ORAL ARGUMENT NOT YET SCHEDULED
No. 15-1312 (Consolidated with No. 15-1359)

IN THE
UNITED STATES COURT OF APPEALS
FOR THE DISTRICT OF COLUMBIA CIRCUIT

MIDWEST DIVISION – MMC, LLC, DOING BUSINESS AS MENORAH MEDICAL CENTER.,
PETITIONER

V.

NATIONAL LABOR RELATIONS BOARD.,
RESPONDENT

NATIONAL NURSES ORGANIZING COMMITTEE-KANSAS/NATIONAL NURSES UNITED,
INTERVENOR

BRIEF OF *AMICI CURIAE* THE AMERICAN HOSPITAL ASSOCIATION, KANSAS HOSPITAL ASSOCIATION, TEXAS HOSPITAL ASSOCIATION, TEXAS NURSES ASSOCIATION, FEDERATION OF AMERICAN HOSPITALS, AMERICAN ORGANIZATION OF NURSE EXECUTIVES, AND THE TEXAS ORGANIZATION OF NURSE EXECUTIVES IN SUPPORT OF PETITIONER'S REQUEST TO VACATE THE RESPONDENT BOARD'S ORDER

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RULE 26.1 CORPORATE DISCLOSURE STATEMENT

Pursuant to Federal Rule of Appellate Procedure 26.1 and Circuit Rule 26.1, counsel for amici states the following:

All seven Amici Curiae are representative organizations of hospitals and nurses that are concerned about the peer review privilege. Amicus American Organization of Nursing Executives is a subsidiary of Amicus American Hospital Association, and Amicus The Texas Organization of Nurse Executives is a chapter affiliate of Amicus American Organization of Nurse Executives. None of the Amici on whose behalf this brief is filed are publicly traded.

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GLOSSARY OF TERMS

Abbreviation	Meaning
"ALJ"	Administrative Law Judge Christine E. Dibble
The "Committee" or "Peer Review Committee"	Nurse Peer Review Committee at Menorah Medical Center
The "Decision"	The August 27, 2015 Decision and Order of the Board in Case Nos. 17-CA-088213 and 17-CA-091192, reported at 362 NLRB No. 193
"Joint Exhibit"	Exhibits submitted jointly by the parties in the hearing before the ALJ in Case Nos. 17-CA-088213 and 17-CA-091192
"Menorah" or the "Hospital"	Petitioner Midwest Division, MMC, LLC, d/b/a Menorah Medical Center
"Menorah Exhibit"	Exhibits submitted by Menorah Medical Center in the hearing before the ALJ in Case Nos. 17-CA-088213 and 17-CA-091192
"NLRA" or the "Act"	National Labor Relations Act
"NLRB" or the "Board"	National Labor Relations Board
The "Nursing Board"	Kansas State Board of Nursing
The "Plan"	The Risk Management Plan in effect at Menorah Medical Center
PSQIA or Patient Safety Act	Patient Safety and Quality Improvement Act of 2005
"Tr."	Transcript from the hearing before the ALJ held on August 6 and 7, 2013
The "Union"	National Nurses Organizing Committee – Kansas/National Nurses United
"Weingarten"	*NLRB v. J. Weingarten, Inc.*, 420 U.S. 251 (1975)

STATEMENT OF INTEREST

The American Hospital Association ("AHA") is a national not-for-profit association that represents the interests of approximately 5,000 hospitals, health care systems, networks, and other health care providers, as well as 37,000 individual members. It is the largest organization representing the interests of the Nation's hospitals. The members of the AHA are committed to finding innovative and effective ways of improving the health of the communities and the patients they serve. The AHA educates its members on health care issues and trends, and it advocates on their behalf in legislative, regulatory, and judicial forums to ensure that their perspectives and needs are understood and addressed.

The Kansas Hospital Association ("KHA") is a non-profit association of health care provider organizations and individuals that are committed to the health improvement of their communities. KHA membership includes 215 member facilities, of which 127 are full-service community hospitals. Founded in 1910, KHA maintains its vision of "an organization of hospitals working together to improve access, quality and the affordability of health care for all Kansans."

Founded in 1930, the Texas Hospital Association ("THA") is the leadership organization and principal advocate for the state's hospitals and health care systems. Based in Austin, THA enhances its members' abilities to improve accessibility, quality and cost-effectiveness of health care for all Texans. One of

the largest hospital associations in the country, THA represents more than 85 percent of the state's acute-care hospitals and health care systems, which employ some 369,000 health care professionals statewide.

The Texas Nurses Association ("TNA") is a non-profit professional association for registered nurses in Texas. TNA is the only statewide association in Texas representing registered nurses in all areas of practice and all practice settings. Since its founding in 1909, TNA has been an active advocate for nurses and their patients in the public policy arena.

The Federation of American Hospitals is the national representative of more than 1,000 investor-owned or managed community hospitals and health systems throughout the United States. Dedicated to a market-based philosophy, the Federation provides representation and advocacy on behalf of its members to Congress, the Executive Branch, the judiciary, media, academia, accrediting organizations, and the public.

The American Organization of Nurse Executives (AONE) is a subsidiary of the American Hospital Association (AHA) representing over 9,000 registered professional nurses who aspire to and function as leaders in health care settings that include but are not limited to primary, acute, community, long-term and palliative care. AONE provides leadership education, professional development, and advocacy, and conducts research in areas related to advancing professional

nursing practice, and patient care, promoting nursing leadership excellence and shaping health care policy. AONE collaborates with the AHA to achieve their shared goals of providing safe, high quality, and accessible health care to patients entrusted to their care.

