Confidentiality and Privilege of Peer Review Information: More Imagined Than Real

Susan O. Scheutzow

Sylvia Lynn Gillis

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CONFIDENTIALITY AND PRIVILEGE OF PEER REVIEW INFORMATION: MORE IMAGINED THAN REAL

SUSAN O. SCHEUTZOW¹
SYLVIA Lynn GILLIS²

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I. INTRODUCTION

Peer review of health care professionals has become a standard process in hospitals and many other health care facilities. State legislatures have encouraged good faith peer review in three major ways: by providing

¹Partner, Bricker & Eckler, Cleveland, Ohio. B.A., Kent State University 1975; M.A. Political Science, The Ohio State University 1977; J.D. (cum laude), Capital University Law School 1982.

²Associate, Bricker & Eckler, Columbus, Ohio. B.A. (magna cum laude), Northern Arizona University 1975; M.A., University of Washington 1980; J.D. (with honors), The Ohio State University College of Law 1989.
immunity from damages to peer review participants; by making peer review information privileged and thus not admissible in certain judicial and/or administrative proceedings; and by requiring that peer review participants keep information regarding the peer review process confidential.

These legal protections of the peer review process—immunity, privilege and confidentiality—while related, are distinct concepts. Quite obviously health care professionals will be reluctant to participate in the peer review process if they later may find themselves subject to damages for their participation. Therefore, the granting of immunity from damages to peer review participants is one of the most important ways of encouraging effective peer review. Congress passed the Health Care Quality Improvement Act of 1986 ("HCQIA") with the express purpose of promoting peer review by limiting potential liability of the participants. Most states have enacted similar immunity provisions. Immunity granted to peer review participants by

342 U.S.C.A. §§ 11101, 11111-11152 (West Supp. 1993). The HCQIA provides standards for professional review activities. For example, professional review action, as defined in the Act, must be taken "in the reasonable belief that the action was in the furtherance of quality health care" and "after a reasonable effort to obtain the facts of the matter." 42 U.S.C.A. §11112(a). The other HCQIA standards are discussed in Section II. The Act provides that professional review actions will be presumed to have met these standards unless the presumption is rebutted by a preponderance of the evidence. The Act further identifies certain requirements necessary to meet the adequate notice and hearing standard. These requirements govern the types of notice that must be given the affected physician and the conduct of the hearing.

If the HCQIA standards are met, certain immunities from damages are available. In addition, if a hospital or other health care entity covered by the Act follows the adequate notice and fair hearing procedures outlined in the Act, court review should be limited to whether the affected physician received these protections. If the court determines that the standards have been met, the case should be dismissed with respect to those covered by the Act.

For a general discussion of state peer review statutes, see B. Abbott Goldberg, The Peer Review Privilege: A Law in Search of a Valid Policy, 10 AM. J.L. & MED. 151, 154 (1984); Note, Medical Peer Review Protection in the Health Care Industry, 52 TEMP. L.Q. 552, 558 (1979); Note, Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review, 51 U. PITT. L. REV. 1025, 1033 (1990) ("At present this fear is uncomfortably realistic.") (citations omitted).

Many states specifically identify the bases for enactment of the peer review protections: Arkansas, comment to subchapter 5 ("it is essential to the proper and effective operations of [peer review] committees that immunity be granted members of such committees for acts of the members performed within the scope of the functions of the committee and without malice and fraud"); Hawaii, HAW. REV. STAT. § 671D-2 ("purpose of this chapter is to provide incentives and protection for physicians engaging in effective professional peer review"); Tennessee, TENN. CODE ANN. §63-6-219(a)(1) ("It is the stated policy of Tennessee to encourage committees made up of Tennessee's licensed physicians to candidly, conscientiously, and objectively evaluate and review their peers' professional conduct, competence, and ability to practice medicine. Tennessee further recognizes that confidentiality is essential to both effective functioning of these peer review committees and to continued improvement in the care and treatment of patients.")
federal and state law has been commented upon widely\textsuperscript{6} and generally is outside the scope of this article.

Despite the immunity for participation in peer review proceedings, health care professionals may still be reluctant to participate in the peer review process if they fear information regarding the process may later be admitted into a judicial or administrative proceeding. They may also be concerned that they may be called upon to testify against their colleagues or that the information regarding the proceedings and their role in such proceedings may otherwise be revealed to third parties. While there appears to be widespread belief that information presented in peer review proceedings and the deliberation of such committees are privileged and are to remain confidential, the reality is that peer review proceedings are afforded very little privilege and confidentiality protection pursuant to federal law and very inconsistent protection by state law. Most states have a peer review privilege statute, yet many of these statutes significantly limit the applicability of the privilege and permit the information to be released in judicial and administrative proceedings. There is similarly little protection of peer review information and the attendant privileges, immunities, or confidentiality of such information pursuant to federal law.\textsuperscript{7}

Many state laws provide that peer review information is to remain confidential. However, only a very few states give any guidance as to how this confidentiality protection is to be interpreted or provide any sanctions for violation of these confidentiality requirements.\textsuperscript{8} Without sanctions for violation of the confidentiality provisions, the protection granted may be rendered almost meaningless. Similar to the law on privileges, federal law offers little confidentiality protection to peer review records.\textsuperscript{9}


\textsuperscript{7}The only federal statute that makes specific provision for peer review activities is the HCQIA. This Act does not create a privilege \textit{per se}, although it does give some protections to good faith reporting of information in the context of peer review actions if the requirements identified in the Act have been met. The Act does make some provisions for confidentiality, as discussed in Section IV(C), of the information required to be reported under the Act, but this information does not include by definition any information related during a professional review action.

\textsuperscript{8}For example, Texas makes the unauthorized and unlawful disclosure of confidential peer review information by the state board of registration a Class A misdemeanor. TEX. REV. CIV. STAT. ANN. art. 4495b, § 5.06(s)(4). Rhode Island imposes both civil and criminal penalties. R.I. GEN. LAWS § 5-37.3-9. New Mexico classifies a violation of its peer review statute as a petty misdemeanor and provides for a minimal fine ($100) and/or imprisonment not to exceed 6 months. N.M. STAT. ANN. § 41-9-6.

\textsuperscript{9}Again, the HCQIA mandates that certain types of information be reported to the National Practitioner Data Bank ("NPDB"), which was created as a result of the HCQIA. The types of information that must be reported are described in Section IV(C).
This article will discuss the status of the privileges and confidentiality protection today at both the state and federal level. It will also address the concerns present among those individuals and organizations participating in peer review regarding the law of privileges and confidentiality and offer suggestions for health care providers to take full advantage of the statutory protections.

II. PEER REVIEW

"Peer review." The phrase conjures up general images of physicians and hospital staff members meeting to review and discuss the quality of care rendered on an on-going basis in a hospital or other health care setting. More specifically, it includes the review of individual physicians and other health care professionals appointed to the medical staff of a hospital or other health care organization when there are quality of care concerns with respect to the health care services provided by that individual.

In reality, what is encompassed within peer review activities that will fall within the statutory peer review protections varies widely from state to state. Some states specifically define the functions that are protected; others broadly apply to "peer review" or "medical review" committees. Within these definitions of peer review activities, peer review may encompass the initial review and decision-making process with respect to medical staff appointment and reappointment and the delineation of clinical privileges, both with respect to initial appointments and requests for modifications or expansion of clinical privileges at other times. Whether or not this function falls within the statutory definition, peer review in the form of utilization review and quality assessment and improvement activities is an important element of the continual monitoring and assessment of quality of care in hospitals and other health care

The HCQIA provides that these reports are to be confidential and are not to be disclosed, except "with respect to [certain] professional review activity" identified in the Act. The Act also provides that any disclosure authorized by state law will not be prevented by the Act. If information is reported in a manner that does not allow the identification of the physician, patient, any other health care practitioner, or the health care entity, that information will not be considered confidential and may be disclosed. Although at this time, this information is, under most circumstances, available only to licensing boards and certain health care entities, such as hospitals and other entities that provide health care services and that follow formal peer review processes, there are continuing efforts to have the information in the Data Bank more widely available to the public.

One option proposed by the Clinton administration as part of its reform plan is limited access to the NPDB by consumers that would allow consumers to discover if a practitioner is a "repeat offender." Such efforts are strongly opposed by organized medicine, but consumer groups are becoming more active and wider access may result. See Linda Oberman, Data Bank Access Debate: Any middle ground? AMERICAN MEDICAL NEWS, Jan. 3, 1994, pp. 3-4.
facilities, including professional associations. It is required by the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO") and the American Osteopathic Association ("AOA"), both of which are private bodies by which hospitals and other health care organizations may receive accreditation which is also useful for federal certification for Medicare and state licensing purposes.

As noted above, the peer review process is performed in large part by health care professionals who are appointees to a health care organization's medical staff. Underlying peer review is the responsibility of a health care facility, which can be imposed by law or accreditation agency or be self-imposed, to permit only competent, capable persons to engage in the practice of medicine or the provision of other health care services at the health care facility. Since the board and administration of individual health care facilities generally are comprised of persons who are not thought to be qualified to evaluate the quality of medical

10Because the majority of peer review is performed at the hospital level, the comments in this article will be generally addressed to hospital-based peer review. However, the discussion will be applicable to peer review in other health care settings as well. The same analysis may also be useful when examining privilege, confidentiality, and immunity issues in the context of peer review in other fields.

11Today's JCAHO grows out of the Joint Commission on Accreditation of Hospitals, which was founded in 1952. Although not a government entity, JCAHO accreditation is sought by health care organizations because organizations who are accredited by JCAHO are deemed eligible to participate in the Medicare program. Over the years, compliance with JCAHO standards has become an accepted method of achieving accreditation for the majority of hospitals in the United States.

The JCAHO standards, which are published annually in the organization's Accreditation Manual for Hospitals, specifically require the development and implementation of mechanisms to assure "the uniform performance of patient care processes throughout the organization." JCAHO Standard, LD.1.6 (1994) (the equivalent of this standard was formerly found in the Governing Board Standards at GB.1.16.1 ("The governing body requires mechanisms to assure that all patients with the same health problem are receiving the same level of care in the hospital," GB.1.16.1 (1993)). The 1994 Standards have significantly reorganized the standards and regrouped some of the medical staff and governing board requirements from prior years within a new section titled "Improving Organizational Performance." Also included in this new section are many of the standards found in the Quality Assessment and Improvement section of the 1993 Accreditation Manual for Hospitals. The first standard within this new section requires "[t]he organization [to have] a planned, systematic, organizationwide approach to designing, measuring, assessing, and improving its performance." JCAHO Standard, PI.1 (1994).

The AOA also has an accreditation program for health care facilities and annually publishes standards by which it conducts surveys of health care facilities. The AOA's program has also been granted "deemed" status to conduct surveys of health care facilities for compliance with Health Care Financing Administration requirements. The AOA standards similarly require review of practitioners' competence to perform services for which they have been granted privileges and the maintenance of a high level of professional competence and knowledge.
and other health care services provided at the facility, this task is delegated to the health care professionals practicing at each health care facility.\textsuperscript{12}

Depending upon the size of the health care organization, the individuals performing peer review and the person reviewed may work together on a daily basis and may even practice in the same specialty. Concerns on the part of the health care professionals participating in the peer review process with the nature and discoverability of peer review proceedings and information generated within those proceedings, as well as immunities from suit and testimonial privileges, are evident. Equally important, however, are the concerns of the health care organization itself with the confidentiality of the information generated within the peer review process and available immunities from suit and damages for its participation in and conducting of the process.

Peer review information may have many uses outside of the hospital credentialing process. Information presented to peer review committees and the deliberations of such committees may be useful to plaintiffs and defendants in malpractice lawsuits. It could also prove useful to third party payers in making payment decisions and in determining which providers may participate on select provider panels. News media, consumer groups, and competitor health care providers may all be very interested in peer review information for a variety of reasons.

In contrast, participants in the peer review process may be reluctant to participate or to be totally open in such proceedings if they believe they may be later called into court to testify or if their comments and role in the process may later be revealed to third parties. While a physician may be willing to chastise a physician in private and, for example, suggest sanctions such as remedial training, the physician almost assuredly would not like his comments aired on the six o’clock news.

In the absence of law to the contrary, parties may obtain discovery regarding any matter not privileged.\textsuperscript{13} Similarly, absent law or agreement to the contrary, no person is required to keep any information confidential. Therefore, without specific provisions of law, peer review information would be subject to discovery, and there would be no requirement that peer review participants keep the information confidential. Even agreements to keep peer review

\textsuperscript{12} State peer review statutes provide protection to a variety of persons serving as members of peer review committees or otherwise providing service to the committee. Most broadly, committee members, consisting of both health care professionals and hospital staff and administration employees, together with consultants hired to assist in the evaluation process, and any other persons involved and providing services, such as legal counsel, are protected. See, e.g., ALASKA STAT. § 18.23.020. In the least protective states, only health care professionals (i.e., physicians in most cases) are afforded the statutory protections. See, e.g., MO. REV. STAT. § 537.035(2). Some states describe the required composition of peer review committees. See, e.g., IND. CODE ANN. § 34-4-12.6-1(c)(2).

