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What's Left of the Peer Review Privilege?

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IT AIN'T DEAD YET, but the words 'peer review' do not command the respect they did years ago. Recent cases, at the state and federal level, should be analyzed to evaluate litigation trends and potential approaches to address peer review discovery issues.

Ohio State Courts

The relevant state statute is R.C. § 2305.252:

> Proceedings and records within the scope of a peer review committee . . . shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a health care entity or . . . provider . . . arising out of matters that are the subject of evaluation and review by the . . . committee.

This statute has been invoked in countless lawsuits as a bar to the use of peer review material in civil litigation, often in cases involving medical staff privileging issues brought by a physician against a hospital. However, judges are suspect of the statutory protection and are increasingly willing to investigate whether documents are truly protected as 'peer review' material.

Many state courts are willing to entertain a request by plaintiff's counsel to conduct an *in camera* inspection of documents which a hospital claims are subject to peer review, and perform a careful analysis to determine exactly what documents might be subject to a peer review privilege claim.[1] A good example of this approach may be found in *Giusti v. Akron General Medical Center*, a case illustrating that a blanket claim of privilege is unlikely to carry the day and will be scrutinized by the court.[2]

The Court in *Giusti* noted that privileges are to be strictly construed and the party claiming the privilege has the burden of proving it applies to the requested information. In examining objections made at a deposition, the Court noted as follows:

> If a hospital were to establish that a qualifying peer-review committee investigated a particular incident, the next question for the trial court would not be whether the privilege applies to some general category of communications among peers. The question would be whether the privilege actually does apply to each question the hospital's lawyer instructed its witness not to answer at deposition.

The Court stated that the hospital must show, at a "bare minimum," that a peer-review committee existed and actually investigated the incident. Just because information might be of a type that usually makes up a peer review committee file does not mean that it will be protected, and the Court concluded that not every inquiry made by a peer constitutes a peer review.

Note that an order compelling production of documents, over an objection that the documents are protected by a peer review privilege, is immediately appealable.[3]

Federal Courts

There is no federal privilege statute.[4] Courts have routinely followed *Virmani v. Novant Health, Inc.*, and held that peer review records are discoverable.[5] In that case, involving claims of race and national origin discrimination, the court ordered disclosure of peer review records for all physicians at the institution for over a twenty year period. Virmani and similar cases have caused attorneys representing physicians to actively examine whether there is a basis for federal court jurisdiction, usually via the antitrust laws or employment discrimination related statutes. Given the resurgence of the employment-based model in hospital/physician relationships, this has converted what would have been "routine" medical staff privileging issues into entirely different lawsuits. However, even absent a peer review privilege, no one should think that discovery is unfettered.

A recent decision by the court in *Cohlmia v. Ardent Health Services* is instructive.[6] The court rather quickly concluded that there was no peer review protection in federal court. However, that did not end the court's analysis. As the Court stated:

> A number of courts have addressed the issue of whether peer-review privilege applies in cases such as this [federal and state antitrust claims] and have held that it does not . . . however, this court has found no case – and the parties have cited none – in which the court discussed the next level of concern: relevance, over-breadth, and burdensomeness in the context of a physician's anti-trust action.

The court then reviewed the plaintiff's discovery claims and, using traditional analysis of the factors it had cited, concluded that many of the requests were not relevant, were overbroad, or overburdensome. The plaintiff's requested discovery was substantially curtailed.

Indeed, the health care arena offers defense counsel an arsenal on which to base potential objections, in addition to traditional discovery

objections predicated on relevance, etc. Other well-founded objections which might apply in the health care setting include HIPAA, which would generally prevent the disclosure of protected health information ("PHI") by a provider absent the following exceptions:[7]

A. When the patient has provided HIPAA-compliant written authorization permitting disclosure;

B. When required under law (if a court orders compliance with a subpoena, that disclosure would be required);

C. When the disclosure is made in response to a subpoena without an order and (1) the provider receives satisfactory assurances from the party seeking PHI that sufficient notice and opportunity to object was given to the patient (not recommended to rely on this exception); or

D. The parties enter into a qualified protective order.

When patient records are sought, another basis for objection may be the physician-patient privilege. In addition to the HIPAA statute, the privilege exception set forth in R.C. § 2317.02 must also be satisfied. Under *Pacheco v. Ortiz*, the court held that "unless there was a waiver by the plaintiff himself, either actual or implied, of his privilege in regard to his hospital records, then they may not be released even though a subpoena has been properly served upon . . . the custodian of the hospital records."[8]

Other objections may be made if the records requested involve alcohol or drug treatment as Federal law provides special protections for such programs. For these records, a qualified protective order is not sufficient and either a patient authorization specifically covering alcohol and drug abuse records or a court order are required.[9] Similarly, HIPAA has special rules governing psychotherapy notes which generally require a special written HIPAA psychotherapy note authorization.[10] Finally, state law provides that HIV testing and AIDS information generally may not be disclosed except in very limited circumstances. Unless a patient release is obtained, the attorney seeking the records must obtain a court order.[11]

Lessons Learned

Giusti and similar cases make it clear that a physician's attorney should never allow the hospital's assertion of peer review privilege to go unchallenged in state court. Is, in fact, the information sought part of the records of a peer review committee? Was, in fact, a peer review committee constituted to investigate the situation at issue? Even if a committee did investigate the incident, are the records sought part of the committee's investigation?

From the hospital's standpoint, to be able to credibly argue that the privilege should apply, care must be taken that a peer review committee does actually investigate the incident at issue and that the relevant documents are reviewed by the committee during an investigation. Blanket claims of 'peer review' protection are unlikely to be persuasive in state court.

At the federal level, for attorneys representing physicians, finding a credible basis to invoke federal court jurisdiction will almost certainly allow for a broader range of discovery as the state peer review statute will not apply. However, hospital counsel should never let discovery requests go unchallenged. Even though it no longer makes sense to argue that the peer review privilege should apply in federal court, efforts should be made to curtail a physician's discovery requests on other grounds. Courts appear willing to apply traditional discovery limitations as appropriate and are particularly sensitive to patient confidentiality issues. ■

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[1] See Manley v. Heather Hill (2007) 175 Ohio App.3d 155, 885 N.E.2d 971. This is a good decision to note as it analyzes the reasoning of several courts that addressed *in camera* review in the wake of the 2003 amendments to the peer review statute.

[2] (2008) 178 Ohio App.3d 53.

[3] R.C. § 2305.252.

[4] Although the Health Care Quality Improvement Act, 42 U.S.C. § 1112, et seq. provides for immunity under certain conditions for those engaged in the peer review process, it does not provide any protection for peer review documents.

[5] (C.A. 4, 2001) 259 F.3d 284. See also Dorsten v. Lapeer Cty. General Hospital, (E.D. Mich. 1980) 88 F.R.D. 583 (adopting same rationale followed by Virmani twenty-one years later).

[6] 2008 U.S. Dist. LEXIS 92831 (2008).

[7] The Health Insurance Portability and Accountability Act of 1996.

[8] 11 Ohio Misc. 2d 1 (1983).

[9] 42 C.F.R. Part 2, Subpart B.

[10] 45 C.F.R. § 164.508(a)(2).

[11] R.C. § 3701.243(C)(2).