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State Variability in Peer Review Protections Heightens Liability Risks

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Abstract

Objective: To highlight various state-specific gaps in legal protections involving the peer review process with the goal of helping participants better identify and address potential hazards so they may continue to confidently engage in peer review activities.

Methods: State laws regarding peer review protections involving privilege and confidentiality were searched through Westlaw (a legal research database) and state government websites and categorized.

Results: Gaps in protection were identified in 17 states and the District of Columbia. In the 18 jurisdictions in which potential legal gaps were identified, the most common exceptions involved peer review activities that were initiated without a legally required number of participants, were not formally mandated by the institution or other external body, or that were voluntarily discussed outside of the peer review context by participants in the process.

Conclusion: The widespread variability in state-based peer review protections showcases the complexity of deciphering peer review law and emphasizes the need to not just read the relevant state and federal laws but to obtain the professional guidance of a lawyer experienced in peer review law before engaging in peer review activities. These measures will improve providers' engagement in peer review and strengthen an important tool for quality improvement.

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Clinical peer review is a longstanding tradition in medicine, designed to allow providers to scrutinize and provide feedback on the medical care provided to individual patients, especially in cases with an unexpected outcome. During the peer review process, sensitive information is routinely discussed and medical decision-making is often critiqued. Because of this, there has been resistance by both physicians and institutions to engage in the peer review process based on the fear that information discussed could be subsequently used to impugn the care provided or to retaliate against the providers performing the reviews, potentially with steep legal and/or financial consequences.

To counteract these reasonable concerns and encourage participation in the peer review process, both the federal and state governments have passed legislation that creates legal protections for peer review participants. These protections address three main areas: immunity, confidentiality, and privilege. Immunity in this context refers to protection for participants of peer review from retaliatory lawsuits brought by providers who were adversely affected by their decisions. In contrast, privilege and confidentiality deal with the release of peer review information, with privilege preventing the discoverability or admissibility of evidence in a legal proceeding, and confidentiality prohibiting the release of information outside of the judicial context.[1] It is the latter two of these, privilege and confidentiality, that directly relate to the ability of physicians and hospitals to engage in peer review activities without fear that their candid discussions will potentially increase their risk for malpractice lawsuits.

On a federal level, the first piece of relevant legislation was the 1986 Health Care Quality Improvement Act, which provided immunity to participants in qualifying peer review activities.[2] So, for example, if a peer review body made the determination to revoke a physician's hospital privileges, the

participants of that body generally could not be sued, such as for damages or defamation. The publication of the Institute of Medicine's landmark publication, *To Err is Human*, almost 15 years later highlighted the persistent lack of involvement in meaningful quality improvement activities and became a major impetus for passage of the 2005 Patient Safety and Quality Improvement Act.[3] This legislation addressed the concern that peer review could heighten malpractice risks and provided confidentiality and privilege to qualifying peer review activities, marking the first federal protections of this type. While these pieces of legislation were welcome changes, only narrow categories of peer review activities qualify for their protections. For example, federal immunity may not apply if there were any allegations of discrimination or if a court determines that the process leading to a negative peer review decision was unfair or inadequate in some way.[2] Similarly, federal confidentiality and privilege protections apply primarily to information submitted to patient safety organizations and therefore offer no benefit to most peer review activities that are undertaken at an individual group practice or departmental level.

In the setting of these incomplete federal protections, all 50 states and the District of Columbia have enacted legislation surrounding peer review activities, also designed to encourage participation by minimizing legal risks. Because this legislation has occurred piecemeal through the states, however, the level of protection and the requisite steps to qualify for those protections vary considerably. Several recent cases have highlighted state gaps in peer review protections and given providers renewed pause about participating in peer review activities.[4,5] The purpose of this study is to highlight various state-specific gaps in legal protections involving the peer review process, primarily involving privilege and confidentiality, with the goal of helping participants better identify and address potential hazards in the process so they may continue to confidently engage in peer review activities in the future.

ARTICLE HIGHLIGHTS

- Clinical peer review is an important initiative to ensure quality and safety of patient care
- There is widespread variability in state-based peer review protections for those conducting quality reviews.
- Knowledge of state-specific gaps in legal protections involving the peer review process helps providers mitigate risk while conducting this essential practice.

METHODS

State laws regarding peer review protections involving privilege and confidentiality were searched through Westlaw (a legal research database) and state government websites. State peer review laws were independently reviewed by three authors (RLC, RJH, and RAL), and any disagreements were arbitrated by RAL (resolved by consensus). Exceptions to peer review activities being considered confidential or privileged were confirmed by a fourth author (SR) and, once confirmed, were recorded and categorized.

RESULTS

Laws granting confidentiality and privilege protections for peer review activities were identified for all 50 states and the District of Columbia. In almost all states, laws exempted peer review activity from legal protections if the information would be relevant to complaints involving criminal activity or discipline against a health care provider. Outside of these exceptions, additional gaps in protection were identified in 17 states and the District of Columbia.