\textsuperscript{13} See, e.g., OHIO R. CIV. P. 26(b)(1).
information confidential would be ineffective in preventing its disclosure pursuant to legal process.\footnote{For example, medical staff bylaws should impose confidentiality requirements upon medical staff appointees serving on peer review committees. In addition, any consultant retained to assist in the review process should by agreement be bound to similar confidentiality provisions. However, these agreements would be ineffective should a court order disclosure of information that is not made confidential or privileged by law.}

To encourage open peer review, the overwhelming majority of state legislatures\footnote{Apparenty, Oklahoma is the only state that has not adopted a peer review statute. Oklahoma has enacted a Hospital and Medical Services Utilization Review Act, OKLA. STAT. tit. 36, §§ 6551 to 6561, which provides for utilization review for insurance purposes.} have adopted statutory protections for the peer review process. The nature of these statutory protections varies from state to state. The protections take the following forms: providing immunity from suit or damages for those individuals participating in the peer review process; granting a privilege from discovery or admission into evidence to peer review information; and providing that peer review information is to remain confidential.

III. PEER REVIEW IMMUNITY

While this article does not provide an analysis of the various state laws regarding immunity as this is adequately covered in other writings,\footnote{See, e.g., supra notes 5 and 6.} some discussion of such laws and the HCQIA is necessary to understand the privilege and confidentiality protections afforded the peer review process by the states.

For example, when an individual applies for medical staff appointment at a health care organization and is denied appointment or granted a conditional appointment with fewer clinical privileges than requested or granted restricted privileges, that individual may initiate a lawsuit against the health care organization and/or participants on the committees that considered the application and made recommendations for the denial of appointment or the granting of limited or restricted clinical privileges. Similarly, an appointee to the health care organization's medical staff may file a lawsuit when the
appointee’s privileges or appointment is terminated or restricted as a result of an investigation arising out of quality of care concerns that are the subject of internal peer review proceedings. Such lawsuits may be brought at the state or federal level\(^\text{18}\) and can allege causes of action including defamation, tortious interference with a business relationship, and antitrust. The fear of becoming embroiled in lawsuits as a result of candid discussion within the peer review process is recognized as a deterrent to effective peer review.\(^\text{19}\)

As alluded previously, the immunities provided for peer review information and participants vary among the states, ranging from no immunities to individuals and entities participating in peer review activities to the grant of immunity from damages and/or suit to members of certain committees identified in the state statute that perform peer review functions\(^\text{20}\) when acting on behalf of the committee within the scope of its authority. In addition, any immunities granted are narrowly construed according to the terms of the

\(^{18}\)As will be discussed later in this article, whether a lawsuit is brought in state or federal courts determines the availability of privileges, which may be recognized under state law, but may not be similarly recognized under federal law.

\(^{19}\)See Restructuring Hospital-Physician Relations, supra note 5. In that note, the author states that “[t]he most serious obstacle to effective peer review is the potential fear felt by the reviewer that participation in an adverse recommendation will lead to a lawsuit against him or her personally,” id. at 1033, and cites an article appearing in the August 20, 1984 issue of Medical Economics titled Peer Review: Is Testifying Worth the Hassle? and a statement by Representative David Waxman appearing in the Congressional Record that “[a]t the hearing [held for debate over barriers to peer review], nearly every witness indicated that the threat of litigation under current law is a major barrier to effective peer review.” 132 CONG. REC. H11588 (daily ed. Oct. 17, 1986). These congressional proceedings preceded the enactment of the HCQIA at the federal level. See also Note, The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?, 74 VA. L. REV. 1115, 1119 (1988) ("One fear of physicians is involvement in litigation either in the form of a suit filed by a physician who has been denied staff privileges or a malpractice suit filed by a patient of the physician under review.")

See also Scott, supra note 6, at 327 ("Whether the belief is justified or not, many physicians believe that to serve in any peer-review capacity is necessarily to risk being named in a lawsuit.").

But see Scott supra note 6, at 327 n.42, citing Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the House Comm. on the Judiciary, 99th Cong., 2d Sess. 52 (1986), at pp. 96-99, 121-23 (no evidence that legislation is needed), and 132 CONG. REC. H9961 (daily ed. Oct. 14, 1986) (statement by Rep. Edwards that "peer review participants’ fear of damage claims is unfounded. . . . The view of several witnesses was, ‘if it ain’t broke, don’t fix it.’"). The cited references suggest, "[a]lthough there was considerable testimony about the chilling effect that litigation was thought to have on peer review, . . . some vigorously disputed both the fact of and the basis for such deterrence."

\(^{20}\)See OHIO REV. CODE § 2305.25 and § 2305.28, both of which grant immunity from damages to persons acting within the scope of certain committees identified in the statutes. Cf. this language to that contained in the HCQIA, which does not specifically grant immunities from suit, but does limit damages with respect to professional review actions when these actions meet the standards listed in the Act.
statutory grant. No immunity is given to individuals who are not identified in
the statute or who serve on committees that are not included on the statutory
list. For example, if the statute reads that certain individuals performing certain
functions will be immune from damages, but not immune from suit, courts will
strictly interpret the statute to provide immunity only from damages, but not
from any other actions.21 Similarly, the immunity from damages does not give
peer review participants immunity from criminal prosecution or other
non-damage actions, such as injunctive or declaratory relief, unless specifically
provided in the statute. Any immunities granted under state law, as with
privileges and confidentiality, will have no application if a lawsuit is brought
in the federal courts.

Until the enactment of the Health Care Quality Improvement Act of 198622
by Congress, peer review in the health care field was governed exclusively by
state legislation. The HCQIA, the only federal legislation on the subject, was
enacted specifically to encourage peer review by physicians.23 The HCQIA
represented the federal Congress' finding that "[t]here is an overriding national
need to provide incentive and protection for physicians engaging in effective
professional peer review."24 Congress further found that "[t]he 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."25

The protections actually provided by the HCQIA are limited, as courts
applying the Act have found.26 The plain words of the Act limit the immunity

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21See Decker v. IHC Hospitals, Inc., 982 F.2d 433 (10th Cir. 1992), cert. denied 113 S.
         Ct. 3041 (1993) (federal court found that state statute (Utah Medical Practice Act)
         provided protection from damages only, not immunity from suit, for participation in
         peer review activities).


23For a discussion of the HCQIA, see Kathleen L. Blaner, Physician, Heal Thyself:
         Because the Cure, The Health Care Quality Improvement Act, May be Worse than the Disease,
         37 CATH. U.L. REV. 1073 (1988); The Health Care Quality Improvement Act of 1986, supra,
         note 19.


26The HCQIA provides immunities from damages, but some courts have found that
it does not provide immunity from suit. While physicians who participate in peer review
activities that fall within the protections of the HCQIA will undoubtedly be dismissed
from a lawsuit brought against them at an early stage in the litigation, the act does not
explicitly provide them with immunity from suit. See Decker, 982 F.2d 433 (neither the
Utah Medical Practice Act nor the HCQIA provided immunity from suit; the acts
provided protection "only from damages arising from participation in private actions,
and only for proper peer review") Id. at 437; Austin v. McNamara, 979 F.2d 728 (9th Cir.
1992) (court of appeals upheld district court's granting of summary judgment against
physician participant in peer review proceedings when it determined peer reviewers
complied with HCQIA due process requirements); Smith v. Ricks, 798 F. Supp. 605 (N.D.
Cal. 1992) (plaintiff failed to overcome the presumption of immunity for denial of
from damages to those individuals who participate and provide information to professional review bodies "unless such information is false and the person providing it knew that such information was false." Professional review bodies, persons who act as a member of the professional review body, persons acting under a formal agreement or contract with the professional review body, and any other person who participates and/or assists the professional review body with the action is also granted immunity from civil damages.

The HCQIA also provides standards for professional review actions that must be met before the peer review body or individuals described in the Act will be entitled to the immunities from damages provided in the Act. To qualify for the protections of the Act, the following conditions must be met:

[a] professional review action must be taken—
   (1) in the reasonable belief that the action was in the furtherance of quality health care,
   (2) after a reasonable effort to obtain the facts of the matter,
   (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
   (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

The HCQIA provides a basis against which effective peer review can be measured when professional review actions have the adverse effect of

privileges afforded by the HCQIA. See also Manion v. Evans, 986 F.2d 1036 (6th Cir.), cert. denied, 114 S. Ct. 71 (1993) (HCQIA provides immunity to physician and hospitals participating in peer review activities from liability for damages in civil actions; it does not immunize physicians and hospitals from suit as a result of their participation in peer review activities).


Section 11112(b) of the Act details the requirements that must be fulfilled for a health care entity to be deemed to have met the adequate notice and hearing requirement of Section 11112(a)(3). These requirements include notice to the affected physician of the proposed action, which must include the reasons for the proposed action, inform the physician that he/she has the right to request a hearing on the proposed action (the time within which to request such a hearing cannot be limited to less than 30 days), and a summary of the hearing rights available to the physician. 42 U.S.C.A. § 11112(b)(1). The notice of proposed action must be followed by a notice of hearing when the physician requests a hearing within the time provided in the notice of proposed action. The notice of hearing must contain the place, time, and date of the hearing, a date not less than 30 days after the date of the notice, and a list of witnesses expected to testify on behalf of the professional review body. 42 U.S.C.A. § 11112(b)(2). These hearing rights include the right to be represented by counsel or another person of choice, to call, examine, and cross-examine witnesses, to present evidence, and to submit a written statement at the close of the hearing. 42 U.S.C.A. § 11112(b)(3).

30Id. § 11112(a).
"reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." Professional review actions are limited to those actions taken or made in the conduct of professional review activity that is "based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician." While the HCQIA may do no more than provide a framework within which peer review should be conducted, that alone is a step in the right direction for effective peer review.

IV. PEER REVIEW PRIVILEGE

The peer review privilege has developed as an "institutional privilege"—a privilege which protects the institution and participants and not necessarily the person being subjected to peer review. Courts have been reluctant to adopt a common law peer review privilege and so the privilege if it exists at all flows from statutory enactment. The statutes which exist are not consistent and do not seem to address adequately the underlying reason for the privilege.

A. Privileges

"Privilege" in the law is the right to keep certain information from being used in evidence. The recognition of a privilege with respect to communications between parties or with respect to an institution's self-examination of its activities represents "an exception to the general liability of every person to give testimony upon all facts inquired of in a court of justice." At common law no privilege is created by the "mere fact that a communication was made in express confidence, or in the implied confidence of a confidential relation." Wigmore, one of the foremost authorities on privileges, delineated four conditions necessary before a privilege against the disclosure of certain communications and information may be established.

(1) The communications must originate in a confidence that they will not be disclosed.

(2) This element of confidentiality must be essential to the full and satisfactory maintenance of the relation between the parties.

(3) The relation must be one which in the opinion of the community ought to be sedulously fostered.

31 Id. § 11151(1).
32 Id. § 11151(9).
33 Wigmore, Evidence (McNaughton rev. 1961), ¶ 2285, p. 527.
34 Id. at 528.
(4) The injury that would inure to the relation by the disclosure of the communications must be greater than the benefit thereby gained for the correct disposal of the litigation.\cite{footnote}

Courts have been very reluctant to create common law privileges absent statutory authority and generally strictly construe those privileges that do exist. The United States Supreme Court has continually admonished courts to be cautious in fashioning privileges. Even in discussing the widely accepted attorney-client and priest-penitent privileges, the Court has urged caution in their application:

These and other interests [referring to the privileges held by attorneys and priests] are recognized in law by privileges against forced disclosure, established in the Constitution, by statute, or at common law. Whatever their origins, "these exceptions to the demand for every man's evidence are not lightly created nor expansively construed, for they are in derogation of the search for truth."

\cite{footnote}


"Limitations are properly placed upon the operation of this general principle only to the very limited extent that permitting a refusal to testify or excluding relevant evidence has a public good transcending the normally predominant principle of utilizing all rational means for ascertaining truth."

\textit{See also} Trammel v. United States, 445 U.S. 40, 50 (1980) ("Testimonial exclusionary rules and privileges contravene the fundamental principle that 'the public... has a right to every man's evidence...'") (citations omitted).

The most recent United States Supreme Court decision to address this issue occurred in the context of academic peer review proceedings. In University of Pennsylvania v. EEOC, 493 U.S. 182 (1990), the Court was called upon to "fashion a new privilege [claimed by petitioner to be] necessary to protect the integrity of the peer review process, which in turn is central to the proper functioning of many colleges and universities." \textit{Id.} at 189. The Court declined, stating:

We do not create and apply an evidentiary privilege unless it "promotes sufficiently important interests to outweigh the need for probative evidence..."

\textit{***}

Moreover, although Rule 501 manifests a congressional desire "not to freeze the law of privilege" but rather to provide the courts with flexibility to develop rules of privilege on a case-by-case basis, we are disinclined to exercise this authority expansively. We are especially reluctant to recognize a privilege in an area where it appears that Congress has considered the relevant competing concerns but has not provided the privilege itself. The balancing of conflicting interests of this type is particularly a legislative function.

