Joint Select Committee to Study the Medical Peer Review Process

Interim Report to the 80th Legislature

January 2007

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A Report to the Texas Legislature
80th Legislature

Senator Kyle Janek & Representative Burt Solomons
Co-Chairmen

Joint Select Committee to Study
the Medical Peer Review Process

January 24, 2007

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Dear Fellow Members:

The Joint Select Committee to Study the Medical Peer Review Process of the Seventy-Ninth Legislature hereby submits its interim report including recommendations for consideration by the Eightieth Legislature.

Respectfully Submitted,

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Senator Kyle Janek, Co-Chairman	Representative Burt Solomons, Co-Chairman
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Senator Robert Deuell	Rep. Jodie Laubenberg
________________________	________________________
Senator Royce West	Rep. Patrick Rose

Introduction

During the 79th Regular Session of the Texas Legislature, SB 419 was introduced as a result of the Sunset Advisory Commission's review of the Texas Medical Board (TMB), then the Texas Board of Medical Examiners. Section 1.52 of the House Committee Substitute to SB 419 requires the appointment of the Joint Interim Committee to Study the Medical Peer Review Process (the Committee). The Committee included the following members as appointed by The Honorable Tom Craddick, Speaker of the House, and The Honorable David Dewhurst, Lieutenant Governor: Representatives Glenda Dawson, Co-Chair; Patrick Rose; Burt Solomons; and Senators Kyle Janek, Co-Chair; Bob Deuell; and Royce West.

On September 12, 2006 the Honorable Glenda Dawson passed away unexpectedly. As a result, Speaker Craddick appointed Representative Jodie Laubenberg to the Committee and Representative Solomons assumed the responsibilities of Co-Chair.

During the interim the Committee was assigned the following charges:

1. The use of medical peer review in identifying and reporting to the TMB the conduct of or the quality of care provided by physicians who are members of the medical staffs of hospitals and other health care entities;

2. The use of medical peer review in disciplining a physician based on the conduct or quality of care provided by the physician as a member of the medical staff of a hospital or other health care entity;

3. The appropriate level of immunity protections for hospitals and other health care entities, medical peer review committees, and individuals who participate on those committees in health care liability claims brought by patients alleging bad faith physician credentialing;

4. Whether there are adequate mechanisms in state law to ensure appropriate regulatory supervision of the appropriateness and effectiveness of medical peer review in hospitals and other health care entities;

5. The adequacy of the TMB's oversight and investigation of physician claims that the medical peer review process is misused, including whether the board's oversight and investigation powers should be strengthened and how other states investigate claims of misuse of the medical peer review process;

6. The state regulatory reporting mechanisms relating to the appropriateness and effectiveness of medical peer review in hospitals and other health care entities and the oversight and authority of the state to ensure good faith medical peer review in hospitals and other health care entities in this state;

7. The potentially negative impact on medical peer review in this state that could result from potential changes to:
   (A) immunity protections; or

(B) the oversight and investigation of physician claims of misuse of the medical peer review process;

8. How the laws of other states address immunity protections for medical peer review;

9. Any other matter relevant to the medical peer review process, including how state and federal law identifies physician conduct that is considered to be unprofessional or unsafe by a medical peer review committee.

The Committee held one public hearing on September 27, 2006, at which time both invited and public testimony were heard. The members would like to thank the following individuals for their participation in the proceedings: The Honorable Patricia Gray, JD, LLM (Health, Law and Policy Institute, University of Houston Law Center), Mr. Tommy Jacks (Jacks Law Firm), Dr. Andrew Kent, MD (KSF Orthopedic Center), Mr. Michael J. Regier (Seton Family of Hospitals), Dr. Mari Robinson, MD (TMB), Mrs. Michele Shackelford (TMB), Mr. Matthew Wall (Texas Hospital Association), Mr. Timothy Weitz (McDonald, MacKay & Weitz, LLP) and Dr. Josie Williams, MD, MMM (Texas A&M University Health Science Center, Rural and Community Health Institute).

Background

> *Peer review is a common method for exercising self regulation and evaluating the performance of physicians. The purposes of this system is to improve the quality of health care, and reflects a widespread belief that the medical profession, in most cases, is best qualified to police its own.*[1]

A. Purpose of a Medical Peer Review Committee

The Texas Occupations Code defines a medical peer review committee as:

> "a committee of a health care entity, the governing board of a health care entity, or the medical staff of a health care entity, that operates under written bylaws approved by the policy-making body or the governing board of the health care entity and is authorized to evaluate the quality of medical and health care services or the competence of physicians."[2]

In practical application, a medical peer review committee is assembled by the executive board of a hospital or other health care entity for one of three purposes: physician credentialing, in response to a standard of operation complaint, or in response to a standard of care complaint.

1. Physician Credentialing - Typically physicians are not direct employees of a hospital and so must seek the privileges to see patients and use the hospital's facilities. Privileges are obtained through a peer approval process conducted at the involved hospital and with the participation of other physicians already under contract with the hospital. This

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[1] Michael Logan, *Peer Review: How to Avoid the Poliner Result*, Presentation before the American Bar Association, Health Law Section, Chicago (2005) at 1.
[2] TEX. OCC. CODE §151.002(8) (2006).

type of peer review committee is not established as a result of a complaint filed against the physician or out of suspicion of any wrongdoing within the scope of the applying physician's professional duties.

2. Standard of Operation Complaint - This type of complaint may be filed against a physician for reasons related to his or her administrative duties. For example, a physician may have failed to complete medical paperwork in a timely fashion or filled out medical charts and other documents incorrectly.

3. Standard of Care Complaint - A complaint of this type involves the manner in which a physician has treated a patient. That is, a complaint may be filed against a physician who is believed to have been negligent in his or her treatment or diagnosis of a patient. The level of a physician's education, their lack of expertise in a certain specialization, or an unusually high complication or mortality rate may also constitute the basis for a standard of care complaint.[3]

The ultimate goal and function of a medical peer review committee is to educate the hospital in order to achieve better patient care. As stated by Dr. Josie Williams in her testimony to the Committee, the purpose of a peer review committee is to assess, "How can we do it better? How can we make it happen never again...How can we fix it so that we do it right the first time, every time?"[4]

B. Process of a Medical Peer Review Committee within a Health Care Entity

The review process of a physician is initiated by the filing of formal paperwork either regarding a physician's request for privileges or regarding a complaint of physician care or operation. If the process is initiated by a complaint, a physician need not be notified of this or of any investigation that is underway.[5]

After the complaint is filed, the hospital or health care entity's executive board will then decide which of the facility's physicians are to serve on the medical peer review committee. The membership of a medical peer review committee is generally composed of three to four physicians within the same hospital or health care entity who practice in either the same or similar field as the physician being investigated. Members are also chosen for their ability to enter the process unbiased and in a professional position which will not be bolstered by an adverse action on the physician in question. Beyond these general requirements, the composition of a peer review committee will vary among health care entities as each is given the ability to assemble a medical peer review committee as deemed appropriate by their respective bylaws.