The Texas Organization of Nurse Executives (TONE) is a non-profit organization of nurse leaders and is an affiliate of AONE and THA, representing the voice of nurse leaders in Texas. TONE is the second largest affiliate of AONE in the nation and was begun in the 1960s. The TONE mission is to represent nurse leaders in Texas who improve healthcare through collaboration and innovation in a rapidly changing environment. TONE exists as a forum for nurse leaders to advocate and facilitate the provision of compassionate, effective, and efficient healthcare with an emphasis on nursing's role in that process.

All parties have consented to the filing of this brief. No party or party's counsel has authored this brief in whole or in part or contributed any money intended to fund its preparation or submission, and no person other than amici, their members, or their counsel have contributed any money intended to fund its preparation or submission.

Counsel states that a separate amicus brief was necessary on Petitioner's side because of the particular interest of these Amici in the importance of peer review confidentiality, and this brief accordingly stresses the nature and function of peer

review as it relates to the NLRB's decisions, a topic not addressed in depth by Petitioner or another amicus, and a topic particularly within the knowledge and experience of these Amici.

SUMMARY OF THE ARGUMENT

The National Labor Relation Board's decision to extend union participation to medical peer review proceedings is unprecedented. The Board's endorsement of union encroachment into peer review, and the consequent loss of confidentiality, promises to frustrate efforts to promote better quality health care throughout the United States.

Amici are national and state hospital associations and nursing professional associations, well-versed in all aspects of peer review, that have great concern about the Board's decision to make peer review a subject of union representation. At the outset, the Court should adopt Petitioner's argument that, because peer review participants are state actors under the applicable Kansas law, the Board lacked jurisdiction in the first instance under Section 2(2) of the Act over the peer review proceedings at issue. If the Court reaches the merits, however, it should vacate the Board's decision because the Board has misconstrued both the importance of confidentiality to peer review as well as the scope of Kansas law.

For more than sixty years, peer review has been an essential way to monitor and improve health care delivery. But it requires strict confidentiality in order to

succeed. If peer review participants cannot be assured that their views will be held in confidence, their critiques will be less robust, and the free exchange of ideas will suffer. For these reasons, every state, including Kansas, as well as the federal government, has codified a peer review privilege to protect deliberations and encourage frank discussion (Point I).

The Board's decision inexplicably fails to give any meaningful weight to this need for peer review confidentiality. Even if peer review proceedings had relevance to unions' representation duties, which they do not, any fair balancing between the attenuated union concerns and the universally-recognized need for effective peer review would weigh heavily in favor of confidentiality. The Board's decision to require wholesale production of records submitted to, and generated by, Petitioner's peer review proceeding, a proceeding mandated by Kansas law and squarely covered by privilege, cannot reasonably be explained. And the Board's determination that Petitioner had discretion in implementing statutory peer review is flatly contradicted by the Kansas peer review scheme. (Point IIA).

The Board also erred in failing to recognize that the Hospital's rule limiting discussion applied solely to professionals involved in peer review proceedings, so that the strong confidentiality concerns underlying peer review provided a legitimate business justification for the narrowly-drafted rule. (Point IIB).

Finally, the Board erred in granting *Weingarten* union representation rights in peer review proceedings for the reasons advanced by Petitioner (peer review is not disciplinary, and the employee's appearance is voluntary). Amici believe a further ground supports reversal on this point – allowing third-party union participation in a peer review proceeding presents a genuine threat to peer review confidentiality in that it could be construed as a general waiver of the privilege. (Point IIC).

The Board's decision consistently undervalues the need for strict confidentiality in medical peer review. The Court should vacate the Board's order for lack of jurisdiction, or alternatively reverse the erroneous Board determinations that directly threaten peer review confidentiality.

ARGUMENT

I. The Board's Decision Misapprehends The Importance Of Peer Review And The Need For Strict Confidentiality.

Amici agree with Petitioner that the Board lacks jurisdiction here because the peer review at issue is a creature of Kansas law, which expressly makes peer review participants state actors. The Board's Decision and Order should be vacated on this ground alone under Section 2(2) of the National Labor Relations Act, 29 U.S.C. § 152(2). But if the Court does not vacate for lack of jurisdiction, it should refuse to enforce the Decision and Order for the separate reason that the Board's misunderstanding of peer review, and particularly of the strict

confidentiality essential for its success, has led the Board to a series of erroneous conclusions.

Amici have considerable experience with peer review and its overarching goal of improving quality health care. They recognize that candid and meaningful peer review would be irretrievably harmed if peer review information must be disclosed to individuals or organizations outside of peer review proceedings. Requiring confidential and privileged information to be shared with third-party union representatives, as the Board's decision does here, would undermine the ultimate goal of improving patient care.

Amici, as health care providers experienced in administering and participating in peer review proceedings, will emphasize for the Court the importance of peer review and stress why strict confidentiality—confidentiality that the Board's order repeatedly undervalues—is universally seen as essential to peer review's success.

A. Peer Review Promotes The Public Interest Of Improving And Maintaining Quality Health Care In The United States.

Health care professionals use peer review to critically analyze medical services performed by their colleagues. *See* Kenneth Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 Mass. L. Rev. 157, 157 (2002). The proper focus of peer review is to improve the quality and safety of patient care by identifying treatment that may not meet the standard of care and

correcting it when necessary to reduce the potential for future medical incidents. *Id.* Peer review is performed in a variety of settings, including hospital quality assurance programs, medical societies, and managed care organizations. *Id.* It is the most widely used and effective tool for improving the quality of health care in the United States.

