COMMONWEALTH OF MASSACHUSETTS

SUPREME JUDICIAL COURT
FOR THE COMMONWEALTH
No. 7473

NEW ENGLAND DEACONESS HOSPITAL
PLAINTIFF-APPELLANT,

v.

SUPERIOR COURT DEPARTMENT OF THE TRIAL
COURT OF MASSACHUSETTS AS A NOMINAL
PARTY, JOHN F. CARR AND MARJORIE A. HOWARD,
ADMINISTRATRIX OF THE ESTATE OF STANLEY W. HOWARD,
DEFENDANT-APPELLEE

RESERVATION AND REPORT OF THE SINGLE JUSTICE
OF THE SUPREME JUDICIAL COURT

BRIEF *AMICUS CURIAE* OF THE AMERICAN HOSPITAL ASSOCIATION IN SUPPORT OF THE PLAINTIFF-APPELLANT

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COMMONWEALTH OF MASSACHUSETTS

Suffolk, SS. SUPREME JUDICIAL COURT
SJC No. 7473

NEW ENGLAND DEACONESS HOSPITAL, Plaintiff-Appellant,	
v.	RESERVATION AND REPORT OF THE SINGLE JUSTICE OF THE SUPREME JUDICIAL COURT
SUPERIOR COURT DEPARTMENT OF THE TRIAL COURT OF MASSACHUSETTS, AS A NOMINAL PARTY, JOHN F. CARR AND MARJORIE A. HOWARD, ADMINISTRATRIX OF THE ESTATE OF STANLEY W. HOWARD, Defendant-Appellee.	

BRIEF *AMICUS CURIAE* OF THE
AMERICAN HOSPITAL ASSOCIATION
IN SUPPORT OF PLAINTIFF-APPELLANT

I. STATEMENT OF INTEREST OF THE *AMICUS CURIAE*

The American Hospital Association ("AHA") is the primary organization of hospitals in the

United States. The AHA's mission is to promote high quality health care and health services through leadership and assistance to hospitals in meeting the health care needs of their communities. Its membership includes approximately 5,000 hospitals, health systems, and other providers of care. In addition, over 40,000 health care professionals hold individual memberships in the AHA. Through participation here, AHA seeks to further the "overriding national need" for effective physician peer review expressed by the Congress in the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101 *et seq.* ("HCQIA").

Peer review is a vital means by which hospitals can protect patients from physicians who are incompetent or who engage in unprofessional behavior. It is also a vital means by which

hospitals can make critical self assessments so necessary to avoiding future harm. Effective peer review is difficult, however. It depends upon candid assessments by those involved that are often contrary to self interest, a willingness to speak up on the part of those with relevant information that is also very often against self interest, and a willingness to participate as a volunteer in the case of peer review committee members in a very time-consuming process. One of the reasons candor is against self interest is that it carries with it the threat of retaliatory litigation or action. Candor may result in retaliatory litigation by a disgruntled physician whose privileges have been restricted. Or, in the case of a nurse speaking out against a physician, it may pose a threat of losing a job. The powerful disincentives that exist must be overcome

by powerful protections, or there will be little to stand in the way of future harm. A medical malpractice action or an action based upon a claim of negligence can address past harm. But of even greater importance to the public generally is the need to encourage strong action that will prevent harm before it occurs. That is the critical business of peer review.

Because peer review is so essential to the prevention of future harm and therefore so essential to the welfare of all patients, and because strong protections are needed to encourage peer review, as a matter of public policy HCQIA provides immunity from liability under almost all state and federal laws, even the antitrust laws, for actions taken in accordance with its standards. 42 U.S.C. § 11111. Congress in passing HCQIA clearly recognized the greater good

achieved by effective peer review even at the expense of otherwise justifiable individual causes of action.

Similarly, every state in the Union has adopted laws providing some level of immunity for peer review participants and confidentiality for the process and the records. *See* American Medical Association, A Compendium of State Peer Review Immunity Laws (1988 & Supp. 1994). There are variations among these laws, but the fact that all states have them speaks to the importance of the public policy behind them as established by each state's legislature.