\textit{Id.} (citations omitted).
It is generally accepted that the privilege ascribed to peer review proceedings does not arise from any recognized common law principle, but is rather a legislative creation developed to protect facets of peer review proceedings in order to encourage open and effective peer review. The peer review privilege is one of the privileges characterized as an institutional privilege which protects confidentiality of communications not because of the importance to the individuals involved but due to the importance of the protection to the institutions (and indirectly the public) relying upon the privilege. Clearly the peer review privilege was created to encourage peer review and thus protect the institutions performing peer review and not to protect the individuals who were subject to review.

Peer review itself is a relatively recent development and stems from the health care profession's concern with establishing a minimal standard of care for health care services provided to the public. Today's tradition of self-regulation and evaluation within the health care profession flows from early attempts by hospitals to regulate the quality of care provided within their walls. With the development of the accreditation organizations, such as the JCAHO and AOA's Committee on Hospital Accreditation, and state licensing regulations, the requirements for the peer review process have been imposed.

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37 See The Medical Review Committee Privilege: A Jurisdictional Survey, supra note 6, at 189 ("[w]hether medical review records were afforded any privilege at common law is at best uncertain").

38 See Section IV(C) infra.


40 Formal medical education in the United States did not begin until 1765 when a chair was founded at the College of Philadelphia. Note, Medical Peer Review Protection in the Health Care Industry, 52 TEMP. L.Q. 552, 554 (1979). Hospitals at that time were generally not-for-profit private institutions and frequently developed out of almshouses. Minimal standards for medical graduates were set by the American Medical Association when it was established in 1847 as a means to attempt to establish a minimum level of competence in the profession. Id. Later states adopted regulations for the licensing of physicians. Id.

Continuing the movement toward monitoring of physicians by their peers, which developed out of a concern for the poor quality of health care providers, the American College of Surgeons was organized in 1913. Id. Membership in the College was based on professional qualifications and merit. Id. at 554-55. As one commentator describes the College, it:

[s]ought to establish standard requirements for hospital quality of care. . . . The standards favored close-staff hospitals, where staff membership is a privilege conferred solely on merit as determined by the hospital. . . . A procedure of medical audit, a form of peer review, was recommended during this time, but the innovation was not instituted until decades later as hospital medical staff standards and review became more rigorous.

Id.
from outside the health care institution. "The conventional justification for the privilege is that protecting doctors from testifying against their colleagues promotes candor during peer review proceedings."\textsuperscript{41}

The issue before the courts and legislatures is how to give health care professionals the protections and immunities necessary to promote thorough and effective peer review and at the same time allow certain information from the peer review proceedings to be used in a meaningful way.\textsuperscript{42}

C. Federal Peer Review Privilege

Federal Rule of Civil Procedure 26(b)(1) provides that parties may obtain discovery regarding any matter not privileged which is relevant to the subject matter in the action. Rule 501 of the Federal Rules of Evidence provides that for federal civil cases based upon state claims (generally diversity cases) the determination of privilege is based upon the state law being applied in that specific case. With all other federal cases where federal law is applied, whether or not communications are privileged is based upon federal statute and if none exists, by common law as interpreted by the federal courts. There is no federal statute granting a peer review privilege and therefore whatever peer review privilege protection there is falls to the federal courts to fashion. The federal courts, however, have been reluctant to adopt common law privileges in general, even rejecting a physician-patient privilege in federal cases.\textsuperscript{43} Likewise the federal courts have been reluctant to adopt a common law peer review privilege, although this is not absolute.

In \textit{Bredice v. Doctors Hospital, Inc.},\textsuperscript{44} the most widely cited case for adopting a federal peer review privilege, the United States District Court for the District of Columbia denied discovery in a malpractice case of reports made to hospital committees on the grounds that, absent extraordinary circumstances, a hospital is entitled to a qualified privilege of information submitted to committees formed pursuant to JCAHO guidelines for the "sole objective" of improving available care and treatment for its patients.\textsuperscript{45} Despite the holding in \textit{Bredice},

\textsuperscript{41} See, e.g., Goldberg, \textit{ supra} note 5, at 154.

\textsuperscript{42} See Scott, \textit{ supra} note 6, at 319 ('We ought to give immunity to doctors to participate in peer review in order to encourage that peer review, but we have to protect the public by making the information available from peer review to an institution so that information will be used in a meaningful way.').


most federal courts addressing the issue have refused to adopt a common law peer review privilege.46

While the U.S. Supreme Court has not yet addressed the issue of a federal health care peer review privilege, the Court recently addressed the issue of peer review in the academic setting and refused to recognize a common law privilege against disclosure of confidential peer review information:

We do not create and apply an evidentiary privilege unless it "promotes sufficiently important interests to outweigh the need for probative evidence...." Inasmuch as "[t]estimonial exclusionary rules and privileges contravene the fundamental principle that 'the public...has a right to every man's evidence,... any such privilege must be strictly construed."47 (citations omitted).

It is unlikely that the United States Supreme Court, if faced with the issue of health care peer review would hold differently.

While there is little support for a federal peer review privilege at common law, neither is there a statutory basis for a medical peer review privilege in federal law. The HCQIA statutorily granted antitrust immunity to medical peer review participants when the review conforms to the standards of the Act. The HCQIA, however, did not grant any privilege to the proceedings of peer review committees. Presumably Congress would have addressed the issue of privilege if it intended for a privilege to be granted. The Act does provide for the limited confidentiality of information reported to hospitals from the NPDB:

Information reported under this subchapter is considered confidential and shall not be disclosed (other than to the physician or practitioner involved) except with respect to professional review activity. ... Nothing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.48

The court in LeMasters v. Christ Hospital,49 held that this portion of the Act provides for confidentiality of only that information provided to the NPDB and does not create any type of peer review privilege.

Another basis for the privilege argued for with respect to peer review proceedings is the newly emerging privilege recognized for self-evaluative


47 University of Pennsylvania, 493 U.S. at 189 (citations omitted).


processes. As stated above, the Bredice decision is recognized as the first case to allow for a privilege based upon a self-evaluative basis.\textsuperscript{50} From that beginning, the "general public policy favoring confidentiality for self-criticism has been expanded and applied, although by no means uniformly, to protect documents in other contexts, including police department investigations and academic peer reviews."\textsuperscript{51}

One commentator has described the purpose for the development of the self-critical analysis privilege as a means "to foster, within a given institution, frank deliberations designed to improve the institution's mission.\textsuperscript{52} The privilege is generally described as a qualified privilege and its application is determined on a case-by-case basis. Three factors have been recognized by courts when determining whether the self-criticism privilege applies. These include: (1) the document must result from an institution's internal investigation conducted to review or evaluate the institution's procedures or products; (2) it must have been the intent of the institution that the document remain confidential and it must remain confidential for the institution to function effectively; and (3) "protecting the communication must be in the public interest and serve an important public need."\textsuperscript{53}

By far the most common application of the self-critical analysis privilege occurs within the context of the academic peer review function. In this context a qualified privilege for the peer review process conducted by colleges and


\textsuperscript{51}Discovery of Affirmative Action Plans, supra note 50, at 409 (citations omitted).

Courts declining to recognize the self-evaluative privilege: Nazareth Literary & Benevolent Inst. v. Stephenson, 503 S.W.2d 177, 179 (Ky. App. 1973) (court stated that "claims of privilege are carefully scrutinized and impediments to the discovery of truth are afforded validity in relatively few instances"); Shibilski v. St. Joseph's Hosp., 266 N.W.2d 264 (Wis. 1978) (court would not judicially recognize a self-criticism privilege on the basis that only the legislature can create a privilege).

\textsuperscript{52}Note, Making Sense of Rules of Privilege Under the Structural (Il)logic of the Federal Rules of Evidence, 105 HARV. L. REV. 1339, 1351 (1992). See also The Privilege of Self-Critical Analysis, supra note 50, at 1083 ("a privilege of self-critical analysis has developed to shield certain institutional self-analyses from discovery").

\textsuperscript{53}Criticizing the Self-Criticism Privilege, supra note 50, at 680. The author notes that although "the practical scope of the privilege remains undefined," id., courts have consistently applied it to three types of documents—"committee or peer review reports, corporate internal investigation documents, and affirmative action forms voluntarily recorded in compliance with federal equal employment opportunity statutes." Id. at 681 (footnote omitted) (further concluding that these documents differ so greatly the court's recognition of them provides "inadequate precedent for courts to utilize in evaluating claims of the privilege"). Id. The author further notes that the application of Professor Wigmore's conditions for the recognition of a privilege does not support the self-criticism privilege. Id. at 683-84.
universities when considering promotion and tenure of professors was first recognized in 1981.54 In 1983, the Seventh Circuit Court of Appeals recognized a qualified academic freedom privilege with respect to disclosure of the identities of individuals participating in the university peer review tenure process.55 However, the United States Supreme Court has refused to recognize a common law privilege for peer review materials prepared in connection with such promotion and tenure decisions.56

As in the health care profession, the rationale for the recognition of such a privilege with respect to academic peer review is based upon the reluctance of individuals to participate in the process without assurances of confidentiality. Without the certainty of confidentiality to those individuals participating in the peer review process, commentators have argued that there will be a failure "to foster honest, open criticism of faculty members under review. Indeed, the institution's fear of possible future litigation might actually facilitate ad hoc, discriminatory employment decisions without full consideration of the applicant's merits and without benefit of accurate records."57

Corporations have also attempted to use the self-evaluation privilege; however, the success with which such corporations have maintained confidentiality of certain internal documents has been founded on other privileges—e.g., the attorney-client privilege and attorney work product doctrine.

While the self-critical privilege has been applied successfully at times in the context of academic peer review, it has not met with favor when applied to the peer review procedures conducted within the health care profession.58 Moreover, because the privilege, when recognized, is characterized as a "qualified" privilege, courts hold that it only protects subjective as opposed to factual or objective data contained in reports and that the privilege can be overcome if the plaintiff can demonstrate its need for the information


55 EEOC v. University of Notre Dame Du Lac, 715 F.2d 331, 337 (7th Cir. 1983).

56 University of Pennsylvania, 493 U.S. at 182 (holding that university must respond to EEOC subpoena for information because the applicable EEOC statute plainly provides that the EEOC shall have access to relevant evidence).

57 Recent Development, supra note 54, at 1405-06 (arguing that reliance on judicial discretion in determining on a case-by-case basis whether peer review proceedings will be protected "provides uncertain and therefore unsatisfactory protection for the universities' interest in confidentiality").

58 See Morgenstern v. Wilson, 133 F.R.D. 139 (D. Neb. 1990) (interest in enforcing antitrust laws outweighs interest in protecting patients' records and peer review committee's work); Wei v. Bodner, 127 F.R.D. at 91 (information sought in antitrust suit against hospital was not protected by peer review privilege or self-evaluative privilege).
outweighs the public interest in prohibiting disclosure. In addition, the fact that the privilege is applied entirely within the discretion of the court leads to its application on a case-by-case basis with the result that one court may reach the opposite conclusion as another court on identical facts. Therefore, the self-criticism privilege should not be relied upon alone to provide protection for peer review proceedings.

D. State Peer Review Privileges

In stark contrast to federal law, almost all states and the District of Columbia recognize some type of peer review privilege. While at least one state court has suggested that absent a statute, public policy might still dictate that information regarding peer review proceedings not be admitted into court, most state privilege protections flow from statutory law. Despite almost universal mention of peer review privilege, there is extremely wide variation in the privilege granted by the states. The variation focuses on the types of entities granted privilege protection, whether such protection is offered for all judicial and administrative proceedings and the scope of the protection granted.

1. Health Care Entity Proceedings Granted Protection

State statutes vary significantly in the types of health care facilities granted peer review privilege protection. Most states protect peer review performed by hospitals. Once outside the hospital context, there is broad variance in what types of entities are offered protection for peer review activities. Some states offer protection to peer review conducted by free-standing surgical centers and health maintenance organizations. A very few offer protection to third party payers.

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59 The chart following this Article summarizes the state peer review statutes and the protections afforded participants and proceedings.

60 Bay Medical Center v. Sapp, 535 So. 2d 308, 311 (Fla. App. 1988) (citations omitted).

61 Committees performing peer review functions, which may include utilization review and credentialing, governing boards, administration, and all varieties of health care facilities, have been given statutory protection in some form. Individuals associated with these entities, as members, employees, agents, and advisers, are also typically included and given immunity from civil and/or criminal liability from damages and/or suit.

62 For example, Delaware’s peer review statute protects any committee appointed by an HMO to perform quality review and makes the records and proceedings of such a committee confidential and privileged. Kentucky’s peer review statute provides similar protection for HMOs. Louisiana’s peer review statute protects and makes confidential records of peer review committees of free-standing surgical centers, HMOs, and group medical practices of 20 or more physicians.

