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Federal Efforts to Impose Uniformity in Health Care Regulations: Peer Review

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Since the development of the Standards for Hospital Accreditation promulgated by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), hospitals have been required to maintain an organized medical staff. Part of the duties and responsibilities of the medical staff is to credential physicians applying for hospital privileges and to enforce standards of quality care and adherence to the administrative requirements of the hospital. Current hospital peer review procedures are a direct result of the JCAHO’s mandates in this regard. Additionally, all accredited hospitals have organized a committee process to evaluate new applicants for the medical staff, to determine the scope of their privileges, to evaluate the renewal of privileges based on their performance, and to address concerns regarding practice below the applicable standard of care by individual physicians.

The peer review process is remedial and corrective, not punitive. The value of open communication among practicing physicians, without fear that their comments could be used to establish malpractice liability, is universally seen as essential for improvement of quality in the delivery of health care services by physicians. This process has been protected in the laws of District of Columbia and elsewhere as necessary to quality assurance, based on the belief that physicians are in the best position to evaluate and oversee the clinical performance of each other. The proceedings of these peer review committees have generally been immune from discovery in civil litigation and inadmissible in court proceedings such as a malpractice case against the subject physician.

The rationale for this protection has been that if the minutes and records of peer review discussion and physician evaluation serve as evidence, they would have significant weight as expert opinion and their use would have “a chilling effect” on the entire review period. Physicians involved in the evaluation of their colleagues would not volunteer to sit on such committees, considering that their comments could end up being used against them in court, in the press as criticism of the subject physician, in the peer review process, and even in the hospital at which the patient care took place.

The rule in the District of Columbia has been that the underlying medical records are certainly discoverable by a plaintiff in a medical malpractice case, but that peer review committee meeting minutes, where those same records could be evaluated, would be off limits to the plaintiff. The practical effect is that plaintiffs are required to obtain their own expert evaluation and to present their own expert testimony and cannot “piggyback” on what a hospital peer review committee did or said about the particular case.

By differentiating between the underlying factual material, including the entire medical record, and the opinions, statements, and expressions of peer review committee members or special reviewers, the District of Columbia has joined virtually all jurisdictions in the United States in putting these mental impressions, work product, opinions, and recommendations of peer review committee use “off limits” to plaintiffs in medical malpractice cases. A recent survey of peer review statutes in the United States demonstrates this relative uniformity.

The state Boards of Medicine are responsible for the licensing of physicians to practice in their respective jurisdictions. Part of this responsibility includes taking disciplinary actions against physicians who have demonstrated an inability to provide patient care that meets the applicable standards of the medical profession. Under the rules of the National Practitioner Data Bank, hospitals that take final adverse action against physicians, for any reason, must report that to the Data Bank when the action involves a suspension of hospital medical staff privileges for more than 30 days, termination of privileges, or other serious discipline.

Medical boards throughout the United States monitor the Data Bank and, as in the District of Columbia, are notified that such action has been taken against the physician and receive a brief summary of the grounds for that action.

At this point, the Medical Board would normally proceed further to determine whether or not there was any basis for action beyond that taken by the hospital. Some examples of such actions include suspension of a physician license, remedial action, e.g., mentoring or actual termination of a license. The Board would then exercise its subpoena power to attempt to obtain

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all the information it could from the hospital that took the initial action and this is the point in time when these issues, which are the subject of this article, become joined. Query whether under the laws of each state the hospital can assert the peer review privilege and successfully seek to quash that subpoena.

Hospital medical staffs have a legitimate and well-recognized responsibility to perpetuate and protect the peer review process. Medical Boards have a similarly well-recognized duty to protect the public from physicians who are not capable of adhering to the standards of the profession. The question is how a hospital’s peer review organization can accommodate the needs of the Medical Board without compromising the immunity from discovery and protection from being used to prove a malpractice case.

It is understood that hospital medical staff activities are private in nature and that the Board of Medicine of the District of Columbia is a public body whose records are subject to Freedom of Information Act requests, and which holds public hearings and publishes the results of its decisions on its website. Presumably, the entire transcript of a hearing before the Medical Board or before a hearing officer appointed by the Medical Board to gather evidence, including all oral testimony and exhibits, is available to members of the general public once a case has gone to a final decision.

In civil litigation, when one party is seeking documents that are viewed as privileged from discovery or confidential or highly sensitive, a process exists for balancing the rights of the parties requesting this information to support his case in litigation versus the rights of the persons and other parties mentioned in the records that may have a right of privacy or need for protection from public disclosure. An excellent example of what a court might deal with in this regard would be child abuse records where the names of innocent children are found in reports regarding an abuser. In this situation the party demanding production of the documents is typically told by the custodian of the records that they will not be produced and why. If the party requesting the records does not agree with the rationale for withholding the records or redacting the records to eliminate the names of individuals, this can be brought before a judge for resolution. After both sides are provided an opportunity to state why, on the one hand, the records should be produced and, on the other hand, why they should be either redacted or withheld entirely, courts typically issue the ruling which is usually described as a “protective order.”

