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The Evolution of Medical Peer Review in North Dakota

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THE EVOLUTION OF MEDICAL PEER REVIEW IN NORTH DAKOTA

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I. INTRODUCTION

Recent state court decisions and legislation have substantially impacted effective medical peer review in North Dakota. This article will explain the importance of peer review, summarize the judicial decisions which triggered recent state legislation, and analyze the state legislation which re-established an effective peer review process in North Dakota.

II. MEDICAL PEER REVIEW

Medical peer review is a process in which practicing physicians evaluate the quality, efficiency, and effectiveness of the performance of other physicians and health care professionals.[1] In the mid-1980s, Congress established federal guidelines for effective medical peer review as a response to the increasing problem of medical malpractice.[2] The intent of medical peer review is to reduce the number of occurrences of medical malpractice and improve the quality of health care by using practicing physicians to identify and discipline incompetent or unprofessional physicians.[3] Medical peer review committees, usually consisting of an impartial hearing officer and practicing physicians who are not in direct economic competition with the physician being reviewed, conduct the peer review.[4] The rationale for using practicing physicians to conduct peer review is that they are able to observe each other on a

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1. Robert S. Adler, *Stalking The Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L.J. 683, 696 (Winter, 1991); *see also* Clark C. Havighurst, *Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1117, 1117 (1986) (defining professional peer review as fellow physicians overseeing practices of individual physicians for purposes of maintaining quality and containing cost of medical care); William G. Kopit, *Commentary: Professional Peer Review and the Antitrust Laws*, 36 CASE W. RES. L. REV. 1170, 1172 (1986) (defining professional peer review as the process whereby a hospital establishes standards for appropriate quality of care and then the medical staff judges individual physicians for compliance with standards).

2. 42 U.S.C. § 11101(1) (1995).

3. Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S.C.C.A.N. (100 Stat.) 6384 (codified at 42 U.S.C § 11101 (1994)).

4. *Id.* at 6393 (codified at 42 U.S.C. § 11101). However, finding hearing officers and physicians who are not in direct economic competition with the physician being reviewed may be difficult in rural areas or in situations involving highly specialized medicine. *Id.* Furthermore, it may not be feasible to find physicians who are of the same specialty as the reviewed physician but who are not in direct economic competition. *Id.*

regular basis and they also have the expertise to evaluate the quality of each other's work.[5]

A. HISTORICAL DEVELOPMENT OF PEER REVIEW AND THE HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986

In 1952, the American College of Surgeons, the American Medical Association, the American Hospital Association, and the American College of Physicians joined in an effort to improve the standard of care in hospitals and established the Joint Commission on Accreditation of Hospitals, now referred to as the Joint Commission on Accreditation of Health Care Organizations (JCAHO).[6] The purpose of forming the JCAHO was, and continues to be, to establish hospital accreditation standards.[7] Under JCAHO accreditation standards, hospital medical staffs[8] are responsible for establishing peer review guidelines, which require uniform criteria for evaluating persons applying for medical staff jobs and for current medical staff members.[9]

Until 1986, state legislation exclusively governed peer review.[10] However, in November 1986, Congress enacted the Health Care Quality Improvement Act (HCQIA) which established federal guidelines for effective peer review.[11] These peer review guidelines were established after congressional findings revealed that the increase in medical malpractice and the need for quality health care were national problems that individual states could not remedy.[12] Thus, the goal of the HCQIA was to improve the quality of health care nation wide using peer review to identify and discipline incompetent or unprofessional physicians.[13]

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5. *See* Adler, *supra* note 1.

6. James F. Blumstein & Frank A. Sloan, *Antitrust and Hospital Peer Review*, 51 LAW & CONTEMP. PROBS. 7, 10 (Spring, 1988); *see also* JOINT COMMISSION ON THE ACCREDITATION OF HEALTH CARE ORGANIZATIONS, ACCREDITATION MANUAL FOR HOSPITALS (1995).

7. *See* Blumstein & Sloan, *supra* note 6, at 10. Although not all states require their hospitals to be JCAHO accredited, the JCAHO is considered the foremost authority in establishing the standards for hospital accreditation in the United States. *Id.* It is completely voluntary for states to participate in the JCAHO accreditation program, however, many states participate because JCAHO accreditation is required for certain federal funding programs. Kym Oltrogge, *An Ounce Of Prevention Is Worth A Pound of Cure: The Need for States to Legislate in the Area of Hospital Professional Review Committee Proceedings*, 46 WASH. & LEE L. REV. 961, n.4 (1989). In addition, JCAHO accreditation is required if a hospital is affiliated with a medical school. *Id.*

8. As early as 1919, the American College of Surgeons organized the hospital medical staff concept when it established minimum standards in which physicians and surgeons had to comply in order to practice medicine in hospitals. Mark A. Kadzielski et al., *The Hospital Medical Staff: What is its Future?*, 16 WHITTIER L. REV. 987, 988 (1995).

9. *See* Blumstein & Sloan, *supra* note 6, at 11.

10. Susan O. Scheutzow & Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined Than Real*, 7 J. L. & HEALTH 169, 170 (1992/1993).

11. 42 U.S.C. §§ 11101, 11111-152 (1994).

12. *Id.* § 11101(1).

13. *Id.* § 11101. The HCQIA was enacted after congressional findings revealed an increase in

In order to get hospitals and physicians to perform peer review, the HCQIA protects these entities against damages in suits initiated by physicians who lose their hospital privileges after peer review action has been taken.[14] Nevertheless, hospitals and physicians, also known as professional review bodies,[15] are not protected unless the peer review actions[16] they take meet the standards promulgated in the HCQIA.[17] In addition, if a doctor is disciplined after peer review action has been taken, the HCQIA requires the reviewing body to report the action taken to the state medical board.[18] The state medical board is then responsible for reporting this information to the Secretary of the Department of Health and Human Services (Secretary).[19]

Other information which must be reported to the Secretary is the amount paid on a medical malpractice claim.[20] The entity which makes payment on the medical malpractice claim is responsible for making this

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the occurrence of medical malpractice, the national need to restrict the ability of incompetent physicians to move state to state without having to disclose previous incompetent performance, the need to encourage physicians to participate in effective peer review, and the need to provide protections and incentives to physicians who engage in effective peer review. *Id.*

14. *Id.*; *see also* Austin v. McNamara, 979 F.2d 728 (1992) (finding that participants in a professional review action are entitled to HCQIA immunity if they demonstrate the peer review action complied with fairness standards as set out in the HCQIA, they satisfied the requirement of adequate notice and hearing, the results of the action were reported to state authorities, and the action commenced on or after the effective date of the HCQIA); Mathews v. Lancaster General Hospital, 883 F. Supp. 1016, 1024 (E.D. Pa. 1995) (stating that the HCQIA provides immunity from money damages but does not provide immunity from suits arising from professional physician review activities or from injunctive or declaratory relief).

