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A Jury of Their Peers? The High Price of Peer Review Confidentiality

By Mark McGrath

Patricia Scott was only 42 years old when she died on a hospital operating table during routine spinal surgery. In an adjoining hospital waiting room, Mrs. Scott's doctors informed her devastated family that the circumstances of her death were unprecedented, inexplicable, even bizarre. Unknown to the Scott family, these same doctors met repeatedly in the coming weeks to discuss the cause of her death. The substance of these discussions has never been shared with the Scott family, and in an ongoing malpractice action, Mrs. Scott's physicians have refused to divulge the findings that emerged from these meetings. Indeed, Mrs. Scott's attending anesthesiologist blithely conceded at his deposition that even if a definitive cause of death had been determined during these sessions, this information would not have been shared with the family.

he peer review privilege ensures that patients and their families will never know much of what goes on behind closed hospital doors. The privilege protects from disclosure all activities of peer review committees- bodies of physicians and other providers that are formed for the purpose of evaluating the quality of services rendered in healthcare institutions and to oversee the credentialing and assessment of medical staff members. The self-governing peer review process is the only mechanism for conducting these activities. Licensing boards and other agencies involved with the oversight of physicians have demonstrated a profound aversion to involving themselves with such matters. As a result of this abdication, doctors are left in complete control of the process by which their colleagues are reviewed, assessed and disciplined. Remarkably, this process goes on in complete secrecy, with no supervision, regulation, oversight, or review being conducted by governmental agencies or regulatory bodies.

Evolution of the Peer Review Privilege in North Carolina

Prior to enactment of the current peer review statutes, our courts recognized a species of peer review privilege under existing common law. In Cameron v. New Hanover Memorial Hospital, several podiatrists filed suit against New Hanover Memorial Hospital for its failure to grant clinical privileges to them. At issue was whether the minutes of medical staff credentialing meetings should have been admitted at trial. The court held that the minutes were subject to a qualified privilege under North Carolina common law.

Following Cameron, the General Assembly codified the peer review privilege. The most frequently cited statutes are the provisions governing physicians and hospitals, which can be found at N.C. Gen. Stat. sections 90-21.22A and 13IE-95, respectively.4 Prior to the amendment of these statutes in 2004, N.C. Gen. Stat. section 13IE-95 provided in pertinent part:

"The proceedings of a medical review committee, the records and materials it produces and the materials it considers shall be confidential. . . and shall not be subject to discovery or introduction into evidence in any civil action against a hospital, an ambulatory surgical facility. . . or a provider of professional health services which results from matters which are the subject of evaluation and review by the committee."

Prior to its amendment, the privilege applied only to the proceedings of "medical review committees. "The pre-amendment section 131E-76(5)defined medical review committee as "a committee of a State or local professional society, or a medical staff of a licensed hospital or a committee of a peer review corporation or organization which is formed for the purpose of evaluating the quality, cost of, necessity for hospitalization or health care, including medical staff credentialing." Each element of the definition had to be satisfied if materials generated by the committee were to enjoy the protections of the privilege.

Before the 2004 amendments, the pivotal threshold question when determining whether a given committee was a peer review body was whether the information sought in discovery was the product of a medical review committee. Medical review committees had to be composed of physicians who were members of a hospital's medical staff. For example, risk management departments and committees that included non-physicians in their membership fell outside the definition of medical review committee.

The pre-amendment case law was similarly straightforward. The leading case under the old peer review statute was Shelton v. Morehead Memorial Hospital.6 In Shelton, the plaintiff filed a malpractice action against her physicians and the hospital at which she was treated, claiming that the hospital had negligently allowed the individual defendants to retain their privileges long after it knew or should have known that they were unfit to practice medicine. The dispute involved the discoverability of certain records and materials in the possession of the hospital, including personnel investigations and determinations made by the hospital as to whether the physicians were sufficiently competent to treat patients.

The parties agreed that the hospital's Medical Staff Executive Committee was a medical review committee under the statute. The parties also agreed that section 13IE-95 prohibited disclosure of any and all medical review committee materials relating to the plaintiff's surgery. The plaintiff argued, however, that because she had alleged corporate negligence by the hospital based on its failure to monitor the performance of its medical staff, the peer review privilege should not apply to materials relating to other patients and other surgeries.

The court of appeals disagreed, noting that the Hospital Licensure Act, of which section 131E-95 was a part, had as its stated objective the promotion of "the public health, safety and welfare and to provide for basic standards for care and treatment of hospital patients."? The court went on to hold that:

"It would severely undercut the purpose of section 95, i.e., the promotion of candor and frank exchange in peer review proceedings, if we adopted plaintiff's construction of the statute, for it would mean these proceedings were no longer protected whenever a claim of corporate negligence was made alone or coupled with a claim of negligence against an individual physician."

