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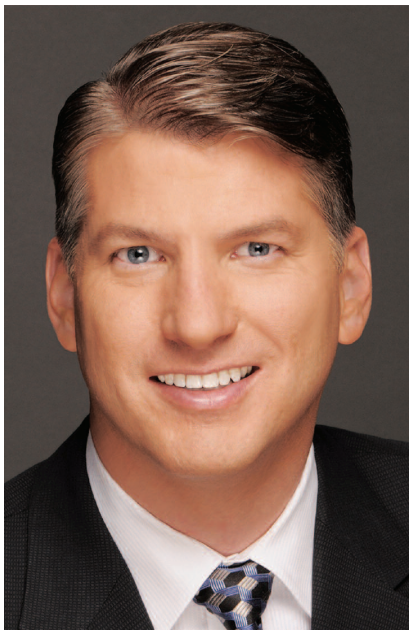
MED-MAL MATTERS



FATAL FLAWS

Does the peer-review privilege kill?

By THOMAS A. DEMETRIO and KENNETH T. LUMB

Secret audio recordings of morbidity and mortality meetings at a children's hospital, reported by *The New York Times*, raise troubling questions about the danger to patient safety and autonomy posed by peer-review secrecy.

The recordings were made during pediatric cardiology meetings in 2016 and 2017 at the University of North Carolina Children's Hospital, during a time of crisis for the pediatric heart surgery program. The *Times* reported children with complex heart conditions were dying at higher-than-expected rates and those undergoing even low-risk surgeries were suffering excessive complications.

The chief of cardiology summarized the situation in one recorded meeting as a "nightmare" and stated: "We are in a crisis, and everyone is aware of it."

UNC's pediatric cardiologists, who diagnose heart conditions and can treat only some of them, must refer patients who need surgery to pediatric heart surgeons. Throughout 2016 and 2017, the cardiologists repeatedly sought answers in their meetings about why their patients were faring so poorly in surgery to allow them to decide if they should refer patients to other hospitals. According to the *Times*, recordings of those meetings reveal physicians concerned about their ethical obligations to their patients while their bosses worried about harming the surgical program.

In 2019, after repeated requests by the *Times*, UNC released limited mortality data that showed it had a higher death rate in 2014 to 2017 than all 82 pediatric heart surgery programs that publicly report data. Throughout 2016 and 2017, UNC's cardiologists requested this data, but were rebuffed by the hospital. UNC refused to tell the *Times* whether it had conducted a systematic internal review of its program with outside experts. Further, UNC physicians interviewed for the story stated that they were never briefed regarding the results of any internal reviews.

The *Times* article understandably focuses on the quality and consistency of the care provided by the dozens of pediatric heart surgery programs across the country. Dr. Carl Backer, a heart surgeon at Lurie Children's Hospital in Chicago, states that these programs need to perform a high number of procedures to remain competent, but that adequate case volume is elusive because many hospitals are competing for a relatively small number of patients.

But UNC's crisis raises even more fundamental questions about secrecy and patient safety. For instance, why were the parents of children undergoing operations at UNC not aware of its ongoing "crisis" in patient safety? Even more troubling, why were their cardiologists kept out of the loop?

The answer likely lies in the peer-review privilege, which essentially drops a curtain of secrecy around materials used for peer review or quality control. In Illinois, the Medical Studies Act renders a broad range of information and documents created for a broad range of quality improvement committees not only inadmissible as evidence, but also nondiscoverable.

This statute is a medical-care specific version of the "self-critical analysis privilege," long sought by corporate America in all contexts. The latter privilege would shield all documents that contain candid or self-critical analyses — i.e., the truth — from disclosure. Think accident reports, statements by corporate employees, etc.

In 2015, the Illinois Supreme Court specifically refused to create a common law self-critical analysis privilege in Illinois, deferring to the legislature. Privileges are strongly disfavored, the court noted, "because they operate to exclude relevant evidence and thus work against the truthseeking function of legal proceedings."

The Medical Studies Act, and other formulations of the peer-review privilege nationwide, are, according to the Illinois Appellate Court, premised on the belief that, absent a veil of secrecy, healthcare providers would be reluctant to sit on peer-review committees and engage in frank evaluations of their colleagues. In other words, members of one of the "noble professions" cannot be trusted to tell the truth or do the right thing to protect patient safety unless they can conceal the truth.

This contortion of the "truthseeking function" is bad enough when it buries relevant information in a lawsuit, but what about when it literally prevents a parent from making an informed choice about a child's medical care?

As Backer put it, "People don't buy a car without knowing what the gas mileage is," and yet important mortality data is withheld from parents faced with the most important decision of their lives. CL

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