated that under the North Carolina statute, privilege would prevent disclosure and the outcome would be different.[164] Unless the good faith provision of the state statute would allow the court to permit discovery or at least examine the records in camera, North Carolina's statute maintains a privilege for peer review.[165]

This exemplifies the inconsistency in the application of peer review privilege when a case is tried in a state court versus a federal court.[166] If *Virmani* were tried in certain state courts, the result might be that the defendant would be compelled to turn over the document, even though privilege is recognized, because the statute allows the subject of the peer review access to his records.[167] Maryland, for instance, recognizes a peer review privilege, but allows the subject of peer review to discover his or her records.[168] Physicians participating in peer review in Maryland are thus

163. *See, e.g.*, FLA. STAT. § 395.0193 (1998) (providing good faith participants with immunity from retaliatory tort suits and federal antitrust suits); MD. CODE ANN., HEALTH OCC. § 14-501 (2000) (allowing exception to privilege for physician who is subject of committee's adverse determination); S.C. CODE ANN. § 40-71-20 (Law. Co-op. 2001) (providing confidentiality of proceedings and data unless respondent in proceeding requests in writing that information be made public).

164. *See Virmani*, 259 F.3d at 286 n.3 (stating that "[i]f North Carolina law supplied the rule of decision, the materials would be privileged"). The court did not address the issue that the North Carolina statute restricts privilege to good faith actions in part A of the provision. *See id.* (reviewing statute without discussing good faith exception).

165. *See* N.C. GEN. STAT. § 131E-95 (1999) (citing "member . . . who acts without malice or fraud"); *see also* LeMasters v. Christ Hosp., 791 F. Supp. 188, 191 (S.D. Ohio 1991) (citing 42 U.S.C. § 11111(a)(1)). In *LeMasters*, a discrimination case, the court emphasized that the immunity provisions have specifically not been extended where actions "that violate civil rights laws . . . will not be protected under this bill." *Id.*; *see also* Univ. of Pa. v. EEOC, 493 U.S. 182, 193 (1990) (citing EEOC v. Franklin & Marshall Coll., 775 F.2d 110, 116 (3d Cir. 1985)) (explaining that alleged party to discrimination cannot choose what evidence should be submitted for investigation). An aggrieved party would be able to have some relief if he could demonstrate "that the peer review was not conducted in good faith" so the outcome here, even under state law, could be identical. *See* Scheutzow, *supra* note 3, at 30 (explaining good faith exception).

166. For a further discussion of inconsistency between state and federal peer review privilege, see *supra* notes 86-91 and accompanying text.

167. *See, e.g.*, Balt. Sun Co. v. Univ. of Md., 584 A.2d 683, 687 (Md. 1991) (explaining exception to peer review privilege under Maryland statute). The court in *Baltimore Sun* held that the state statute did not preclude a physician from discovery of his peer review records. *See id.* (citing holding). The Maryland court, in its analysis, stated that peer review records are not insulated from either discovery or admissibility when a physician, who is the subject of the proceedings, files a claim in a civil action. *See id.* (citing Stone v. Univ. of Md. Med. Sys., 855 F.2d 167 (4th Cir. 1988)); *see also* Brem v. Decarlo, 162 F.R.D. 94, 98 (Md. 1995) (stating that action initiated by physicians who challenged review committee determination is only statutory exception to privilege in peer review).

168. *See* MD. CODE ANN., HEALTH OCC. § 14-501 (e)(1) (2000).

> Exceptions . . . of this section do not apply to: (1) A civil action brought by a party to the proceedings of the medical review committee who claims to be aggrieved by the decision of the medical review committee; or (2) Any record or document that is considered by the medical review com-

protected under the statute; however, the aggrieved party may obtain evidence without a discovery battle, which ultimately allows meritorious claims to proceed.[169]

B. *Reconciliation of Privilege*

The *Virmani* court failed to reconcile the confusion generated by varied interpretations of the peer review privilege.[170] The lack of uniformity for peer review privilege does not lie solely in the difference between the federal courts' refusal to grant a privilege and the statutory recognition of the same privilege; rather, it is compounded by the variation in the scope of state privilege statutes.[171] The court's refusal to recognize a privilege in a discrimination case is a vague statement creating the possibility that there may be a privilege in other contexts; the court, however, failed to define those conditions.[172] Privilege is only a reliable protection when it is guaranteed in advance of the communication and is applied consist-

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mittee and that otherwise would be subject to discovery and introduction into evidence in a civil trial.