However, the court went on to recognize the limitations of the privilege. First, the court held that the privilege did not protect factual material that was available from sources other than the medical review committee:

"[I]nformation, in whatever form available, from original sources other than the medical review committee is not immune from discovery or use at trial merely because it was presented during medical review committee proceedings; neither should one who is a member of a medical review committee be prevented from testifying regarding information he learned from sources other than the committee itself, even though that information might have been shared by the committee.(9)"

Allowing discovery of this information, the court reasoned, would not compromise the policy underlying the privilege:

"The statute is designed to encourage candor and objectivity in the internal workings of medical review committees. Permitting access to information not generated by the committee itself but merely presented to it does not impinge on this statutory purpose. These kinds of materials may be discovered and used in evidence even though they were considered by the medical review committee. This part of the statute creates an exception to materials which would otherwise be immune under [the statute]."

The Shelton court also scrutinized the definitional boundaries of the term medical review committee. The Shelton defendant argued that the hospital's board of trustees was a medical review committee. The court of appeals disagreed, holding that:

"[A] board of trustees. . . is not a committee of a medical staff, nor is it a committee of a peer review corporation organization. . . even though. . . the board reviews personnel recommendations of the medical review committees and has ultimate decision making authority upon these recommendations by virtue both of the hospital's bylaws and [the definitional provisions] of the Act.(11)"

The court also rejected the defendants' argument that the common law privilege articulated in Cameron had survived the enactment of section l3lE-95 and therefore was available as an alternate means of immunizing the documents from discovery. The statute merely codified previously existing common law, the court said, and no supplementary common law privilege survived the enactment of the statutory privilege. The Shelton court went on to rule that while records of the hospital's medical review committee were privileged, documents in the possession of the hospital's board of trustees were not and, therefore, were subject to discovery.

Significantly, the pre-amendment statutes did not extend peer review protection to the actions of nursing home committees. Interpreting the pre-amendment peer review statutes, the North Carolina Court of Appeals recently held in Windham v. Britthaven that "[n]ursing homes do not fit into any of the four categories of health care providers whose records and materials from medical review committees are protected from discovery."(13) As a result, the court concluded that neither N.C. Gen. Stat. section 131E-l07 nor section 90-21.22Aprotected incident or accident reports generated by the nursing home medical review committee from discovery.(14)

The 2004 Amendments

The North Carolina General Assembly overhauled the North Carolina peer review statutes in its 2004 session.(15) The amendments significantly expanded the peer review privilege applicable to hospitals as codified in section 131E-95.The General Assembly amended the definition of "medical review committee" set forth in section 13lE-76(5) to include specified categories of committees that are involved with credentialing medical staff or evaluating the quality, cost, or necessity for hospital or health care, including: (1) committees of state or local professional societies; (2) committees comprised

of hospital medical staff; (3) committees of a hospital or local hospital that are created by the hospital's governing board or medical staff; and (4) committees of peer review corporations or organizations.

The primary significance of the amendment lies in its expansion of the term "medical review committee" to include specified hospital committees other than medical staff committees that are formed for quality assurance or credentialing purposes. For example, a committee including medical staff, legal counsel, risk managers, and administrators could feasibly qualify as a medical review committee, so long as it was created for the purpose of evaluating quality of care issues.

The General Assembly significantly amended N.C. Gen. Stat. section 90-21.22A, as well, broadening its protection to include the actions of "quality assurance committees," which are defined to include "risk management employees of an insurer licensed to write medical professional liability insurance" in the state of North Carolina who work "in collaboration with" licensed physicians "to evaluate and improve the quality of health care services." In other words, if employees of a medical malpractice insurance carrier sit on a quality assurance board with a committee comprised of physicians, the actions and materials of that committee are covered by the peer review privilege and not subject to discovery.

In response to the Windham decision, the General Assembly also created a broad peer review privilege for nursing home committees in the 2004 amendments. N.C. Gen. Stat. section 131E-l07 now extends peer review immunity to the proceedings of nursing home "quality assurance," "medical review," and "peer review" committees. Quality assurance committee is broadly defined as any:

". . . committee, agency, or department of a state or local professional organization, of a medical staff of a licensed hospital, nursing home, of nurses or aides on the staff of a nursing home, or adult care home, of physicians having privileges within the nursing home or adult care home, or of a peer review corporation or organization that is formed for the purpose of evaluating the quality of, or necessity for health care services under applicable federal and State statutes, regulations and rules."

Scope of the Privilege

Even as amended, North Carolina's peer review privilege protects only very specific activities and categories of information from disclosure. The threshold questions in a given case will be: (1) whether the activities were conducted by a peer review body; and (2) if so, whether the documents or other data were created or generated by that committee.