In the 18 jurisdictions in which potential legal gaps were identified, the most common exceptions involved peer review activities that were initiated without a legally required number of participants, were not formally mandated by the institution or other external body, or that were voluntarily discussed outside of the peer review context by participants in the process. Another important exception to note is that legal protections may not apply if the provider under review attends the peer review meeting. The identified exceptions are summarized in the Table.

DISCUSSION

Despite the longstanding role of clinical peer review in medical practice, legal protection of

TABLE. Potential Exceptions to Confidentiality and Privilege Protections by State

State	Potential exceptions to confidentiality and privilege protections
Alabama	If information is presented as evidence at a public hearing
Alaska	If plaintiff contends information provided to peer review was known to be false
California	If peer review committee exceeds 10% of the society it is reviewing
Colorado	If an investigation is legally to be carried out by the Department of Health
Connecticut	If any relevant information was written down outside of the peer review meeting
Hawaii	If review committee size exceeds 10% of society it is reviewing. No protection for incident reports or submissions to review organizations.
Kansas	If information is discussed by participants to non-participants
Louisiana	If medical group has fewer than 20 physicians
Maine	If information is not required for accreditation, state or federal law, or if review is not conducted by the relevant medical society
Maryland	If peer review activities are not explicitly approved by institutional bylaws
Massachusetts	If information is requested by licensing boards or boards of public health
Michigan	If medical group has fewer than 10 physicians
Nevada	If information is provided by the person who is being reviewed and attends the meeting
New Hampshire	If disclosure of information is wanted by hospital or its board of directors
New Mexico	If the information "constitutes evidence which is critical to the cause of action"
Pennsylvania	If peer review conducted by group not considered a "professional healthcare provider" (eg, private group that contracts with hospital)
South Carolina	If person under review requests disclosure of the information
Washington, DC	If the mayor requests the information

peer review activities remains variable across states. Providers and institutions often encourage and participate in peer review activities with the assumption that their statements and conclusions cannot be disclosed in court or elsewhere, but this study identified many potential scenarios in which that information may not be protected. This variability highlights the need for peer review participants to be proactive about ensuring that their activities meet either federal or state-specific criteria for legal protection so that they can continue to engage in these reviews without fear of exposing themselves to future lawsuits.

Information regarding peer review protections is progressively more relevant as physicians are increasingly acquired by hospitals, with 2018 marking the first year that physicians were more likely to be employed by a hospital than a private practice.[6] Although peer review is not required for individual or group practices, it is required for hospitals, both as a Condition of Participation in Medicare and a requirement for accreditation by the Joint Commission.[7] Physicians moving into this more highly regulated environment may be less aware of the peer review protections and gaps discussed here and would benefit from additional education or training before their involvement in peer review activities.

The growth of telemedicine, especially in the setting of coronavirus disease 2019, also increases the importance of being aware of state-specific rules around peer review. Multiple initiatives have reduced barriers to providing medical care across state lines with the use of telemedicine, leading to a rapid rise in its use. Within this period of rapid expansion, quality assurance activities such as peer review are being conducted regularly to ensure smooth care processes. Given that courts generally apply the law from the state in which the patient resides, physicians should receive state-specific training before engaging in any peer-review activities involving their telemedicine encounters or they run the risk of inadvertently putting themselves or their colleagues at risk for legal action.

Finally, the list of 18 jurisdictions identified here having gaps in their legal protections is

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likely not comprehensive. The laws surrounding peer review in each state are frequently interpreted by the courts in individual cases, and each of these cases has the potential to open new gaps in protection. For example, in New Mexico, the law itself seems to offer thorough confidentiality and privilege to records of peer review, with no apparent exceptions.[8] However, when this was challenged during a malpractice case, the court determined that it could compel peer review information if it was "critical" to the case.[9] Similarly, Pennsylvania provides peer review protection to all "professional healthcare providers" and provides a long list of these, "including, but not limited to, [. . .] a corporation or other organization operating a [. . .] health care facility." However, when a patient wanted access to peer review records of an emergency medicine contracting group that staffed the hospital's emergency department, the court found that the group did not meet the definition of a health care provider and thus was not afforded the protection of the state's peer review laws.[5] There are likely other states in which the wording of the law has been interpreted through court cases in ways that are not intuitive but pivotal for providers to understand.

The widespread variability in state-based peer review protections and the above examples of case-based interpretations showcase the complexity of deciphering the law and this area. In our opinion, this complexity emphasizes the need to not just read the relevant state and federal laws but to obtain the professional opinion of a lawyer experienced in this area prior to engaging in peer review activities. We recommend reviewing peer review protections with legal counsel on a periodic basis, and especially before making any changes to the peer review process or the structure of the practice itself. For providers already engaged in peer review, we recommend avoiding the assumption that your practices are protected and taking the same steps to ensure your procedures are in line with state or federal protections. While this may temporarily hinder the peer review process in some settings, we believe avoiding unexpected lawsuits related to peer review activities will reduce the chilling effect that such cases have and will actually improve providers' engagement in peer review in the future, ultimately strengthening an important tool for quality improvement.

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