The Need to Foster and Protect Physician Group Practice Malpractice Prevention Programs

By Robert N. Swidler

Larger physician group practices may be able meet the same rigorous malpractice prevention program standards that hospitals must meet.[1] Those that do so should be afforded the same malpractice prevention program confidentiality and immunity protections that are afforded to hospitals.[2] If the legislature were to implement that simple principle, physician group practices across the state would enhance their malpractice prevention efforts, and thereby improve the quality and safety of patient care.

Hospital Malpractice Prevention Programs

Every general hospital in New York is required "to maintain a coordinated program for the identification and prevention of medical, dental and podiatric malpractice."[3] Such "Malpractice Prevention Program" must include at least these elements:[4]

(a) A quality assurance committee.

(b) A medical staff[5] privileges sanction procedure to check credentials, capacity and competence periodically and when warranted.

(c) A procedure to check credentials, capacity and competence in delivering health care of other persons employed or associated with the hospital.

(d) A procedure for the prompt resolution of grievances by patients;

(e) The collection of information concerning negative health care outcomes and incidents injurious to patients and other data.

(f) The maintenance of information gathered above concerning individual practitioners;

(g) Education programs dealing with patient safety, injury prevention, and other matters;

(h) Continuing medical education programs; and

(i) Policies to ensure compliance with the obligation to report professional misconduct.

In other provisions, hospitals are required to conduct investigations prior to the granting or renewal of privileges[6] and to report adverse events to the Department of Health.[7]

The law requires hospitals to maintain the confidentiality of the information collected pursuant to PHL § 2805-j and other provisions, "except as to the department."[8] It then goes on to protect from disclosure in litigation records and information gathered pursuant to the Malpractice Prevention Program, with a focus on protecting information discussed at quality assurance committee meetings (which would include "peer review committees" set up to review specific incidents):

> 2. Notwithstanding any other provisions of law, none of the records, documentation or committee actions or records required pursuant to sections §2805-j[9] and 2805-k of this article, the reports required pursuant to section 2805-l of this article nor any incident reporting requirements imposed upon diagnostic and treatment centers pursuant to the provisions of this chapter shall be subject to disclosure under article six of the public officers law or article 31 of the civil practice law and rules, except as hereinafter provided or as provided by any other provision of law. No person in attendance at a meeting of any such committee shall be required to testify as to what transpired thereat. The prohibition relating to discovery of testimony shall not apply to the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting.[10]

In addition, the law protects individuals who participate on a quality assurance committee from liability on account of the communication of information in the possession of such person or entity, or on account of any recommendation or evaluation, regarding the qualifications, fitness, or professional conduct or practices of a physician.[11]

These twin protections—the protection of QA information from disclosure, and the protection of participants in the QA process from liability, are not a reward or political trade-off to hospitals. Rather they are essential components of an effective quality assurance program. More generally they are a necessary part the public policy to promote quality of care. As the Court of Appeals stated in *Logue v. Velez*:

> ...The purpose of the discovery exclusion is to "enhance the objectivity of the re-

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> view process", and to assure that medical review committees "may and objectively analyze the quality of health services rendered" by hospitals....[12]

Education Law § 6527.3 offers protections similar to those in PHL § 2805-m but, as discussed further below, it is not clear whether the provision protects the confidentiality of medical group practice quality assurance and peer review activities unrelated to a hospital.

In 2011, the Legislature granted accountable care organizations similar authority by deeming them to be a "hospital" solely for purposes of malpractice prevention programs under PHL § 2805-m and Education Law § 6527.3.[13]

Physician Group Practices in New York

For decades, health care services have been moving from inpatient settings to ambulatory settings including physician practices. In a related development, physician practices have grown exponentially in size and sophistication. For example, Beckers Hospital Review reports that Northwell Health Physician Partners in Syosett, N.Y. has 2,700 physicians; Physician Affiliate Group of New York (PAGNY) has 1,511 physicians.[14] Many other physician groups have hundreds of physicians.

Some of these groups are associated with hospitals, others are not. In either case, large group practices can dwarf independent community hospitals in size, revenue, infrastructure, sophistication. Many could implement malpractice prevention program activities on par with those implemented by hospitals. Patient safety and quality of care would benefit if they did so.

The Inapplicability of PHL § 2805-m Protections to Events Outside the Hospital

The twin protections in PHL § 2805-m—the protection of QA information from disclosure, and the protection of participants in the QA process from liability—are afforded only to general hospitals, not to physician practices. To be sure, physicians in group practices fall under the protections of PHL § 2805-m when there is a review of an event that occurred in a hospital, including a hospital-operated extension clinic. And they have immunity under PHL § 2805-m when they sit on or testify before a hospital peer review committee. But they do not have PHL § 2805-m protection for events that have no connection with a hospital.

