2011 General Assembly Amendments to Va. Code § 8.01-581.17:
Quality Assurance and Peer Review Protection

by W. Scott Johnson

W. Scott Johnson is a founding director of Hancock, Daniel, Johnson & Nagle P.C. His emphasis is governmental relations at the Virginia General Assembly. He serves as general counsel to The Medical Society of Virginia, the Virginia Dental Association, and the Medical Society of Northern Virginia. He was appointed by Governor Bob McDonnell to the Virginia Health Reform Initiative.

With the passage of HB2373 and SB1469 by the 2011 Virginia General Assembly, the quality assurance and peer review privilege has been strengthened, providing helpful protection against discovery of quality and peer review information in civil litigation. To understand the rationale for and impact of the legislation, some history is in order.

As part of the Medical Malpractice Act (the Act) passed by the Virginia General Assembly in 1976, privileges and protections to certain peer review and quality assurance communications were deemed a benefit to society by encouraging quality improvement in health care via deliberative analysis. The Act achieved a fair balance between what information should be discoverable in a medical malpractice action and the policy of encouraging health care providers to undertake quality and peer review initiatives.

In the thirty years that ensued, a number of circuit courts across the commonwealth ruled on specific questions of what was discoverable based on the language of the statute and interpretative case law. There are ample circuit court opinions and orders addressing the discoverability of incident reports. The case law also addresses discoverability of policies and procedures and other information provided to or maintained by privileged committees. Although these rulings were fact-based and provided different degrees of protection on a case-by-case basis, prior to 2006 incident reports and other analytical information provided to qualified committees were generally shielded from disclosure in civil litigation.

In 2006, the Virginia Supreme Court decision of *Riverside Hospital v. Johnson*, 273 Va. 518 (2006) changed the landscape and scope of privilege protection by expanding the discoverability of these documents. Historically, medical records of a patient and factual information surrounding the patient's care and treatment had routinely been discoverable, but incident reports were treated as privileged analysis. The decision in *Riverside,* however, held that although the statute protected deliberative analysis, it did not protect "facts" even when the source of those facts was documents provided to a qualified committee in an incident report. Under the facts as presented to the court in the *Riverside case,* the Court ruled that factual incident reports and other documentation prepared as part of an investigation were deemed to have been compiled in the routine course of business and further deemed to be "medical records of the hospital made in the normal course of the operation of the hospital." *Id.,* p. 534.

Circuit courts thereafter interpreted and applied *Riverside's* rational somewhat inconsistently, but the general impact of the ruling was that incident reports and other investigative documents, once generally protected from discovery, were now often subject to disclosure to the extent that they contained "facts" in addition to deliberative analysis. Because what constitutes a "fact" and what constitutes "analysis" is often not clear, trial courts took on the task of reviewing entire documents and attempting to make the distinction.

For several years following the *Riverside* decision, legislation was introduced at the Virginia General Assembly which proposed a rewrite of § 8.01-581.17 to restore the protections that had been skewed by the Supreme Court's decision. The legislation was opposed by the Virginia Trial Lawyers Association and therefore the legislators requested that all stakeholders, including the Virginia Hospital & Healthcare Association and the Medical Society of Virginia, find a solution and bring it back to the General Assembly.

Attempts to hammer out a solution through many meetings, including the use of an outside facilitator, were not productive.

The facilitated discussions stalled for almost two years and in the interim the stakeholders received another request to work together, this time on the issue of the medical malpractice cap. Delegate Dave Albo of Springfield and Senator Henry March of Richmond, chairs of the House and Senate Courts of Justice committees, called together the stakeholders in 2009 with instructions to find a solution for the medical malpractice cap. These discussions were launched and an initial attempt was made to determine if they should be merged with the requested discussions to find a solution on *Johnson v. Riverside*. The inquiry to merge the two issues was quickly rejected and the discussions proceeded separately.

In the fall of 2010, the Medical Society of Virginia and the Virginia Association of Trial Lawyers were able to negotiate a solution on the medical malpractice cap, sending the issue back to the legislature. In the 2011 General Assembly session, all stakeholders signed off on a long-term agreement on the medical malpractice cap. With the malpractice cap resolved, the General Assembly took up the privilege statute. The paths of the cap legislation and the of the peer review legislation wove a convoluted history lesson. Two identical versions of legislation were passed by the Virginia General Assembly and signed by the governor, those being House Bill 2373 co-patroned by Delegate Chris Peace of Hanover and Delegate Bill Cleaveland of Botetourt, along with Senate Bill 1469 co-patroned by Senator Richard Saslaw of Fairfax and Senator Tommy Norment of James City County.

The peer review bills passed the House of Delegates and the Senate without a single dissenting vote and arrived at the governor's desk prior to seven days being left in the regular session of the General Assembly. Bills arriving prior to that timeframe pursuant to the Constitution must be acted on by the governor, and he signed them into law. Meanwhile, the medical malpractice bills advanced, both passing the Senate without a dissenting vote and achieving overwhelming majorities in the House with votes of 89 to 7 and 92 to 6, respectively. But these bills did not arrive on the governor's desk prior to seven days being left in the regular session of the General Assembly.

The governor faced a deadline of March 29, 2011, to exercise one of his four Constitutional choices on the medical malpractice cap bills: veto them, sign them into law, amend them, or do nothing and let them become law without his signature. Numerous letters from organizations encouraging the governor to sign the medical malpractice cap bills into law were received. Motivated by a campaign promise made in 2009 not to raise the medical malpractice cap, the governor opted for a veto.