Upon creation of the medical peer review committee, the actual process undertaken to investigate a physician will also vary according to the hospital or health care entity's bylaws. However, the availability of information to the participating physicians on the peer review committee remains

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[3] Hall, Render, Killian, Heath & Lyman, *Executive Summary: Health Care Quality Improvement Act of 1986* (2005) at. 3.
[4] Oral testimony of Dr. Josie Williams before the Joint Select Committee to Study the Medical Peer Review Process (Sept. 27, 2006). Dr. Williams is the Director for the Texas A&M University System Health Science Center, Rural and Community Health Institute.
[5] 42 U.S.C. §11112(b)(1) (West 2005).

constant throughout the hospitals' varying processes. During an investigation, the medical peer review committee members are to be allowed confidential access to all appropriate information regarding the physician under review. With access to information beyond the complaining event, the members are able to discover whether the complaint relates to an isolated incident or whether it may be indicative of a trend of transgression by the physician. A more detailed look into the rules and implications of being privy to such information will be discussed later in this report.

Following the completion of a peer review committee investigation, a recommendation for action will be submitted to the executive board of the health care entity. The executive board will then review the recommendation before submitting it to the TMB for a final decision. The continuation of the process once a committee decision is sent to the TMB will be addressed in the section entitled State Regulation.

C. Health Care Quality Improvement Act

Prior to 1986, the medical peer review process was not held to any sort of regulation beyond that which was enforced at the individual hospital or health care entity. However, due to the significant increase in incidents of medical malpractice and physician negligence, coupled with the scant protections offered to physicians who participated in the medical peer review process, the U.S. Congress passed the Health Care Quality Improvement Act of 1986 (HCQIA).[6] HCQIA can be regarded as set of national minimum standards to which hospitals and health care entities set their peer review activities. The primary way in which HCQIA fortified the medical peer review process involves immunity protections for participating physicians and health care entities. The immunity protections granted by HCQIA will be addressed in a later section of this report.

In response to the belief that "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," HCQIA created the National Practitioner Data Bank (NPDB).[7] NPDB is a resource for information regarding individual physician's disciplinary actions, malpractice payments, and adverse review actions. During an investigation by a medical peer review committee, any information regarding the involved physician contained in the NPDB may be accessed.

As set forth by HCQIA, the submission of physician information to the NPDB is required if a medical peer review committee recommendation calls for an adverse action to last for more than 30 days.[8] An action taken that lasts for fewer than 14 days does not have to be reported nor does it allow the physician HCQIA rights. Any action lasting 15 days or more is considered "adverse" and thus will allow the physician his fair hearing and HCQIA rights.[9]

The information collected about a physician includes his or her name, residential and business address, social security number, date of birth, name of professional school attended, graduation date, field of licensure and state where it is held, description of reason for peer review action and resulting decision,

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[6] Hall, Render, Killian, Heath & Lyman, *Executive Summary: Health Care Quality Improvement Act of 1986* (2005) at 1-2.
[7] 42 U.S.C.A. §11101(1) (West 2005).
[8] *Id*. at §11133(a)(1).
[9] *Id*. at §11112(c)(1).

date of action imposition, effective date of action, and any other information pertinent to the peer review investigation.[10] If incidents of peer review investigations and actions are reported correctly, the NPDB is able to more effectively prevent a physician from moving from one state to another following a hospital's adverse action against the physician.

The Texas Medical Board and Bylaws

A. Texas Medical Board

The power to regulate physicians within Texas was formalized with the creation of the Texas State Board of Medical Examiners in 1937.[11] With the passage of SB 419 during the Regular Session of the 79th Legislature, it is now called the TMB. Among the duties of the TMB is the formulation of an expert physician review panel to handle standard of care complaints filed against licensed physicians. Under §154.056(e) of the Texas Occupations Code, the TMB is required to establish guidelines for the appointment and termination of physicians to the panel.

Although Congress enacted HCQIA to improve the quality of care and restrict a physician's ability to move from state to state, Congress also required, in HCQIA, *mandatory* reporting by health care entities to the Board of Medical Examiners. The mandatory reporting requirement is triggered when the entity takes any one of the following actions:

1. Takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;

2. Accepts the surrender of clinical privileges of a physician—

    a. while the physician is under investigation by the entity relating to possible incompetence or improper professional conduct, or

    b. in return for not conducting such an investigation or proceeding; or

3. In the case of such an entity which is a professional society that takes a professional review action which adversely affects the membership of a physician in the society.[12]

HCQIA requires the following specific information, at a minimum, to be included in a report made to the Medical Board:

1. the name of the physician,

2. a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and

[10] 45 C.F.R. § 60.9(a)(3).
[11] Bill Analysis for 79R SB 419, Enrolled.
[12] 42 U.S.C.A §11133(a)(1) (West 2005).

3. such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.[13]

Mandatory reports by a medical peer review to the TMB are codified in the Occupations Code.[14] In addition to the HCQIA reporting requirements, the Texas Legislature went further by enacting stronger reporting requirements, including a broader group of practitioners. The following additional practitioners are required to report quality of care or unprofessional conduct to the TMB:

1. a medical peer review committee in this state;
2. a physician licensed in this state or otherwise lawfully practicing medicine in this state;
3. a physician engaged in graduate medical education or training;
4. a medical student;
5. a physician assistant or acupuncturist licensed in this state or otherwise lawfully practicing in this state; and
6. a physician assistant student or acupuncturist student.[15]

The report from the additional practitioners shall include "relevant information" if, "in the *opinion of the person or committee* that physician poses a continuing threat to the public welfare through the practice of medicine."[16] Thus, the TMB receives information relating to medical peer review from a number of sources. Although the TMB expressed at the hearing that it does not receive many peer review committee reports, the conclusion was made, by that agency, that such actions are underreported. Testimony was received stating that hospital medical peer review committees will impose a 31 day sanction making the peer review a reportable event to the TMB. Moreover, the additional practitioners required to report concerns about a continuing threat to the public welfare *are not* restricted by the sanction imposed, membership affected or in any manner from reporting their concerns to the TMB.