15. "The term 'professional review body' means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity." 42 U.S.C. § 11151(11) (1994).

16. Under the HCQIA:

> [t]he term 'professional review action' means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.

42 U.S.C. § 11151(9) (1994).

17. *Id.* § 11151(9). To meet these standards, these actions must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care, (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 act was warranted by the facts known after such reasonable effort to obtain facts.

42 U.S.C. § 11112(a)(1-4) (1994). A peer review action is not based on competence if it is based on the physician's relationship with a professional society or association, the advertising, charging of lower fees, or engaging in other competitive acts, the financial arrangement for delivering health care, and the relationship the physician has with practitioners who are not physicians. 42 U.S.C. § 11151(9).

18. 42 U.S.C. § 11133 (1994).

19. 42 U.S.C. § 11134(b) (1994).

20. 42 U.S.C. § 11131 (1994).

report.[21] In addition, the paying entity must also identify the hospital or physician for whose benefit the payment was made and the injuries sustained by the patient.[22] This information is then compiled in a national data bank, consisting of information on all physicians who have been the subject of disciplinary actions, which hospitals throughout the country can access.[23] Thus, the creation of the national data bank is consistent with the HCQIA's requirement that hospitals obtain such information before hiring any health care professionals.[24]

B. PURPOSE OF PRIVILEGE AND CONFIDENTIALITY IN THE PEER REVIEW PROCESS

In addition to the protection against damages for hospitals and physicians who participate in the peer review process, the HCQIA[25] and many states[26] have peer review statutes providing for confidentiality.[27] Many states also have statutes which provide a medical peer review privilege, but the HCQIA does not address this issue.[28] The purpose of these statutes is to protect the communications that occur during peer review proceedings.[29] The rationale is that without such statutes, physicians may be reluctant to participate in peer review because of the fear that the information discussed during the proceedings will later be used in a judicial or administrative proceeding, or that they may be called to testify against their colleagues.[30]

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21. *Id.* § 11131(a).

22. *Id.* § 1131(b)(1)(4).

23. Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S.C.C.A.N. (100 Stat.) 6384.

24. 42 U.S.C. § 11135(a)(1) (1994).

25. *See* Pagano v. Oroville Hospital, 145 F.R.D. 683 (E.D. Cal. 1993) (finding that the HCQIA provides for confidentiality only on information provided to the national data bank pursuant to the Act).

26. The following are examples of states that have confidentiality provisions in their peer review statutes: ALASKA STAT. § 18.23.030 (Michie 1996); D.C. CODE ANN. § 32-505 (1997); FLA. STAT. ANN. § 766.101(5) (West 1988); GA. CODE ANN. § 88-3204 (1983); HAW. REV. STAT. § 624-25.5(b) (1993); IND. CODE § 34-4-12.6-2 (1986); KY. REV. STAT. ANN. § 311.377(2) (Michie 1995); ME. REV. STAT. ANN. tit. 32, § 3296 (West 1994); MASS. GEN. LAWS ch. 111, § 204 (1988); MINN. STAT. § 145.65 (1971); MISS. CODE ANN. § 41-63-9 (1994); MO. REV. STAT. § 537.035(4) (1985); NEB. REV. STAT. §§ 71-2047, 71-2048, 25-12,123 (1971); N.C. GEN. STAT. § 131E-95 (1983); N.D. CENT. CODE §§ 31-08-01, 23-01-02.1) (Supp. 1997), PA. CONS. STAT. ANN. tit. 63, § 425.4 (West 1978); R.I. GEN. LAWS § 5-37.3-7 (1995); S.C. CODE ANN. § 40-71-20 (Law. Co-op 1979); TENN. CODE ANN. § 63-6-219 (1994); VT. STAT. ANN. tit. 26, § 1443 (1976); W. VA. CODE § 30-3C-3 (1980); and WIS. STAT. § 146.38 (1992).

27. 42 U.S.C. § 11137(b) (1994).

28. *See* Pagano v. Oroville Hospital, 145 F.R.D. 683 (E.D. Cal. 1993) (finding that there is no federal statutory basis for medical peer review privilege); Wei v. Bodner, 127 F.R.D. 91 (D.N.J. 1989) (finding that to the extent that a privilege exists, its application should be limited to those situations where privilege serves a greater public good than predominate the principle that courts seek the truth).

29. Scheutzow & Gillis, *supra* note 10, at 171.

30. *Id.* Prior to Congress' enactment of the HCQIA, one of its initial findings was that there was a threat of private money damage liability under Federal laws which unreasonably discouraged physicians from participating in peer review. 42 U.S.C. § 11101(4) (1994).

Privileged information is not admissible as evidence in a trial.[31] In peer review settings, privilege protects the entities conducting the proceedings, not the person who is the subject of peer review.[32] Conversely, confidentiality deals with the obligation to refrain from disclosing information to third parties except with respect to professional review activity.[33] Thus, although privilege and confidentiality are two separate concepts, they often work together[34] because if there is a privilege to protect certain information, there is also a requirement to keep that information confidential.[35]

C. COMPETING PUBLIC INTERESTS

In order to improve the quality of health care that patients receive, it is essential for health care providers to have information regarding physicians against whom peer review action was taken.[36] Congress recognized this need when it enacted the HCQIA because under § 11135 of the Act, hospitals are required to request information from the Secretary whenever a physician or health care practitioner applies to be on the medical staff at that hospital.[37] The purpose of this requirement is to prohibit incompetent physicians from moving to different hospitals or states and continuing their practices or unprofessional behavior.[38] Thus, this section of the HCQIA works to reduce the number of injuries and deaths associated with incompetent physicians.