Consider these two scenarios: A radiologist fails to diagnose a tumor, causing a delay in treatment that results in a patient death.

If the imaging was performed in a hospital or a hospital operated extension clinic, the hospital would conduct a root cause analysis and/or convene a peer review committee.[15] The goal is to determine what happened, and to identify steps that should be taken to avoid a recurrence, and to review physician performance. Due in part to the confidentiality protection for these activities, physicians and staff are willing to engage in a full and frank discussion of the case. The result is that the hospital might take corrective actions with regard to the radiologist, or implement changes in processes in the department to improve patient safety.

If the same error occurred by a physician in a 1,000-person physician group practice, the practice certainly has the "bandwidth" to convene a peer review committee, determine what occurred, take corrective steps if warranted with respect to the physician, and take steps to prevent a recurrence. But the effort would be impeded by the lack of confidence in confidentiality and immunity protections. Physicians and staff—including investigators, witnesses and peer reviewers—would be less willing, or unwilling, to participate, and the discussion would be less frank and full.

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It is hard to identify a policy rationale for affording such protections to the hospital quality assurance process, but not to an equivalent physician practice process.

Notably, in both instances, a malpractice plaintiff would retain full access to evidence necessary to make his or her case: i.e., the medical record, the pre-trial and testimony of fact witnesses, expert testimony, policies, etc. But the plaintiff would not have access to the records of activities that were conducted specifically to improve quality.

N.Y. Education Law § 6527

N.Y. Education Law § 6527.3 offers liability immunity to individuals who engage in certain quality assurance activities, and protects from disclosure in litigation information about certain medical and quality assurance review activities.

The immunity protection is limited to individuals who serve on specified types of committees, including hospital quality assurance committees, hospital utilization review committees, medical review committees of professional societies, professional standards review organizations, other hospital malpractice prevention program related committees. It does not specify or apply to physician group practice quality or peer review committees.

The reach of the § 6527.3's confidentiality provision is more debatable.[16] It states in relevant part:

> Neither the proceedings nor the records relating to performance of a medical or a quality assurance review function or participation in a medical and dental malpractice prevention program nor any report required by the department of health pursuant to PHL § 2805-l of the described herein, including the investigation of an incident reported pursuant to MHL § 29.29, shall be subject to disclosure under CPLR Article 31 except as hereinafter provided or as provided by any other provision of law.

On one hand, the opening clause plainly appears to protect physician practice quality assurance and peer review activities:

> Neither the proceedings nor the records relating to performance of a medical or a quality assurance review . . . shall be subject to disclosure under CPLR Article 31 except as hereinafter provided or as provided by any other provision of law.

Accordingly, physician practices can and should point to the clause above to protect their quality assurance activities. But on the other hand it is unsettling that:

- The clause does not define the phrase "medical or quality assurance function," and the preceding clause, relating to immunity, uses these terms in the context of hospital or professional organization functions;
- Arguably the phrase is linked to "... required by the department of health pursuant to PHL §2805-l;"
- Westlaw shows 193 decisions construing EL § 6527 as of April 19, 2018. It appears that none of those reported court decisions apply EL § 6527.3 to a physician group practice quality assurance or peer review activity; and
- Numerous court decisions describe the purpose of EL § 6527, as stated by the NYS Court of Appeals in *Logue v. Velez*, "to assure that medical review committees 'may objectively analyze the quality of health services rendered' *by hospitals.*"[17]

In these circumstances, physician practices are deterred from instituting quality assurance programs and conducting peer review activities.

A Legislative Proposal

In 2017, Senator Kemp Hannon and Assemblymember Richard Gottfried, the respective chairs of the Senate and Assembly health committees, introduced identical bills to address this issue.[18] The bills provide that a medical, dental or podiatric group practice that operates a malpractice prevention program that meets largely the same standards of a hospital malpractice prevention program (a "qualified group practice") will have the same confidentiality and immunity protections as a hospital.