The TMB testified that once it receives information concerning a peer review action, the agency undertakes its own independent investigation.[17] It does not accept the medical peer review committee's action as the only disciplinary action taken in the quality of care or unprofessional conduct incident under review. In fact, the TMB testified that it would impose its own practice restrictions, over and above the sanctions imposed by the medical peer review committee.[18] The TMB proceeds with its standard investigatory process including the gathering of records and interviewing witnesses. Within the Medical Practice Act, the TMB has plenary access via subpoena to any records that the TMB believes it needs to perform its statutory mandates.[19] From these records, including the confidential

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[13] *Id.* at §11133(a)(3).
[14] TEX. OCC. CODE §160.002 (2006).
[15] *Id.* at §160.003 (a)(1)-(6).
[16] *Id.* at §160.003 (b).
[17] TMB, Mari Robinson, Enforcement Director (TMB Testimony). Testimony before the Joint Select Committee to Study the Medical Peer Review Process (Sept. 27, 2006).
[18] *Id.*
[19] TEX. OCC. CODE §160 (2006).

peer review records, the TMB may identify other quality of care concerns not reviewed by the medical peer review committee, additional documents and witnesses.

Although the TMB may obtain confidential peer review documents, these records retain their confidentiality throughout any administrative proceeding.[20] Prior to the enactment of Senate Bill 419, a concern was raised that the TMB was unable to utilize confidential peer review documents during an administrative hearing, thereby limiting the TMB's ability to effectively discipline physicians. With the enactment of Senate Bill 419, this concern was eliminated thus affording the TMB with additional oversight and investigatory mechanisms.[21] Although the records of the medical peer review committee are confidential, the confidentiality shield does not:

> "apply to records used by a medical peer review committee, including a patient's medical records or records made or maintained in the regular course of business, if the records are not considered confidential under this chapter or any other law and are otherwise available to the board."[22]

While under both HCQIA and Texas Statute reporting of adverse peer review actions must be made to the TMB, the TMB generally does not investigate physician claims of misuse of the medical peer review process. The mission of the TMB is to:

> "protect and enhance the public's health, safety and welfare by establishing and maintaining standards of excellence used in regulating the practice of medicine and ensuring quality health care for the citizens of Texas through licensure, discipline and education."[23]

Thus, it is not within the TMB's mission to investigate physician-to-physician complaints of misuse of the medical peer review. Misuse of the medical peer review process will be addressed in a later section of the report.

B. Bylaws

The definition of a medical peer review committee under Texas Law includes the requirement that the committee operate under written bylaws approved by the policy-making body or the governing board of the health care entity.[24] Bylaws will outline the peer review process for that health care entity, and the rights and responsibilities of all parties involved in a peer review audit. Although each health care entity's governing board adopts their own bylaws, all bylaws for health care entities must include the minimal obligations outlined in the federal and state statutes discussed above, such as disclosure, due process, immunity and referral requirements.

All bylaws for health care entities will share certain essentials for the peer review process which federal and state law necessitate, but may also include requirements from certifying organizations. In

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[20] *Id.* at §160.006(d).
[21] Texas Hospital Association, Matthew T. Wall, Associate General Counsel (THA Testimony). Testimony before the Joint Select Committee to Study the Medical Peer Review Process (Sept. 27, 2006).
[22] TEX. OCC. CODE §160.006(e) (2006).
[23] TMB (TMB). (n.d.) Retrieved October 31, 2006, available at http://www.TMB.state.tx.us/.
[24] TEX. OCC. CODE §151.002(8) (2006).

addition to federal and state standards, many health care entities performing peer reviews are also accredited by national certification organizations. The Texas Hospital Association testified that 75 percent of Texas hospitals are accredited by the Joint Commission on Accreditation of Healthcare Organizations, a voluntary, national accrediting organization which, among other things, has requirements for peer review to obtain certification.[25] *The Comprehensive Accreditation Manual for Hospitals* requires hospitals to have a credentialing process for physicians as well as an ongoing evaluation of their ability to provide quality care, treatment, and services.[26] It requires the hospital to identify a minimum set of circumstances that require further intensive review to determine whether a practitioner's performance may require corrective or disciplinary action.[27]

Although the bylaws must incorporate the state and federal standards for a peer review audit, report and referral to regulatory authorities, there is broad discretion for the health care entity to define the formality of the process. Testimony before the Committee highlighted the differences between peer review processes at various health care entities. Mr. Tim Wietz testified that inconsistencies were very evident between different health care entities.

> "From an attorney's standpoint, for me to go to and do a peer review down in the Valley, I get one set of bylaws which might seem very much like a coffee class situation; you show, you have coffee and doughnuts and it's a very, very informal around the table. On the other hand I can go to… a Columbia facility in San Angelo, Texas and I walk into something akin to a very formal trial process."[28]

Although this nonuniformity may lead to difficulties and create a disincentive for defense attorneys with state-wide practices, as inferred by Mr. Weitz, the bylaws would create consistency for the process within the individual health care entities.

These bylaws are legally binding on the actions of the peer review committee who are acting as agents of the health care entity. Mr. Michael Regier, Senior Vice-President for Legal Affairs for Seton Family of Hospitals testified before the Committee that the standards within bylaws are enforceable legally as a contractual obligations of the health care entity.[29] In this way, the members of the peer review committee, the governing board and the health care entity itself are obligated to the standards and process outlined in their bylaws. Enforcement of these bylaws is available to participants through judicial review.

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[25] Written testimony of Mr. Matt Wall submitted on behalf of the Texas Hospital Association before the Joint Select Committee to Study the Medical Peer Review Process on Sept. 27, 2006. Mr. Wall is the General Counsel for the Texas Hospital Association.

[26] Commission on Accreditation of Healthcare Organizations, *2006 Comprehensive Accreditation Manual for Hospitals*, MS 4.20, MS 4.40.

[27] Commission on Accreditation of Healthcare Organizations, *2006 Comprehensive Accreditation Manual for Hospitals*, MS. 4.90.

[28] Oral testimony of Mr. Tim Weitz before the Joint Select Committee to Study the Medical Peer Review Process on Sept. 27, 2006. Mr. Weitz is an attorney for McDonald, Mackay & Weitz who specializes in defense administrative law for physicians.