Id.

169. *See Balt. Sun*, 584 A.2d at 687 (stating exception to peer review statute that records are subjected to pre-trial discovery and admitted as evidence during civil action).

170. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 291 (acknowledging "no evidence that state legislatures considered the potential impact on discrimination cases of a privilege for medical peer review"). The court also stated that because states' policy decisions reflect different concerns than those at issue they "do not inform the judgment of this court in this case." *Id.*

171. *See id.* at 290 (pointing to policy decisions for peer review privilege in some states to prevent disclosure in malpractice claims); *see also* Graham, *supra* note 61, at 115 (discussing split in court decisions and inconsistent outcomes due to discretion given by FRE). For a further discussion regarding the variation in protection offered in state statutes, see *supra* note 15 and accompanying text.

172. *See* Jaffee v. Redmond, 518 U.S. 1, 17 (1996) (rejecting balancing component stating that "promise of confidentiality contingent upon . . . judge's later evaluation . . . would eviscerate the effectiveness of the privilege"). For a further discussion of *Jaffee*, see *supra* notes 78-82 and accompanying text. *See, e.g.*, Teasdale v. Marin Gen. Hosp., 138 F.R.D. 691, 693 (N.D. Cal. 1991) (discussing HCQIA as basis of peer review privilege). In *Teasdale*, the plaintiff requested peer review documents in a discrimination action against the defendant hospital after the hospital revoked plaintiff's surgical privileges. *See id.* (citing facts). The court held that the HCQIA was not in effect at the time of the peer review, but did provide guidance about Congress' intent. *See id.* at 694-95 (explaining additional limits of protection to information that is not "false or misleading or . . . not in furtherance of quality health care"). The court also discussed the importance of looking to state law for guidance, although it acknowledged that it was not required to adopt it under FRE. *See id.* at 694; *see also* Johnson v. Nyack, 169 F.R.D. 550, 560 (S.D.N.Y. 1996) ("*University of Pennsylvania* does not eliminate the possibility of a federal medical peer review privilege."); *Brem*, 162 F.R.D. at 102 (holding that state peer review statute "would be thwarted if confidentiality of the proceedings were not protected" in sex and religious based discrimination claim).

ently.[173] When it is not provided absolutely it is worthless as an incentive to encourage behavior.[174]

By declining to recognize a peer review privilege, the court in *Virmani* failed to follow state trends under the *Trammel* and *Jaffee* reasoning.[175] If the *Virmani* court had followed these Supreme Court cases it would have looked to state and federal recognition of privilege and, finding clear evidence, would likely have approved privilege.[176] Consistent with the doctrine of comity, there would be no substantial cost to federal policy in doing so because Congress has already approved federal peer review privilege in other contexts.[177] Accordingly, plaintiffs would have access to evidence because of the good faith exception that allows courts to review documents in camera.[178] Furthermore, consistent with many state stat-

173. *See Jaffee*, 518 U.S. at 17-18 (discussing need for notice); *see also* Graham, *supra* note 61, at 138-39 (concluding that contradictory state and federal court decisions in privilege determinations complicate this issue).

174. *See Jaffe*, 518 U.S. at 18 (quoting Upjohn v. United States, 449 U.S. 383 (1981)).

175. For a further discussion of circumstances under which the federal courts follow state court trends, see *supra* notes 139-42 and accompanying text. Congress offered limited immunity under the 1986 HCQIA but later provided that the relevant state statutes should not be restricted by the immunities provided under the Act. *See, e.g.*, Graham, *supra* note 61, at 119 (noting that 1987 congressional amendment to subsection (a) of HCQIA stating that "'nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law'" would provide greater protection than those provided by HCQIA); Scheutzow, *supra* note 3, at 17 (explaining policy reasons for states to broaden peer review protection). A physician may find it an ethical duty to evaluate an incompetent peer to improve health care and protect future patients from harm, but may be much less willing to participate in this process if his appraisal is then used as evidence in a plaintiff's medical malpractice action. *See id.* at 18 (explaining ethical concerns as motivation for peer review).