AHA's hospital and health care provider members share a keen interest in seeing that judicial construction of the laws protecting and encouraging peer review does not weaken these laws by interpretations that give the laws less than

their full measure of intended impact. This is a risk from trial judges used to the balancing of interests called for in the discovery process and who may fail to take into account the overarching importance to the public as a whole of protecting the peer review process as intended by Congress and all state legislatures. Judicial construction of statutes protecting peer review that undermines that protection is therefore a matter of grave concern to the AHA and its members.

II. STATEMENT OF THE ISSUES PRESENTED

The American Hospital Association adopts the Statement of the Issues Presented of New England Deaconess Hospital, now known as Beth Israel Deaconess Hospital ("Deaconess"), Plaintiff-Appellant in this case.

III. STATEMENT OF THE CASE

The American Hospital Association adopts the Statement of the Case of the Plaintiff-Appellant Deaconess.

IV. ARGUMENT

A. PEER REVIEW EXPOSES WITNESSES AND PARTICIPANTS TO SIGNIFICANT RISKS AND REQUIRES THE FULLEST PROTECTION PERMITTED BY LAW.

Physicians whose performance is subject to peer review have much at stake and the threat of litigation by such individuals against those who speak up and those who must decide whether or not to take decisive action against them is ever present in the process.[1]

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[1] The facts in this case are not illustrative of the most extreme risks involved in peer review, but the principle established by a decision in this case will potentially affect all types of peer review cases and must (continued . . .)

The threat of such litigation, enhanced by the new reporting requirements under HCQIA was recognized in the legislative history of that Act where the following was noted:

> To suggest that most of these doctors would simply accept the loss of clinical privileges - and the enormous undermining of their medical practices implicit in such a loss - without suing simply defies logic and human nature.[2]

It was also noted that the protection provided was not for those physicians involved in the process, but was instead "for the benefit of

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be considered with the full range of peer review cases in mind.

[2] H.R. Rep. No. 903, 99th Cong. 2d Sess. 6, reprinted in 1986 U.S. Code Cong. & Ad. News 6384 at 6391; see also 132 Cong. Rec. H11588, H11590 (daily ed. Oct. 17, 1986 (statement of Rep. Waxman).

millions of patients at risk from these physicians."[3]

Persuading members of a hospital's medical staff to participate on peer review committees, persuading those with critical information to speak up against a physician or colleague and persuading experts to give candid and firm evaluations can be very difficult in the face of verdicts of several million dollars against peer review participants in some cases. Patrick v. Burget, 486 U.S. 94 (1988). The risk of significant liability remains even after the passage of HCQIA. Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324 (10th Cir. 1996), cert. denied sub nom. Miller v. Brown, 117 S.Ct.

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[3] Id.

1461 (1997). Yet hospitals are dependent upon such persuasion when action is required to restrict or revoke the medical staff privileges of an incompetent physician. The inclination not to get involved is strong. The mere possibility that all that is said in a peer review proceeding will be revealed to the person subject to review or may be used in a medical malpractice action can easily be the difference between effective review and ineffective review, i.e., between the ability to restrict or revoke a marginal physician's privileges and the lack of reliable evidence that will permit such bold action.

B. PROTECTION OF PEER REVIEW IS INTENDED BY STATE AND FEDERAL LAWS TO TAKE PRECEDENCE OVER OTHER IMPORTANT PUBLIC INTERESTS.

So critical to the public's welfare is the need for effective peer review that as a matter of

sound and well established public policy at both a state and federal level the protection and encouragement of effective peer review takes precedence over other well established interests. Congress when it adopted HCQIA found:

> (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.. . .
> (3) This nationwide problem can be remedied through effective professional peer review.
> (4) The 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.
> (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