At the reconvened session the members of the General Assembly were lobbied aggressively by representatives of the Medical Society of Virginia, the Virginia Hospital & Healthcare Association, and the Virginia Trial Lawyers Association to overturn the governor's veto. The veto on House Bill 1459 was overridden in the House by a vote of 93 to 3. A more arduous battle arose in the Senate as horse trading took place between other amendments that the governor had offered to the budget and the position that the Senators would take regarding his veto on the medical malpractice cap. Twenty-seven Senate votes out of forty were needed to override the veto. The twenty-two Democratic Party Senate majority was solidly in support of overriding the veto, and in the end seven Republicans joined ranks for a vote of 29 to 11 to override.

With the medical malpractice cap legislation law, attention then turned to the practical implications of peer review on the delivery of everyday health care in physician offices and hospitals around the state. The new legislation, which became effective July 1, 2011, abandoned prior attempts to rewrite the statute and instead brought in the fresh idea of creating a clear line of demarcation on what is discoverable and what is not.

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What is Discoverable

The legislation clarifies that any factual information regarding a specific patient is discoverable. This includes the discoverability of incident reports that document facts about a specific patient's care. The discoverability of the factual information applies whether the information is communicated orally, electronically, or in writing.

Next, information by a witness with knowledge of facts or a treating health care provider is not privileged simply because it is provided to a quality or peer review committee. For example, if a nurse completes an incident report involving a patient event, the fact that the incident report is given to a quality committee for review does not cloak it with privilege. As a statement about the facts of a patient event, by a person with first-hand knowledge, it remains discoverable.

What is Not Discoverable

The legislation reaffirms that the vast scope of communications and documentation, which had been protected since the passage of the privilege as part of the Act, is restored. For example, the analysis, findings, conclusions, and recommendations together with the deliberative process of any of the medical staff committees, utilization review committees, boards, groups, commissions or other entities defined in § 8.01-581.16 remain privileged. In addition, the proceedings, minutes, records, and reports (including the opinions of expert witnesses of the preceding bodies) are privileged under the new statutory section.

In an effort to clearly reverse the ruling in *Riverside*, the General Assembly specifically included new statutory language that states: "However, the proceedings, minutes, records, reports, analyses, findings, conclusions, recommendations in the deliberative process, including opinions and reports of experts of any medical staff, committee, utilization review committee, or other committee, board, group, commission or other entity specified in § 8.01-581.16 **shall not** constitute medical records and are privileged in their entirety and are **not** discoverable." *Emphasis added.*

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Under the new statute:

- If a quality committee conducts a root cause analysis to determine why a certain number of patients have fallen on a particular floor or a certain number of infections have occurred in an operating room suite, such root cause analysis would not constitute a medical record and would therefore be privileged;
- If an expert witness is hired by a medical staff committee to determine the appropriate clinical performance of a surgeon, the report of the expert witness to the medical staff committee would not constitute a medical record and would be privileged;
- If a quality review committee requests a risk manager to interview witnesses involved in the care of a patient and write a report to the quality committee outlining that person's analysis and findings, such report would not constitute a medical record and would be privileged.

Service on Committees, Boards, and Entities

A related issue addressed by the Virginia General Assembly stemmed from the hesitancy of health care providers to serve on quality and peer review committees for fear that their service would enable them to learn about facts of a case and therefore subject them to being deposed or becoming a witness in a medical malpractice action. The General Assembly adopted the policy of encouraging health care providers to serve on these committees and included a provision that states: "A person involved in the work of the entities referenced in this subsection shall not be made a witness with knowledge of facts by virtue of his involvement in the quality assurance, peer review, or credentialing process."

Practical Considerations

A number of practice considerations can be gleaned from the statutory changes. First, staff should be trained that information contained in an incident report should reflect only factual information and not opinion or analysis. Further, it is prudent to educate health care providers to carefully and accurately document in incident reports the same facts that are included in the medical record for consistency. Third, to the extent that any uncertainty or inconsistency remains in circuit court rulings across the commonwealth as to whether incident reports are discoverable, health care providers need to be educated that after July 1, 2011, the bright line rule is that when they are factual documents, they are discoverable. The form of incident reports, irrespective of what the report is called, whether documented on paper or entered electronically into a computer database, does not alter the bright line rule. Incident reports should be in a format that encourages recordation of necessary facts to initiate the internal quality assurance or

peer review process. Speculation, analysis, or opinion should be engaged in cautiously and only elsewhere within the clear protection of the statutory privilege, rather than in incident reports.

The amendments to the privileged communication statute apply to all health care providers engaged in a statutorily protected peer review or quality assurance process: whether hospital inpatient, hospital out-patient, ambulatory care center or private physician office. In compliance with accreditation requirements, the vast majority of hospital and health systems, together with ambulatory care centers, have in place an established quality or peer review committee. Physicians in private practice continue to have the opportunity to create an office-based quality or peer review committee under a number of different resources, including adoption of the guidelines approved by the Medical Society of Virginia which can be accessed at www.msv.org/peerreview.[1]

In conclusion, the 2011 amendments restore a level of certainty to the quality and peer review process to enable healthc are providers to take the necessary steps to confidently initiate quality improvement efforts. These efforts will improve patient safety, without fear of such efforts being used against providers in civil litigation, while simultaneously promoting fair disclosure of the facts of a patient's care and treatment in civil litigation.

[1] (member login required)