Peer review information is also valuable to non-medical entities. For instance, peer review information is very useful to litigants in medical malpractice actions because the information may assist in proving or disproving essential elements of the claims for relief.[39] In addition, peer review information must be disclosed to the Secretary or the private or public agency designated to receive such information, in order to provide licensing boards and other health care providers with the information as prescribed by the HCQIA.[40]

Beyond the medical community, litigants, and the Secretary, other entities such as insurance companies, the media, consumer groups, and competing health care providers may also have an interest in peer review

31. Scheutzow & Gillis, *supra* note 10, at 179.
32. *Id.*
33. *Id.* at 192.
34. *Id.*
35. *Id.*
36. Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S.C.C.A.N. (100 Stat.) 6384.
37. 42 U.S.C. § 11135 (1994).
38. Act of Nov. 14, 1986, Pub. L. No. 99-660, 1986 U.S.C.C.A.N. (100 Stat.) 6385.
39. Scheutzow & Gillis, *supra* note 10, at 174.
40. 42 U.S.C. §§ 11136-11137 (1994).

information for various reasons.[41] Although it is easy to identify various entities who may compete for access to peer review information, it is essential to realize the tensions between these entities gaining access to the information and the statutes which protect the information from being disclosed. Thus, the interplay of privilege and confidentiality statutes with the competing public interests provides for interesting debate.[42]

D. THE AMERICAN MEDICAL ASSOCIATION POSITION ON PEER REVIEW

The American Medical Association (AMA) is a leading supporter of medical peer review. The 1997 *Policy Compendium*[43] of the AMA states that the AMA: "(1) strongly reaffirms its continuing commitment to the development and maintenance of voluntary,[44] professionally directed peer review of medical care; and (2) encourages physicians to expand their efforts to ensure that such care is of high quality, appropriate duration and reasonable cost."[45] In addition, the AMA takes the position that it is the ethical duty of a physician to share truthful information about the quality of care a colleague gives to his or her patients when

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41. Scheutzow & Gillis, *supra* note 10, at 174.

42. *See* Pagano v. Oroville Hosp., 145 F.R.D. 683, 694 (E.D. Cal. 1993) (finding that the Health Care Quality Improvement Act provides for confidentiality only of information provided to national repository pursuant to the Act); Manthe v. VanBolden, 133 F.R.D. 497, 503 (N.D. Tex. 1991) (finding that the federal statute controlling the release of information regarding physicians had no application to documents in the hospital's peer review file); Wei v. Bodner, 127 F.R.D. 91, 99 (D.N.J. 1989) (holding that the federal statutory privilege did not apply to hospital's peer review committee in antitrust action brought by the anesthesiologist unless requested information had been "reported" under the Health Care Quality Improvement Act).

43. The *Policy Compendium* is a compilation of the current polices of the AMA.

44. The AMA has established principles for voluntary medical peer review. House of Delegates Policy H-375.997 states:

> (1) Medical peer review is an organized effort to evaluate and analyze medical care services delivered to patients and to assure the quality and appropriateness of these services. Peer review should exist to maintain and improve the quality of medical care.
> (2) Medical peer review should be a local process.
> (3) Physicians should be ultimately responsible for all peer review of medical care.
> (4) Physicians involved in peer review should be representatives of the medical community; participation should be structured to maximize the involvement of the medical community. Any peer review process should provide for consideration of the views of individual physicians or groups of physicians or institutions under review.
> (5) Peer review evaluations should be based on appropriateness, medical necessity and efficiency of services to assure quality medical care.
> (6) Any system of medical peer review should have established procedures.
> (7) Peer review of medical practice and the patterns of medical practice of individual physicians, groups of physicians, and physicians within institutions should be an ongoing process of assessment and evaluation.
> (8) Peer review should be an educational process for physicians to assure quality medical services.
> (9) Any peer review process should protect the confidentiality of medical information obtained and used in conducting peer review.

AMERICAN MED. ASSOC. COUNCIL ON LONG RANGE PLANNING & DEV., AM. MED. ASSOC., POLICY COMPENDIUM 403-04 (1996).

45. *Id.* (referring to House of Delegates Policy H-375.996).

such information is requested by a credentialing body, so long as the information shared is not a proceeding or a document which is protected by a statute or regulation as confidential peer review information.[46]

The AMA also recognizes that confidentiality is an essential component to the peer review process. The AMA advocates legislation to ensure confidentiality of the peer review process.[47] Further, in order to preserve confidentiality, the AMA encourages medical staff peer review committees to exclude non-physicians from evaluating the professional practices of licensed physicians.[48]

III. STATE LEGISLATION FOSTERING PEER REVIEW

A. NORTH DAKOTA CENTURY CODE SECTION 23-01-02.1

The North Dakota Legislature approved the first legislation to protect peer review records in 1969, and the statute was subsequently amended in 1981, 1983, and 1985.[49] The law, which was effective until April 18, 1997,[50] stated:

> Any information, data, reports, or records made available to a mandatory hospital committee or extended care facility committee as required by state or federal law *or by the joint commission on accreditation of hospitals* by a hospital or extended care facility *or any physician or surgeon or group of physicians or surgeons operating a clinic or outpatient care facility* in this state *or to an internal quality assurance review committee of any hospital or extended care facility in this state* are confidential and may be used by such committees and the members thereof only in the exercise of the proper functions of the committees. The proceedings and records of such a committee are not subject to subpoena or discovery or introduction into evidence in any civil action arising out of any matter which is the subject of consideration by the committee. Information, documents, or records otherwise available from original sources are not immune from discovery or use in any civil action merely because they were presented during the proceedings of such a committee, nor may any person who testified before such a committee or who is a member of it be

46. *Id.* (referring to House of Delegates Policy H-375.984).
47. *Id.* (referring to House of Delegates Policy H-375.992).
48. *Id.* (referring to House of Delegates Policy H-375.993).
49. 1969 N.D. LAWS 251; 1981 N.D. LAWS 278; 1983 N.D. LAWS 287; 1985 N.D. LAWS 288.
50. This statute was repealed, effective April 18, 1997. 1997 N.D. LAWS 234; *see also* N.D. CENT. CODE § 23-01-02.1 (Supp. 1997).

prevented from testifying as to matters within that person's knowledge, but a witness cannot be asked about that witness' testimony before the committee. This section does not relieve any person of any liability which the person has incurred or may incur to a patient as a result of furnishing health care to the patient. No physician, hospital, or institution furnishing information, data, reports, or records to any such committee with respect to any patient examined or treated by such physician or confined in such hospital or institution is, by reason of furnishing such information, liable in damages to any person, or answerable for willful violation of a privileged communication. No member of such a committee is liable in damages to any person for any action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that such action or recommendation is warranted by the facts known to him.[51]

B. NORTH DAKOTA CENTURY CODE SECTION 31-08-01

Additional legislation to protect peer review records was enacted in 1975, by amending the statute governing the admissibility of business records. That statute, until April 18, 1997, provided:[52]

A record of an act, condition, or event shall be competent evidence insofar as relevant, if:

1. The custodian or other qualified witness testifies to its identity and the mode of its preparation.
2. It was made in the regular course of business, at or near the time of the act, condition, or event.
3. The sources of information and the method and time of preparation, in the opinion of the court, were such as to justify its admission.