The North Carolina appellate courts have not yet had occasion to interpret the definitions in the amended peer review statutes. In reasoning that will continue to apply, however, North Carolina courts have held that when making decisions as to whether a given committee is a peer review body, they will accord great weight to the description of the committee's purpose and membership as set forth in the hospital's bylaws, policies and procedures.(16) If a committee is formed for the purpose of reviewing and renewing credentials, assessing physician performance, or investigating the conduct of medical staff members with an eye toward improving quality, it is likely to be deemed a protected committee. If, on the other hand, the function of the body is largely administrative or more in the nature of risk management or loss prevention, it will not be given peer review protection.

Once the determination is made that a given organization is a peer review body, counsel must then establish the categories of materials and information that are protected by the privilege. First and most obviously, the privilege immunizes "the proceedings" of the peer review committee. Accordingly, discovery that specifically targets communications, conversations, criticisms, or other activities that take place in the context of a medical review committee meeting can properly be objected to on the basis of privilege.

Second, the privilege applies to documents generated or considered by the committee. For example, reports, written recommendations, or other documents prepared by the committee are not subject to disclosure unless they are otherwise discoverable. CriticaIly, however, the statutes provide that "information, documents or records otherwise available are not immune from discovery or use in a civil action merely because they were presented during proceedings of the committee." Put another way, otherwise discoverable material does not become privileged merely because it is reviewed or considered at a medical review committee meeting. The privilege extends only to documents that are the direct work product of the committee. As the courts have held, "these provisions mean that information, in whatever form available, from original sources other than the medical review committee is not immune from discovery or use at trial merely because it was presented during medical review committee proceedings. . ."

Third, the privilege prohibits the taking of testimony from a person who was present at a medical review committee meeting regarding the proceedings of the committee, or any finding, recommendation, evaluation, or opinion rendered by the committee. Of course, a member of the committee who possesses knowledge or information that is relevant to the matters at issue in the litigation still can be required to testify so long as the questioning does not target the actions undertaken by the committee. As the North Carolina Supreme Court has held, no member of a medical review committee can "be prevented from testifying regarding information he learned from sources other than the committee itself, even though that information might have been shared by the committee."

The "original source" rule codified in the North Carolina peer review statutes is part of the broader principle that purely factual matters are not subject to the peer review privilege. This principle has been applied in a variety of situations. The recent case of Armstrong v. Barnes provides a useful illustration of the "original source rule" in practice.20 In Armstrong, counsel for the plaintiff discovered prior to the defendant's deposition that the defendant had a history of drug abuse and had sought treatment through the North Carolina Physicians Health Program (PHP). During the deposition, plaintiff's counsel questioned the defendant regarding both his past drug use and his participation in the PHP. The defendant moved for the entry of a protective order on the grounds that both fields of inquiry were precluded by N.C. Gen. Stat. section 90-21.22A.

On appeal, the defendant argued that questions regarding his participation in the PHP were expressly prohibited by the plain language of the statute. The court of appeals agreed. With respect to questions regarding the general circumstances of his past drug use, the defendant contended that the privilege foreclosed any inquiry into the details of his drug abuse. Here, the court disagreed, holding that the defendant was required to answer questions regarding the factual circumstances of his drug abuse. The court observed that:

"Nothing in N.C. Gen. Stat. section 90-21.22 evinces a legislative intent to insulate a participant from the details of his drug abuse merely because he related the details of his drug abuse to a society administering an impaired physicians program during the course of his participation in that program. Such a holding would allow a participant in an impaired physician program to use the program as a shield to escape liability for his negligence by foreclosing any meaningful discovery by an injured party. This was not the intended function of this statutory privilege. Although the statute protects a physician's participation in an impaired physicians program, it does not insulate him from discovery of records or information unrelated to his participation in such a program. Accordingly, we hold that [the defendant] may not invoke the privilege. . . to shield the details of his drug abuse from discovery to the extent his knowledge of those details exists irrespective of his participation in the PRP."

Courts in other jurisdictions universally have held that purely factual matters existing independently of peer review proceedings are not privileged. For example, it has been held that where hospital policies and procedures required the preparation of medication incident reports following all medication errors, and where a report contained merely factual descriptions of the event at issue and was not prepared by or at the direction of an organized peer review committee for committee purposes, the peer review privilege could not be invoked to shield the report from discovery. It also has been held that notes, records, and memoranda regarding a hospital's consideration, approval, and use of surgical hardware were not protected by the peer review privilege. Similarly, if a physician is asked during his deposition whether his hospital privileges have been suspended or terminated, he cannot refuse to answer the question by invoking the peer review privilege on the basis that his termination or suspension was effected within the context of peer review proceedings. Likewise, the fact that a hospital has elected to investigate a botched surgery in the confines of a peer review setting does not relieve the hospital of its obligation to produce a Rule 30(b)(6) designee with information that reflects its collective corporate knowledge regarding the facts and circumstances comprising the surgical mishap. Similarly, while the deliberations and internal workings of a peer review body are not discoverable, ultimate decisions or actions taken by a peer review committee, such as revocation, modification, and restriction of privileges, and revision of hospital rules, regulations, policies and procedures, are not privileged if that information can be obtained from other sources.