63 Kentucky includes review by health insurers within its peer review statute.
Similarly there is little consistency about the type of information granted protection at the facilities mentioned in the state statutes. For instance, Arizona law broadly offers protection to review of professional privileges performed by hospitals, while Ohio law provides protection only for utilization, quality assurance, and tissue committees and hospital boards and committees reviewing professional qualifications or activities of the hospital medical staff or applicants for admission to the staff. Therefore, the Arizona statute would offer protection to all hospital review of professional privileges, however that review is done, and would include review performed by departments, department chairmen and otherwise. Ohio's statute, in contrast, only protects the proceedings of specific committees and the hospital board. The protection afforded by Arizona, however, appears to be limited to traditional review of professional credentials review, while the Ohio statute more broadly covers ongoing review by named committees of any medical staff activities. Most of the case law in the area of peer review centers around the issues of what is

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64 Ariz. Rev. Stat. Ann. § 36-445.01 (1993). In a recent case, Yuma Regional Medical Center petitioned the Arizona Court of Appeals on the sole issue of whether it was required to produce certain requested information. The medical center argued that to provide the information would violate the peer review privilege conferred by § 36-445.01(A), which provides in pertinent part: "All proceedings, records and materials prepared in connection with the reviews provided for in § 36-445, including all peer reviews of individual health care providers . . . and the records of such reviews, shall be confidential and shall not be subject to discovery . . . ." Discovery of the names of participants in the peer review proceeding and a list of written or documentary items submitted to the committee were sought. On both issues, the court found that the plaintiffs were trying to "thwart" the privilege and held that neither type of information was discoverable. The court specifically held:

The peer review privilege, A.R.S. § 36-445 et seq., protects from disclosure the names of the participants in a peer review proceeding as well as the listing of any written or documentary items submitted to the peer review committee. Such information is inherent in the privilege as indicative of the "discussions, exchanges and opinions" of the committee. Yuma Regional Medical Center v. Superior Court, 852 P.2d 1256, 1262 (Ariz. Ct. App. 1993) (emphasis added).


66 Interestingly, and of great concern to hospital governing boards in Ohio, the Ohio Supreme Court rejected a hospital's argument that certain information fell within the peer review privilege. The Court was presented with a negligent credentialing claim that was brought after traditional interpretations of the applicable statute of limitations for such actions. The Court specifically found that the hospital was not involved in the provision of information or participation on a peer review committee and therefore not entitled to the immunities of Ohio Rev. Code § 2305.25. The Court also dismissed without meaningful discussion the hospital's protest that it would be unable to defend itself due to the prohibition of Ohio Rev. Code § 2305.251, which generally prohibits disclosure of peer review committee proceedings and records. The Court stated that information from other sources would be available to the hospital, ignoring the fact that the very information it would need to defend itself against the negligent credentialing claim involves the type and extent of peer review conducted by the hospital and its medical staff. See generally Browning v. Burt, 613 N.E.2d 993, 1006 (1993).
covered by the privilege and what is not covered, creating a crazy quilt effect among the states. If the policy reasons for granting privilege to peer review information exist, i.e., encouraging open and effective peer review to ultimately increase the quality of medical care rendered, then this reason should exist whether the peer review is conducted by a hospital, ambulatory surgery center, an alternative delivery system, or other health care entity and regardless of how it is performed within the institution. With the advent of credentialing decisions being made by alternative delivery systems, extension of the privilege to this setting may be important. While many credentialing decisions at the third party payer level are not being made by peers but by the administration of the third party payer, protection of this credentialing information may be useful to encourage such review to be performed at all. Currently if the information is not protected there may be a tendency for third parties not to engage in the review for fear of retaliation by health care professionals.

2. Scope of Privilege

There is wide variation by the states as to the scope of privilege. While generally the privilege extends to civil actions, some states limit the applicability of the privilege even in civil actions. Some states extend the privilege to criminal and administrative actions, as well as civil actions.

a. Civil Actions

Some states, such as Alabama and California, offer broad privileges for civil actions; peer review records are simply not admissible or discoverable in civil actions. Other states such as Arizona start out by offering similarly broad protection, but then carve out large exceptions which provide that the information may be obtained in actions by staff members against the entity conducting the peer review for improper limitation of privileges.


68 At least 12 states at this time specifically include peer review by entities such as HMOs, PPOs, and other health care delivery systems in their peer review statutes.


A relatively large number of states—Arkansas, Connecticut, Florida, Georgia, Maryland, Minnesota, North Carolina, North Dakota, Ohio, Pennsylvania, Vermont and West Virginia—provide only that the information shall not be discoverable or admissible in actions arising out of the subject of review by the committee. The information would therefore be protected against disclosure in actions brought against the entity for the peer review process, but it is questionable whether the information would be protected from discovery in malpractice actions unless the particular alleged error or omission generating the malpractice action was the subject of the peer review meeting. A Florida appeals court permitted discovery of peer review records from one hospital in a malpractice case arising at a second hospital holding:

[W]here the circumstances giving rise to the suit were the very ones considered in the committee evaluation, the documents and transcribed proceedings of the said committee hearings are precluded from discovery. But if the subject matter of the suit and the subject of the medical review committee evaluation are not the same, the statute does not apply.

b. Criminal Actions

Some of the states that offer the peer review privilege in civil actions also offer the privilege in criminal actions. Pennsylvania and Rhode Island both provide that members and employees who furnish information or participate in the peer review process will not be found to have violated any criminal law. The Utah statute simply provides that participants will be immune from liability. Most states simply state that the immunity of individual participants is from civil damages or suits.

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71 The Connecticut peer review statute does not protect the discovery of facts; the statute provides that the fact of restrictions or termination of privileges can be disclosed in a civil action, together with the nature of the restrictions.

72 In contrast, 19 states expressly recognize an exception to the peer review privilege and allow discovery of peer review information when the physician under investigation brings a civil action to challenge the peer review outcome. These states are: Alabama, Arizona, California, Colorado, Idaho, Indiana, Iowa, Kansas, Louisiana, Mississippi, Missouri, New Hampshire, New Mexico, Oregon, Rhode Island, South Carolina, South Dakota, Washington, and West Virginia. Although West Virginia also provides that peer review information is not to be available for use in actions arising out of the peer review activity, it allows use of the information in judicial actions reviewing the peer review outcome, but specifically provides that the court "shall enter such protective orders as may be appropriate to provide for the confidentiality of the records provided the court ..." W. VA. CODE § 30-3C-3 (1993).

With respect to the proceedings themselves and the information acquired and produced as a result of the peer review process, eight states\(^\text{74}\) provide that the peer review records and proceedings are not subject to discovery, use or admissible into evidence in any action of any kind, which appears to provide protection from use in civil, criminal, and administrative proceedings. The peer review protection statutes in five states\(^\text{75}\) provide that such information is not available for discovery or subpoena, leading to the conclusion that the information is not available for criminal, civil or administrative matters. Until the statutes have been judicially construed, the facial interpretation points to the protection of peer review information in these states in civil, criminal, and administrative proceedings. It is certainly understandable that, as a matter of public policy, the states would be more restrictive in granting privileges in criminal actions.

c. Administrative Actions

The states are split about whether peer review information can be admitted into evidence in administrative actions. A number of state statutes specifically provide that peer review information is not available to licensing bodies in administrative actions, while a number of states take an opposite approach and specifically do permit the information to be admitted in licensing actions. At least one court has interpreted a statute which provided for judicial privilege not to include a privilege for administrative proceedings. Since the advent of the HCQIA, arguably this distinction is less important, because any significant peer review sanctions taken by hospitals as a result of peer review will be reported to state licensing agents and to the NPDB.

3. Waiver

The issue of waiver of peer review privilege is particularly interesting. Many privileges such as the attorney-client and physician-patient privilege provide that the privilege may be waived by one of the parties to the communication. Most of the states that provide a privilege for peer review information do not provide any way in which the privilege may be waived.\(^\text{76}\) Without such a statutory waiver, it is unlikely that the court will permit the privilege to be waived.

If the privilege is truly an institutional privilege, protecting the participants in the process, then waiver, if permitted at all, should be exercised by the participants and not by the person who was the subject of the review. Despite this, Nebraska provides for specific waiver of the privilege by the patient whose information is being discussed in the peer review proceedings. Certainly the

\(^{74}\)Idaho, Massachusetts, Michigan, Missouri, Montana, New Hampshire, South Dakota, and Utah.

\(^{75}\)Nebraska, Nevada, New Jersey, Rhode Island, and Tennessee.

\(^{76}\)Six states offer a specific way in which to waive the statutory privilege or confidentiality provided in the peer review statute.
patient is not going to be particularly interested in the sanctity of the peer review process, but will be more concerned about his or her feelings about the physician or how release of the information may impact any pending malpractice action. Permitting the patient to waive the privilege may render it almost meaningless. New Hampshire appears to understand the rationale behind the privilege and permits the hospital board to waive the hospital peer review privilege. Texas, similarly, allows the peer review committee to waive the privilege of confidentiality; however, the waiver must be in writing and signed by the committee chair, vice-chair, or secretary. Permitting the board to waive the privilege may not provide particular comfort for the physicians on the medical staff who have participated in peer review proceedings and who are expected to participate in such proceedings as part of their medical staff responsibilities.

In a very interesting case, West Covina Hospital v. Superior Court, the California Supreme Court held that the California privilege statute, which provided that a peer review participant could not be required to testify about peer review proceedings, did not preclude a participant from voluntarily testifying as to the proceedings. The court reasoned that the privilege statute was to protect physician's time from being burdened with required testimony. The court further reasoned that if a physician volunteered to testify, then the physician obviously chose to bear the burden of testifying. Obviously, interpretations such as West Covina would render absolutely meaningless what peer review privilege protection exists as physicians would always be concerned that one of the participants would choose voluntarily to disclose the proceedings.

If the policy reasons for the peer review privilege exist, the states do not appear to be successful in advancing those policies. Participants in the peer review process are generally not guaranteed that they will not be called to testify against a colleague about what transpired in peer review in some future action. Some commentators have, however, argued that the privilege is unnecessary. If the true fear of peer review participation is the "potential fear felt by the reviewer that participation in an adverse recommendation will lead

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77 The Texas statute also allows any individual or entity who participated in peer review and who is then named as a defendant in a civil action to use otherwise confidential information to present a defense to the charges. The plaintiff is then also entitled to disclose records or other peer review information to rebut the information supplied by the defendant. Tex. Rev. Civ. Stat. Ann. art. 4495b, § 5.06(j) (West Supp. 1994).

78 718 P.2d 119 (Cal. 1986).

79 Perhaps for this reason many state peer review statutes provide that individual members or advisors to peer review committees will not be required or permitted to testify as to what transpired at the committee meetings or any of its deliberations.

80 See Goldberg, supra note 5.
to a lawsuit against him or her personally,"\textsuperscript{81} peer review immunity statutes should protect against such suits and privilege statutes should not be necessary for such protection. "Regrettably, the widespread adoption of the privilege cannot be justified in view of its limited benefits and its adverse impact upon a patient's ability to show negligence."\textsuperscript{82}

V. CONFIDENTIALITY

Confidentiality and privilege are two compatible, yet distinct, concepts. Privilege addresses a person's right not to have another testify as to certain matters as part of a judicial process, while confidentiality addresses the obligation to refrain from disclosing information to third parties other than as part of legal process. Confidentiality may be imposed by law or by agreement. In many cases, if there is a privilege against testifying, there is also a requirement to keep information confidential; for instance, many states which recognize the attorney-client privilege or physician-patient privilege also provide that the attorney or physician can be subject to state license disciplinary action for willful betrayal of a professional confidence.\textsuperscript{83} This is, however, not the case with all privileges. For example, although the spousal privilege prevents one spouse from testifying against another regarding certain communications, a spouse is not required by law to keep all spousal communications confidential outside of the judicial context. Indeed tabloids and other publications might not survive if it were not for the telling of spousal secrets. The only recourse of a spouse against another for telling secrets may be to stop talking to the spouse or divorce.

In the case of peer review, voluntary revelation of peer review findings may be particularly damaging to the process. As discussed previously with respect

\textsuperscript{81}Scibetta, supra note 5, at 1033.

\textsuperscript{82}Id. See also Clark C. Havighurst, Professional Peer Review and the Antitrust Laws, 36 CASE W. RES. L. REV. 1117, 1118 (1986), in which Professor Havighurst concludes that "[e]ncrusting the law with special exceptions for privileged groups or special treatment for particular activities is a poor approach precisely because it relieves courts of the necessity to rethink basic antitrust doctrine to make certain that it frustrates only conduct that is truly incompatible with competition and consumer welfare."

For the view of the judiciary finding the privilege inappropriate, see also Ott v. St. Luke Hosp. of Campbell County, Inc., 522 F. Supp. 706 (E.D. Ky. 1981), in which the court held that there was no showing that the hospital peer review committees' functions would be substantially impaired by denial of the privilege. Indeed, the true efficacy of such committees may be fostered by an atmosphere of openness, in that they may be less likely to rely on hearsay or information tainted by bias or prejudice in making their decisions, if the underlying reasons therefor can be required to be disclosed in a proper case. Id. at 711.