Physicians first developed peer review over sixty years ago to evaluate and improve the quality of medical services. More recently, medical peer review has expanded to other licensed health care professions and has become the principal method of evaluating the quality of patient care. Peer review of nursing practice—the subject of this action—is now required in many states.[1]

Peer review proceedings "are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care." *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249, 250 (D.D.C. 1970), *aff'd*, 479 F.2d 920 (D.C. Cir. 1973). "The obvious legislative intent is to promote open and frank discussion during the

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[1] Alaska Stat. § 18.20.075 (2013) & Alaska Admin. Code tit. 7 § 12.860: Risk Management (2012); Ariz. Rev. Stat. Ann. § 36-450.01 (2013); Colo. Rev. Stat. Ann. § 12-36.5-103 (2013); Ga. Code Ann. § 31-7-15 (2013); Idaho Code Ann. § 39-1392f (2013); Ind. Code Ann. §§ 34-30-15-5, 34-30-15-7(a) (2013); Kan. Stat. Ann. § 65-4922 (2013); Mass. Gen. Laws Ann. ch. 111, § 203 (2013); Mo. Rev. Stat. § 190.245 (2013); Okla. Stat. tit. 36, § 6907(B)(2)(g) (2013); R.I. Gen. Laws Ann. § 23-17-24 (2012); Tex. Occ. Code Ann. § 303.0015 (2013); Wash. Rev. Code Ann. § 70.41.200(1) (2013); Wyo. Stat. Ann. § 35-2-910 (2013).

peer review process among health care providers in furtherance of the overall goal of improvement of the health care system." *HCA Health Servs. of Va., Inc. v. Levin*, 530 S.E.2d 417, 420 (Va. 2000).[2]

B. Strict Confidentiality Is Necessary For Peer Review To Work.

Confidentiality is paramount in peer review. In order to foster the strong public policy in favor of peer review proceedings and to encourage and facilitate participation in them, peer review statutes typically immunize participants from civil liability, preclude the materials used and the statements made in such proceedings from being introduced into evidence in a subsequent action for damages, and maintain the confidentiality of such proceedings by prohibiting disclosure to the public. *See* G. Gosfield, *Medical Peer Review Protection in the Health Care Industry*, 52 Temp. L.Q. 552, 553 (1979)); *see also Morse v. Genty*, 520 F. Supp. 470, 472 (D. Conn. 1981) (if the purpose of the statute is to encourage doctors to evaluate their peers without fear of disclosure, that purpose

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[2] *See also Adams v. St. Francis Reg. Med. Ctr.*, 955 P.2d 1169, 1187 (Kan. 1998) ("[T]he legislature granted a peer review privilege to health care providers to maintain staff competency by encouraging frank and open discussions and thus improving the quality of medical care in Kansas."); *Bredice*, 50 F.R.D. at 250 ("The purpose of these staff meetings is the improvement, through self-analysis, of the efficiency of medical procedures and techniques. They are not part of current patient care but are in the nature of a retrospective review of the effectiveness of certain medical procedures. The value of these discussions and reviews in the education of the doctors who participate, and the medical students who sit in, is undeniable. This value would be destroyed if the meetings and the names of those participating were to be opened to the discovery process.").

would be hampered by public release of any proceedings...); *see also Mem. Hosp. The Woodlands v. McCown*, 927 S.W.2d 1, 3 (Tex. 1996) ("An atmosphere of confidentiality is required for candid, uninhibited communication of such critical analysis within the medical profession.")

Confidentiality makes possible the brutally honest assessment necessary for successful peer review. "The overriding importance of these review committees to the medical profession and the public requires that doctors [and other health care providers] have unfettered freedom to evaluate their peers in an atmosphere of complete confidentiality." *Morse*, 520 F. Supp. at 472. "[T]he need for confidentiality in the peer review process stems from the need for comprehensive, honest, and sometimes critical evaluations of medical providers by their peers in the profession." *Young v. Western Pa. Hosp.*, 722 A.2d 153, 156 (Pa. Super. Ct. 1998); *Sanderson v. Frank S. Bryan, M.D., Ltd.*, 522 A.2d 1138, 1139 (Pa. Super. Ct. 1987) ("Generally, hospital peer review findings and records are protected from public scrutiny.... The purpose for such protection is to encourage increased peer review activity which will result, it is hoped, in improved health care."), *appeal denied*, 538 A.2d 877 (Pa. Super. Ct. 1988); *Barnes v. Whittington*, 751 S.W.2d 493, 497 (Tex. 1988) (Phillips, C.J., concurring) ("Medical professionals are more likely to come forward with information about professional incompetence and misbehavior when protected from personal liability or public disclosure.")

In contrast, "external access to peer investigations conducted by staff committees stifles candor and inhibits objectivity…." *W. Covina Hosp. v. Superior Court*, 718 P.2d 119, 123 (Cal., 1986); *see also Morse*, 520 F. Supp. at 472 ("[I]f the purpose of the statute is to encourage doctors to evaluate their peers without fear of disclosure, that purpose would be hampered by public release of any proceedings, not just those involving the patient who has sued. The danger of inhibiting candid professional peer review exists by the mere potential for disclosure."); *Trinity Med. Ctr., Inc. v. Holum*, 544 N.W.2d 148, 155 (N.D. 1996) (In analyzing the legislative history of the state peer review statute, the court noted, "[c]oncerns were expressed that physicians would be unwilling to serve on quality assurance committees, and would not feel free to openly discuss the performance of other doctors practicing in the hospital, without assurance that their discussions in committee would be confidential and privileged. It was this purpose to encourage frank and open physician participation, and the resulting improvement in patient care, which underlies the privilege.")

Without strict confidentiality, peer review's effectiveness would collapse. As shown below, jurisdictions throughout the country have recognized this plain fact and have thus codified a privilege to keep peer review proceedings confidential.