For the purpose of this section, the term "business" shall include every kind of business, profession, occupation, calling, or operation of institutions, whether carried on for profit or not. *The records and proceedings of any regularly constituted medical review committee of a licensed medical hospital or a*

51. N.D. CENT. CODE § 23-01-02.1 (1991). The 1981 amendments are indicated in italics, the 1983 amendments (except for minor grammatical amendments) by underlining, and the 1985 amendments by underlined italics.

52. This statute was amended, effective April 18, 1997. 1997 N.D. LAWS 234.

medical society in this state shall not be subject to discovery or admissible as evidence.[53]

C. NORTH DAKOTA CENTURY CODE SECTION 43-17.1-05.1

A 1993 amendment to the law governing the Commission on Medical Competency began an erosion of the quarter-century of legislation to protect peer review records.[54] The law required reports to the Commission concerning physicians "who may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to safely engage in the practice of medicine."[55] This statute did not include any exception for records or information which was previously protected by the 1969-1985 peer review legislation:

> A physician, the state medical association and its components, a health care institution in the state, a state agency, a law enforcement agency in the state, or a court in the state having actual knowledge that a licensed physician may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to safely engage in the practice of medicine shall promptly report that information to the commission. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges, shall report that licensee's action to the commission if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment. Upon receiving a report concerning a licensee, or on its own motion, the commission may investigate any evidence that appears to show a licensee is or may be medically incompetent, guilty of unprofessional conduct, or mentally or physically incapable of the proper practice of medicine. Any person required to report under this section, who makes a report in good faith, may not be subject to criminal prosecution or civil liability for making the report. A physician, who obtains information in the course of a physician-patient relationship in which the patient is another physician, is not required to report if the treating physician successfully

53. N.D. CENT. CODE § 31-08-01 (1996). The 1975 amendment is indicated by italics. 1975 N.D. LAWS 292.

54. 1993 N.D. LAWS 426.

55. *Id.*

counsels the other physician to limit or withdraw from practice to the extent required by the impairment.[56]

IV. EFFORTS BY MEDICAL MALPRACTICE PLAINTIFFS TO OBTAIN "CONFIDENTIAL" PEER REVIEW RECORDS

For many years attorneys assumed that peer review records would not be admissible in medical malpractice actions (i.e., were confidential *and* privileged).[57] That assumption was attacked in several actions against a Minot physician concerning medical treatment from 1991 to 1992 in *Trinity Medical Center, Inc. v. Holum*.[58] After summarizing Trinity's recruitment of Dr. Mark De Naples, his treatment of three patients in 1991 through 1992, the resulting lawsuits against several defendants, and the fact that Dr. De Naples was later diagnosed with Alzheimer's Disease, the supreme court explained:

> Disputes arose during discovery over application of the peer review/quality assurance privilege, codified in Sections 23-01-02.1 and 31-08-01, N.D.C.C. Keplin [one of the plaintiffs] sought, through interrogatories and depositions, to elicit information relating to Dr. De Naple's practice at Trinity, and specific information regarding any in-hospital review of Dr. De Naple's care of these plaintiffs. Trinity [one of the defendants] objected, asserting application of the statutory privilege and urging an expansive reading of the privilege to cover all documents and information produced, collected, or presented in the entire quality assurance process. Keplin urged a narrow view of the privilege to cover only testimony to and discussions of the quality assurance committee. After briefing and a hearing, the district court, on June 30, 1995, issued its order directing Trinity to produce all requested information and documents, and to produce individuals requested for depositions, except:
>
> > Any complaints regarding Dr. De Naples made by physicians, nurses or hospital staff to the internal Quality Assurance Committee and any records of those complaints, or discussions of those complaints, with the internal Quality Assurance Committee.

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56. N.D. CENT. CODE § 43-17.1-05 (1993). This statute was amended twice in 1997. 1997 N.D. LAWS 234, 373.

57. Interview with Lance Schreiner, Partner in Zuger Kirmis & Smith, in Bismarck, N.D. (June 3, 1997).

58. 544 N.W.2d 148, 150-51 (N.D. 1996).

> The district court granted Trinity's motion for a stay pending application to this court for a supervisory writ.[59]

The supreme court granted the supervisory writ to address two issues: "Which hospital committees are covered by the privilege and what information and documents are protected?"[60] The parties, of course, differed about which committees were protected by the state laws. The supreme court continued:

> Keplin asserts that these statutes protect only committees mandated by law or the joint commission [JCAHO], and a single medical review/quality assurance committee of the medical staff. Trinity asserts that the statutes are not meant to limit coverage to specific committees, but are designed to protect the entire peer review/quality assurance *process* from disclosure. Trinity argues this protection extends beyond mandatory and quality assurance committees to any hospital committee performing any quality assurance function, to departments, and to individual hospital employees assigned to a quality assurance function. . . . Trinity argues that the privilege should also be extended to cover the entire quality assurance process, including other, non-mandatory hospital committees, and departments and individuals when performing quality assurance functions. Trinity asserts that the public policy underlying the peer review privilege, as expressed in caselaw and statutes from other jurisdictions supports this broad protection . . .[61]

The supreme court disagreed with Trinity's broad interpretation of the North Dakota peer review laws:

> If our legislature had intended to provide a broad statutory privilege for the entire quality assurance process, or for all committees performing any quality assurance function, it could have said so. The language employed in our statutes limits the privilege to committees mandated by law or the JCAHO standards, and to an internal quality assurance/medical review committee.
>
> Our conclusion is further supported by the legislative histories of Sections 23-01-02.1 and 31-08-01, N.D.C.C., which demonstrate that the primary purpose of the peer review

59. Trinity Medical Center, Inc. v. Holum, 544 N.W.2d 148, 151 (N.D. 1996) (footnotes omitted and explanation in brackets added).

60. *Id.* at 152.

61. *Id.* at 154.