\textsuperscript{83}For example, Ohio's Medical Practice Act, OHIO REV. CODE Ch. 4731, provides that "[w]illfully betraying a professional confidence . . . " constitutes grounds for discipline by the state medical board. OHIO REV. CODE ANN. § 4731.22(B)(4) (Anderson Supp. 1992).
to the *West Covina* case, the ability of one participant in the peer review process to waive the privilege and disclose information from the proceeding without the consent of the entire group or health care facility administration cuts at the very basis of the concept—protection of certain information, usually considered in a committee setting and any decision or recommendation arising from that committee review, from disclosure on the basis that individual participants will be more willing to participate openly and honestly if their comments and recommendations are not made known outside the context of the proceeding.

A. State Law

Eighteen of the states that provide privilege protection to peer review information—Arkansas, California, Connecticut, Florida, Georgia, Hawaii, Kansas, Maryland, Mississippi, Missouri, Nebraska, Nevada, New Jersey, New York, Oregon, South Dakota, Virginia, and Washington—do not mention the confidentiality of such information in the statute. Therefore, while the admissibility of such information during judicial or administrative process will be governed by the state law on privileges, the peer review participants are free to voluntarily discuss peer review information as they choose. One way to help ensure that committee members keep any information confidential is to have them individually agree to maintain confidentiality as one of their committee responsibilities. Medical staffs can also provide for confidentiality by including such provisions in the medical staff bylaws and also obtaining appointees' specific agreement to abide by this provision at the time of appointment and reappointment to the staff as a specific condition of appointment.

Seventeen states—Arizona, Idaho, Illinois, Iowa, Kentucky, Maine, Massachusetts, Michigan, Minnesota, Montana, New Hampshire, North Carolina, Pennsylvania, Utah, Vermont, West Virginia, and Wyoming—and the District of Columbia simply mention, in conjunction with granting a privilege, that the peer review information is to remain confidential. Since almost all the states mention the confidentiality in the same clause as the description of privilege, it could be argued that the confidentiality language actually applies solely to the judicial context and is part of the privilege granted, but is not meant to give rise to any actionable requirement that the peer review participants keep the information confidential. If this is the case, thirty-five states grant little or no confidentiality protection to peer review proceedings. Even if this is not the

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84 Refer to the chart following the text for statutory cites and a brief description of the statutory provisions.

85 Although there is no express discussion of "confidentiality" in the statute, the statutes of Arkansas and Maryland title one section of the peer review statute "Proceedings and Records Confidential" and "Proceedings, Records and Files Confidential," respectively.

86 For example, the Michigan statute states that information from review functions performed by review committees of hospital medical staffs is confidential and is not available by subpoena. *Mich. Comp. Laws §§ 333.21515, 333.21513(d) (1993).*
case, the statutes offer no sanction for violation of the confidentiality requirement. Presumably, therefore, if participants in the peer review process see fit to discuss the proceedings with, for example, third party payers, other health care facilities, or the news media, they are free to do so without fear of recourse.

The peer review statutes of Alabama, Delaware, Louisiana, North Dakota, and Ohio all provide that peer review information is to remain confidential and only be used in the exercise of proper functions of the committee. This language at least implies that the reference to confidentiality is not meant to be limited to judicial privilege and that there is an affirmative obligation to keep the information confidential. Alaska broadly provides that all information and data of a peer review committee may not be disclosed to anyone.

A number of states provide that peer review information is to remain confidential and provide specific instances when the information may be released. For example, Indiana permits release to other peer review and professional organizations as well as state disciplinary boards; South Carolina permits the professional who is the subject of review to authorize the release to third parties; Tennessee permits the information to be used as advocacy for the professional before other peer review bodies; and Texas permits a judge to authorize the disclosure in an anti-trust action. Colorado, while stating that peer review information is to remain confidential, affirmatively permits the voluntary release of all such information, provided there are no patient identifiers. Penalties for unlawful disclosure are imposed by only 2 of the states identified above—Alabama and Minnesota.

New Mexico, Ohio, Rhode Island, Texas, and Wisconsin are the only states which appear to fully appreciate the concept of confidentiality as distinct from privilege and provide sanctions for peer review participants’ failure to keep the information confidential. Both New Mexico and Rhode Island provide criminal sanctions for violation of the confidentiality requirement and provide

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87 This would imply that the confidentiality provision is not meant as a separate legal requirement but applies only to the privilege from admission in judicial proceedings.

88 In all, only 6 states provide penalties for violation of statutory peer review confidentiality requirements—Alabama, Minnesota, New Mexico, Rhode Island, Texas, and Wisconsin. In addition, Ohio allows a right of action against a member of a utilization or quality assurance committee, "similar to that a patient may have against an attending physician for misuse of information, data, reports, or records arising out of the physician-patient relationship, . . . for misuse of information, data, reports, and records furnished to the committee by an attending physician." OHIO REV. CODE ANN. § 2305.24 (Anderson 1991). This provision has not been judicially interpreted, but it would not appear to apply to information reviewed or generated by a peer review committee since the following statutory section, § 2305.25, discusses separately quality assurance and peer review committees. Section 2305.24 defines "utilization committee" as "the committee established to administer a utilization review plan of a hospital. . . ." If peer review were included as a function of the utilization review plan, then arguably the cause of action provided for misuse of information provided to utilization committees would also apply to misuse of information provided to peer review committees.
for fines and potential jail sentences. Ohio and Wisconsin expressly permit civil damage actions against those breaching the confidentiality requirements.\footnote{Remember that Ohio’s cause of action appears to be limited to misuse of information provided to a utilization review or quality assurance committee by an attending physician. \textit{Ohio Rev. Code Ann.} § 2305.24 (Anderson 1991).}

It is interesting to note that the existence of sanctions for violation of confidentiality may actually discourage active peer review participation if a participant realized he or she could later be subject to sanctions for revealing what was known about the process. Presumably, however, participants in the process are used to protecting patient confidences and are comfortable with the notion of confidentiality.

A review of the case law on peer review revealed almost no interpretation of peer review confidentiality status. The \textit{West Covina} case discussing the permissibility of voluntary testimony even in the face of a privilege statute was the sole case to address the issue of participants voluntarily revealing peer review information.

\section*{B. Federal Law}

Public demand for physician accountability led to the enactment of HCQIA, which resulted in the establishment in 1990 of the NPDB. Pursuant to HCQIA, the following must be reported to the NPDB: certain adverse actions regarding medical staff membership or clinical privileges taken by hospitals and other health care providers which engage in peer review activities; adverse actions taken by professional review societies regarding their members; payments on certain malpractice claims; and adverse actions taken by state licensing boards. Information submitted to the NPDB later may be obtained by the following: hospitals acting upon medical staff membership or clinical privileges; other health care providers which engage in professional review activities or contract with health care professionals; health care professionals regarding themselves; state licensing boards; and, in very limited circumstances, parties to malpractice actions.

The NPDB regulations provide that any person or entity which receives information directly or indirectly from the NPDB must consider such information confidential and use the information solely with respect to the purpose for which it was provided; however, nothing prevents disclosure of information which is "authorized" under applicable state law. Violations of this confidentiality regulation are subject to a civil monetary penalty of up to $10,000 for each violation.\footnote{45 C.F.R. § 60.13(a).} As shown, a great number of states do not require confidentiality of peer review information. The lack of a confidentiality mandate however, arguably does not "authorize the release of such information." Therefore, to be safe, health care providers should maintain the confidentiality of NPDB information. Outside of the NPDB information,
however, HCQIA does not give rise to any federal law requirement that peer review information remain confidential.

VI. MAXIMIZING WHAT LIMITED PEER REVIEW PROTECTION EXISTS

Health care providers when faced with performing peer review must be concerned with maximizing what limited peer review protection exists. Clearly the first step is for the provider to understand the peer review privilege and confidentiality statutes as they exist in the provider's state. For peer review privilege, if a court orders discovery of peer review records, there is little a provider can do once the provider has challenged the court's order and lost. The planning to maximize the peer review privilege statutes, to the extent that they exist, must arise prior to the request for documents. Clearly, a health care provider should understand the statute in that state, and tailor the peer review activities in that state to the statute. For instance, if the statute only grants peer review privilege protection to proceedings of certain committees, the hospital should provide in its bylaws that peer review is only performed by those committees. All administrative and departmental review and other peer review activities should take place as part of the committee process and not as an independent process. Any peer review proceeding or meeting of a peer review committee should be kept strictly confidential. Any minutes or documents generated as a result of that meeting or proceeding should be clearly labeled as peer review materials and maintained in a secure place. Peer review functions should be clearly described in any statements of policies or procedures identifying committee duties so that no question can be raised that the entity performing the peer review activity was acting within its proper authority and therefore entitled to any available protections. Such policies and procedures should include a description of the types of information that can be disclosed without violating the statutory confidentiality requirements, such as the facts underlying the investigation or the fact that an investigation is taking place or has taken place and any resulting restrictions on privileges or the termination of privileges and staff appointment.

With respect to peer review performed by entities for which there is no statutory protection, these entities could attempt to "piggy back" onto the peer review performed by protected entities. For example, a provider-controlled preferred provider organization may wish to rely upon hospital peer review rather than performing independent peer review.

Similarly to protect the confidentiality of peer review proceedings, all health care providers should contractually provide that peer review participants will keep the information confidential. Hospital bylaws should provide that it is a requirement of sitting on the medical staff that physicians who participate in peer review keep all information confidential, and it would be advisable as part the appointment process to any peer review committee that each participant sign an agreement to keep the information confidential. This gives rise to a contractual claim for breach of contract should any participant breach the confidentiality and voluntarily testify or divulge peer review information. Such contractual provisions, however, would in all probability only be able to be enforced by the health care provider securing the agreement and not by other participants in the peer review process. Therefore, should a peer review participant violate the confidentiality of the process and reveal information
which is damaging to another participant in the proceeding, but not damaging to the health care facility itself, it is questionable whether or not that damaged participant would have a cause of action against the individual who breached the confidentiality, unless such argument was on some type of third party beneficiary claim. Health care facilities performing peer review may, therefore, want to consider contractually obligating all parties in a manner in which each party to the contract would have a cause of action against any other party.

Of course, seeking and entertaining statutory changes is also a free course to health care providers who determine that sufficient peer review protection does not exist in their state. In the meantime, current laws are subject to conflicting interpretation by courts on nearly identical facts. While a health care facility cannot be absolutely certain that its peer review activities will withstand a court's scrutiny, the best approach is to continue to fulfill its peer review obligations, as required by state and federal law, as well as accreditation organizations, and to treat all peer review activities and attendant records and information, including deliberations and work product, of any meetings and proceedings as highly confidential. Communicating both the importance of maintaining confidentiality to preserve the effectiveness of the process and the potential liabilities for both individual participants and sponsoring entities will encourage the observance of a high degree of confidentiality by those participating in the process. Adding bylaw provisions and requiring separate agreements of physicians to maintain the confidentiality of any peer review proceedings and materials will help ensure that health care entities, and those individuals performing peer review functions for them, will be in a position to argue for the greatest protections available under applicable law for peer review information.
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<td>ALABAMA</td>
<td>ALA. CODE §§ 6-5-333, 34-24-58 (1991)</td>
<td>*Individual doctors, dentists, and chiropractors serving as members of peer review committees formed at the request of a government agency, fiscal intermediary responsible for the administration of group health care programs, recipient of healthcare services, or licensed healthcare professionals; same protections given to healthcare professionals serving as members of or consultants to such committees formed by state/local professional associations. *Utilization review committees of hospitals or clinics or their medical staffs.</td>
<td>*Information, interviews, reports, statements, or memoranda furnished to the committee and any findings, conclusions, or recommendations resulting from the proceeding are PRIVILEGED; records and proceedings are CONFIDENTIAL, are not public records, and are not available for court subpoena or for discovery. Specifically does not apply to records made in the regular course of business of the hospital. *Individual members and participants immune from damages for actions by committee taken without malice.</td>
<td>*Records and proceedings of the committee are to be used only in the exercise of the proper functions of the committee.</td>
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<td>ALASKA</td>
<td>ALASKA STAT. §§ 18.23.010 to 18.23.070 (1988)</td>
<td>*Review organizations (hospital governing boards or committees of healthcare providers and administrative staff) gathering and reviewing information for the purposes identified in the statute. *Individual members, employees, and advisors.</td>
<td>*All information and data acquired shall be held in CONFIDENCE, may not be disclosed to anyone, not subject to subpoena or discovery. *Individuals described not liable for damages or other relief. *EXCEPTION: May be obtained by healthcare provider who claims privilege is unreasonable or by plaintiff in civil action claiming information was false; available to person subject of investigation and state medical board.</td>
<td>*Individual members, employees, advisors may not disclose what transpired at meetings unless within one of identified exceptions. *Penalty for disclosure of data and information of what transpired is misdemeanor.</td>
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<td>ARIZONA</td>
<td>ARIZ. REV. STAT.</td>
<td>*Committees (or other organizational structures of peer review committees)</td>
<td>*All proceedings, records and materials of peer reviews shall be CONFIDENTIAL and not</td>
<td>*Contents and records of peer review proceedings are fully</td>
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1 The focus of this summary is on healthcare facilities, such as hospitals, and their medical staffs which are performing peer review functions. Statutes may provide broader protections for other entities and types of activities; the specific statute should be consulted for a complete understanding of that state’s peer review protections.