C. The Need For Confidentiality Is Universally Recognized At Both State And Federal Levels.

Given the importance of confidentiality to effective peer review, it should not be surprising that state and federal laws universally protect the confidentiality of peer review proceedings.

1. State Peer Review Laws Mandate Confidentiality.

All fifty states and the District of Columbia recognize some form of medical peer review confidentiality privilege.[3] As one court put it, "[t]he legislatures in

[3] Ala. Code §§ 6-5-333(d), 22-21-8(b), 34-24-58(a) (2013); Alaska Stat. § 18.23.030 (2013); Ariz. Rev. Stat. § 36-445.01 (2013); Ark. Code Ann. §§ 20-9-503, 16-46-105 (2013); Cal. Evid. Code §§ 1156, 1157, 1157.7 (2013); Colo. Rev. Stat. §§ 12-36.5-104(10)(a-b), 13-21-110 (2013); Conn. Gen. Stat. § 19a-17b(d) (2013); Del. Code Ann. tit. 24, § 1768(b) (2013); D.C. Code Ann. § 32-505(1) (2013); Fla. Stat. ch. 395.0193(8) (2013); Ga. Code Ann. §§ 31-7-133(a), 31-7-143 (2013); Haw. Rev. Stat. § 624-25.5(b) (2013); Idaho Code § 39-1392, 39-1392b, 39-1392e (2013); Ill. Rev. Stat. Ch. 735, para. 5/8-2101, 8-2102 (2013); Ind. Code Ann. §§ 34-30-15-8, 34-30-15-9 (2013); Iowa Code § 147.135(2) (2013); Kan. Stat. Ann. § 65-4915(b) (2013); Ky. Rev. Stat. Ann. § 311.377(2) (2013); La. Rev. Stat. Ann. §§ 40:2205, 13:3715.3(A)(2) (2013); Me. Rev. Stat. Ann. tit. 32 §§ 2599, 3296 (2013); Md. Code Ann. Health Occ. § 14-501(d) (2013); Mass. Gen. Laws Ann. ch. 111, §§ 204(a), 205(b) (2013); Mich. Comp. Laws §§ 333.20175(8), 333.21515 (2013); Minn. Stat. Ann. § 145.64 (2013); Miss. Code Ann. § 41-63-9 (2013); Mo. Rev. Stat. § 537.035(4) (2013); Mont. Code Ann. § 37-2-201(2), 50-16-205 (2013); Neb. Rev. Stat. § 71-2048 (2013); Nev. Rev. Stat. § 49-265 (2013); N.H. Rev. Stat. Ann. § 151:13-a (2013); N.J. Rev. Stat. § 2A:84A-22.8 (2013); N.M. Stat. Ann. § 41-9-5 (2013); N.Y. Educ. Law § 6527(3) (2013); N.Y. Pub. Health Law § 2805-m(2) (2013); N.C. Gen. Stat. § 131E-95(b) (2013); N.D. Cent. Code § 23-34-03 (2013); Ohio Rev. Code Ann. §§ 2305.251, 2305.252(B) (2013); Okla. Stat. tit. 63, § 1-1709 (2013); Or. Rev. Stat. § 41.675(3) (2013); Pa. Stat. Ann. tit. 63, § 425.4 (2013); R.I. Gen. Laws § 23-17-25(a) (2013); S.C. Code Ann. § 40-71-20 (2013); S.D. Codified Laws Ann. § 36-4-26.1 (2013); Tenn. Code Ann. § 63-6-219(e) (2013); Tex.

every state in the Nation have concluded that without a peer review privilege, physicians will be discouraged from participating in the full and frank expression of opinion that is essential if peer review is to fulfill its vital role in advancing the quality of medical care." *Sevilla v. United States*, 852 F.Supp.2d 1057, 1060 (N.D. Ill. 2012).

2. Federal Peer Review Law Mandates Confidentiality.

Federal law similarly recognizes the national importance of a peer review privilege. The privilege is codified in the Patient Safety and Quality Improvement Act of 2005 (the "PSQIA"), 42 U.S.C. § 299b-21 *et seq.* The PSQIA "announces a more general approval of the medical peer review process and more sweeping evidentiary protections for materials used therein." *KD ex rel. Dieffenbach v. United States*, 715 F.Supp.2d 587, 595 (D. Del. 2010).

The PSQIA creates a voluntary program through which health care providers can share information relating to patient safety events, with the aim of improving patient safety and the quality of care nationwide. 42 U.S.C. 299b-21(b) *et seq.* "The statute attaches significant privilege and confidentiality protections to this information, termed 'patient safety work product,' to encourage providers to share

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Health & Safety Code Ann. § 161.032 (2013); Utah Code Ann. §§ 26-25-1, 26-25-2, 26-25-3 (2013); Vt. Stat. Ann. tit. 26, § 1443 (2013); Va. Code Ann. § 8.01-581.17 (2013); Wash. Rev. Code Ann. §§ 4.24.250, 70.41.230(5) (2013); W. Va. Code § 30-3C-3 (2013); Wis. Stat. Ann. § 146.38(2) (2013); Wyo. Stat. Ann. § 35-17-105 (2013).

this information without fear of liability. These protections enable all health care providers, including multi-facility health care systems, to share data within a protected legal environment, both within and across states, without the threat that the information will be used against the subject providers." 73 Fed. Reg. 70732 (Nov. 21, 2008).

Specifically, the PSQIA creates a privilege for "any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements" that a health care provider assembles or develops and reports to a patient safety organization on a timely basis. 42 U.S.C. §§ 299b-21(7) and 299b-22(a). Federal law also extends confidentiality to the medical quality assurance activities of some government agencies.[4] The PSQIA privilege preempts all inconsistent federal, state, or local law, provides whistleblower protection, and authorizes private and governmental enforcement mechanisms. 42 U.S.C. § 299b-22.