42 U.S.C. § 11101.

HCQIA, when its standards are met, provides for immunity for all participants from

liability for damages from most all claims state and federal, even antitrust claims notwithstanding the strong public policy behind the enforcement of such laws. The confidentiality of peer review records, other than reports issued by the National Practitioner Data Bank (*see* 42 U.S.C. § 11137(b)) is left to the states. All the states to varying degrees have laws protecting the confidentiality of peer review records. The Massachusetts law is as strong as any state law could be in that regard. Excepting only proceedings held by certain state boards of registration, the law using mandatory language provides that peer review records "shall be confidential and shall not be subject to subpoena or discovery." G.L. c. 111 § 204(a) (1996 Official ed.). Such a provision does more than make peer review records and proceedings privileged communications. If the

protection accorded peer review communications by law were merely a privilege, the privilege would be waivable. The statutory language does not allow for waiver or for any balancing of interests. It states categorically, if the records are peer review records, they are not subject to subpoena or discovery. Thus the law of Massachusetts reflects the legislature's choice to have protection of peer review take precedence over even the legitimate public need for full and fair discovery.

C. *IN CAMERA* REVIEW OF PEER REVIEW RECORDS COULD HAVE A CHILLING EFFECT ON PEER REVIEW AND SHOULD NOT BE PERMITTED UNDER MASSACHUSETTS LAW.

Though *in camera* review seems harmless enough at first blush, it clearly threatens the principle at stake in making peer review records confidential. Either there will be a bright line

drawn that gives certainty to peer review participants, or the limits of the confidentiality in a given case will always be unknown. If there is always the possibility of disclosure based upon a judge's discretion in each individual case as to the relative weight of the interests involved or some other finding, the protection will necessarily have limited value when it comes to persuading witnesses to comment freely. Thus even *in camera* inspection, which presumes there is some judgment to be made about what will be discovered and what will not be discovered from among documents acknowledged to be peer review records, represents an undermining of legislative intention. That intention, as reflected by the language in the law, is that participants know with certainty that peer review records will not be subject to subpoena or discovery.

To the extent the issue is whether or not particular documents are peer review records protected by the law, an *in camera* review as to the documents' content should not be required. That is because the protection depends not on content, but on the records' source and use which would have to be established in any case by reference to information other than the content of the records. Protection under Massachusetts law extends to "the proceedings, reports and records of a medical peer review committee," i.e., the protection depends upon the records' source, as covered by G.L. c. 111 § 204(a) (1996). Protection also extends to

> [i]nformation and records which are necessary to comply with risk management and quality assurance programs established by the board of registration in medicine and which are necessary to the work product of medical peer review committees, including incident reports

> required to be furnished to the board of registration in medicine,

i.e., the protection also depends upon the records' use. G.L. c. 111 § 205(b) (1996 Official ed.). Based upon such use, the records are deemed "to be proceedings, reports or records of a medical peer review committee for purposes of section two hundred and four . . . and may be so designated by the patient care assessment coordinator." Id. Thus, any dispute as to whether certain records are peer review records or not should be determined by evidence as to the disputed records' source or use. Appropriate to and consistent with the purpose of the peer review protection, the laws protecting the confidentiality of peer review records do not justify or warrant any review of content of the documents at issue and none should be permitted if

the great principle and purpose of promoting candor and participation in peer review is to be furthered.

V. CONCLUSION

The ability to carry out effective peer review in hospitals across the United States is essential to promoting the prevention of harm to patients generally before it occurs. Peer review benefits the public as a whole. Promoting effective peer review is therefore a worthy goal that justifies certain limitations on the interests of individuals in particular cases, even interests supported by other recognized public policies such as those of promoting competition or full and fair discovery. State legislatures such as that of the Commonwealth of Massachusetts have adopted legislation reflecting strong policies clearly intended to further that goal. Favorable

judicial interpretation is vital to the furtherance of that worthy purpose and is sought in this case. In comparison with what is gained from protecting peer review, little is sacrificed.

Respectfully submitted,
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ADDENDUM

Copies of G.L. c. 111 § 204 and § 205 (1996 Official ed.) are attached hereto.

G.L. c. 111 § 204

§ 204. Confidentiality of proceedings, reports and records; exceptions; immunity

(a) Except as otherwise provided in this section, the proceedings, reports and records of a medical peer review committee shall be confidential and shall not be subject to subpoena or discovery, or introduced into evidence, in any judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work, or psychology, and no person who was in attendance at a meeting of a medical peer review committee shall be permitted or required to testify in any such judicial or administrative proceeding, except proceedings held by the boards of registration in medicine, social work or psychology, as to the proceedings of such committee or as to any findings, recommendations, evaluations, opinions, deliberations or other actions of such committee or any members thereof.