2 This summary includes a description of the committees and individual members within the hospital setting that are afforded protection for peer review activities; individual statutes may protect other committees formed by other entities, which form peer review functions (such as these functions are described in the statute itself); examples include professional societies, state licensing boards, and third party payers.

3 The information in this column describes the privileges, immunities, and confidentiality protections specifically imposed by statute; it further describes what are protected—e.g., records and proceedings, individual committee members and participants in the review process.

4 As discussed in the text, state statutes vary greatly. Some do not even mention confidentiality of the records and proceedings of the peer review committee. Although courts may imply such a protection, the trend appears to be a strict construction of the peer review statute. The description in this column indicates whether confidentiality is mentioned and the content of any such references or whether confidentiality is not addressed.
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<td>Ann. §§ 36-445 to 36-445.02 (1993)</td>
<td>physicians admitted to practice at the hospital) that review professional practices within the hospital. Individuals making decisions or recommendations as members, agents, employees of medical/administrative staff of hospital or peer review committee.</td>
<td>subject to discovery. No committee member may testify in any judicial or quasi-judicial proceeding. Individuals described are not subject to liability for civil damages or legal action as a result of their committee activities. *EXCEPTION: Proceedings before state examiners or actions by individual healthcare professional against hospital based on peer review proceeding.</td>
<td>confidential and inadmissible as evidence in any court of law, unless exceptions apply.</td>
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<td>ARKANSAS</td>
<td>Ark. Code Ann. §§ 20-9-501 to 20-9-503 (Michie 1991)</td>
<td>*Peer review committees of state or local professional associations formed to evaluate and improve quality of healthcare provided.</td>
<td>*Proceedings and records not subject to discovery or admissible in any civil proceeding against healthcare provider arising out of the peer review. *Committee members may not testify in any civil action about peer review proceeding. *Committee members protected from monetary liability and from suit. *Statute does not confer immunity from liability for services performed other than as a member of a peer review committee, as defined by statute.</td>
<td>*Confidentiality not specifically addressed, although title of section includes word &quot;confidential.&quot;</td>
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<td>CALIF.</td>
<td>Cal. Bus. &amp; Prof. Code § 805; Cal. Evid. Code § 1157; Cal. Civil Code § 43.7 (West 1994 Supp.)</td>
<td>*Hospital peer review committees performing functions identified in statute and their members.</td>
<td>*Proceedings and records shall not be subject to discovery. *Persons in attendance shall not be required to testify (NOTE: West Covina case held individual could testify voluntarily). *IMMUNITY: No monetary liability or cause of action for damages against any member of the committee. *EXCEPTION: Statements made by person at meeting who is a party to an action arising out of the committee's review, or person requesting staff privileges, or action against insurance carrier alleging bad faith by carrier in refusing to accept settlement.</td>
<td>*No express provision for confidentiality of proceedings. *Form 805, which is required to be filed with the relevant agency whenever certain actions are taken with respect to privileges or appointment, and the information therein is required to be kept confidential. Whether this extends to all peer review proceedings themselves is not clear.</td>
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<td>COLORADO</td>
<td>Colo. Rev. Stat. Art. 36.5, §§ 12-36.5-101 to 12-36.5-</td>
<td>*Professional review committees established by hospital medical staff, if it operates pursuant to</td>
<td>*Records (any and all written or verbal communications, including complaint, response, correspondence, recordings, minutes, formal</td>
<td>**All proceedings, recommendations, records, and reports involving professional</td>
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<td>CONN.</td>
<td>CONN. GEN. STAT. §</td>
<td>*Medical review committees engaging in peer review for purposes listed in statute (includes credentialing).</td>
<td>*Proceedings not subject to discovery or introduction into evidence in civil action arising out of matters evaluated and considered by the committee.</td>
<td>*No express confidentiality language.</td>
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<td>19a-17b (1993 Supp.)</td>
<td>*Hospital boards are included.</td>
<td>*No member shall be permitted or required to testify.</td>
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<td>*Committee members are not subject to monetary liability or any cause of action for damages.</td>
<td>*EXCEPTION: Testimony as to facts; any independent writing; data discussed or developed may be used in proceedings, other than peer review, concerning termination or restriction of privileges; in civil action, can disclose fact that privileges were terminated or restricted, and such restrictions.</td>
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<td>DELAWARE</td>
<td>DEL. CODE ANN. III</td>
<td>*Any committee appointed by HMOs or hospitals to perform quality review.</td>
<td>*Committees shall not be subject to, and shall be immune from, claim, suit, liability, damages or any other recourse, civil or criminal.</td>
<td>*Records and proceedings are confidential.</td>
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<td>24, § 1768 (1992 Supp.)</td>
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<td>*Records and proceedings of committee shall be CONFIDENTIAL and shall be used only in the proper function of the committee; shall not be public records; shall not be subject to discovery.</td>
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<td>*No person shall be required to testify as to what transpired.</td>
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<td>DISTRICT OF</td>
<td>D.C. CODE ANN. §§</td>
<td>*Peer review bodies.</td>
<td>*Files, records, findings, opinions, recommendations, evaluations, and reports shall be CONFIDENTIAL, not be discoverable or</td>
<td>*Confidentiality protection separate from privilege.</td>
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<td>*Individual members and participants.</td>
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written bylaws and procedures approved by the governing board.  
*Members of committees immune from suit in any civil or criminal action.  
*Governing board of hospital establishing the committee shall be immune from suit for any damages in civil or criminal actions.  
*Quality management information is confidential and persons performing such review are granted a qualified immunity.

review committees shall be confidential.