Applying the Peer Review Privilege to Corporate Negligence Claims

Corporate negligence claims typically hinge on allegations that a hospital knew or should have known that the physician who caused the plaintiff's injury was not qualified to practice in the hospital, but he or she was negligently permitted to do so.

The initial credentialing of new medical staff members, as opposed to assessments of existing medical staff members, has been treated differently by the North Carolina courts. The Shelton court held that materials initially submitted to. credentialing committees in support of an application for medical staff privileges were not subject to peer review protection, observing that "section 95 offers no protection to the records and documents furnished by the individual physicians in their applications for hospital privileges." Accordingly, Shelton makes clear that only documents relating to assessments of existing medical staff members are protected by the peer review privilege.

The plaintiff in Shelton also argued that assessments involving the treatment of patients other than the plaintiff-patient (i.e., peer review proceedings that did not address the medical care at issue in the malpractice litigation) were not subject to the privilege. The court disagreed, holding that the plaintiff's construction of the statute "would mean these proceedings were no longer protected whenever a claim of corporate negligence was made alone or coupled with a claim of negligence against the individual physician."

Countering the plaintiff's contention that extending the privilege to such activities effectively prohibited plaintiffs from bringing corporate negligence or negligent credentialing claims, the court observed that:

"Information in whatever form available, from original sources other than the medical review committee is not immune from discovery or use at trial merely because it was presented during medical review committee proceedings; neither should one who is a member of a medical review committee be prevented from testifying regarding information he learned from sources other than the committee itself, even though that information might have been shared by the committee." (30)

The Shelton court also noted that:

"The statute is designed to encourage candor and objectivity in the internal workings of medical review committees. Permitting access to information not generated by the committee itself but merely presented to it does not impinge on this statutory purpose. These kinds of materials may be discovered and used in evidence even though they were considered by the medical review committee. This part of the statute creates an exception to materials which would otherwise be immune under the third category of items set out above [materials considered by the committee.]"

The High Cost of Peer Review Confidentiality

The unfairness of the peer review privilege in practice is illustrated by the case of Patricia Scott, whose family may never learn why she died in the course of a routine surgery. When an impenetrable curtain conceals the errors of an entire profession, neither justice nor patient safety is served. The only beneficiaries of this archaic privilege are health care providers and institutions who would like nothing more than to bury their errors in a sealed peer review vault.

Despite the hardship that the privilege works upon injured patients, it appears that no professional organization or governmental agency has attempted to learn whether peer review actually enhances patient safety. (33) One recent study involved a multi-jurisdictional examination of peer review statutes to determine if there was a correlation between the stringency of a given state's peer review statutes (i.e., those providing for broader privileges and immunities) and the quality of the peer review conducted by physicians in that state. If proponents of the privilege are to be believed, one would expect to find the most intrepid and thorough self-assessments taking place in those states with the strongest peer review statutes. The study concluded that there is no such correlation, suggesting that there is, indeed, no existing evidence to support the contention that peer review confidentiality results in improved health care quality.

In its 2000 report, To Err is Human, the Institute of Medicine conceded that "information about the most serious adverse events which result in harm to patients and which are subsequently found to result from errors should not be protected from public disclosure," and that peer review confidentiality should be confined to events not falling within this category.(35) The inescapable truth, however, is that the peer review system is used most ambitiously in those cases where medical errors result in death or serious injury. If the collective experience of the members of the Academy in prosecuting medical malpractice actions offers any guidance, medical errors are reported to the patient or her family only when they are flagrant, open, and obvious. In settings where the only witnesses to the malpractice are potential defendants-as is usual in operating room cases-hospitals and physicians typically elect to investigate these events in the peer review setting, thus ensuring that their findings and conclusions will never be shared with the patients whose treatment was the subject of those proceedings.

Transparency, not confidentiality, is the best insurance against medical errors. Bringing the investigation of medical errors and physician incompetence into the sunshine will foster improvements in medical quality by identifying problematic physicians and poorly managed medical institutions. Patients will begin to vote with their feet-improving business for good doctors and sending bad doctors in search of new careers.

This much is clear: the present scheme of peer review confidentiality is failing miserably in its purpose. The Institute of Medicine has estimated that upward of 98,000 patients die each year as a result of medical errors. As many as 7,000 patients die annually as a result of medication errors. (36) As long as doctors retain exclusive control over the process by which physicians are assessed and disciplined, unqualified, impaired, and incompetent doctors will remain on medical staffs, and their patients will continue to suffer.