D. The Kansas Peer Review Scheme Also Requires Confidentiality.

Hospital licensure in Kansas, the state where Petitioner operates, is governed by the Kansas Medical Facilities Survey and Construction Act. Kan. Stat. Ann. § 65-410 (2013). The Act's purpose is to provide for the development, establishment, and enforcement of standards for the treatment of patients in

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[4] *See, e.g.*, Department of Defense (DoD), 10 U.S.C. § 1102 (2012); Coast Guard (USCG), 14 U.S.C. § 645 (2012); Department of Veterans Affairs (VA), 38 U.S.C. § 5705 (2012); and certain programs supported by the Indian Health Service (IHS), 25 U.S.C. § 1675 (2012).

medical care facilities and the maintenance and operation of medical care facilities. Kan. Stat. Ann. § 65-426 (2013). All medical care facilities in the state must be licensed. Kan. Stat. Ann. § 65-427 (2013).

Health professional practice acts are statutory and establish licensing boards to regulate health care practice. In Kansas, nursing licensure is governed by the Kansas Nurse Practice Act, Kan. Stat. Ann. § 65-1113 *et seq.* (2013) and accompanying regulations. *See e.g.*, Kan. Admin. Regs. § 60-3-101 *et seq.* (2013). Kansas nursing licensure is not unique; all states license nursing.[5]

Like many other states, Kansas "recognizes the importance and necessity of providing and regulating certain aspects of health care delivery in order to protect the public's general health, safety and welfare," and its legislature identified the "[i]mplementation of risk management plans and reporting systems as required by K.S.A. §§ 65-4922, 65-4923 and 65-4924 and peer review pursuant to K.S.A. § 65-4915 and amendments thereto effectuate this policy." Kan. Stat. Ann. § 65-4929 (2013).

Kansas risk management plans specifically require a professional practices peer review committee, which "shall have the duty to report to the appropriate state

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[5] *See, e.g.*, California Nursing Practice Act is located in the California Business and Professions Code starting with Section 2700; The DC Nurse Practice Act is in the Health Occupation Revision Act, Title 3, Chapter 12; Missouri Nurse Practice Act, RSMo. § 335.011 *et seq.*; The New York Nursing Practice Act is found in State Education Law, Article 139.

licensing agency any finding by the committee that a health care provider acted below the applicable standard of care which action had a reasonable probability of causing injury to a patient, or in a manner which may be grounds for disciplinary action by the appropriate licensing agency,[6] so that the agency may take appropriate disciplinary measures." Kan. Stat. Ann. § 65-4923(a)(1), (2) (2013) and Kan. Admin. Regs. § 28-52-3(a) (2013). Kansas law defines a "Peer Review Officer or Committee" as "[a]n individual employed, designated or appointed by, or a committee of or employed, designated or appointed by, a health care provider group and authorized to perform peer review." Kan. Stat. Ann. § 65-4915(a)(4) (2013).[7]

Kansas statutes guarantee confidentiality and privilege to Kansas peer review:

> [T]he reports, statements, memoranda, proceedings, findings and other records submitted to or generated by peer review committees or officers shall be privileged

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[6] Appropriate licensing agency means the agency that issued the license to the individual or health care provider who is the subject of a report under this act. Kan. Stat. Ann. § 65-4921(a) (2013).

[7] The term "health care provider group" is defined to include a "health care provider" as defined by Kan. Stat. Ann. § 40-3401, which includes "a medical care facility licensed by the department of health and environment." Kan. Stat. Ann. § 65-4915(a) (2013). Moreover, "Peer review" means any of the following functions: "(A) Evaluate and improve the quality of health care services rendered by health care providers; (B) determine that health services rendered were professionally indicated or were performed in compliance with the applicable standard of care..." *Id.*

> and shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity or be admissible in evidence in any judicial or administrative proceeding. Information contained in such records shall not be discoverable or admissible at trial in the form of testimony by an individual who participated in the peer review process.

Kan. Stat. Ann. § 65-4915(b) (2013). This privilege is held by the Committee, its officers, and the medical facility where the Committee sits. *Id.* Consequently, the Committee's "proceedings" and documents "submitted to or generated by" the Committee or its officers are privileged and confidential. *Id.*

Kansas risk management statutes also establish peer review privilege and confidentiality. Reports, records, and proceedings of peer review conducted under the risk management statutes "shall not be subject to discovery, subpoena or other means of legal compulsion for their release to any person or entity and shall not be admissible in any civil or administrative action other than a disciplinary proceeding by the appropriate state licensing agency." Kan. Stat. Ann. § 65-4925 (2013). Even when hospital peer review records are later used in a state licensure proceeding, the documents remain confidential and privileged. A licensure disciplinary proceeding during which any peer review committee report, record or testimony is used is held in closed session. Kan. Stat. Ann. § 65-4925(e) (2013). The portions of the licensing agency record in which peer review records or reports

are disclosed are subject to a protective order prohibiting further disclosure and the peer review information is not discoverable. *Id.*

Against this backdrop of a universally-recognized need for peer review, and the incontestable fact that confidentiality is essential for it to succeed, the Board's failure here to protect that confidentiality, or even to understand fully the Kansas peer review scheme, led to a series of erroneous conclusions, discussed below, that this Court should reverse to the extent that it finds that the Board even had jurisdiction in the first instance over this Kansas state activity.

II. The Board's Consistent Failure To Value Peer Review Confidentiality, And Its Misunderstanding Of Kansas Peer Review, Led To A Series Of Specific Errors In Its Decision.