176. *See* Mem'l Hosp. v. Shadur, 664 F.2d 1058, 1061 (7th Cir. 1981) (citing United States v. King, 73 F.R.D. 103, 105 (E.D.N.Y. 1976)). The court in *Shadur* emphasized that federal courts should consider state law when assessing privilege and stated, "'[a] strong policy of comity between state and federal sovereignties impels federal courts to recognize state privileges where this can be accomplished at no substantial cost to federal substantive and procedural policy.'" *Id.* (quoting *King*, 73 F.R.D. at 105); *see also* Weekoty v. United States, 30 F. Supp. 2d 1343, 1347 (D.N.M. 1998) (citing Lora v. Bd. Educ., 74 F.R.D. 565, 576 (E.D.N.Y. 1977)). The court in *Weekoty* recognized that "if a state holds out the expectation of protection to its citizens, they should not be disappointed by a mechanical and unnecessary application of the federal rule." *See Weekoty*, 30 F. Supp. 2d at 1347.

177. *See* 38 U.S.C. § 5705 (1994) (providing privilege for peer review proceedings at veteran's hospitals); 10 U.S.C. § 1102 (1994) (creating privilege for peer review documents at military hospitals). For a further discussion of federal instances of peer review privilege, see *supra* notes 63-69 and accompanying text.

178. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 287 n.4 (4th Cir. 2001) (explaining court protective order to redact extraneous confidential information); *see also* Marrese v. Am. Acad. of Orthopedic Surgeons, 726 F.2d 1150, 1160 (7th Cir. 1984) (en banc), *rev'd on other grounds*, 470 U.S. 373 (1985) (explaining in camera review as procedure to balance privilege against need for evidence); Holland v. Muscatine Gen. Hosp., 971 F. Supp. 385, 387 (S.D. Iowa 1997) (reviewing documents in camera to determine whether they fall outside scope of discovery).

utes, the court could allow disclosure when a physician challenges an adverse peer review outcome.[179] The *Virmani* court could have recognized peer review privilege and thereby harmonized the doctrine with other state and federal statutes.[180] Doing so would have thus guaranteed a reliable and consistent peer review privilege.

Finally, when the *Virmani* court allowed Dr. Virmani to review documents from the previous twenty years, it exceeded the scope of privilege for several reasons.[181] First, if non-white physicians were treated more harshly than white physicians, there would be better ways to establish this disparate treatment than through the peer review records.[182] Second, the

179. *See, e.g.*, ARIZ. REV. STAT. § 36-445.01 (1993) (excepting from privilege provider in action arising from discipline of that provider); IOWA CODE § 147.135 (2) (1997) (allowing discovery for "affected licensee"); LA. REV. STAT. ANN. § 13:3715.3 (West 1991) (excepting records by physician in proceedings affecting hospital staff privileges); *cf.* TEX. OCC. CODE ANN. § 160.007 (Vernon 2000) (allowing affected physician to have copy of committee report and final decision). For a further discussion regarding state statutes, see *supra* note 15 and accompanying text.

180. *See Virmani*, 259 F.3d at 293 (discussing holding). Under the proposed approach, Dr. Virmani would have had access to his peer review documents whether under state or federal law because he was the subject of the review. *See id.* at 291 (noting that both state legislatures and Congress decided to allow victims of discrimination to pursue claims rather than hold medical review records as privileged). Furthermore, the case could have proceeded on the merits if there was evidence of discrimination. *Cf.* Pamintuan v. Nanticoke, 192 F.3d 378, 379-80 (3d Cir. 1999) (citing case of physician claiming discrimination in peer review process).

181. *See* EEOC v. Franklin & Marshall Coll., 775 F.2d 110, 117 (3d Cir. 1985) (suggesting that confidential material regarding other candidates' qualifications would be point of comparison to measure discrimination). Important to note is the fact that the court specified that the candidates be of a "similar time frame." *See id.* (suggesting time is relevant factor); *Pamintuan*, 192 F.3d at 387-89 (analyzing need to conduct comparative review of physician who had privileges revoked after peer review proceeding and who claimed race based discrimination). The court in *Pamintuan* agreed, "nothing [that] the statute, legislative history, or case law suggests [that] competency of other doctors is relevant." *See id.* at 389 (citing Smith v. Ricks, 31 F.3d 1478 (9th Cir. 1994)). Given these facts, the focus of the investigation under the HCQIA was not how the plaintiff measured up against other physicians, but whether "disciplinary actions were justified." *See id.* (evaluating physicians based on individual skills rather than as comparison). Similarly, by reviewing records of physicians over twenty years, the court in *Virmani* will not be conducting a comparative contemporaneous study. *Cf. Pamintuan*, 192 F.3d at 387-89 (stating that lack of study does not support discrimination claim). Moreover, substandard care that was not appropriately sanctioned in prior years does not necessarily prove or disprove discrimination in a peer review by current standards. *See id.* (describing evaluation of physician).