Hearings before judges on matters of discovery rights, privacy and privilege are commonplace, especially in medical malpractice cases, and take into account one party’s need for the information as well as the other party’s desire to protect individual privacy, trade secrets, business reputation, and so forth. This approach is recommended where a hospital review organization wishes to withhold basic documents from the Board of Medicine.

The utility of both parties appearing before a judge to sort out what should be produced and what might be withheld can be illustrated by looking at the kinds of documents that a peer review organization might have. In a matter involving serious discipline, there may have been a hearing before a panel of physicians specially appointed to hear the case. In that situation, the hearing would include the presentation of an evaluation of each case under review by, for example, the chairman of a particular department in the hospital. There might be follow-up testimony by an expert in the field retained for an independent review of the cases in question. The subject physician may have retained his or her own expert to rebut the findings of the hospital’s peer review committee and especially retained independent expert. Witnesses to what occurred in various cases might not appear and testify as to what they saw, what was done, and so forth. Throughout, members of the peer review panel might ask questions of witnesses and might express their points or opinions for the record. Finally, the subject physician would testify in response to the criticisms on a case-by-case basis, additional witnesses might be called and the peer review committee would adjourn to discuss the appropriate action that it would recommend. Typically, this recommendation is provided to the subject physician and to the medical executive committee for final action, along with a summary of the testimony, selected exhibits, the opinions of the peer review panel, and its recommendations. This would then be discussed by the Medical Executive Committee, which typically has the authority to finalize a remedy or disposition of that action, unless appealed to a higher body. If this is provided for in the by-laws, then it would become the final action of the hospital staff and would then be reported to the Data Bank.

One can easily see that this record provides a mix of substantially different kinds of information. In this situation, a judge looking at the entire proceedings might decide that the medical records that were the subject
of the hearing, the testimony of the subject physician, and the final decision of the Medical Executive Committee be turned over to the Medical Board, while the on-record discussions of the members of the peer review panel, the testimony of various experts, draft statement of facts, draft report to the Medical Executive Committee, and so forth, not be produced. This would put the Medical Board in the position of having just about all factual information that the peer review committee worked with, but none of the opinions of individual peer review members or the debates or discussions of the panel or the Medical Executive Committee. That should be sufficient for the Medical Board to conduct its own separate evaluation.

One of the values to be protected regarding peer review is the opportunity for candor, frank statements, and discussions by all participants. If the subject of a peer review meeting or hearing knew that the licensure authorities could later use anything said in that context against him or her, the strategy might be to say nothing that could be seen as an admission of wrongdoing, poor quality, or a violation of hospital policy.

One of the purposes of peer review activities is to bring them to the attention of the subject physicians, identify problems, and ask for remedial action. If any part of that dialogue could support the suspension of a physician’s license or other public disciplinary action, the subject would be extremely reluctant to admit anything. That could tend to discourage the formal peer review activity and to encourage dialogue “off the record” which can be very problematic in a situation where there are undocumented repeated problems. Admitting a mistake is frequently seen as a strong indication of willingness to correct the problem.

Disclosures of information by the hospital’s peer review committees to the Medical Board should be sensitive to the problems that will arise if subject physicians believe they have to fight every allegation or criticism of their patient care to avoid admitting to grounds for licensure discipline. For this very important reason, unless a medical staff peer review matter proceeds to a formal hearing, a Board of Medicine should never attempt to obtain or provide records and documents from the preliminary stages of quality assurance, case evaluation, and discussion, nor the opinions of members of any peer review panel, hearing body or outside expert.

The encouragement for uniformity in peer review that the Health Care Quality Improvement Act sought to achieve is only partial. What remains to be assessed is whether some accommodation can be reached between hospital peer review bodies and licensure boards who are on notice of problems because of reporting to the National Practitioner Data Bank that maintains the protection necessary for voluntary peer review to continue.

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1. Accreditation materials available from the Joint Commission on Accreditation of Healthcare Organizations, One Renaissance Boulevard, Oakbrook Terrace, Illinois 60181.
7. Unpublished survey on file with author, copies available upon request.
10. See, e.g., Spinks v. Children’s National Medical Center, 12 F.R.D. 9 (D.D.C. 1989) (holding that the minutes of a Mortality and Morbidity Committee were privileged peer review documents and that the statements of eye witnesses made to the Committee were outside the scope of discoverable information).