[29] Oral testimony of Mr. Michael Regier before the Joint Select Committee to Study the Medical Peer Review Process on Sept. 27, 2006.

Immunity Protections

Medical peer review can be a valuable tool in improving the standard and quality of patient care.[30] The rationale on which peer review statutes are generally based involves the belief that an open analysis of the competence and performance of healthcare providers by their peers will result in fewer medical errors and better patient care.[31] Effective peer review requires a level of candor and openness from its participants which cannot be achieved without the existence of immunity protections. All states provide some level of immunity protection for those involved in the medical peer review process.[32] Texas' current immunity protections provide that neither a hospital nor a member of a medical peer review committee is subject to civil liability for actions taken or recommendations made within the scope of the medical peer review committee, so long as the actions in question were made without malice.[33]

Successful medical peer review can be hindered by low participation levels. There are a number of reasons physicians may express reluctances to participate in the peer review process, including fear of becoming a defendant in a lawsuit brought by a physician who was the subject of a peer review proceeding. In addition, physicians and hospitals face a number of non-legal disincentives to participate in peer review, such as loss of referrals from the physician under review or loss of admissions.[34] Without immunity protections in place for medical peer review participants it would prove extremely difficult, if not impossible, to recruit capable participants. Immunity protections cultivate effective medical peer review by allowing its participants to candidly contribute to the process without fear of retribution. Exposing participants in the peer review process to increased liability will frustrate peer review activities, which may have harmful effects on the quality of the care provided.

A. Federal and State Immunity Protections

i. Health Care Quality Improvement Act (HCQIA)[35]

Congress enacted HCQIA in 1986 to enable healthcare professionals to decisively review the actions of their colleagues without the threat of liability for any adverse actions or recommendations resulting from such review.[36] Congress believed that the threat of liability under Federal antitrust laws "unreasonably discourages physicians from participating in effective professional peer review" and

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[30] COMMITTEE ON QUALITY OF HEALTH CARE IN AMERICA, INSTITUTE OF MEDICINE, TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM (Linda T. Kohn, et al. eds., 2000) (estimated that as many as 98,000 patients die annually from preventable medical errors).
[31] *Id*.
[32] AMERICAN MEDICAL ASSOCIATION, PEER REVIEW PRIVILEGES AND IMMUNITIES: A 50 STATE SURVEY AND ANALYSIS 4 (2006).
[33] TEX. OCC. CODE §160.0101(a)-(b) (2006); *Romero v. KPH Consolidation, Inc*., 166 S.W.3d 212 (Tex. 2005).
[34] Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit – Is It Time for a Change?*, 25 AM. J.L. AND MED. 7,11(1999).
[35] 42 U.S.C.A §11101 (West 2005).
[36] Casey L. Moore, *"In the Wake of the Rose" and "Life After Romero": The Viability of a Cause of Action for Negligent Credentialing in Texas in Light of Recent Texas Supreme Court Decisions*, 58 BAYLOR L. REV. 549, 556 (2006).

thus there was a need to provide protection for physicians participating in peer review.[37] Prior to HCQIA, a physician's adverse actions, including errors in treatment and care of patients, were not subject to the scrutiny of other professionals in part because of the fear of legal recourse brought by the physician under review.[38]

HCQIA provides immunities for entities and participants engaged in peer review activities, as long as the review process satisfies specific due process requirements.[39] HCQIA also affords protection for individuals providing information to professional review bodies:

> no individual "providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State… unless such information is false and the person providing it knew that such information was false."[40]

Section 11112(a) provides that in order to qualify for the immunity provided by HCQIA, a professional review action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality healthcare,
> (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).[41]

A professional review action is presumed to have met the preceding standards for protection unless the presumption is rebutted by a preponderance of the evidence.[42]

"The immunity created by HCQIA appears to be immunity from liability for damages, not immunity from being sued."[43] Injunctive and declaratory relief are not damages and therefore not covered under the immunity shield created by HCQIA.[44] HCQIA does not alter "liabilities or immunities under law" and does not preempt or override "any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by HCQIA."[45] HCQIA does not provide for peer review privilege or confidentiality and therefore allows the states to determine the appropriate levels.[46] States, including Texas, typically provide broader immunity than HCQIA.[47]

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[37] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, Legislative Briefing: Medical Peer Review. Written testimony submitted to the Joint Select Committee to Study the Medical Peer Review Process (Sept. 27, 2006). (copy on file with the Joint Select Committee to Study the Medical Peer Review Process).
[38] Moore, *supra* note 36, at 3.
[39] AMERICAN MEDICAL ASSOCIATION, *supra* note 32, at 4.
[40] 42 U.S.C.A. §11111(2) (West 2005).
[41] 42 U.S.C.A. §11112(a) (West 2005).
[42] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37, at 4.
[43] *Id*.
[44] *Id*. at 3 (summarizing *Manion v. Evans*, 986 F.2d 1036 (6th Cir. 1993).
[45] 42 U.S.C.A. §11101-11152 (West 2005).
[46] *Id*.
[47] AMERICAN MEDICAL ASSOCIATION, *supra* note 32, at 4.

ii. Texas Occupations Code

In 1987 the Texas Legislature formally enacted medical peer review privilege and immunity provisions, including but not limited to those protections found in HCQIA.[48] State law provides a broad range of immunity to a number of entities, including:

> [a] member, employee, or agent of the board, [or] a medical peer review committee… who takes an action or makes a recommendation within the scope of the functions of the board [or] committee… if that member, employee, agent, or intervenor acts without malice, and in the reasonable belief that the action or recommendation is warranted by the facts known to that person…

The medical peer review immunity provisions also provide that:

> [a] cause of action does not accrue against a member, agent, or employee of a medical peer review committee or against a healthcare entity from any act, statement, determination, or recommendation made, or act reported, without malice, in the course of medical peer review.