(b) Documents, incident reports or records otherwise available from original sources shall not be immune from subpoena, discovery or use in any such judicial or administrative proceeding merely because they were presented to such committee in connection with its proceedings. Nor shall the proceedings, reports, findings and records of a medical peer review committee be immune from subpoena, discovery or use as evidence in any proceeding against a member of such committee to establish a cause of action pursuant to section eighty-five N of chapter two hundred and thirty-one; provided, however, that in no event shall the identity of any person furnishing information or opinions to the committee be disclosed without the permission of such person. Nor shall the provisions of this section apply to any investigation or administrative proceeding conducted by the boards of registration in medicine, social work or psychology.

(c) A person who testifies before such committee or who is a member of such committee shall not be prevented from testifying as to matters known to such person independent of the committee's proceedings, provided that, except in a proceeding against a witness to establish a cause of action pursuant to section eighty-five N of chapter two hundred and thirty-one, neither the witness nor members of the committee may be questioned regarding the witness' testimony before such committee, and further provided that committee members may not be questioned in any proceeding about the identity of any person furnishing information or opinions to the committee, opinions formed by them as a result of such committee proceedings, or about the deliberations of such committee.

(d) A court or administrative body may place reasonable restrictions on the use which may be made of the information obtained hereunder so as to maintain, so far as necessary or practicable, the confidentiality of such information.

(e) No proceeding, report or record of a medical peer review committee obtained hereunder and disclosed in an action pursuant to section eighty-five N of chapter two hundred and thirty-one or a proceeding before an administrative body, shall be subject to subpoena or discovery, or introduced into evidence in judicial or administrative proceedings other than those proceedings or investigations specified in subsections (a) and (b).

Added by St.1986, c. 351, § 9. Amended by St.1987, c. 467, § 3; St.1987, c. 579, § 2.

G.L. c. 111 § 205

§ 205. Information and records necessary to comply with risk management and quality assurance programs; confidentiality; definitions

(a) As used in this section the following terms shall have the following meanings:

"Health care facility", any entity required to participate in risk management and quality assurance programs established by the board of registration in medicine.

"Patient care assessment coordinator", a person or committee designated by a health care facility to implement and coordinate the facility's compliance with risk management and quality assurance programs established by the board of registration in medicine.

"Risk management and quality assurance programs established by the board of registration in medicine", programs and activities undertaken pursuant to regulations promulgated by the board of registration in medicine under section two hundred and three of this chapter and sections five and five I of chapter one hundred and twelve.

(b) Information and records which are necessary to comply with risk management and quality assurance programs established by the board of registration in medicine and which are necessary to the work product of medical peer review committees, including incident reports required to be furnished to the board of registration in medicine or any information collected or compiled by a physician credentialing verification service operated by a society or organization of medical professionals for the purpose of providing credentialing information to health care entities shall be deemed to be proceedings, reports or records of a medical peer review committee for purposes of section two hundred and four of this chapter and may be so designated by the patient care assessment coordinator; provided, however, that such information and records so designated by the patient care assessment coordinator may be inspected, maintained and utilized by the board of registration in medicine, including but not limited to its data repository and disciplinary unit. Such information and records inspected, maintained or utilized by the board of registration in medicine shall remain confidential, and not subject to subpoena, discovery or introduction into evidence, consistent with section two hundred and four; however, such records may not remain confidential if disclosed in an adjudicatory proceeding of the board of registration in medicine, but the information and records shall be otherwise subject to the protections afforded by section two hundred and four. In no event, however, shall records of treatment maintained pursuant to section seventy of this chapter, or incident reports or records or information which are not necessary to comply with risk management and quality assurance programs established by the board of registration in medicine be deemed to be proceedings, reports or records of a medical peer review committee under this section; nor shall any person be prevented by the provisions of this section from testifying as to matters known by such person independent of risk management and quality assurance programs established by the board of registration in medicine.

Amended by St.1996, c. 348, § 2.