> privilege was to encourage physician participation in the peer review process. Concerns were expressed that physicians would be unwilling to serve on quality assurance committees, and would not feel free to openly discuss the performance of other doctors practicing in the hospital, without assurance that their discussions in committee would be confidential and privileged. It was this purpose to encourage frank and open physician participation, and the resulting improvement in patient care, which underlies the privilege. The legislative history, however, does not address similar concerns for participation by departments, nurses, or other hospital employees. . . .
>
> We conclude on this record, that the privilege applies only to the Medical Staff Quality Assurance Committee, the Safety Committee, the Infection Committee, the Medical Staff Executive Committee, and the Credentials Committee.[62]

After the supreme court addressed the committees that were protected by the peer review law, the court focused on the information that was protected by the law. The parties' positions on this issue were also diametrically opposed:

> Trinity asserts that, under Section 23-01-02.1, all information, data, reports, or records made available to protected committees are privileged. Keplin asserts the privilege is limited to "proceedings and records of" protected committees.[63]

The supreme court sided with the plaintiffs-patients on this issue:

> Trinity's argument is flawed by its misreading of Section 23-01-02.1. . . . Trinity has confused confidentiality with privilege . . . .Trinity argues that, even if the privilege applies only to proceedings and records, information provided to the committee and data collected by the departments and hospital employees for review by the committee are included within "proceedings and records of" the committee. The statute, however, clearly distinguishes between "information, data, reports, or records made available" to the committee, and the "proceedings and records of" the committee. The former are merely confidential; the latter are privileged.[64]

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62. *Id.* at 155.
63. *Id.* at 156.
64. *Id.* at 156-57.

Accordingly, the supreme court concluded that "only the proceedings and records of covered committees are protected by the statutory privilege."[65]

Trinity Medical Center immediately caused a furor—and created anxiety—in the medical community. Plaintiffs could now subpoena peer review records which were previously considered privileged and physicians were reluctant to participate in a peer review process which could subject them to increased risk of personal liability. For example, one day after the opinion was released, the counsel for the North Dakota Hospital Association[66] advised the Association:

> It would be difficult to overstate the negative impact this opinion will have on the operations of every hospital in North Dakota. For many years, North Dakota's hospitals have relied on sections 23-01-02.1 and 31-08-01 of the North Dakota Century Code to protect from discovery a broad range of information gathered by hospital departments and personnel and utilized by quality assurance and peer review committees of the hospital medical staff. In the *Trinity Medical Center* case, the North Dakota Supreme Court has applied an extremely narrow and strict statutory interpretation to those provisions. It would now appear that little of the information previously thought protected will be granted protection by the courts of North Dakota.[67]

V. EFFORTS BY THE NORTH DAKOTA COMMISSION ON MEDICAL COMPETENCY TO OBTAIN "CONFIDENTIAL" PEER REVIEW RECORDS

The North Dakota Commission on Medical Competency was established in 1977.[68] The role of the Commission was summarized in *Commission on Medical Competency v. Racek*:[69]

> The Commission is an arm of the Board of Medical Examiners (Board), and it investigates allegations of misconduct or incompetency against physicians licensed in this state. If the Commission decides that neither disciplinary action nor further investigation are warranted, it may dismiss the matter. If the

65. *Id.* at 157.

66. The North Dakota Hospital Association is now the North Dakota Health Care Association.

67. Memorandum from John C. Kapsner, Attorney for Kapsner & Kapsner, to Arnold "Chip" Thomas, Director of North Dakota Hospital Association (February 29, 1996) (on file with the NORTH DAKOTA LAW REVIEW).

68. N.D. CENT. CODE § 43-17.1-02 (1993).

69. 527 N.W.2d 262 (N.D. 1995).

> Commission decides that there are grounds for disciplinary action, it files a formal complaint with the Board. Although all records of the Commission are confidential and exempt from the open records law under NDCC 43-17.1-08, the records of the Board are not exempt and are open to the public. Accordingly, once the Commission files a formal disciplinary complaint with the Board, it becomes a public record.[70]

The Commission initiated an informal investigation in 1992, concerning a Fargo physician, which the Commission initially designated Dr. Doe. The actions by the Commission are summarized in *Racek:*

> The Commission conducted a lengthy investigation of Dr. Doe beginning in 1991. In November 1993 the Commission voted to file a formal disciplinary complaint against Dr. Doe. Dr. Doe learned of the pending investigation, and settlement negotiations began between the Commission and Dr. Doe and his attorneys. The Commission informed Dr. Doe generally of the nature of the charges against him, and identified eight specific patient files that entered into the complaint. Dr. Doe was also given a draft copy of the complaint. When settlement negotiations broke down, Dr. Doe requested and received a confidential conference before the Commission under NDCC 43-17.1-06(6). After Dr. Doe, his witnesses, and his attorneys appeared at the June 9, 1994, conference, the Commission again voted to file a disciplinary complaint with the Board.[71]

Dr. Doe sued the Commission in an effort to avoid the filing of a public complaint with the Board. Dr. Doe was successful in the district court:

> Dr. Doe then sought a temporary restraining order and preliminary injunction against the Commission in district court. After a hearing, the court ordered the Commission to refrain from filing a complaint or making public any allegations against Dr. Doe until it has advised Dr. Doe of the specific nature of the complaints against him, including names of the complainants, and holds a confidential hearing giving Dr. Doe a reasonable and meaningful opportunity to be heard. The Commission sought certification under NDRCivP 54(b) to facilitate an immediate appeal; the district court refused. The

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70. Commission on Med. Competency v. Racek, 527 N.W.2d 262, 263 (N.D. 1995) (interpreting N.D. CENT. CODE §§ 43-17.1, -17.1-05 (2-3), -17.1-08, 44-04-18 (1993 & Supp. 1997)).