Finally, the provisions set forth that:

> [a] person, medical peer review committee, or healthcare entity that, without malice, participates in peer review or furnishes records, information, or assistance to a medical peer review committee or the board is immune from any civil liability arising from that act.[49]

State law currently provides greater immunity than HCQIA by immunizing any participant in a healthcare peer review who acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts shown.[50] In Texas, a hospital is not liable for improperly credentialing a physician through its peer review process unless the hospital acts with malice.[51] Malice must be proven by clear and convincing evidence as a predicate to the recovery of exemplary damages.[52]

iii. How Texas Compares To Other States

"All fifty states and the District of Columbia have enacted immunity statutes limiting liability for certain medical peer review participants." [53] The extent of immunity protections provided differs by state.[54] Texas' immunity protections fall firmly in the middle of the spectrum measuring the strength

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[48] *See* TEX. REV. CIV. STAT. ANN. Art 4495b, § 5.06(l)-(m); Act of June 1, 1987, 70th Leg., R.S. ch 596, § 18, 1987 Tex. Gen Laws 2325, 2335.
[49] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37 (citing TEX. OCC. CODE §160.010(a)-(c) (Vernon Supp. 2006).
[50] TEX. OCC. CODE §160.010(a)(2) (2006).
[51] *Id.*; TEX. OCC. CODE §160.010(b) (2006).
[52] *Id*.
[53] AMERICAN MEDICAL ASSOCIATION, *supra* note 32.
[54] *Id*.

of state immunity protections.[55] "All states immunize peer review committee members and most statutes extend immunity to a wider class of individuals, e.g., persons providing consultation to the committee."[56] Every state provides immunity from civil damages and many states extend immunity to cover injunctive or equitable relief.[57] Some states, including Georgia, even extend the immunity protections for peer review participants to criminal liability.[58] The California Supreme Court has recently strengthened its peer review protection by holding that hospital medical staff peer review proceedings are an "official proceeding," and that meritless lawsuits brought in connection with these proceedings are thus subject to a special motion to strike under California's anti-SLAPP statute.[59] This ruling allows a physician peer reviewing another medical staff member an immediate procedural defense that can result in a speedy judicial review.[60]

B. Confidentiality of Peer Review Reports

Legislation relating to peer review privilege and confidentiality promotes the belief that, absent such protections, physicians would be reluctant to sit on peer review committees and engage in open evaluations of their colleagues. The protections attach to information determined to be from a peer review committee are covered by the statute. "A peer review privilege confers on a person or entity the right to prohibit another person or entity from discovering or using peer review records or deliberations during the course of litigation."[61] "Peer review confidentiality prohibits the disclosure of peer review records and deliberations outside of the judicial process."[62] The level of confidentiality is determined by "the desire to promote candor and objectivity in the peer review process versus a plaintiff's access to evidence."[63]

i. Texas Peer Review Confidentiality

In Texas, the proceedings and records of a medical peer review are confidential and any records or determinations of, or communications to, a medical peer review committee are privileged.[64] Unless disclosure is required or authorized by law, a record or determination of or a communication to a medical peer review committee is not subject to subpoena or discovery and is not admissible as evidence in any civil judicial or administrative proceeding without waiver of the privilege of confidentiality executed in writing by the committee.[65] In *Memorial-Hosp.-The Woodlands v. McCown*, the Supreme Court of Texas explained the purpose behind the discovery protection of Texas peer review regulation:

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[55] Matt Wall, Associate General Counsel, Texas Hospital Association. Testimony before the Joint Select Committee to Study the Medical Peer Review Process (Sept. 27, 2006).
[56] *Id*.
[57] AMERICAN MEDICAL ASSOCIATION, *supra* note 32.
[58] *Id*.; GA. CODE ANN. §31-7-132 (2006).
[59] CA CODE CIV. PRO. §425.16 (2006).
[60] *Kibler v. Northern Inyo County Local Hospital District, et al*., 39 Cal. 4th 192 (2006).
[61] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37 at 7.
[62] *Id*.
[63] AMERICAN MEDICAL ASSOCIATION, *supra* note 32, at 4.
[64] TEX. OCC. CODE §160.007(a) (2006).
[65] *See* TEX. OCC. CODE §160.007(e) (2006).

> [F]irst, that exacting critical analysis of competence and performance of physicians and other healthcare providers by their peers will result in improved standards of medical care; and second, that an atmosphere of confidentiality is required for candid, uninhibited communication of such critical analysis within the medical profession.[66]

The Texas medical peer review committee privilege does not apply to records made or maintained in the regular course of business by a hospital, HMO, or medical organization.[67] As discussed earlier, the TMB and the Department of State Health Services can obtain access to peer review proceedings and evaluate the process and those participating. The medical peer review committee privilege does not prohibit discovery of privileged information from alternative sources.[68] The identities of the members of the committee are not privileged under the state statute.[69]

Although Texas statute clearly states that medical peer review committee proceedings and records are confidential and not subject to subpoena,[70] the Texas Supreme Court has held that a party may be entitled to *in camera* inspection to determine the discoverability of the documents.[71] This means that a judge may review the documents produced by the peer review committee to determine whether the court believes that actions were taken maliciously, and if so, may enter the documents into record.

ii. Comparison with Other States

Some states, such as Georgia, show a strong preference for peer review protection and provide an "absolute embargo upon the discovery and use of all proceedings, records, findings, and recommendations" of peer review committees.[72] Georgia protects purely factual information, e.g., the time and date of meetings, and the identities of any peer review committee attendees.[73] Other states choose to limit the privilege protection to certain documents, i.e. information, interviews, reports, statements, memoranda, and recommendations.[74]

Illinois, a state with a more moderate level of peer review protection, has a privilege which protects "information, interviews, reports, statements, memoranda, recommendations, letters of reference or other third party confidential assessments of a healthcare practitioner's professional competence…"[75] However, Illinois courts have ruled that this privilege does not apply to information generated prior, or subsequent to, the peer review process.[76] Kentucky's privilege shows a preference for medical liability and negligent credential plaintiffs' access to evidence.[77] Kentucky courts have ruled that the privilege was enacted to protect reviewers from lawsuits by disgruntled healthcare practitioners, and courts have

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[66] *Memorial Hosp.-The Woodlands v. McCown*, 927 S.W.2d 1,3 (Tex. 1996).
[67] TEX. HEALTH & SAFETY CODE §161.032(f) (2006).
[68] *Irving Healthcare System v. Brooks*, 927 S.W.2d 12, 18 (Tex. 1996).
[69] *In-re Liberty-Dayton Hosptial*, 144 S.W. 3d 642, 646 (Tex. App.—Beaumont 2004).
[70] TEX. HEALTH & SAFETY CODE §161.032(a) (2006).
[71] *Living Ctrs. of Texas*, 175 S.W. 3d at 255.
[72] AMERICAN MEDICAL ASSOCIATION, *supra* note 32, at 5.
[73] *Id*. at 83.
[74] *Id*. at 6.
[75] *Id*.
[76] *Id*. at 84.
[77] *Id*. at 124.

consistently ruled that the Kentucky privilege, unlike the Texas privilege, does not prevent a plaintiff in a medical liability action from discovering peer review information.[78]