182. *See* Appellant's Petition for Rehearing (En Banc) at 14, *Virmani*, 259 F.3d 284 (discussing alternative means to access possible evidence of disparate treatment). Novant suggested that the plaintiff use discovery to gather names and ethnicity of the OB-GYN physicians who have patients with similar complications and determine whether their privileges have been revoked. *See id.*; *cf. Franklin & Marshall Coll.*, 775 F.2d at 116 (discussing comparison of qualifications of candidates in academic setting in similar time frame). In *Franklin & Marshall College*, the plaintiff's tenure consideration was in 1980, and he requested discovery of tenure

peer review process is based on the members comprising the committee; in twenty years these members change.[183] Moreover, physicians twenty years ago, whether white or non-white, were held to different standards of care than they are today.[184] Technological advances, surgical techniques, outcome criteria and mortality and morbidity studies are different and may make any comparison meaningless.[185] It would be inequitable to hold past reviews to today's standards of conduct and still make a true comparison, unless data of past standards could somehow be incorporated.[186]

VI. IMPACT

There are three groups likely to be affected by the *Virmani* court's decision not to recognize a federal peer review privilege.[187] First, in the Fourth Circuit, plaintiffs similar to Dr. Virmani possess precedent when moving for discovery of peer review documents.[188] The court failed to hold, as a matter of law, that all physicians adversely affected are entitled to their peer review records. As a result, future plaintiffs must assert a federal claim because the state statute continues to provide a privilege.[189] This could result in the same lengthy process that Dr. Virmani himself had to pursue in order to have access to his peer review records.[190]

A second group impacted by the *Virmani* decision are the peer review members.[191] These members may now be even more uncertain as to the privileges granted during civil proceedings and to peer review documents

decisions for candidates from 1977 to 1981. *See* 775 F.2d at 112-17 (discussing dates requested as appropriate comparative base).

183. *See, e.g.*, Appellant's Brief at 5, *Virmani*, 259 F.3d 284 (noting that first and second peer review had different reviewers); Plaintiff's Complaint at 15, *Virmani*, 259 F.3d 284 (requesting review by external reviewers).

184. *See* David Orentlicher, *The Influence of a Professional Organization On Physician Behavior*, 57 ALB. L. REV. 583, 597-601 (Summer 1994) (discussing different rates of development of guidelines). Over a span of twenty years physician practice standards have changed, as have many technological advances in treatment. *See id.* (discussing guidelines, some of which are "rapidly adapted to medical innovation").

185. *See id.* (discussing fact that standards of practice for physicians have changed, as have many technological advances).

186. *Cf. Pamintuan*, 192 F.3d at 384 (discussing use of comparative review analysis rather than anecdotal studies).

187. *See generally Virmani*, 259 F.3d 284 (illustrating that plaintiff's access to documents will impact his ability to proceed with discrimination suit). Notably, physicians who participate in peer review will be impacted either as the defendant suggested— because "physicians will be reluctant to speak openly"—or, as the court suggested—because "disparate treatment ceases to occur." *Id.* at 289.

188. *See id.* at 288 (stating case is issue of first impression).

189. For a further discussion of state statutes and common law holdings, see *supra* notes 114-33 and accompanying text.

190. *See Virmani*, 259 F.3d at 285-86 (citing facts of case).

191. For a further discussion of peer review participants, see *supra* notes 53-55 and accompanying text.

as they evaluate their peers.[192] Further, where participants are subject to a federal discrimination suit, they will have to assume that the least amount of privilege applies because it appears that no privilege exists for proceedings involving a federal question of discrimination.[193]

Physicians involved in peer review will need to forecast whether the subject of the peer review will sue in federal or state court to determine what degree of privilege might apply.[194] The privilege becomes all but illusory and provides no notice to participants, especially when the privilege is revoked in retrospect but the participants depended on it during the process.[195] Had the court in *Virmani* drawn a line and held that any physician adversely affected by a decision of a peer review committee could, as a matter of law, request and receive a copy of the peer review proceedings, then physicians would likely hold themselves to a higher standard when evaluating their peers.[196] This higher standard may result in two benefits.[197] First, knowing that disclosure will occur, physicians involved in the peer review process would likely be deterred from acting in bad faith.[198] Second, fewer challenges to the peer review privilege would arise.[199]

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192. For a further discussion of protections and immunities under state and federal laws, see *supra* notes 55-77 and accompanying text.

