



STATE OF NEW JERSEY

**N J L R C**

NEW JERSEY LAW REVISION COMMISSION

**FINAL REPORT**

Relating to

**MEDICAL PEER REVIEW PRIVILEGE**

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NEW JERSEY LAW REVISION COMMISSION

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## Background

Medical peer review is a process whereby doctors evaluate the quality of work done by their colleagues, in order to determine compliance with accepted health care standards. This self-regulatory procedure provides quality assurance for the medical community by fostering standardization of appropriate medical procedures and by policing caregivers who could pose risks to patients. The rationale for the process is efficiency: working doctors are best situated to judge the competence of other working doctors because they regularly see each others' work and possess the relevant expertise to evaluate it.

A peer review committee typically performs two functions: the initial process of credentialing (reviewing a doctor's qualifications and recommending whether or not the doctor should be granted privileges at the hospital), and ongoing review of a doctor's work within the hospital. Peer review is one of the chief means of monitoring the quality of doctors' work. Ideally, effective peer review should decrease the number of medical malpractice events and improve overall health care. Doctors, courts and critics recognize the review process as an efficient means of professional self-regulation. "[P]eer review has become widely accepted as the primary means to weed out low quality physicians and to identify and offer assistance to physicians whose skills need to be enhanced in certain areas." Susan O. Scheutzow, "State Medical Peer Review: High Cost But No Benefit – Is it Time for a Change?", *25 Am. J. L. & Med.* 7, 15 (1999).

Statutory provisions and regulations require the use of peer review. All states have statutes mandating minimum monitoring for hospitals seeking state licensure. The federal government additionally requires that new applicants be credentialed and staff members be regularly evaluated for a hospital to be in the Medicare program. Despite mandates and altruistic motivations, doctors often are reluctant to take part in peer review. Jeanne Darricades, "Medical Peer Review: How is it Protected by the Health Care Quality Improvement Act of 1986?", *18 J. Contemp. L.* 263, 270 (1992). Their reluctance derives from hesitation to criticize their peers, lost pay for time spent in review, fear of losing patient referrals and most significantly, possible legal repercussions from adverse decisions, especially discovery and liability aspects of lawsuits. These disincentives chill candor and diminish effective peer review.

New Jersey is the only state that does not statutorily protect the confidentiality of hospital peer review committee materials. It was suggested to the Commission that this lack of protection inhibits full disclosure and discussion of medical failings and ultimately runs counter to the best interests of patients. This issue was brought to the attention of the Commission by a New Jersey physician, and the creation of statutory protection for peer review was supported by the New Jersey Hospital Association. Based upon Staff's preliminary research, the Commission accepted the issue as a project at its April 22, 2004 meeting.

At its January 20, 2005 meeting, the New Jersey Law Revision Commission voted to issue a Tentative Report relating to medical peer review. The Commission does not recommend the adoption of a statute protecting the confidentiality of medical peer review.

### Current law

Peer review of hospital physicians was established to ensure high quality care by monitoring untoward results and deviations from standard patient treatment. Individual hospitals' bylaws establish procedures for conducting peer reviews.

To counter doctors' reluctance to engage in peer review, most State legislatures and Congress have enacted laws that protect peer reviewers from liability, and their work product from discovery. New Jersey protects peer reviewers from liability but does not have a statute that protects work product from discovery. In the struggle between litigation and peer review, statutory privileges and immunities generally are accorded the preferred status. George E. Newton II, Comment, "Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection", 52 *Ala. L. Rev.* 723, 728 (2001).

Statutory peer review protection comprises three closely related kinds of laws: 1) those granting immunity from lawsuits to persons and institutions; 2) those declaring peer review work products to be privileged and inadmissible in court; and 3) those allowing information related to peer review to remain confidential.

The first type of protection, immunity, exists to diminish an individual doctor's or an institution's apprehension of facing damages in cases involving defamation, antitrust or negligent credentialing claims. The majority of states provide peer reviewers immunity from civil liability. The strongest statutes give immunity to all peer review committee members, institutions and persons furnishing information to the committee; weaker statutes give immunity for only a few or specified people.