C. Negligent Credentialing

A cause of action for negligent credentialing arises out of a healthcare entity's direct responsibility to its patients to take reasonable steps to ensure that medical care providers are qualified.[79] Negligent credentialing claims involve "a claimed departure from an accepted standard of healthcare, and the hospital's credentialing of staff was inseparable from the care that a patient received at the hospital."[80] In Texas, the negligent credentialing cause of action has only been applied in narrow circumstances and as such has a limited history.[81]

The plaintiffs in a negligent credentialing claim will be the same plaintiffs who are in a position to bring the underlying medical negligence claim. The defendant in a negligent credentialing claim will be the hospital that has granted staff privileges to the allegedly negligent physician or the managed care organization that allowed an allegedly negligent physician to be part of its healthcare system.[82] To prevail, the plaintiff must show that the hospital negligently granted privileges to a physician and that the negligently credentialed physician was in fact negligent and caused harm to the plaintiff.[83]

A number of states have yet to recognize a negligent credentialing cause of action and a handful, including Kansas and Minnesota, have expressly denied the existence of a cause of action for negligent credentialing.[84] Although the Texas Supreme Court has not expressly denied the existence of the cause of action, it has said that because of a split in the lower courts, it was not a "well-recognized common law cause of action in Texas."[85] There are only three Texas Supreme Court cases that deal with negligent credentialing.[86] In *Garland Community Hospital v. Rose* the Texas Supreme Court interpreted the statutory definition of a healthcare liability claim, "to determine whether a cause of action falls under the … definition of a "healthcare liability claim", we examine the claim's underlying nature."[87] The court also provided that a claim qualifies as a health care liability claim "if the act or omission alleged in the complaint is an inseparable part of the rendition of health care services", of which credentialing is included.[88] The classification of a negligent credentialing claim as a health care liability claim is important because a health care liability claim must meet specific requirements, including notice requirements, expert report requirements and damage caps.[89] The court held that

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[78] *Id*.
[79] *GarlandCommunity Hospital v. Rose*, 156 S.W. 3d 541 (Tex. 2004).
[80] *Id*.
[81] Moore, *supra* note 36 at 2.
[82] 18 Causes of Action 2d 329 (2006).
[83] *Id*.
[84] *Id*.; *Larson v. Wasemiller*, Minn. Ct. App., No. A05-1698 (July 25, 2006).
[85] *St. Luke's Espiscopal Hosp. v. Agbor*, 952 S.W.2d 503 (Tex. 1997); Moore, *supra* note 8, at 551 (stating that in St. Luke's Chief Justice Phillips opined that "a claim [for negligent credentialing], no matter how meritorious, would be virtually impossible to [substantively] prove.").
[86] *St. Luke's Espiscopal Hosp. v. Agbor*, 952 S.W.2d 503 (Tex. 1997); *Garland Community. Hospital v. Rose*, 156 S.W.3d 541 (Tex. 2004); *Romero v. KPH Consolidation, Inc*., 166 S.W.3d 212 (Tex. 2005).
[87] *Garland Community. Hospital v. Rose*, 156 S.W.3d 541 (Tex. 2004).
[88] *Id*.
[89] TEX. CIV. PRAC. & REM. CODE ANN. 74.001-.507 (2006).

negligent credentialing claims were health care liability claims due in part to the fact that "negligent credentialing is an ongoing and continuous process, not a series of discrete events."[90]

Prior to 1997, case law by the Texas Court of Appeals indicated that there was a common law cause of action against a hospital for negligent credentialing.[91] However in 1997, the Texas Supreme Court in *St. Luke's Episcopal Hospital v. Agbor* opined that the immunity afforded in the Texas Medical Act is afforded to peer review committee participants in all peer review committee purposes, whether in a review of standard of care or in credentialing a provider for privileges.[92] Thus, this changed the cause of action available in Texas from negligent credentialing, where a patient must prove that a health care entity was simply negligent in allowing a physician privileges, to malicious credentialing. Although malice is the same standard utilized in actions against a provider in a standard of care review, a patient in a credentialing suit must show that a hospital had blatant disregard or intent to harm patients by granting privileges to a questionable physician. While the immunity provisions are the same, patients find it almost impossible to prove malice.

At the time the first of the three Texas Supreme Court cases dealing with negligent credentialing was decided, malice, with regard to recovery of exemplary damages was defined as:

> (A) a specific intent by the defendant to cause substantial injury to the claimant; or (B) an act or omission: (i) which when viewed objectively from the standpoint of the actor at the time of its occurrence involves an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and (ii) of which the actor has actual, subjective awareness of the risk involved, but nevertheless proceeds with conscious indifference to the rights, safety, or welfare of others.[93]

In 2003, the Legislature passed extensive tort reform legislation which narrowed the definition of malice to "a specific intent by the defendant to cause substantial injury or harm to the claimant."[94] A claim for negligent credentialing in Texas exists but has evolved into a difficult claim for a plaintiff to successfully assert.

D. Physician Claims of Peer Review Misuse

While these same remedies apply equally to malicious peer review suits as to negligent credentialing suits, patients find the same standards more burdensome than providers. Negligent credentialing suits are usually initiated by a patient against the health care entity for credentialing a provider which the peer review committee should have known was a danger to the public welfare and who inflicted injury upon the patient. In comparison, malicious peer review litigation usually involves a claim brought by a provider against members of the peer review committee and/or the health care entity for acting maliciously in denying or suspending privileges.

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[90] *Garland Community. Hospital v. Rose*, 156 S.W.3d 541 (Tex. 2004).
[91] Oral testimony of Tommy Jacks before the Joint Select Committee to Study the Medical Peer Review Process on September 27, 2006. Mr. Jacks is an attorney for The Jacks Law Firm who specializes in defense law.
[92] *St. Luke's Episcopal Hospital v. Agbor*, 952 S.W. 2d. 503 (Tex. 1997).
[93] Act of June 3, 1987, 70th Leg., 1st C.S., ch 2,2.12, sec 41.001(6), 1987 Tex. Gen. Laws 37, 44, amended by Act of Apr. 6, 1995, 74th Leg., R.S., ch 19, 1, sec 41.001(7), 1995 Tex. Gen. Laws 108 (amended 2003) (codified at TEX. CIV. PRAC. & REM. CODE ANN. 41.001(7) (Vernon 1997)).
[94] TEX. CIV. PRAC. & REM. CODE ANN. § 41.003(a)-(b) (2006).