71. *Id.*

> Commission now seeks a supervisory writ, alleging that it has no alternative remedy.[72]

The respective positions of the parties were clearly outlined in the proceedings before the district court. For example, Dr. Doe contended, in the amended complaint: "[Dr. Doe] has been systematically denied knowledge and information of the precise identity of [the Commission's] informants and complainants and the nature and extent of their investigation and inquiries and has been effectively foreclosed from conducting an investigation so as to be able to prepare a competent and complete defense."[73] The Commission responded that:

> There are no requirements that the Commission on Medical Competency afford any notice of its investigation, nor that it take any steps to provide copies of reports, identity of complaining witnesses, or any of the other information that [Dr. Doe], in this action, has demanded. . . . [T]he Commission maintains that there are no due process rights available to [Dr. Doe] at this stage in the proceeding.[74]

The documents filed with the court also reveal a looming battle between the parties concerning access to peer review records. The amended complaint alleged:

> In the course of the investigation, [the Commission's] counsel attempted to subpoena medical records from the hospital at which Plaintiff has medical staff privileges and to secure other records, documents and reports of a medical chart review commissioned by hospital in regard to a general departmental review of certain files and medical records pursuant to confidential quality assurance and peer review processes. [The Commission's] counsel attempted to force the hospital to reveal the results of the hospital's peer review process, despite knowing that such proceedings and records are absolutely exempt from subpoena, discovery, or introduction into evidence under N.D.C.C. § 23-01-02.1 and specifically not subject to the subpoena powers of the Commission as set forth in N.D.C.C. § 43-17.1-06.[75]

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72. *Id.*

73. Am. Compl. (July 20, 1994) at ¶10, Commission on Med. Competency v. Christoferson, Civ. No. 95-02951 (District Court, East Central Judicial District) (1995).

74. Return to Application for T.R.O., Temporary Inj. and Permanent Inj. (July 6, 1994) at 2, *Christoferson*, (Civ. No. 95-02951).

75. Am. Compl. (July 20, 1994) at ¶9, *Christoferson*, (Civ. No. 95-02951).

An affidavit filed by the Commission disputed the discovery allegation in the amended complaint and in an affidavit filed by Dr. Doe:

> [A]t no time has your affiant intentionally attempted to secure from a hospital at which plaintiff practices, records which are by law exempt from subpoena, discovery or introduction into evidence, that such issue was fully addressed and your affiant's intentions made clear, in *Dakota Hospital vs. Commission on Medical Competency*, Civil No. 93-1963, heard by the Cass County District Court on October 28, 1993, before the Honorable Cynthia Rothe.[76]

The court, after hearing oral arguments at the University of North Dakota School of Law in October of 1994, granted the supervisory writ and directed the district court to vacate its order. The court declared that "Dr. Doe has no enforceable right to a confidential pre-complaint hearing by the Commission to clear his name before the complaint is filed publicly with the board."[77] The supreme court's decision allowed the Commission to file the formal complaint with the Board, which continued the investigation of Dr. Doe, now identified as Lee Christoferson, Jr., M.D. The Commission was soon skirmishing with clinics and hospitals over its efforts to subpoena peer review records concerning Dr. Christoferson.

The Board served a subpoena on Dakota Clinic in July 1995. The subpoena demanded the following documents:

1. Copies of any and all incident reports or other complaints (either oral or written) received by Risk Management, Quality Assurance, or any other administrative body regarding Dr. Lee Christoferson, Jr., beginning January 1, 1988 through December 31, 1993. This includes, but is not limited to, all paper documentation, computer printouts, and information stored on computer software, programs and/or disks.
2. All documents that record, refer, or relate in any way to claims which the clinic, its counsel, or representative submitted on behalf of Dr. Lee Christoferson, Jr., M.D. to medical malpractice insurers, including, but not limited to

76. Aff. of Special Assistant Attorney General John M. Olson (July 6, 1994), at ¶13, *Christoferson*, (Civ. No. 95-02951).

77. *Racek*, 527 N.W.2d at 268.

complaints, requests for coverage, medical reports, notes or memoranda.

3. A copy of the credential and/or personnel file of Dr. Lee Christoferson, Jr., M.D.[78]

Concerning the items described in ¶1 of the subpoena, the clinic responded that it would provide "incident reports" or complaints, but the clinic refused to provide the other documents:

> The clinic asserts the quality assurance privilege and the attorney/ client privilege, however, to the extent that this request may be construed as requiring the production of notes or minutes of any quality assurance or peer review proceeding or any correspondence exchanged between Dakota Clinic, Ltd. and its attorneys or their representatives.[79]

Similarly, concerning ¶2 of the subpoena, the clinic stated in part: "Objection is made to this request on the basis that it seeks information which is protected by the quality assurance/peer review privilege, the attorney-client privilege, and the work product privilege." The clinic also objected to ¶3 of the subpoena for the same reasons as ¶1 and ¶2.

Less than two weeks later, the Board sent similar, and much broader, subpoenas to Dakota Clinic and Dakota Heartland.[80] Both subpoenas demanded: "All proceedings and records of the peer review conducted by your institution regarding Dr. Lee A. Christoferson, Jr. (*See Arnett v. Dal Cielo*, 42 Cal. Rptr. 2d 712 (Cal. Ct. App. 1995))."[81] The clinic's response to the second subpoena was curt: "The Clinic asserts the quality assurance review privilege (peer review privilege), the attorney/ client privilege, and the work product privilege with regard to all proceedings and records of any quality assurance or peer review conducted regarding Dr. Lee Christoferson, Jr."[82] Dakota Heartland's response was also very brief:

> Dakota Heartland's objection is based on but not limited to the following reasons:
>
> 1. The information sought by the Commission is not subject to subpoena or discovery per N.D.C.C. §§ 23-01-02.1, 31-08-01, and 43-17.1-06;

78. Am. Subpoena (July 28, 1995) at 1, *Christoferson*, (Civ. No. 95-02951).

79. Objections and Resp. to Am. Subpoena (August 2, 1995) at 2, *Christoferson*, (Civ. No. 95-02951).

80. Both facilities are located in Fargo, North Dakota.

81. Subpoena (August 14, 1995) at 1, *Christoferson*, (Civ. No. 95-02951).

82. Objections and Resp. to Subpoena (August 21, 1995) at 1, *Christoferson*, (Civ. No. 95-02951).

2. The information sought by the Commission is protected by the common law critical self-analysis privilege. Consequently, it is not subject to discovery or subpoena.[83] The Commission was similarly unsuccessful in obtaining information about peer review activities during depositions of key witnesses.