The second type of protection is the work product privilege, which prevents information associated with the peer review process from discovery. Its premise is the belief that doctors are loath to candidly discuss a colleague's shortcomings if their statements later could be discovered in judicial proceedings. The typical state statute protects from discovery a range of documents pertaining to the committee's meetings. The statutes differ as to which documents are protected. The Kansas statute exemplifies those laws that very specifically limit protected documents: "The reports, statements, memorandum, [sic] proceedings, findings and other records of peer review committees or officers." *Kan. Stat. Ann. Sect.* 65-4950 (1993). Only records of the committees, not records given to the committees, receive protection under the statute. Similarly, the District of Columbia law allows discovery of materials produced out of sight of the peer review process. *D.C. Code Sect.* 32-505 (1981). At the other end of the continuum is Arizona law which protects information considered by the entity acting in a quality

assurance process and which treats the records of such consideration as confidential. *Ariz. Rev. Stat. Sect.* 36-2403 (1994).

The third protection, the confidentiality requirement, creates an affirmative duty incumbent on committee members to keep information involving peer review to themselves. Miscellaneous exceptions to peer review protection may occur regarding: 1) the fact that peer review took place, 2) whether licensing boards have access to peer review records, 3) waiver through release of peer review business to entities in an integrated health care delivery system (for example, a part of a centralized credentialing program), 4) applicability to criminal proceedings, and 5) court review and use of a balancing test. Elise Dunitz Brennan, Esq., Chair, Credentialing and Peer Review Substantive Law Committee American Health Lawyers Association, Introduction, 12-15, 50-State Survey on Peer Review Privilege, Spring, 1998. Note that Congress extends its own kind of protection (immunity) to medical review participants and to their work product through the Health Care Quality Improvement Act of 1986 (“HCQIA”). The Act attempted to address national components of the health care quality assurance problem. Charity Scott, “Medical Peer Review, Antitrust, and the Effect of Statutory Reform”, 50 *Md. L. Rev.* 316, 325 (1991).

For years New Jersey hospitals have had peer review committees composed of physicians (and sometimes a person from the Medical Records Department and a nursing supervisor). Patient charts were distributed and studied. If a chart indicated that a particular doctor had deviated from standard care in treating a patient, the doctor was advised and the committee also told the hospital’s Medical Executive Committee (composed of the chiefs of all departments and usually an Administration representative, such as a Trustee).

The New Jersey State Department of Health requires peer review procedures as a prerequisite for licensing a hospital. *N.J.A.C.* 8:43-G-2.12. The necessary elements of the program are set out in *N.J.A.C.* 8:43-G-27.5 and include monitoring patient care, evaluation of patient care, effective corrective actions, procedural changes, educational activities, etc. In *Reyes v. Meadowlands Hosp. Med. Ctr.*, 355 *N.J. Super.* 226, 233 (L. Div. 2001), however, the Court said that the "Code makes no provision for the results of such a process to be privileged. Therefore, those participating do so without any assurance of confidentiality." New Jersey Evidence Rule 500 is the “General Rule” concerning privileges. Comment 3 to that Rule states that:

the New Jersey Supreme Court has expressly declined to adopt “as a full privilege, either qualified or absolute” the protections sought for self-critical analysis materials. *Payton v. New Jersey Turnpike Authority*, 148 *N.J.* 524, 545 (1997). Instead, the Court said that the concerns arising from the disclosure of “evaluative and deliberative materials,” while “deserving of substantial consideration,” could be amply accommodated by a case-by-case weighing process. *Id.* 548-549.

With the advent of Medicare, “utilization review committees” became necessary for hospitals to qualify under the Social Security Act and to take part in state and federally funded programs. Utilization review committees attempt to find out whether patients’ treatments were necessary and suitable.

Unlike its treatment of peer review committees, New Jersey currently protects, by statute, “[i]nformation and data secured by and in the possession of utilization review committees established by any certified hospital or extended care facility in the performance of their duties.” *N.J.S. 2A:84A-22.8(a)*. The Statement accompanying Senate Bill 559 (L. 1970, c. 313) explained that the New Jersey statute, in extending protection to committee members, encourages “willing participation” and effectively “implement[s] the provisions of Medicare and other health care measures.” New Jersey Rule of Evidence 507 adopts the language of *N.J.S. 2A:84A-22.8* verbatim. Rule commentary makes it clear, however, that “The protection afforded by the statute cannot be extended by implication to the records of other hospital committees...*There is no comparable statutory privilege for the information and data collected by a quality assurance or peer review committee....*” [emphasis added]