The bill is short, and is reproduced below:

> Section 1. The public health law is amended by adding a new section 2998-f to read as follows:
>
> § 2998-f. Qualified group practice. 1. For the purposes of this section, "qualified group practice" means a medical, dental or podiatric group practice or other lawful combination of such health care practitioners, licensed or certified pursuant to title eight of the education law, that meets the standards set forth in paragraphs (a) through (h) of subdivision one of section twenty-eight hundred five-j of this chapter, other than the governing board requirements of such paragraph (a).
>
> 2. A qualified group practice may operate a malpractice prevention program independently, or through an otherwise lawful collaborative arrangement with a hospital or accountable care organization program operated pursuant to section twenty-eight hundred five-j or twenty-nine hundred ninety-nine-r of this chapter, in which case the qualified group practice and the hospital or accountable care organization may share, confidential information with each other for purposes of such practice without waiving confidentiality with respect to others.
>
> 3. A qualified group practice shall be deemed a hospital, and its malpractice prevention program shall be deemed a medical, dental and podiatric malpractice prevention program, for the purposes of subdivision two of section twenty-eight hundred five-j, subdivision four of section twenty-eight hundred five-k and section twenty-eight hundred five-m of this chapter, and subdivision three of section sixty-five hundred twenty-seven of the education law. Such provisions of law shall apply to

its information, records, documentation and committee actions, and to participants in committee proceedings.

§ 2. This act shall take effect immediately.

The bill has these notable features:

- To be a "qualified group practice" the group, like a hospital, would need (a) a quality assurance committee;[19] (b) sanction procedures for medical staff members; (c) review of credentials and competence for all; (d) prompt resolution of patient grievances; (e) collection of information about negative outcomes, premiums, settlements, awards, etc.; (e) procedural recordkeeping; (g) education programs on patient safety, injury prevention, etc.
- The qualified group would not be subject to the hospital-specific requirement to report adverse events to the Department of Health.
- The qualified group would be subject to the same limitations in confidentiality protections that apply to hospitals, i.e.:
  - the Department of Health would have access to the materials, as they do with hospital QA materials;
  - the protection from discovery would not apply to" the statements made by any person in attendance at such a meeting who is a party to an action or proceeding the subject matter of which was reviewed at such meeting."[20]

Importantly, the bill is an option for group practices, not a mandate. A group could opt to continue as is, without implementing the elements of a malpractice prevention program, and forgoing the protections described above. Or it could choose to become a qualified group practice and avail itself of those protections. This option is necessary because not all physician groups will have the ability to "measure up" to these standards.

New York would not be inventing a protection for quality assurance activities by physician groups. Indeed, about half the states have some form of protection for physician group quality activities.[21] But with this bill, New York would be imposing perhaps the most detailed and rigorous standards for groups that wish to earn confidentiality and immunity protection for their QA activities.

As a result, the qualified group practice bill, if enacted in New York, will prompt larger group practices to adopt malpractice prevention program standards, and thereby enhance quality of care by physician practices and greatly benefit patients and the public.

Endnotes

1. NY Public Health Law (PHL) § 2805-j.
2. PHL § 2805-m.
3. PHL § 2805-j.
4. PHL § 2805-j. The statute sets forth more detailed requirements for each item.
5. All references in this article to "medical staff" should be considered to include dental and podiatric staff.
6. PHL § 2805-k.
7. PHL § 2805-l.
8. PHL § 2805-m.1.
9. The statute spells these section numbers out. Numbers are used here for readability.
10. PHL § 2805-m.2.
11. PHL § 2805-m.3. The federal Health Care Quality Improvement Act of 1986 (42 USC §§ 11101 et seq.) also protects peer review participants from liability when its standards are met. It does not address confidentiality.
12. 92 N.Y.2d 13 (1998).
13. PHL § 2999-r.
14. *SKA&A: 20 medical groups with the most physicians — The Permanente Groups top the list*, Beckers Hospital Review, January 5, 2017.
15. A "root cause analysis" is a quality assurance investigation focused on improving systems and processes. "Peer review" is a review of a practitioner's performance in one or more cases, conducted by other qualified practitioners.
16. For readability, cross-referenced statute sections are expressed in numerals. In Section 6527.3, these cross references are spelled out.
17. *See* n. 12. Emphasis added.
18. Senate Bill 3662 (2017)(Hannon), Assembly Bill (A.8556) (2017).
19. Hospitals are required to have a member of their governing board on their quality assurance committee. PHL § 2805-j.1. The "Qualified Group Practice" proposal would omit that requirement.
20. PHL § 2805-m.2. An unrelated bill would repeal this exception. Senate Bill 3661 (2017)(Hannon); Assembly Bill 2460 (2017) (Gottfried).
21. E.g., Florida, Fla. Stat § 766.101; Idaho, Idaho Code § 39.1392; Michigan, MCLS. § 331.531; Oregon, Oregon Ann. 2305.25.