The Board's failure to appreciate the need for peer review confidentiality led to three serious errors in its decision, errors that this Court must reverse to preserve the effectiveness of peer review:

First, the Board erroneously required the Hospital to produce documents that were generated by or submitted to the peer review committee, even though these documents are squarely within the Kansas peer review privilege;

Second, the Board incorrectly struck down the Hospital's rule against discussion of peer review proceedings, even though it served the Hospital's legitimate business purpose of protecting peer review; and

Third, the Board's decision to allow *Weingarten* rights in peer review proceedings should be set aside, not only for the reasons addressed by Petitioner, but because allowing third-party union participation threatens to waive peer review privilege.

A. The Decision Improperly Requires The Hospital To Provide Materials Submitted To Or Generated By The Peer Review Committee.

The Board erred in finding that the Hospital did not have a legitimate and substantial confidentiality interest in the peer review records so that the Union's interests in documents from peer review was superior. The Board inexplicably held, despite the universally-recognized need for confidentiality in peer review, that Petitioner "failed to establish a legitimate and substantial confidentiality interest in *any* of the information" (emphasis added). Decision at 4.

Preliminarily, Amici agree with Petitioner that the peer review materials sought were not relevant to the Union's representational duties. The information sought was not presumptively relevant because an employer's obligation to bargain is limited to wages, hours and terms and conditions of employment, none of which is implicated in peer review. *Country Ford Trucks, Inc. v. NLRB*, 229 F.3d 1184, 1191 (D.C. Cir. 2000); *NLRB v. Wooster Div. of Borg-Warner Corp.*, 356 U.S. 342 (1958). State licensing determinations are non-mandatory subjects of bargaining and do not concern terms and conditions of employment because licensing is

dictated by the state. *Economy Stores, Inc.*, 120 NLRB 1, 19 (1958). The Board erred in finding that peer review implicated "terms and conditions of employment" based on its view that the hospital exercised "substantial discretion" in how it implements the state's requirement that it maintain a peer review process. Decision at 3, n. 13. In fact, Kansas law grants virtually no discretion to hospitals in the statutory peer review process.[8]

Even assuming the Union here made a request for relevant information, the Board must still balance any request against confidentiality interests. *Detroit*

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[8] Kansas law requires hospitals to establish and maintain an internal risk management plan which is subject to the state approval. Kan. Stat. Ann. § 65-4922(a), (b), (d) (2013). The plan contents are mandated by Kan. Stat. Ann. § 65-4922(a) and Kan. Admin. Regs. § 28-52-1. Even after a plan is approved, the state conducts periodic inspections to insure that the facility is correctly implementing the plan. Kan. Stat. Ann. § 65-4922(c) (2013).

Under state law, hospitals must investigate a "reportable incident." Kan. Stat. Ann. § 65-4921(f) (2013). The reporting criteria, including definitions of standards of care 1-4 are also dictated by state law. Kan. Stat. Ann. § 65-4923 (2013), Kan. Admin. Regs. § 28-52-1 and § 28-52-4 (2013). Only standard of care violations assigned a level 3 or 4 are reported to the appropriate state licensing authority. Kan. Admin. Regs. § 28-52-4(b) (2013). To assign a level 4 finding, the investigating committee must refer to licensing laws defining grounds for discipline. *See e.g.*, Kan. Stat. Ann. § 65-1120 (2013) and Kan. Admin. Regs. § 60-3-110 (2013). The Kansas Department of Health and the Environment published *Interpretive Guidelines for Standards of Care Determinations Including Involved Provider (Individual/Entity) Accountability*, "to assist hospitals and...others who fall under the Kansas risk management statutes and regulations, in their deliberations when reviewing quality of care issues." The Guidelines include reportable incident scenarios and the appropriate standard of care findings for each scenario. *See* http://www.kdheks.gov/bhfr/download/KHA_KDHE_Interpretive_Guidelines.pdf.

Edison v. NLRB, 440 U.S. 301 (1979). But here, the Board apparently gave *no* weight to the confidentiality of peer review, and thus failed to reach its decision by properly balancing the interests of the competing parties. As the dissent to the Board's decision aptly stated, the Board here "fail(s) to adequately weigh the State's paramount interest in regulating and improving the delivery of health case and improperly second-guesses the State's determination that nondisclosure of some information is fundamental to its regulatory scheme." Dissent, Decision at 8.

The Board's refusal to give any real weight to the well-recognized confidentiality of peer review, even as it accepted the Union's misguided arguments for relevancy, recalls the Supreme Court's criticism in *Detroit Edison,* 440 U.S. at 318 (1979) (emphasis added): "The Board's position appears to rest on the proposition that union interests in *arguably* relevant information must always predominate over all other interests, however legitimate. But such an absolute rule has never been established." *Id.* at 1105.

The Board here failed to follow its own earlier decision on this point in *Borgess Medical Center*, 342 NLRB 1105 (2004). There, the Board held that the public policy of the Michigan peer review statute was to "protect from disclosure health care facilities self-review documentation." *Id.* at 1105. The registered nurse in *Borgess* was terminated from employment and a proper grievance over the terms of the labor agreement was lodged (*i.e.*, whether the employee was terminated for

cause). *Borgess* recognized that peer review records were protected by a state statute, that they constituted "self-critical documentation in the health care context," and that the hospital had a "legitimate confidentiality interest" in them. *Id.*[9]

Rather than following its precedent in *Borgess*, the Board instead mistakenly relied on a federal case, *Hill v. Sandhu*, 129 F.R.D. 548 (D. Kan. 1990) to support its assertion that the peer review records here were not entitled to confidentiality.. But Hill had interpreted an earlier, *superseded* version of the Kansas peer review statute. The amended Kansas peer review statute, in effect at all times relevant to this case, specifically provides that the documents requested by the Union here are privileged. Kan. Stat. Ann. § 65-4915(b) and § 65-4925 (2013).[10]

The Board separately erred in its weighing process by finding that the Union's need for information requested "was considerable" in that the documents were "necessary for the performance of (the Union's) function to police the collective bargaining agreement." Decision at 6. The Board found the information

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[9] The Board's reliance on *Kaleida Health, Inc.*, 356 NLRB No. 171 (2011) is misplaced. *Kaleida* does involve confidential health information, but rather a true grievance over an actual employee termination that was alleged to have breached the labor agreement.