*Voluntary release of non-patient identifying information is not prohibited.
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| FLORIDA | Fla. Stat. Ann. §§ 395.0191, 395.0193 (West 1992) | *Licensed facilities, governing boards and members, peer review panels, medical staff, or disciplinary body, or agents, investigators, witnesses, employees, or any other person involved, with respect to peer review activities or staff appointment and privilege delineation. | admissible in civil, criminal, legislative, or administrative proceeding.  
*Participants may not be compelled to testify or give discovery.  
*EXCEPTION: Court may order information in criminal proceeding if determined essential to protect public interest and not available from another source. Licensee may have minutes and reports introduced into civil action for limited purpose of determining appropriateness of adverse action by the peer review body. | *Any publications by peer review body shall keep patient identities confidential. |
| GEORGIA | Ga. Code Ann. §§ 31-7-140 to 31-7-143 (1991) | *Medical review committee of medical staffs or hospitals, provided medical staff operates pursuant to written bylaws approved by the governing board, formed to evaluate and improve quality of healthcare.  
*Members of medical review committees. | *Proceedings and records shall not be subject to discovery or introduction into evidence in any civil action against a healthcare provider arising out of matters considered by the committee.  
*No person attending shall be required or permitted to testify in civil actions.  
*Members immune from liability for damages and suit.  
*NOTE: Medical review committee does not appear to be immune from suit by patients. | *No confidentiality provision. |
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<td>HAWAII</td>
<td>HAW. REV. STAT. § 624-25.5 (1989); ch. 671D (1989); § 663-1.7 (1992 Supp.)</td>
<td>*Professional review bodies (including healthcare entities, governing body, committees of entity conducting professional review, and any medical staff committee assisting the board in professional review). *Members or staff of body; persons under contract to body; persons participating or assisting the body.</td>
<td>*No liability for damages under any state law to those described if standards specified are met. *Proceedings and records not subject to discovery (records = recordings, transcripts, minutes, summaries and reports of meetings and conclusions; do not include incident reports, occurrence reports, or similar factual statements or records maintained in the regular course of business by a hospital or other healthcare provider). *No person attending meetings shall be required to testify about what transpired at meeting.</td>
<td>*No mention of confidentiality.</td>
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<td>IDAHO</td>
<td>IDAHO CODE §§ 39-1392a to 39-1392b (1993)</td>
<td>*In-house medical staff committees designated by hospital staff bylaws, by action of an organized hospital staff, or by action of the governing board authorized to research or study medical questions or problems.</td>
<td>*All written records of interviews, all reports, statements, minutes, memoranda, charts, and the contents thereof, and all physical materials for purposes identified in statute shall be CONFIDENTIAL and PRIVILEGED, shall not be directly or indirectly subject to subpoena or discovery or be admitted in evidence. *No testimony relating to the foregoing shall be admitted in evidence or in any action of any kind in any court or before any administrative body or agency. *WAIVER: If licensee under investigation sues hospital, confidentiality and privilege are deemed waived and hospital may use information in support of its action.</td>
<td>*Persons becoming aware of such records are prohibited by statute from disclosure unless authorized by law, except hospital governing board or administrative staff may request and receive disclosure, subject to obligation to retain confidential privileged character of information, for the limited purpose of determining hospital privileges. *EXCEPTION: Factual information about inquiry in a civil action; names and addresses of persons (patients) who have direct knowledge of the questioned healthcare. *Disclosures may be voluntary if affected licensee consents and if any privileged or confidential information concerning any other patient, physician or other person will not be disclosed.</td>
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<td>ILLINOIS</td>
<td>ILL. REV. STAT. ch. 210, § 85/10.2 (1993)</td>
<td>*Medical review, medical utilization, patient care audit, medical care evaluation, quality review, credential, peer review, or any other committee of hospital and its members, agents, and employees.</td>
<td>*No hospital and no committee member shall be liable for civil damages. &lt;br&gt; *No privilege provision. &lt;br&gt; *Statute is limited to immunity provision.</td>
<td>*Confidentiality not addressed. &lt;br&gt; *NOTE: Under Long-Term Care Peer Review and Quality Assurance Protection Act, proceedings and communications of peer review committee are privileged/confidential and not to be revealed except pursuant to specific written procedures of the sponsoring organization. Ch 745, ¶ 55/3 and 55/4</td>
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<td>INDIANA</td>
<td>IND. CODE ANN. §§ 34-4-12.6-1 to 34-4-12.6-4 (West 1983); 16-21-2-6 to 16-21-2-8 (West 1993 Supp.)</td>
<td>*Peer review committees having responsibility for evaluation of qualifications of healthcare providers, quality of patient care, or merits of a complaint meeting statutory criteria. &lt;br&gt; *Personnel of such committees.</td>
<td>*All proceedings shall be CONFIDENTIAL. &lt;br&gt; *All communications to the committee shall be PRIVILEGED. &lt;br&gt; *Persons in attendance shall not be permitted or required to disclose what transpired. &lt;br&gt; *EXCEPTION: Licensee under investigation shall be permitted to see records accumulated by committee. &lt;br&gt; *Unless required to be disclosed to licensee, no records or determinations of the committee shall be subject to subpoena or discovery or admissible in evidence. &lt;br&gt; *WAIVER: All witnesses shall invoke the privilege unless waived in writing executed by chair, vice chair, or secretary of committee. &lt;br&gt; *IMMUNITY: Committee members/staff shall be immune from civil action. Also incorporates HCQIA. Governing body immune from civil liability. Members of medical staff committee conducting retrospective medical review have absolute immunity from civil liability.</td>
<td>*Committee personnel may not reveal any content of communications to, the records of, or the determination of a peer review committee outside the committee. &lt;br&gt; *Information may be used for internal business purposes, including legal defense and quality review and assessment. &lt;br&gt; *Governing board may disclose final action taken.</td>
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| IOWA   | IOWA CODE ANN. § 147.135 (West 1989) | *Peer review committees investigating licensee discipline or professional competence. | *Peer review records are PRIVILEGED and CONFIDENTIAL, not subject to discovery or admissible in judicial or administrative proceedings.  
*EXCEPTION: Proceedings involving licensee discipline or proceeding brought by licensee who is subject of peer review proceeding and whose competency is questioned. Also certain information must be provided to state licensing board.  
*Individuals present cannot testify, except for proceedings under "exception." | *If privileged and confidential information becomes discoverable, admissible, or part of a court record, the identity of an individual whose privilege has been involuntarily waived shall be withheld.  
*Identification of witnesses and documents known to a committee may be discovered. |
| KANSAS | KAN. STAT. ANN. § 65-4915 (1992) | *Peer review committees of health care provider groups performing functions identified in statute. | *Reports, statements, memoranda, proceedings, findings, and other records of the committee shall be PRIVILEGED, not be subject to discovery, subpoena or other means of legal process or be admissible in evidence in any judicial or administrative proceeding.  
*Persons present may not testify as to committee proceedings.  
*Privilege may be claimed by legal entity creating the committee.  
*EXCEPTION: Privilege does not apply in actions in which licensee contests committee action.  
*State licensing board may request information; but if furnished, that information is not subject to further discovery, subpoena or other means of legal compulsion or be admissible into evidence in any proceeding other than by the licensing board.  
*Information may be related to the governing board, administrators, or other peer review committees without waiver of the privilege. | *No confidentiality provision. |
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| KENTUCKY    | KY. REV. STAT.  
Ann. § 311.377  
(Baldwin 1991) | *Review committees or entities of medical staffs, hospitals, hospices, home health providers, HMOs, health insurers, etc., performing professional review functions, including review of credentials or retrospective review and evaluation of competency of licensees. | *Proceedings, records, opinions, conclusions, and recommendations are CONFIDENTIAL and PRIVILEGED, not subject to discovery in any administrative or civil action.  
*No person present shall be permitted or compelled to testify as to peer review proceedings. | *Confidential nature of proceedings and other committee information expressly stated. |
| LOUISIANA   | LA. REV. STAT.  
Ann. § 3715.3 (West 1993 Supp.) | *Any hospital committee, including medical staff executive, risk management, credentials, peer review and quality assurance committees, established by bylaws or rules/regulations of the organization, and peer review committees of group medical practices of 20 or more physicians, extended care facilities, free-standing surgical centers, and HMOs. | *Peer review committee records shall be CONFIDENTIAL, shall not be available for discovery or court subpoena.  
*EXCEPTION: AFFECTED LICENSEE MAY OBTAIN RECORDS FORMING BASIS OF DECISION IN PROCEEDINGS AFFECTING HIS/HER HOSPITAL STAFF PRIVILEGES. | *Records are confidential and are to be used by committee and its members only in the exercise of its proper functions. |
| MAINE       | ME. REV. STAT.  
Ann. tit. 32, § 2599, tit. 22 §§ 3293, 3296 (West 1993 Supp.) | *Medical staff review committees of hospitals when such reviews are required by law or are conditions of accreditation.  
*Physician members of such committees. | *Proceedings and records of proceedings are CONFIDENTIAL and exempt from discovery without showing of good cause.  
*Physician committee members are immune from civil liability. | *Blanket confidentiality imposed, but not defined. |
| MARYLAND    | MD. CODE ANN., HEALTH OCC. §§ 14-501 to 14-504 (1991) | *Medical review committee of various entities listed in the statute, including a committee of the medical staff or other committee of a hospital, related institution or alternative health care system, if the governing board forms and approves the committee or approves bylaws under which it operates and performs functions identified in the statute.  
*Committee members or participants in the review process. | *Proceedings, records, and files of medical review committee are not discoverable or admissible in evidence in any civil action arising out of matters reviewed and evaluated by the committee.  
*Members are immune from liability. | *No express provision of confidentiality, although subsection is titled "Proceedings, records, and files confidential and not discoverable or discoverable."
*Certain files may be requested by state agencies; if produced, these remain confidential and are not discoverable.  
*Any record or other information obtained by a hospital staff committee is confidential if it identifies any person and relates to a review proceeding. |
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<td>MASS.</td>
<td>MASS. ANN. LAWS ch. 111, §§ 203 to 205 (Law. Co-op. 1993 Supp.)</td>
<td>*Peer review committees of hospitals and nursing homes.</td>
<td>*Proceedings, reports, and records of peer review committees shall be CONFIDENTIAL and shall not be subject to subpoena, discovery, or admissible in any judicial or administrative proceeding (except for state disciplinary or licensing boards). *No individual present shall be permitted or required to testify. *EXCEPTION: For cause of action against committee member pursuant to ch. 231, § 85(a). If produced in this action, the information is not subject to subpoena or discovery in any other judicial or administrative proceeding.</td>
<td>*Statute provides that such information &quot;shall be confidential,&quot; but does not further limit or describe communication by committee members outside the peer review proceeding.</td>
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<td>MICHIGAN</td>
<td>MICH. COMP. LAWS §§ 333.21515, 333.21513(d) (1993)</td>
<td>*Individuals or committees performing review functions of hospital medical staff with respect to quality of care issues.</td>
<td>*Records, data, and knowledge collected for or by the medical review committee are CONFIDENTIAL, not available for court subpoena, and not public records.</td>
<td>*Information is confidential and its use limited to the purposes of the committee.</td>
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<td>MINNESOTA</td>
<td>MINN. STAT. § 145.61 to 145.67 (1989)</td>
<td>*Review organizations (membership of such committees limited to professional and administrative staff and consumer directors) of hospitals, clinics, HMOs or non-profit health service plans formed to perform review functions identified in statute. *Governing board.</td>
<td>*All data and information acquired by the review organization shall be held in CONFIDENCE, shall not be disclosed to anyone unless necessary to carry out its purposes, and not subject to subpoena or discovery. *No person attending may testify as to what transpired at meeting. *Proceedings and records not subject to discovery or introduction into evidence in any civil action arising out of matters considered by committee. *Review organizations, members, and others involved are not liable in damages or other relief in any action brought by person reviewed.</td>
<td>*Express provision that data and information are confidential and not to be disclosed except as necessary to carry out purposes of the committee. *PENALTY: Violation of the statute is a misdemeanor.</td>
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<td>MISSISSIPPI</td>
<td>MISS. CODE ANN. Ch. 63, §§ 41-63-1 to 41-63-9 (1993)</td>
<td>*Committees composed of staff of hospitals, nursing homes, or other healthcare facilities, if staff operates pursuant to bylaws approved by governing board.</td>
<td>*Proceedings and records not discoverable and may not be introduced into evidence in civil action. *No person present may be required or permitted to testify. *EXCEPTION: Legal action by committee to restrict or revoke privileges or license or action against committee alleging malicious action by licensee investigated.</td>
<td>*No confidentiality provision for proceedings. *Identity of patient studied shall be confidential and not revealed under any circumstances.</td>
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<td>MISSOURI</td>
<td>MO. REV. STAT. § 537.035 (1988)</td>
<td>*Peer review committees of health care professionals (physicians or surgeons, dentists, podiatrists, optometrists, pharmacists, chiropractors, and psychologists) responsible for evaluating, maintaining and monitoring quality and utilization of healthcare services by hospital board, CEO, or medical staff; or other health facility operator; or professional corporation of healthcare professionals. *Members of such committees or participants in the committee proceedings.</td>
<td>*Proceedings, findings, deliberations, reports and minutes of committee concerning healthcare provided are PRIVILEGED and not subject to discovery, subpoena, or admission into evidence in judicial or administrative proceeding. *No person present may be required or permitted to disclose any information acquired within the committee setting. *EXCEPTION: (1) Judicial or administrative proceeding brought by committee or entity forming committee to deny, restrict, revoke privileges or license; (2) member of committee is sued for action taken; (3) otherwise confidential information available to state healthcare licensing board by subpoena or otherwise authorized process for board matters.</td>
<td>*No provision for confidentiality.</td>
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<td>MONTANA</td>
<td>MONT. CODE ANN. §§ 37-2-201, 50-16-201 to 50-16-205 (1993)</td>
<td>*Certain committees of hospitals, long-term care facilities, and societies composed of persons licensed to practice a healthcare profession and their members. *Any member, agent, or employee of a nonprofit corporation engaged in performing functions of peer review, medical ethics review, or professional standards review. *In-house medical staff committees evaluating care and treatment of patients.</td>
<td>*Proceedings and records of committee are not subject to discovery or introduction into evidence in any proceeding. *No member shall be liable in damages to any person for any action taken or recommended within scope of committee's functions.</td>
<td>*Peer review information is not given any specific confidentiality protections. *In-house hospital committees: (1) committee information, data and records are CONFIDENTIAL and PRIVILEGED; (2) name of patients whose records have been studied shall not be disclosed in any report; (3) data is confidential and not admissible in any judicial proceeding.</td>
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| NEBRASKA   | Neb. Rev. Stat. §§ 71-2046 to 71-2048 (1990) | *Medical staff and utilization review committees of licensed hospitals formed to review medical and hospital care provided.                                                                                      | *Proceedings, minutes, records, and reports, and all communications originating in such committees, are PRIVILEGED communications and not to be disclosed or obtained by legal discovery proceedings.  
*EXCEPTION: (1) patient waives privilege; (2) court, after hearing and for good cause shown arising from extraordinary circumstances, orders disclosure. | *Confidentiality not expressly addressed.  
*Records kept in the ordinary course of business are not privileged.  
*Facts or information contained in such records are not privileged.                                                                 |
*Persons attending meetings may not be required to testify concerning the meeting.                                              | *No mention of confidentiality.                                                                                                                                           |
*Hospital, trustees, medical staff, employees, and other committee attendees.                                                 | *Records (records of interviews, all reports, statements, minutes, memoranda, charts, statistics, and other documentation generated during activities of QA committee; but not original medical record or business records kept by hospital) shall be CONFIDENTIAL and PRIVILEGED and protected from discovery, subpoena, or admission into evidence in any judicial or administrative proceeding.  
*EXCEPTION: Legal action brought by QA committee to restrict or revoke privileges or license or proceeding alleging repetitive malicious action and personal injury brought against physician. | *Records are expressly made confidential.  
*WAIVER: Governing board may waive its privilege and release information or present committee records by discovery, subpoena, or admission into evidence in any judicial or administrative proceeding. |
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<td>NEW JERSEY</td>
<td>N.J. REV. STAT. §§ 2A:84A-22.8, 2A:84A-22.10 (1993 Supp.); § 2A:84A-22.9 (1976)</td>
<td>*Utilization review committees of certified hospitals and extended care facilities. *Hospital peer review committees. *Individual members of committees.</td>
<td>*Information and data secured by and in possession of utilization review committee shall not be revealed or disclosed in any manner except to: attending physician, facility CEO, medical executive committee, government agencies, insurance company of patient (if contract provides for disclosure). *Members of utilization review committees not liable for damages or otherwise prejudiced in any manner. *Members of peer review committee or those who assist or participate in process shall not be liable in damages for action taken.</td>
<td>*Judiciary committee states that confidentiality of the information will be guaranteed by contract between insurance carrier and patient. *Bundy v. Sinopoli, 580 A.2d 1101 (1990) held immunity to peer review committee members did not provide privilege against discovery for information contained in the peer review proceeding.</td>
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<td>NEW MEXICO</td>
<td>N.M. STAT. ANN. §§ 41-9-1 to 41-9-7 (Michie 1989)</td>
<td>*Review organizations composed of healthcare providers and staff established by hospital, nonprofit healthcare plan, HMO, emergency medical services system, or professional standards review organization to gather and review patient care information. *Members of the committee, employees, those furnishing counsel or services to committee.</td>
<td>*All data and information acquired by the review organization shall be held in CONFIDENTENCE and shall not be disclosed. *EXCEPTION: As necessary to carry out functions; in judicial appeal of committee action. *No member or other person involved in committee shall disclose what transpired at meeting. *Members and others providing services shall not be liable for damages or other relief in any action brought pursuant to the review action. *Does not create evidentiary privilege. *Southwest Community Health Serv. v. Smith, 755 F.2d 40 (N.M. 1980).</td>
<td>*Statute provides for confidentiality of data and information acquired by committee in the exercise of its duties. *Penalty for unauthorized disclosure: possible petty misdemeanor, up to 6 months in jail and/or up to $100 fine.</td>
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<td>NORTH CAROLINA</td>
<td>N.C. GEN. STAT. § 131E-95 (1982)</td>
<td>*Medical review committees of hospitals and health care facilities. *Members of such committees.</td>
<td>*Proceedings, records and materials produced, and materials considered shall be CONFIDENTIAL, not considered public records, and not subject to discovery or introduction into evidence in any civil action arising out of matters considered by committee. *No person attending shall be required to testify in any civil action. *Members not subject to liability for damages in any civil action arising out of committee actions.</td>
<td>*Confidentiality of information will be narrowly interpreted as provided in the statute. *To be protected and considered confidential, information must arise in the function of a peer review committee.</td>
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<td>NORTH DAKOTA</td>
<td>N.D. CENT. CODE § 23-01-02.1 (1991)</td>
<td>*Mandatory hospital or extended care facility committees required by state or federal law or by JCAHO or internal QA committees. *Members of such committees.</td>
<td>*Any information, data, reports, or records made available to the described committees are CONFIDENTIAL and may be used only to fulfill proper committee functions. *Proceedings and records are not subject to discovery, subpoena or introduction into evidence in any civil action arising out of committee action. *Witness in civil action may not be asked about testimony before committee. *Committee members not liable in damages for actions taken or recommendations made if without malice.</td>
<td>*Information received, considered and generated by committee is confidential. *No provision for confidentiality of proceedings themselves, although this may be imposed through medical staff bylaws or contractual agreements with the individual members or other persons assisting the committee to perform its functions.</td>
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<td>OHIO</td>
<td>OHIO REV. CODE Ann. §§ 2305.24 to 2305.251 (Anderson 1991)</td>
<td>*Utilization review, tissue, and quality assurance committees and committees making credentials decisions of hospitals and not-for-profit corporations, which are members of hospitals, or community mental health centers (<em>Parent</em> corporations of system hospitals), among others described in the statute. *Members of these committees.</td>
<td>*Information, data, reports or records made available to committees shall be CONFIDENTIAL and used only by the committee to carry out its proper functions. *Proceedings and records of all review committees described shall be held in CONFIDENCE and shall not be discoverable or admissible into evidence in any civil action against a healthcare professional or entity arising out of the matters which were the subject of the committee action. *No person present shall be permitted or required to testify in any civil action.</td>
<td>*Identified information and records is to be held confidential. *Cause of action for breach of confidentiality similar to the civil action that may be brought against a physician for breach of a professional confidence may be brought for breach. *But see Browning v. Burt, 66 Ohio St. 3d 544 (1993)—court found that hospital was not immune under court’s analysis that no information had been provided to hospital as part of a review committee function; thus 2305.25 immunity did not apply to hospital.</td>
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<tr>
<td>OKLAHOMA</td>
<td>None</td>
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<td>*Right of civil action provided against committee member for misuse of information provided to utilization or quality assurance committee</td>
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| OREGON   | Or. Rev. Stat. § 41.675 (1989) | *Persons serving on various committees of hospitals and other licensed health care facilities, governing bodies, medical staff committees or tissue committees concerned with training, supervision or discipline of physicians and credentialing. | *Data (written reports, notes, or records) shall be PRIVILEGED and not admissible in evidence in any judicial proceeding.  
*Persons serving on committees or providing information shall not be examined as to any communication to that committee or its findings.  
*Such persons shall not be subject to action for civil damages for actions or recommendations made in good faith.  
*EXCEPTION: Judicial proceedings in which licensee contests action affecting privileges; however, any information disclosed shall not be admissible in any other judicial proceeding. | *No provision of confidentiality of committee information.                                                                                                                                                                                                                                                                                    |
*Hospital governing boards, committees, and individuals responsible for credentialing. | *Proceedings and records of review committee shall be held in CONFIDENCE and shall not be subject to discovery or introduction into evidence in any civil action arising out of matters considered by committee.  
*No person attending meetings shall be permitted or required to testify in such civil action.  
*No member or employee of a review organization or other who furnished professional counsel or services to it, shall be found to have violated any criminal law or to be civilly liable under any law. | *Statute does not grant absolute privilege; privilege is limited to civil actions.                                                                                                                                                                                                                                                                          |
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<td>RHODE ISLAND</td>
<td>R.I. GEN. LAWS §§ 5-37.3-7 to 5-37.3-11 (1987) &amp; § 23-17-25 (1989)</td>
<td>*Peer review committees.</td>
<td>*Proceedings and records shall not be subject to discovery or introduction into evidence. *Confidential healthcare information shall remain strictly CONFIDENTIAL. *No person in attendance shall be required or permitted to testify about committee matters. *EXCEPTION: (1) legal action brought by peer review committee or to restrict or revoke physician's privileges or license; (2) cases in which member or entity which formed committee is sued for committee's actions; provided that in either case personally identifiable confidential healthcare information shall not be used without written authorization of the person or court order. *Bound of medical licensure and discipline may require disclosure; however, personally identifiable confidential healthcare information may not be used unless consent is obtained or upon court order. *No member or the legal entity that formed the committee shall be criminally or civilly liable for committee activity.</td>
<td>*Confidentiality provisions are specific to confidential healthcare information (information relating to patient's healthcare history, diagnosis, condition, treatment or evaluation obtained by healthcare provider who treated patient). *PENALTIES: Civil and criminal penalties provided—Civil: actual and exemplary damages: Criminal: fine not more than $1000 and/or imprisoned for up to 6 months.</td>
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<td>SOUTH CAROLINA</td>
<td>S.C. CODE ANN. §§ 40-71-10, 40-71-20 (Law. Co-op. 1993 Supp.)</td>
<td>*Committee of a medical staff of a licensed hospital, provided medical staff operates pursuant to written bylaws approved by governing board. *Members of such committee.</td>
<td>*All proceedings and all data and information acquired while exercising its duties are CONFIDENTIAL, unless respondent in proceeding makes written request that they be made public. *Proceedings and documents are not subject to discovery, subpoena, or introduction into evidence in any civil action, except upon appeal from committee action.</td>
<td>*Confidentiality of information may be waived at request of respondent. *CASE LAW: McGee v. Bruce Hospital System (S.C. Sup. Ct. No. 23958, Dec. 13, 1993)—release of outcomes of committee decisions to medical malpractice claimant allowable, but physician credentialing files and documents underlying committee's decision on staff privileges not discoverable under state confidentiality statute.</td>
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SOUTH DAKOTA
S.D. CODIFIED LAWS ANN. §§ 36-4-25, 36-4-26.1, 36-4-26.2 (1992)
*Members of medical staff committee of licensed hospitals and consultants to the medical staff or to the governing board of such hospital; provided the medical staff operates pursuant to written bylaws approved by the governing board.