193. *See Virmani*, 259 F.3d at 293 (declining to recognize privilege for peer review in national origin discrimination case). For a further discussion of privilege being applied inconsistently, see *supra* notes 60-62 and accompanying text.

194. *See* Appellant's Petition for Rehearing (En Banc) at 9, *Virmani*, 259 F.3d 284 (arguing inability to predict where legal claim might arise, which will chill candor of assessments). For a further discussion of claims arising in different contexts, see *supra* notes 150-51 and accompanying text.

195. *See* Jaffee v. Redmond, 518 U.S. 1, 18 (1996) (citing need for certainty for privilege to have meaning). For a further discussion of privileges, see *supra* notes 78-81 and accompanying text.

196. *See* Orentlicher, *supra* note 184, at 585 (proposing that physicians have strong need for personal autonomy, resulting in agreement to be "bound by a professional code of ethics").

197. *See id.* at 586 (explaining benefits of professional autonomy "'[b]y collectively engaging in the process of enacting and enforcing'" moral guidelines).

198. *See id.* at 589 (theorizing that physicians accept regulations more readily if developed within profession rather than imposed by external regulations).

199. *See* Scheutzow, *supra* note 3, at 50-51 (outlining confusion in court's interpretation of privilege). The author cites the deviation between the state statutes upholding privilege and the absence of federal recognition of peer review privilege. *See id.* (citing Burrows v. Redbud Hosp. Dist., 187 F.R.D. 606 (N.D. Cal. 1998)); Syposs v. United States, 179 F.R.D. 406, 409 (W.D.N.Y. 1998)). But the author contrasts this with a proposal in the 105th Congress to establish federal peer review privilege and peer review recognition under federal law by the Veterans Administration. *See id.* With so much confusion in peer review privilege, parties are uncertain as to disclosure of information during discovery. *See, e.g.*, Riney, *supra* note 54, at 348 (stating that civil rights and antitrust complainants often benefit because of liberal discovery standard).

A third group who could potentially be affected by the Fourth Circuit's decision are the recipients of incompetent care.[200] It is unclear whether physicians will adhere to the AMA standards for continued commitment to peer review.[201] If physicians continue to effectively participate in peer review without any self-interest, then the goals of peer review as set forth in the HCQIA will be addressed without peer review protections and the quality of health care will improve.[202] If, however, the defendants' assertions in *Virmani* are correct, then candid and frank discussions will be chilled and peer review will no longer provide an adequate protection against incompetent physicians.[203] Privilege, however, should not be absolute, nor should it serve as a shield to protect physicians who use economic or personal bias to discriminate against competent physicians.[204]

VII. CONCLUSION

In *Virmani*, the Fourth Circuit followed Supreme Court precedent disfavoring the creation of new evidentiary privileges and refused to recognize a federal peer review privilege in a case alleging a civil rights violation for discrimination because of national origin.[205] The court did not follow the decisions in *Jaffee* and *Trammel*, which give deference to state legislative and judicial decisions on the underlying issues.[206] Health care is an area

200. *See* Dallon, *supra* note 3, at 616 (discussing patient welfare in proper review of physicians). Defendants posited that privilege needs to be recognized for policy reasons. *See* Virmani v. Novant Health Inc., 259 F.3d 284, 287 (4th Cir. 2001) (arguing confidentiality is essential to effective peer review). *But see* LeMasters v. Christ Hosp., 791 F. Supp. 188, 191 (S.D. Ohio 1991) (refuting defendant's assertion that permitting discovery undermines quality of health care). In *LeMasters*, the court held that in a case where a physician claims discrimination she is entitled to discovery of the peer review proceedings. *See id.* (stating holding). In its reasoning, the court stated that there was not "a scintilla of evidence" to show that discovery of peer review proceedings would dissuade physician participation in the process. *See id.* (discussing physician obligation to participate in review). The court further explained that physicians "feel an ethical duty to the profession and to the public to keep the standard of health high." *Id.* The court suggested that if a hospital could not find volunteer physicians, it could require participation as a requirement of staff privileges. *See id.* at 191-92 (discussing ways to obligate physician participation).