[10] Kan. Stat. Ann. § 65-4915(b) was amended and expanded in 1997 and states that "reports, statements, memoranda, proceedings, findings and *other records submitted to or generated by* peer review committees or officers shall be privileged. 1997 Kan. Sess. Laws 149 (emphasis added).

was relevant to allow the Union "to compare incidents that cause nurses to become targets of investigations" and that "this information will enable the union to properly determine whether to file a grievance on behalf of those who have been targeted for investigation by the Committee." Decision at 6.

As Petitioner points out, peer review matters are not mentioned in or covered by the collective bargaining agreement. (Joint Ex. 16). The agreement makes clear that a grievance can only be filed for "alleged breaches of the contract." (Joint Ex. 6; Art. 10). Thus, no grievance under the collective bargaining agreement could be filed over peer review because there is no possible breach of the contract – peer review is governed by state law, not collective bargaining agreements. The Board's conclusion that the Union's need for the information was "considerable" is thus unsupported by the record in this case.

As the dissent below correctly recognized,

> Peer review does not directly implicate the respondent's disciplinary process nor either party's obligations under the collective-bargaining agreement. Rather, the Union's interest derives, at most, from its suspicion that the Respondent may somehow meddle with or discriminatorily refer incidents for investigation and its general interest in ensuring a transparent disciplinary process. But particularly where there is no direct adverse employment action, the union's interest in the internal workings or committee investigations is weak. Decision at 10.

The Board erred in giving little if any weight to peer review confidentiality even as it misconstrued the Union's tenuous claim to production. The Board's

decision ordering production to the Union of all materials generated by, or submitted to, Petitioner's peer review proceeding should not be enforced.

B. The Board's Decision Incorrectly Strikes Down The Hospital Rule Against Discussion Of Peer Review Proceedings That Serves A Narrow Legitimate Business Purpose Of Protecting Peer Review Confidentiality.

The Board's decision striking down a confidentiality rule in the Hospital's state-approved Risk Management Plan also fails to give appropriate weight to peer review confidentiality; that confidentiality alone provides a legitimate and substantial justification for the rule. The Board's contrary finding has no evidentiary support.

The Hospital's confidentiality rule, as written, "prohibits employees from disclosing any information discussed in the peer review committee meetings, particularly if it involves 'reportable incidents'."[11] Decision at 22. This rule, the Board found, "restricts employees' right to discuss potential discipline, working conditions and other information that employees are entitled to know and share with co-workers." Decision at 22. The Board found the rule "unlawful on its face" and that the Hospital "failed to show that its business justification for … such an overly broad confidentiality rule outweighs the … exercise of Section 7 rights." Decision at 22.

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[11] The Board, in a footnote, adopted the findings of the ALJ on this point without meaningful discussion.

A confidentiality rule for investigations is lawful if it is narrowly applied to investigations where there is a need for confidentiality. *Hyundai Am. Shipping Agency, Inc. v. NLRB,* 805 F.3d 309 (D.C. Cir. 2015). In *Hyundai* this Court held that the need to comply with EEOC guidelines on confidentiality in employers' internal discrimination investigations "may often constitute a legitimate business justification for requiring confidentiality … ." *Id.* at 314. This Court found the *Hyundai* rule violated the Act because its confidentiality rule in investigations applied to "all investigations" – and was not tailored to internal discrimination investigations. *Id.*

Here the Hospital's confidentiality rule does not apply to all investigations, but is limited to those conducted pursuant to the state-approved Risk Management Plan and state statutes requiring confidentiality. K.S.A. §§ 60-437, 65-4915(b), 65-4925 (2013). The rule expressly limited anyone from disclosing "information concerning reportable incidents." Decision at 15.

Thus, the rule in question is limited to peer review matters only; it was drafted to comply with a state statutory scheme, and a specific state statute requiring confidentiality of peer review proceedings. Kansas approved the Hospital's confidentiality rule when it approved the Risk Management Plan.[12]

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[12] The hospital's Risk Management Plan as amended and ultimately approved by the state can be found in Menorah Exhibits 6 – 8; Joint Exhibit 3.

There is no evidence this policy was disseminated by the Hospital to all employees, nor does the policy indicate it applies to any investigation other than peer review.

Furthermore, the confidentiality policy in the Risk Management Plan applied only to professional employees who engage in peer review. As Petitioner points out, it is an unreasonable reading of the peer review confidentiality rule to conclude a nurse would not understand the policy's meaning. *See Community Hospitals of Central California v. NLRB*, 335 F.3d 1079 (D.C. Cir. 2003) (hospital rule restricting disclosure of confidential information lawful). Here the rule in question only furthers the state and the hospital's interest in keeping "information discussed in peer review confidential."