*Proceedings, records, reports, statements, minutes, or any other data whatsoever of the committees described, or any administrative or medical committee, department, section, board of directors or audit group of a licensed hospital relating to the quality, type or necessity of care rendered by a medical staff appointee or committee engaged in credentialing shall not be subject to discovery or disclosure and shall not be admissible in any court action or arbitration forum.

*EXCEPTION: Physician whose privileges were affected by committee action may have access to and use information upon which decision was made; persons and their counsel defending actions may discover these materials; also limitations on use of patient records and committee information in actions dealing with care and treatment of a patient to impeach testimony of certain witnesses called to testify about quality, type, or necessity of care rendered.

TENNESSEE
TENN. CODE ANN. § 63-6-219 (1993 Supp.)
*Peer review committees of licensed healthcare institutions or their medical staffs, medical care foundations or HMOs, PPOs, IPAs or similar entities, including utilization review committees.

*Members of such committees, as well as physicians, surgeons, registered nurses, hospital administrators and employees, members of governing boards, persons acting under contract with committees.

*All information, interviews, incident or other reports, statements, memoranda or other data and any findings, conclusions or recommendations resulting from committee proceedings are PRIVILEGED.

*Records and proceedings are CONFIDÉNTIAL and to be used by members only in the exercise of proper committee functions; shall not be public records, nor available for court subpoenas or for discovery proceedings.

*Individuals identified are immune from liability to any patient, individual or organization for furnishing information, etc. or for damages for any committee action taken in good faith.

*Specific confidentiality provisions, but no confidentiality requirements imposed upon committee members.

*Disclosure of confidential, privileged information to board of medical examiners or to physician under review not a waiver of confidentiality or privilege.

*One proper function of committee is advocacy, and disclosure is authorized during advocacy efforts to other peer review committees, or organizations, health care entities, accreditation bodies, and state medical examiners.

*Records made during regular course of business not included.
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<td>TEXAS</td>
<td>TEX. REV. CIV. STAT. ANN. art. 4455b, § 5.06 (West Supp. 1994)</td>
<td>*Medical peer review committees of health care entities. *Members or participants of peer review committees.</td>
<td>*All proceedings and records are CONFIDENTIAL; all communications to the committee are PRIVILEGED. *Disclosure permitted to: (1) other peer review committees, state and federal agencies, national accreditation bodies, or state boards of licensure; (2) the affected practitioner. *Unless disclosure is authorized or ordered, records or determinations of or communications to the committee are not subject to subpoena or discovery and not admissible in evidence in any civil judicial or administrative case without written waiver of the confidentiality privilege by the committee. *Members and other participants are immune any civil liability arising from committee’s act, may not be found liable in any civil action for failure to report to the board (unless such failure was knowing and willful), and no cause of action shall accrue against them for any committee action.</td>
<td>*Members of committees are required to cooperate with law enforcement in criminal investigations; such action does not waive the privilege or confidentiality of the Act. *If committee or one of its members or the health care entity is named as defendant in civil action arising out of committee activity, confidential information may be used in defense; however, plaintiff then may also disclose peer review information in rebuttal. *Penalties provided for unlawful disclosure of confidential information by the board—guilty of Class A misdemeanor.</td>
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<td>UTAH</td>
<td>UTAH CODE ANN. § 58-12-43(7) (1993 Supp.)</td>
<td>*Hospital board, committee, department, or medical staff or professional organization of health care providers undertaking review of healthcare practitioners. *Individuals who are members of hospital administration, board, committees, department, medical staff, or professional organization of healthcare providers.</td>
<td>*All information, interviews, statements, documents, testimony prepared in anticipation of, preparation for, or as a part of the review and results of the review, are CONFIDENTIAL and not subject to discovery, use or receipt in evidence in any legal proceeding of any kind or character. *Individuals described are immune from liability arising from participation in review.</td>
<td>*Statute provides that data and information required to be provided to the board shall remain CONFIDENTIAL to the board until formal action is initiated. *Statute requires report by hospital board to board of formal disciplinary action relating to medical competence, professional ethics, moral turpitude, or drug/alcohol abuse.</td>
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<td>VERMONT</td>
<td>VT. STAT. ANN. §§ 1441, 1443 (1993 Supp.)</td>
<td>*Peer review committee or other comparable committee established by HMO, hospital or other healthcare provider formed to evaluate and improve quality of healthcare rendered.</td>
<td>*Proceedings, reports, and records shall be CONFIDENTIAL and PRIVILEGED, not subject to discovery or introduction into evidence in any civil action arising out of matters considered by committee. *No person in attendance at committee meeting shall be permitted or required to testify as to proceedings. *EXCEPTION: Board must be provided with all supporting information and evidence pertaining to information that must be provided under § 128 of Title 3.</td>
<td>*Any information provided to the board may be used in its disciplinary proceedings, but may not be disclosed to the public.</td>
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<td>VIRGINIA</td>
<td>VA. CODE ANN. §§ 8.01-581.16, 8.01-581.17 (Michie 1992)</td>
<td>*Committees, boards, groups, commissions, or other entities reviewing adequacy or quality of professional services or competency and qualifications for professional staff privileges, if entity established pursuant to federal or state law, pursuant to JCAHO, or by licensed hospital and made in good faith. *Members or professional healthcare consultants to such committees or entities.</td>
<td>*Proceedings, minutes, records, and reports of any committee described, and all oral and written communications originating in or provided to the committee, shall be PRIVILEGED communications, not subject to disclosure or discoverable unless circuit court orders disclosure after hearing and for good cause based on extraordinary circumstances. *Individuals immune from civil liability for acts, etc. done in performance of committee duties.</td>
<td>*No confidentiality provisions.</td>
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<td>WASH.</td>
<td>WASH. REV. CODE ANN. §§ 4.24.240, 4.24.250 (West 1988)</td>
<td>*Healthcare providers, as defined in statute, presenting evidence to regularly constituted review committee of hospital whose duty it is to evaluate competency and qualifications of licensees or the quality of care provided.</td>
<td>*Proceedings, reports and written records of committee or members of the committee shall not be subject to subpoena or discovery in any civil action, except in actions arising out of the recommendations of the committee involving restriction or revocation of healthcare providers' privileges. *Members or others involved with the committee shall not be liable in a civil action and shall be immune from civil action for damages.</td>
<td>No confidentiality provisions.</td>
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<td>WEST VIRGINIA</td>
<td>W. VA. Code §§ 30-3C-1 to 30-3C-3 (1993)</td>
<td>*Review organizations composed of healthcare professionals engaged in peer review.</td>
<td>*Proceedings, and records shall be CONFIDENTIAL and PRIVILEGED, not subject to subpoena or discovery proceedings or be admitted as evidence in any civil action arising out of committee action.</td>
<td>*Courts are charged with entering appropriate protective orders to provide for confidentiality of records provided to court by review organization.</td>
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<td>WISCONSIN</td>
<td>Wis. Stat. Ann. §§ 146.37, 146.38 (West 1989)</td>
<td>*Persons acting in good faith who participate in review or evaluation of services of healthcare providers or facilities.</td>
<td>*Records of organizations and evaluators are CONFIDENTIAL and may be disclosed only as follows (in which identity of patient whose treatment is reviewed is withheld unless patient has granted permission): (1) to healthcare provider or facility being reviewed; (2) to any person with consent of the healthcare provider or facility; (3) to person requesting review/evaluation; (4) in statistical report; (5) with regard to criminal matter to court of record after issuance of subpoena; (6) to appropriate licensing/examining board.</td>
<td>*No express confidentiality provisions although disclosure is only authorized as defined in statute.</td>
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<td>*No such record may be used in any civil action for personal injuries against the healthcare provider or facility.</td>
<td>*Penalty: Disclosure of information prohibited by statute imposes civil liability to person harmed by disclosure or release.</td>
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<td>*Individuals participating in review/evaluation are prohibited from disclosing information except as provided above.</td>
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<td>*No individual acting in good faith shall be liable for civil damages as result of review or evaluation.</td>
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| WYOMING | Wyo. Stat. §§ 35-2-601 to 35-2-609 (1991) | *Hospital medical staff committees consisting of medical staff members or hospital personnel, engaged in supervision, discipline, admission, privileges, or control of members of the hospital's medical staff, evaluation and review of medical care, utilization of hospital facilities or professional training.  
*Members of committees described, hospitals, medical staff members, employees of hospitals or medical staff members. | *Reports, findings, proceedings, and data (reports, notes, findings, opinions or records of any hospital medical staff committee, including its consultants, advisers, and assistants) shall be CONFIDENTIAL and PRIVILEGED.  
*Individuals described shall be immune from liability—no claim or action shall accrue against them unless their action was arbitrary, capricious and without foundation in fact. | *Specific provisions are made for disclosure of patient healthcare information with patient's consent; appropriate circumstances include peer review. |