The recent case of *Poliner v. Texas Health Systems* shines a light on concerns involving malicious peer review.[95] *Poliner v. Texas Health Systems* arose out of improper care allegations of a peer review committee that led the Hospital to summarily suspend the privileges of Dr. Poliner, a cardiologist.[96] The court discovered sufficient evidence to find Dr. Poliner could recover damages from the hospital and physicians based on his claims for breach of contract, defamation, interference with contractual relations, and intentional affliction of emotional distress.[97] The court reiterated its prior determination that the defendants were not entitled to peer review immunity under the federal or state law protections.[98]

The jury found by a preponderance of the evidence that the defendants had taken an action against Dr. Poliner that was not within the scope of the functions of the medical peer review committee and acted "with malice and not in the reasonable belief that the action was warranted by the facts".[99] The jury originally awarded Dr. Poliner $366 million but the court recently reduced the damages award to $22.5 million.[100] "The [*Poliner*] verdict does not necessarily demonstrate that Texas' peer review statute is infirm, but more likely reflects the unique facts of the case."[101]

Even so, HCQIA has adequate safeguards in place to protect physicians from the misuse of medical peer review. Under the immunity provided in HCQIA, a physician alleging a misuse of peer review has the burden to produce sufficient evidence of existence of genuine dispute as to whether the participants in the peer review process were entitled to qualified immunity prescribed by the federal statute.[102] If the affected physician meets this very high burden then the peer review records along with the individuals and/or entities involved in the litigation lose the confidentiality and immunity protections and are thus subject to all claims and damages available at law to the affected physician. A claim of misuse of the peer review process often involves additional claims of antitrust, conspiracy, deceptive trade practices and other tort and contract claims. If the affected physician prevails, then damages may be available to make the party whole. Remedies exist at law, rather than using state money and resources to address egregious acts of misuse of the medical peer review process.

E. Economic Credentialing

Dr. Poliner accused the hospital of taking actions against him in an attempt to "eliminate him as a competitor."[103] This raises questions as to the proper extent of medical peer review immunity, i.e.

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[95] *Poliner v. Texas Health Sys*, 2006 U.S. Dist. LEXIS 66819 (2006).
[96] *Id*.
[97] *Id*.
[98] *Id*.
[99] *Id*. Examples of malice included: (1) Hospital president testified that he did not have enough information to assess whether Dr. Poliner posed a present danger to his patients at the time he asked Dr. Poliner to agree to the abeyance; (2) Hospital president testified he did not know all of the facts surrounding the abeyance at the time; (3) threatened to terminate all Dr. Poliner's hospital privileges if he did not consent to the abeyance; (4) Dr. Poliner was told not to consult an attorney nor was he provided a chance to be heard at a hearing; (5) Dr. Poliner's medical experts testified that no reasonable hospital could have taken the action it did against Dr. Poliner except by knowingly or recklessly disregarding the medical evidence.
[100] *Poliner v. Texas Health Sys*., No. 00-1007 (N.D. Tex. Sept. 18, 2006).
[101] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37, at 11.
[102] 42 U.S.C.A. § 11111 (West 2005).
[103] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37, at 11-12 (citing Jeff Chu, *Doctors Who Hurt Doctors*, TIME, Aug. 15, 2005 at 52).

should a hospital be able to hide behind the shield of immunity when making credentialing decisions based solely on economic reasoning. However, given the economic pressures being placed on hospitals, there is little doubt that they are focusing on economic considerations in connection with their privileging decisions. This practice has become widely known as "economic credentialing."

The American Medical Association, a critic of such credentialing practices, defines economic credentialing as "the use of economic criteria unrelated to the quality of care or professional competency in determining an individual's qualifications for initial or continuing hospital medical staff membership or privileges" constitutes "economic credentialing."[104] A potential issue affecting medical peer review immunity is whether credentialing decisions based solely on economic factors could expose credentialing committee members to liability for decisions not based on physician competence or professional conduct.

The Arkansas Supreme Court recently addressed the debate concerning economic credentialing by upholding a preliminary injunction that prevented a hospital from denying privileges to six cardiologists with ownership interests in a competing specialty hospital.[105] In *Baptist Health v. Murphy*, the court ruled that a lower court had not abused its discretion in determining that the cardiologists would likely succeed on their claim that Baptist Health tortuously interfered with the business relationship between the cardiologists and their patients.[106] While the decision has no direct impact on hospitals in Texas, it does emphasize the need for hospitals to exercise caution in adopting economic credentialing policies which could potentially subject participants to liability.

F. How Transparency Will Affect Peer Review Immunity and Confidentiality

There is currently a loud demand for more price and quality of care transparency in health care. "The general movement for health care transparency is likely to have some relevance for the state of peer review protections in Texas and beyond."[107] Six states (Pennsylvania, Missouri, Florida, New York, and Virginia) now require hospitals to disclose the rates of hospital acquired infections to the public.[108] In November 2004, Florida voters approved the Patients' Right to Know Amendment, a constitutional amendment giving patients access to records related to 'adverse medical incidents,' including peer review reports.[109] "In the first case to reach appellate review in Florida, the Court expressly ruled that the "Patient's Right to Know Amendment" preempted the statutory peer review privilege "to the extent that such information is obtainable through a formal discovery request made by a patient or a patient's legal representative during the course of litigation."[110]

[104] AMERICAN MEDICAL ASSOCIATION, *Organized Medical Staff Section: Economic Credentialing*, at http://www.ama-assn.org/ama/pub/category/10303.html.
[105] *Baptist Health v. Murphy*, Case No. 04-430 (Ark. Feb. 2, 2006).
[106] *Id*.
[107] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37, at 11.
[108] *Id*.
[109] *Id*. Bills similar to the Florida constitutional amendment have been introduced in both the Maryland and Georgia legislatures within the last five years.
[110] *Id*.

Conclusion

The Committee finds that the peer review process in Texas is being utilized appropriately, and where abuses exist there appears to be appropriate access to remedies for physicians. Standards exist for the medical peer review process in both federal and state law which govern the confidentiality of the process, the obligations of the peer review participants, the disclosure of documents, the rights to due process and the referral of violations of regulatory standards to appropriate licenses boards. Medical peer review in the ongoing review of operations rarely elevate to regulatory or judicial review. A case rising to regulatory or judicial review typically involves the standard of care provided by an individual provider, although occasionally a patient may attempt to litigate over the negligent credentialing of a physician.