The Commission responded by filing a motion in the proceedings before the Board: "Complainant, the Commission on Medical Competency, brings this Motion seeking an Order from the administrative law judge compelling Respondent to fully answer deposition questions and produce all documents regarding the peer review. . . ."[84] After considering extensive briefs from the parties, the administrative law judge partially granted the Commission's motion. The order stated, in part: "Both Dakota Clinic and Dakota Heartland must produce all peer review records or information in their possession regarding Christoferson, as well as the entity's personnel file on him."[85] The order also explained the basis for the decision:

> This is not a civil suit concerning, e.g., malpractice. This is an administrative action against the license of Dr. Christoferson. The public has a vital interest in quality health care. This interest is not subordinated by the North Dakota statutes, or in any case law, or in federal law, cited by the Complainant, Respondent, and Dakota Clinic or Dakota Heartland . . . Again, these records and files may still be confidential under the law and prevented from public disclosure, but they are discoverable and may be admissible in a licensing proceeding. This order does not apply to the minutes of the Quality Assurance Committee, nor does it apply to truly attorney-client privilege information (i.e., information specifically directed to or from the Clinic's or Hospital's attorney; or correspondence between the hospital and its attorney or the clinic and its attorney; or any information about malpractice litigation or strategy resulting because of discussion with any attorney).[86]

The subpoenaed facilities did not produce the peer review records. When the Commission filed a Motion for Enforcement with the state

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83. Dakota Heartland's Objection to Subpoena (August 22, 1995), *Christoferson*, (Civ. No. 95-02951).

84. Complainant's Mot. to Compel Produc. of Docs. and Resp. to Dep. Questions of Dakota (August 28, 1995) at 1, *Christoferson*, (Civ. No. 95-02951).

85. Order on Motion to Compel Produc. of Docs. and Resp. to Dep. Questions of Dakota (September 18, 1995) at 1, *Christoferson*, (Civ. No. 95-02951).

86. *Id.* at 1-2.

district court, the North Dakota Medical Association submitted an *amicus curiae* brief because of its concern "that eliminating the confidentiality of the peer review process will jeopardize the integrity of the . . . process."[87] The *amicus curiae* brief, in addition to commenting on the disputed statutes, explained the AMA's position concerning the importance of the peer review process and the confidentiality of peer review records.[88] The Commission objected to the filing of the *amicus curiae* brief,[89] but the court referenced the brief in its subsequent order.

The district court affirmed the decision of the administrative law judge. The order stated, in part:

> The discovery order at issue does not reach minutes of the Quality Assurance Committee or "truly attorney-client privileged information." The order also states that the information sought may remain confidential even if discoverable "in a licensing proceeding."
>
> The hearing officer's order for discovery is within his authority under the law and is not an abuse of discretion. It is neither arbitrary, capricious, nor unreasonable.
>
> Therefore, IT IS HEREBY THE ORDER OF THE COURT that the Administrative Hearing Officer's "Order on Motion to Compel Production of Documents and Responses to Deposition Questions of Dakota". . . is hereby ENFORCED with the full contempt powers of this court.[90]

Dakota Heartland promptly appealed the district court order to the North Dakota Supreme Court and concurrently applied for a stay from the district court.[91] Dakota Heartland also submitted a petition for a supervisory writ to the supreme court.[92]

Meanwhile, the Commission and Dr. Christoferson negotiated a settlement and Dakota Heartland submitted a motion to withdraw the notice of appeal.[93] The Commission, in an effort to obtain a supreme

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87. Br. in Supp. of Mot. to Submit *Amicus Curiae* Br. (October 4, 1995), *Christoferson*, (Civ. No. 95-2951).

88. Br. of *Amicus Curiae* N.D. Med. Assoc. (October 9, 1995) at 2, *Christoferson*, (Civ. No. 95-02951).

89. Complainant's Br. in Opp'n to N.D. Med. Assoc. *Amicus Curiae* Br. (October 10, 1995), *Christoferson*, (Civ. No. 95-02951).

90. Order to Enforce Disc. (October 11, 1995), *Christoferson*, (Civ. No. 95-02951).

91. Notice of Appeal (October 17, 1995), *Christoferson*, (Civ. No. 95-02951).

92. Pet. for Supervisory Writ (October 25, 1995), *Christoferson*, (Civ. No. 95-02951).

93. Mot. to Withdraw and Dismiss Its Appeal and Pet. for a Supervisory Writ (November 2, 1995), *Christoferson*, (Civ. No. 95-02951).

court decision on the issue, objected to the motion.[94] The Commission argued:

> While the Hospital asserts that the issue is now moot, the Commission believes that this issue is of great public importance and is one that is capable of reptition [sic] yet evading review. The Commission does not believe hospitals should be able to hide evidence of a physician's neglect by beginning a peer review of that physician. The peer review should not provide cover for an internal process that is not working to protect the public. Hospitals and the state licensing board should work together, not in opposite, to protect the public.[95]

The supreme court, obviously declining to provide an advisory opinion about the issue, granted Dakota Heartland's motion.

VI. COMPROMISE LEGISLATION WHICH ADDRESSED THE COMPETING INTERESTS

Peer review in North Dakota was temporarily in chaos for at least three reasons:

1. Plaintiffs in medical malpractice actions had access to documents which were previously considered exempt from discovery.
2. There was continued uncertainty, and the promise of continuing litigation, concerning access by the Commission on Medical Competency to peer review records.
3. The 1993 legislation, section 43-17.1-05.1 of the North Dakota Century Code, required that members of a peer review committee "having actual knowledge that a licensed physician may be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to safely engage in the practice of medicine shall promptly report that information to the commission."

Therefore, the North Dakota medical community recommended emergency legislation, Senate Bill 2301, in the 1997 session to address all three issues. The legislation triggered a public policy debate; the medical community sought confidentiality and privilege, the trial lawyers sought access to peer review records, and the media expressed its

94. Commission on Med. Competency's Objection to Dakota Heartland's Mot. to Withdraw and Dismiss its Appeal and Pet. for a Supervisory Writ (November 3, 1995), *Christoferson*, (Civ. No. 95-02951).

95. *Id.*

traditional opposition to confidentiality. After considerable debate, the legislature approved, and the governor signed, Senate Bill 301. The bill became effective on April 18, 1997, when it was filed with the Secretary of State.[96]

A. CONFIDENTIALITY

Senate Bill 2301 reaffirmed that all peer review records are confidential. Section 23-34-02, now states: "Peer review records[97] are confidential and may be used by a peer review committee[98] and the committee members only for conducting a professional peer review."[99]

B. PRIVILEGE

Senate Bill 2301 clearly declared that all peer review records are privileged with only three exceptions. Section 23-34-03, provides:

> Peer review records are privileged and are not subject to subpoena or discovery or introduction into evidence in any civil or administrative action, except:
>
> 1. Records gathered from an original source that is not a peer review committee;
> 2. Testimony from any person as to matters within that person's knowledge, provided the information was not obtained by the person as a result

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96. With the passage of an emergency clause, the bill was effective when it was filed with the Secretary of State. N.D. CONST. ART. IV, § 13.

