Self-Critical Analysis Without Fear of Reprisal: Taking Advantage of Increased Privilege Protections Under Federal Law

Jeffrey Hendrickson Pierce Couch Hendrickson Baysinger & Green, L.L.P.

Increasingly, medical-malpractice defense attorneys encounter discovery requests seeking information that, at first glance, would appear to be covered by state-law privilege doctrines. One might reasonably assume that a request like "produce risk management and/or investigative files related to the patient's care and treatment," for example, would fall well within your state's peer-review privilege, barring disclosure. After all, protecting things like these seems to make sense, if the goal of peer review is—as the Texas Supreme Court once put it—to "foster a free, frank exchange among medical professionals about the professional competence of their peers" without the fear that the discussions later become evidence in a civil suit.

But one might be surprised. In Oklahoma, for example, items like "incident reports" or "other like documents" that concern "health care services being reviewed" are specifically excluded from the state's definition of peer-review information. Similarly, in Nebraska, certain documents fall within the peer-review privilege only if they were created and maintained for exclusive use by a peer-review committee. And in New York, statements made by a defendant-provider at a peer-review meeting are, similarly in outcome, not covered by the privilege. These are but a few examples, and yes, protections vary from state to state, but what they show is that not everything designed to "foster a free, frank exchange" between healthcare practitioners about patient treatment stays under wraps when litigation comes calling. At least, that is the case when practitioners rely solely on their state's law for protection. There is, however, another option.

THE PATIENT SAFETY QUALITY IMPROVEMENT ACT

In 2005, motivated by recent studies that suggested that medical providers, be they entities, physicians, or otherwise, were refraining from sharing information about medical errors for fear of reprisal via malpractice litigation, Congress passed the Patient Safety and Quality Improvement Act (PSQIA).[1] The PSQIA and its implementing regulations amended an existing federal law to create a national framework by which individual practitioners and healthcare entities can collect, submit, and learn from data regarding patient treatment and outcomes without fear of that information becoming discoverable in malpractice litigation.

Under the PSQIA, participating providers—which include individual providers as well as healthcare entities—can set up internal systems called "patient safety evaluation systems" (PSESs) to which providers submit treatment information, following which the facility transmits the collected data to federally certified institutions called patient safety organizations (PSOs). These PSOs, in turn, collect and analyze the provided information, compare similar cases among providers, identify broad statistical patterns, and then provide feedback and assistance to participating organizations, with the goal of improving patient care.

As the structure of this system suggests, the ultimate aim of the PSQIA was to create a national database of information crossing state lines, where one provider's input from treatment rendered in Oregon, for example, could be used to educate a provider in South Carolina who was performing the same operation—cross-country collaboration that had never previously been achieved at scale. To encourage participation, Congress declared that any "data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements" is, once submitted to an entity's PSES, considered patient-safety work product (PSWP),[2] and PSWP is privileged. Per the Act, PSWP "shall not" be admitted as evidence in any legal proceeding, or *even subject* to discovery in connection with any legal proceeding.

IMPACTS OF THE PSQIA

On its own, the PSQIA program would serve a limited role, arguably applying only to federal healthcare facilities and practitioners. It is, however, the language Congress chose to include regarding the law's interpretation with, and effect on, other state and federal laws that gives it such bite. To wit, the PSQIA section discussing confidentiality for PSWP states, expressly, that "notwithstanding any other provision of Federal, State, or local law" patient safety work product shall be privileged and confidential and shall not be subject to discovery in connection with or admitted into evidence in a "Federal, State, or local civil, criminal, or administrative proceeding." In other words, no contradictory provision of Federal, State, or local law—such as a more limited state-law peer-review privilege—applies to require disclosure in any legal proceeding of information that is otherwise privileged under the PSQIA.[3]

It is these provisions that give the PSQIA such an impact. Many limits on state privilege law are not present in the PSQIA, especially when medical facilities seek to go above and beyond in performing internal, self-critical assessments of patient care. Incident reports that currently fall outside of protection in certain states, like my own of Oklahoma, would likely be privileged under the PSQIA if prepared for that purpose. Likewise, oral statements of a physician that might otherwise be discoverable would likely not be under the PSQIA if made for the purpose of submitting to a PSO. The point is, for an entity that is prepared to go through the lengthy process of establishing a PSES, engaging a relationship with a PSO, and undergoing the type of top-down compliance training so that all relevant staff are familiar with how the PSQIA system operates,[4] the benefits are legion.

LIMITS ON THE PSQIA'S AMBIT

This is not to say that the PSQIA is the end-all be-all. Information that is required to be reported independently to other federal or state health agencies does not qualify as PSWP, even if also placed into a PSES. Moreover, some state appellate courts, no doubt concerned with what could be viewed as federal overreach in an area typically confined to state control, have held that the PSQIA *does not* pre-empt state law in the area of peer-review privilege. The Florida Supreme Court, for example, ruled in 2017 that the PSQIA does not preempt a constitutional amendment to Florida's constitution that gives patients the right to learn about information from adverse events. Several years earlier, in 2014, the Supreme Court of Kentucky likewise limited the PSQIA's preemptive effect to information that is created exclusively as PSWP, and that it did not cover documents required by state law to be prepared and provided to an independent state agency.

These state-by-state considerations must be taken into account, but for the most part (aside from Florida), the limitations on the PSQIA's preemptive effect are no different than the limitations of coverage already recognized by the Act (compare Kentucky's decision that the PSQIA does not preempt state reporting requirements with the PSQIA regulations' own acknowledgment that it does not apply to documents created for state-reporting requirements, for example). That said, given the benefit the PSQIA and its provisions confer on participating facilities, providers and entity administrators should strongly consider exploring the process involved in setting up a PSES and engaging with a PSO. That process is, to be fair, complicated, lengthy, and outside the scope of this article, but the benefits are wide-ranging. Not only does participation in the PSQIA provide access to a large database of interstate information on adverse events from other facilities that risk managers can use in assessing a facility's own procedures, but it permits a facility to broaden the scope of its internal review processes to better allow the facility to review its own adverse incidents for the betterment of care down the road. And, practically, it expands a facility's ability to maintain privileges over peer-review items. Everyone: facilities, physicians, providers, and patients, win in the long run.

Jeffrey C. Hendrickson is a partner at the USLAW firm of Pierce Couch Hendrickson Baysinger & Green, L.L.P., in Oklahoma City, Oklahoma. He practices primarily in the areas of medical malpractice defense and labor/employment defense.

1 42 U.S.C. § 299b-21 *et seq.*
2 *See* 42 U.S.C. § 299b-21(7).
3 *See* 42 U.S.C. § 299b-22(a)-(b).
4 This type of training is a must, as the PSQIA imposes a financial penalty on anyone who knowingly or recklessly discloses information that is considered patient-safety work product. *See* 42 U.S.C. § 299b-22(f)(1).