201. *See* Scheutzow, *supra* note 3, at 47-53 (citing statistical data of study showing conflicting views of impact of privilege on physician outcomes).

202. *See* Orentlicher, *supra* note 184, at 585 (advancing theory of patients benefiting from physician self-regulation). For a further discussion of physician behaviors, see *supra* notes 184-85 and accompanying text.

203. *See Virmani*, 259 F.3d at 287 (stating courts "have found that . . . physicians would be reluctant to serve on the committees or would be less candid . . . if they did serve . . . [and] as a result, the quality of health care would suffer").

204. *See* Riney, *supra* note 54, at 348-49 (discussing use of peer review to shield unfair practices).

205. *See Virmani*, 259 F.3d at 291 (refusing to recognize privilege).

206. For a further discussion of *Jaffe* and *Trammel*, see *supra* notes 156-59 and accompanying text.

that is left to the states to regulate.[207] Accordingly, states have recognized the need for some form of peer review protection in advancing the principles of the HCQIA.[208] Although Congress did not create a federal peer review privilege under HCQIA, it did not preclude the states from setting their own standards.[209] If peer review committees believe that they are protected by privilege under state law and the HCQIA when they deliberate to advance the quality of health care, then the Fourth Circuit's refusal to recognize this in federal court has eviscerated the peer review privilege.[210] The vestiges of the privilege do not provide protection to members who serve on peer review committees and only creates confusion in the courts.[211]

A better solution is to strengthen the privilege where it is proven to be beneficial and create exceptions where it is against policies of fairness.[212] A clear peer review privilege will protect subjects of peer review, the physician participants and ultimately the consumers who benefit when the quality of health care is improved.[213]

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207. *See* Appellant's Petition for Rehearing at 9, Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001) ("'[G]eneral health care regulation . . . historically has been a matter of local concern.'") (citing N.Y. State Conference of Blue Cross & Blue Shield Plans v. Travelers Ins. Co., 514 U.S. 645, 707 (1995)).

208. *See* Dallon, *supra* note 3, at 625 (explaining enactment of statutes by state legislatures to encourage peer review). *But see* Scheutzow, *supra* note 3, at 55 (concluding that statistics do not prove that strong privilege and immunity protections will encourage effective peer review). Scheutzow suggests that peer review is not enhanced by a simple formula to strengthen the statutory protections. *See id.* at 55-57 (discussing other means to enhance review). Scheutzow states:

> [T]he existence of a privilege statute should be reexamined and tailored to accomplish the intended result. Currently, the strongest privilege statutes have myriad effects. These statutes keep information out of the courtroom in lawsuits brought against hospitals and peer review participants by physicians challenging peer review decisions. . . . Legislatures should determine whether the privilege is warranted in all or any situations. . . . If the peer review protection statutes are to serve as anything more than special interest laws that only protect peer review participants, state legislatures must reassess these statutes and develop new methods to ensure that health care organizations perform effective and meaningful peer review.

Id. at 56-57.

209. *See Virmani*, 259 F.3d at 292 n.10 (citing 132 CONG. REC. 33,117 (1986) (stating bill was not intended to override state acts)). For a further discussion of health care regulations, see *supra* notes 54-58 and accompanying text.

210. *See* Upjohn v. United States, 449 U.S. 383, 393 (1981) (stating "[a]n uncertain privilege . . . is little better that no privilege at all.").

211. *See id.* (stating privileges that are applied with variations are equivalent to having no privileges at all).

212. *See* Scheutzow, *supra* note 3, at 47-53 (discussing statistical analysis of data in peer review process).

213. *See Virmani*, 259 F.3d at 289 (agreeing with defendant that privilege serves important interests); *see also* Appellant's Petition for Rehearing (En Banc) at 3-4, *Virmani*, 259 F.3d 284 (discussing compelling reasons for peer review privi-

lege). Novant posed several arguments, first, the need to safeguard patients from incompetent physicians through peer evaluation where discovery of substandard care can be reviewed. *See id.* Second, the effectiveness of the process depends on the willingness of the participant whose only incentive flows directly to the public. *See id.* This willingness does not serve the participant and without protection can in fact harm him or her by virtue of future litigation. *See id.* Third, confidentiality is essential, and allowing discovery of proceedings will eliminate the role the process will have in the delivery of quality health care. *See id.*