The Board tellingly departed from the ALJ's findings on this rule. The Board, in a brief footnote, without explanation, found the rule in question not only prohibited the disclosure of "reportable incidents" but also prohibited "discussions about the events underlying the peer review investigations." Decision at 1, footnote 3. This finding was contrary to the ALJ's express finding that "an individual may discuss the facts underlying the incident report to the extent patient information protected by Health Insurance Portability and Accountability Act (HIPAA) is not disclosed." Decision at 16. The Board's decision on the right to

discuss facts underlying the peer review investigations is inconsistent with the ALJ's findings, unsupported by substantial evidence, and should not be enforced.

C. The Board's Decision To Allow *Weingarten* Rights In Peer Review Proceedings Should Not Be Enforced For The Additional Reason That Allowing Third-Party Union Participation Threatens To Waive Peer Review Confidentiality.

Amici fully endorse and agree with Petitioner's argument that *Weingarten*[13] rights do not apply in this case, both because state-mandated peer review for professional licensing purposes does not constitute employer-imposed discipline and because the employee's appearance in peer review meetings is strictly voluntary. But Amici believe an additional ground precludes *Weingarten* rights: the Board's requirement that the hospital disclose peer review documents and information to third parties will likely waive the confidentiality and privilege protections given to this information for all purposes.

The issue of privilege waiver is a real concern for healthcare providers because "a recent judicial trend has been to expand the conduct that constitutes waiver of peer review protections. Several Court decisions have stripped peer review committees of their protection when records were disclosed to non-committee members." Frederick Levy, *The Patient Safety and Quality Improvement Act of 2005*, 31 J. Legal Med. 397, 422 (2010) (citing Daniel

[13] *NLRB v. J. Weingarten, Inc.*, 420 U.S. 251 (1975).

Mulholland & Phil Zarone, *Waiver of the Peer Review Privilege: A Survey of the Law*, 49 S.D. L. Rev. 424, 428 (2004)).

In *State ex rel. Brooks v. Zakaib*, for example, a patient brought a medical malpractice action against a doctor and hospital. 214 W. Va. 253, 588 S.E.2d 418 (W. Va. 2003). The doctor subsequently filed a defamation action against the hospital and a newspaper. Following the action's dismissal, the patient requested and received records regarding the defamation action, including the doctor's peer review records. *Id.* The court found that the peer review privilege may be waived if a party fails to treat information in a confidential manner and remanded the case for further findings on the issue of waiver. *Id.* at 429.[14]

The Kansas statutory peer review privilege is broad, but it is subject to being waived if outsiders are allowed into the proceedings. Kansas law dictates that a privilege is waived if the holder of the privilege (the peer review committee) has,

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[14] *See also Whitman v. United States*, 108 F.R.D. 5 (D.N.H. 1985) (finding waiver of privilege as a result of voluntary disclosure of information during deposition); *State ex rel. St. John's Regional Med. Ctr. v. Dally*, 90 S.W.3d 209 (Mo. App. S.D. 2002) (medical center had waived peer review privilege on such materials by putting materials at issue through its pleadings and using peer review privilege as both a shield and a dagger in dispute with radiological service, and without disclosure of materials there was a substantial potential that medical center's conduct would result in an unfair trial for radiological service); *Kymissis v. Rozzi*, No. 93 Civ. 8609, 1997 WL 278055 (S.D.N.Y. May 23, 1997) (disclosure of peer review information to a party outside peer review waives the privilege); *Ronald G. Connolly, M.D., P.A. v. Russell J. Labowitz, M.D., P.A.*, 1984 WL 14132 (Del. Sup. Ct. 1984) (parties giving testimony to a peer review committee can waive the privilege as to their testimony, but not committee deliberations).

"without coercion, or without any trickery, deception, or fraud practiced against him or her, and with knowledge of the privilege, made disclosure of any part of the matter or consented to such a disclosure made by anyone," Kan. Stat. Ann. § 60-437 (2013). Adding a union representative to the peer review meeting is contrary to the fundamental privilege and confidentiality obligations imposed by Kansas law, and risks a general waiver of the privilege.

This Court previously elected not to decide whether *Weingarten* rights should apply to peer review because it was unnecessary to its decision. *See National Federation of Federal Employees, Local 589 v. Federal Labor Relations Authority*, 73 F.3d 390 (D.C. Cir. 1996). If the Court reaches this issue in the present case, it should deny enforcement of the Board's holding on *Weingarten* rights in peer review for the reasons advanced by Petitioner, and for the additional reason that allowing third-party union participation in peer review threatens a general waiver of the privilege.

CONCLUSION

For the above reasons, and the reasons advanced by Petitioner, the Board's Decision should be vacated, and the Court in all events should refuse to enforce the Board's erroneous rulings (1) requiring production of confidential peer review materials, (2) striking the Hospital's rule on discussion of peer review, and (3) extending *Weingarten* rights to peer review.

Respectfully submitted,

Dated: January 13, 2016

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CERTIFICATE OF COMPLIANCE

I hereby certify that the foregoing brief complies with the type-volume limitation of Fed. R. App. P. 29(d) and Fed. R. App. P. 32(a)(7)(B) because it contains 5,702 words, excluding the parts of the brief exempted by Fed. R. App. P. 32(a)(7)(B)(iii) and D.C. Cir. R. 32(a)(1), as counted using the word-count function on Microsoft Word 2010 software.

This brief complies with the typeface requirements of Fed. R. App. P. 32(a)(5) and the type style requirements of Fed. R. App. P. 32(a)(6) because it has been prepared in a proportionally spaced typeface using Microsoft Word 2010 in 14-point Times New Roman font.

Date: January 13, 2016 *<u>/s/ William E. Quirk</u>*

CERTIFICATE OF SERVICE

I hereby certify that on this 13th day of January, 2016, I electronically filed the foregoing with the Clerk of Court using the CM/ECF system, which will send an electronic notification of such filing to all parties.

/s/ William E. Quirk