The federal standards are outlined in HCQIA, which clearly indicates its purpose is to improve the quality of medical care in the United States and to prevent incompetent providers from moving from state to state. The statute not only provides for the structure of peer review committees, protections from liability for the participants of a committee, and the due process procedures required to perform a review, but it also sets forth a reporting requirement to the NPDB which collects and distributes reports of physician disciplinary actions, malpractice payments and professional review actions by health care entities.

It is important to note that the federal requirements for a peer review committee do not preempt "any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by the federal law. "[111] In other words, the state can only enhance the federal standards.

Texas has chosen to enhance the standards for peer review committees beyond that afforded in federal statutes. Texas heightened the privilege, confidentiality, and immunity provisions for the health care entity and the medical peer review committee members and its documents. These fortifications indicate a policy determination that peer review is essential to the provision of quality care in hospitals and that accordingly, exposing participants in the peer review process to the specter of liability will frustrate peer review activities.[112]

Although many operational and liability provisions are outlined in federal and state statutes, these minimal standards still leave great leeway for the individual health care facility to customize the formality of the process. The standards are adequate to outline the major rights and responsibilities of the individual parties to a peer review including the health care entity, the members of the peer review committee, the patient and the provider being reviewed. While the Committee heard testimony that the process would be enhanced by a standardized process, this did not seem to be an overwhelming concern and did not outweigh the need for individualization in the process due to the different types of entities performing peer review. Further, there was no indication that these inconsistencies became issues at the regulatory or judicial level.

[111] 42 U.S.C.A. §11115(a) (West 2005).
[112] UNIVERSITY OF HOUSTON HEALTH LAW AND POLICY INSTITUTE, *supra* note 37, at 11.

Judicial review for medical peer review committees may be under either state or federal jurisdiction. Litigation usually centers around either immunity provisions or confidentiality provisions. Frequently an immunity suit will also contain confidentiality issues.

Immunity litigation under the federal statute is extremely limited since HCQIA provides immunity for actions taken by the peer review committee which is reasonably taken in the furtherance of quality health care.[113] Courts have interpreted these "reasonableness" requirements as creating an objective standard[114] which becomes even more importantly since the Act provides that a peer review committee action shall be presumed to have met these standards unless the presumption is rebutted by a preponderance of the evidence.[115] Although all medical records and witnesses relating to a particular event are discoverable, many parties to a suit still attempt to obtain statements and documents from the medical peer review committee.

When proving a malicious peer review action, plaintiffs often find access to peer review documents difficult. Texas statute clearly states that medical peer review committee proceedings and records are confidential and not subject to subpoena.[116] However, the Texas Supreme Court has held that a party may be entitled to *in camera* inspection to determine the discoverability of the documents.[117] Patients may find the malice standard required in such cases more burdensome since they must prove that a health care entity willfully intended to harm a patient by credentialing a questionable provider. Although the Committee recognizes that the standards required in a malicious peer review action may be difficult to reach, the integrity of the peer review process is maintained while still affording remedies through litigation.

Outside of litigation, the Committee also reviewed the requirements for medical peer review committees in conjunction with the regulatory oversight of the TMB. The TMB provided testimony that several provisions of the federal and state statute hinder effective oversight of providers and quality of care in Texas. For example, the TMB asserted that although they have subpoena power over any document, confidential or not, from a peer review committee, they frequently are unaware of the occurrence of peer review action since the statute only requires reporting sanctions to the TMB which last longer than 30 days.[118] The board asserts that frequently a peer review committee will issue a sanction for 29 days to avoid this requirement; however they were unable to produce any empirical evidence or data to confirm this assertion.

While the Committee acknowledges that this provision would allow some sanctions to evade reporting to the TMB, the Committee feels this reporting requirement is appropriate and still provides protections for the public welfare. First, the reporting of all sanctions which last longer than 30 days mirrors the federal requirement of reporting to the NPDB. To require that all sanctions be reported to the TMB, just for the TMB's edification would possibly inundate the TMB with write-ups for trivial matters or for violations of internal hospital rules.

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[113] 42 U.S.C.A. §11112(a) (West 2005).
[114] *Manzetti v. Mercy Hosp. of Pittsburgh,* 776 A.2nd 938, 945 (Pa. 2001).
[115] 42 U.S.C.A. §11112(a) (West 2005).
[116] TEX. HEALTH & SAFETY CODE §161.032(a) (2006).
[117] *Living Ctrs. of Texas*, 175 S.W. 3d at 255.
[118] TEX. OCC. CODE §160.002(a)(1) (2006).

Secondly, all peer review participants are required to report relevant information to the TMB "relating to the acts of a physician in this state if, in the opinion of the person or committee, that physician poses a continuing threat to the public welfare through the practice of medicine."[119] Thus, regardless of the final sanction issued by the peer review committee, the committee members, both jointly and individually, have a statutory duty to report individuals to the TMB which may jeopardize the welfare of the public.

Further, the TMB felt that it should be able to utilize peer review documents in disciplinary hearings at TMB and at the State Office of Administrative Hearings. However, the Committee found that the Legislature had already addressed this issue last session by allowing the TMB to:

> "...disclose peer review documents in disciplinary hearings, subject to confidentiality provisions already in statute, at the Medical Board and at the State Office of Administrative Hearings (SOAH); clarifies that peer review documents remain confidential at the Medical Board and at SOAH; specifies that if medical peer review documents are admitted into evidence at SOAH, the documents must be admitted under seal; and clarifies that medical records, such as a patient's medical records, that are otherwise available outside of the peer review process are not confidential."[120]

The representatives from TMB indicated that they utilize confidential peer review documents in their own disciplinary hearings, but were unable to in SOAH hearings. Perhaps this is an educational issue for the SOAH.

In conclusion, the Committee found that the medical peer review process is one which is governed by multiple, overlapping jurisdictions and regulations. These regulations provide a peer review process which is accountable and subject to scrutiny.

Federal and state regulations provide a framework in which frank and uninhibited communication among medical peer review participants result in improved quality medical care and immediate reaction to threats to public welfare. The immunity provisions, which are largely outlined in federal statute but are enhanced in state statute, are appropriate and comparable to the regulations in other states. The confidentiality provisions in the statute, while stringent, are not absolute but rather are subject to judicial review *in camera*. Judicial relief is equally applied to all grievances and have resulted in addressing inappropriate use of the peer review process.

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[119] TEX. OCC. CODE §160.003(b) (2006).
[120] Bill Analysis for 79R SB 419, Enrolled.