One additional New Jersey statute needs to be distinguished from those dealing with peer review. The Patient Safety Act, *N.J.S. 26:2H-12.23* through *12.25*, requires health care facilities to report to the Department of Health and Senior Services “every serious preventable adverse event that occurs in that facility” (*N.J.S. 26:2H-12.25(c)*) and encourages health care professionals or other employees of a health care facility “to make anonymous reports to the department ... regarding near-misses, preventable events and adverse events that are otherwise not subject to mandatory reporting ... (*N.J.S. 26:2H-12.25(e)(1)*). This statute is a variation of many states’ laws that address “medical errors.” The statute outlines in detail the protections afforded communicants and documents, stating that reports regarding “serious preventable adverse events, near-misses, preventable events, and adverse events that are otherwise not subject to mandatory reporting pursuant to subsection c. . . . shall not be . . . subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal, or administrative action or proceeding.” *N.J.S. 26:2H-12.25(f)*. Moreover, subsection (g) provides the same protection to documents, materials, or information that was “developed by a health care facility as part of a process of self-critical analysis conducted pursuant to subsection b. of this section,” regardless of whether such information is reported to State regulators. *N.J.S. 26:2H-12.25(g)*. However, the statute also concludes by stating (in *N.J.S. 26:2H-12.25(k)*) that “Nothing in this act shall be construed to increase or decrease the discoverability, in accordance with *Christy v. Salem*, [366 *N.J. Super.* 535 (App. Div. 2004)], of any documents, materials or information if obtained from any source or context other than those specified in this act.”

*Christy v. Salem*, decided in February 2004, analyzes earlier case law reasoning regarding peer review confidentiality. The plaintiff in *Christy* maintained that hospitals should not be entitled to maintain absolutely confidential peer evaluations. The court decided that plaintiff was entitled to information in one specific line of the report that might supply a critical element in his case, and also to some purely factual material. The

court held that plaintiff was not entitled to the committee's "opinions, analysis, and findings of fact." These "evaluative and deliberative materials" need not be disclosed. 366 *N.J. Super.* at 542.

In *C.A. ex rel. Applegrad v. Bentolila*, the Court clarified the relationship between the protections that the Patient Safety Act provides for confidentiality and the protections that *Christy* provides. 428 *N.J. Super.* 115 (App. Div. 2012). The court delved into the legislative intent behind the Patient Safety Act and determined that the reference to *Christy* in section (k) was intended to create a dual approach, in which materials that are exclusively developed under the Patient Safety Act are subject the Act's specific confidentiality terms, while other internal materials *not* developed exclusively for the purposes of the Public Safety Act are treated according to the standards set forth in *Christy* or other common law. *Id.* at 147.

### Commission Deliberations

The Commission discussed the basic principles of peer review; federal and state peer review protections (immunity, privilege and confidentiality); and the law pertaining to self-critical analysis as applied by New Jersey courts. The Commission considered relevant statutes of other states, particularly those of Missouri, Ohio, Alabama, Arizona and Massachusetts. To understand how the statutes work in practice, Staff attempted to contact two hospitals in each state and speak to their legal counsel or Risk Management Manager. Staff asked three questions regarding the extent of the protection afforded peer review materials. The responses, from attorneys and Risk Management Managers, were substantially uniform. 1) A government agency cannot obtain peer review committee materials work product from discovery; 2) A physician on the peer review committee or the committee as a whole never wishes to waive the protection; 3) Physicians would be more reluctant to discuss their peers without the protections afforded peer review materials. Most people Staff spoke with expressed surprise that New Jersey did not offer peer review materials statutory protection from disclosure and said they believe that the privilege is essential.

The Commission reviewed two drafts of a statute which proposed that "The evaluative and deliberative materials of hospital peer review committees concerning the health care provided any patient are privileged and not subject to discovery." The Commission also considered the impact of the federal Health Insurance Portability and Accountability Act (HIPAA) upon New Jersey law.

### Recommendation

After months of deliberation and drafting the Commission decided not to recommend the enactment of a statute protecting peer review materials.

The Commission decided that under case law, peer review materials are afforded sufficient protection. Deliberative materials are not disclosed. Even factual material presented to a peer review committee is not subject to discovery without a compelling

reason. In attempting to draft a privilege statute, the Commission encountered substantial difficulty deciding what circumstances would justify exceptions to the privilege. The Commission found that exceptions were very fact-sensitive and would be decided better through the exercise of judicial discretion than with a more rigid statutory rule. The Commission decided that even codification of the current case-law rules could negatively affect the balancing process that the courts now employ on a case by case basis. The Commission also based its decision on reluctance to expand privileges. Finally, while recognizing that New Jersey is alone in declining to provide protection for peer review, the Commission observed that the most recent case law in this area seemed to very carefully weigh and consider the competing interests, and provide the same kind of protection that a proposed statute would provide.