97. The term "peer review records" is broadly defined in the new § 23-34-01(4):

> "Peer review records" means all data, information, reports, documents, findings, compilations and summaries, testimony, and any other records generated by, acquired by, or given to a peer review committee as a part of any professional peer review, regardless of when the record is created. The term does not include original patient source documents. Peer review records also include all communications relating to a professional peer review, whether written or oral, between peer review committee members, peer review committee members and the peer review committee's staff, or peer review committee members and other persons participating in a professional peer review, including the person who is the subject of the professional peer review.

N.D. CENT. CODE § 23-34-01(4) (Supp. 1997).

98. The term "peer review committee" is also broadly defined in the new § 23-34-01(3):

> "Peer review committee" means any committee of a health care organization, composed of health care providers, employees, administrators, consultants, agents, or members of the health care organization's governing body, which conducts professional peer review.

N.D. CENT. CODE § 23-34-01(3) (Supp. 1997).

99. The term "professional peer review" is defined in § 23-34-01(5):

> "Professional peer review" means all procedures a peer review committee uses or functions it performs to monitor, evaluate, and take actions to review the medical care provided to patients by health care organizations or health care providers to improve patient care and treatment or to provide quality assurance.

N.D. CENT. CODE § 23-34-01(5) (Supp. 1997).

of the person's participation in a professional peer review; or

3. Peer review records subpoenaed in an investigation conducted by the commission on medical competency pursuant to chapter 43-17.1 or subpoenaed in a disciplinary action before the board of medical examiners pursuant to section 43-17-30.1. Any peer review records provided to the commission or introduced as evidence in any disciplinary action before the board are confidential and are not subject to subpoena, discovery or admissibility into evidence in any civil or administrative action, and are not public records subject to section 44-04-18 and section 6 of article XI of the Constitution of North Dakota.

During the Senate hearings, a senator questioned whether this section would be an unconstitutional encroachment on the supreme court's authority to promulgate procedural rules. The staff of the Legislative Council submitted a lengthy memorandum to the senator which concluded:

> [I]f a legal challenge is made regarding Section 1 of Senate Bill No. 2301 and a claimed legislative encroachment on the Supreme Court's constitutional right to promulgate procedural rules, it is likely the court will determine the limitations in Section 1 are procedural. A legislative statute governing judicial procedure is not unconstitutional on its face. A procedural statute is constitutional if the Supreme Court determines it does not conflict with or engulf its rules.[100]

Subsection 3 of section 23-34-03, was part of a compromise between the Board of Medical Examiners and the Commission on Medical Competency, which sought relatively unrestricted access to peer review records, and the North Dakota Medical Association and the North Dakota Health Care Association, which considered confidentiality and privilege an essential component of the peer review process. Another compromise, as explained below, was the required reporting to the Commission on Medical Competency.

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100. Memorandum from the North Dakota Legislative Council Staff to Senator Lee (Mar. 14, 1997) (on file with the NORTH DAKOTA LAW REVIEW). Although this memorandum may not have the same authority as an attorney general's opinion, the memorandum does reflect that the issue was considered before the legislature acted on the legislation.

C. LIMITATION ON LIABILITY

Senate Bill 2301 addressed the anxiety of persons participating in the peer review process. A new section 23-34-06, states:

1. A person furnishing peer review records to a peer review committee with respect to any patient examined or treated by a health care provider[101] is not, by reason of furnishing the records, liable in damages to any person or for willful violation of a privileged communication.
2. A health care organization,[102] health care provider, or member of a peer review committee is not liable in damages to any person for any action taken or recommendation made regarding a professional peer review, if the organization, provider, or committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the organization, provider, or committee member.

D. MANDATORY REPORTING

The issue of required reports to the Commission on Medical Competency remained a contentious issue through the legislative session, and the interested parties did not agree on mutually acceptable legislative language. Section 3 of Senate Bill 2301, which was supported by the North Dakota Health Care Association and the North Dakota Medical Association, amended section 43-17.1-05.1 of the North Dakota Century Code by adding two sentences:

> A physician who obtains information in the course of a professional peer review pursuant to [chapter 23-34] is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer

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101. The term "health care provider" is broadly defined in § 23-34-01(2):

> "Health care provider" means a physician or other person licensed, certified, or otherwise authorized by the law of this state to provide health care services.

N.D. CENT. CODE § 23-34-01(2) (Supp. 1997).

102. The term "health care organization" includes many types of medical facilities. Section 23-34-01(1) states:

> "Health care organization" means any hospital, hospital medical staff, clinic, long-term or extended care facility, ambulatory surgery center, emergency medical services unit, physician, group of physicians operating a clinic or outpatient care facility, combination of these entities, or federally designated state peer review organization.

N.D. CENT. CODE § 23-34-01(1) (Supp. 1997).

review is not subject to criminal prosecution or civil liability for not making a report.

In addition, Senate Bill 2301 was amended in the Senate to include a new section, now section 23-34-04:

> A peer review committee shall report to the commission on medical competency any information that indicates a probable violation of subsection 4, 5, 16, or 17 of section 43-17-31.[103] A health care organization is guilty of a class B misdemeanor if its peer review committee fails to make any report required by this section.[104]

However, section 4 of House Bill 1135, which was introduced at the request of the Board of Medical Examiners, extensively amended section 43-17.1-05.1:

> Reports to commission on medical competency—When required. A physician, ~~the state medical association and its components~~ *a physician assistant, or a fluoroscopy technologist*, a health care institution in the state, a state agency, *or* a law enforcement agency in the state, ~~or a court in the state~~ having actual knowledge that a licensed physician, *a physician assistant, or a fluoroscopy technologist* may ~~be medically incompetent, guilty of unprofessional conduct, or mentally or physically unable to safely engage in the practice of medicine~~ *have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board* shall promptly report that information *in writing* to the commission. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the commission if that action occurs while the licensee is under

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103. Section 43-17-31 states in part:

> Disciplinary action may be imposed against a physician upon any of the following grounds:
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> . . .
>
> 4. Habitual use of alcohol or drugs.
> 5. Physical or mental disability materially affecting the ability to perform the duties of a physician in a competent manner.
>
> . . .
>
> 16. Sexual abuse, misconduct, or exploitation related to the licensee's practice of medicine.
> 17. The prescription, sale, administration, distribution, or gift of any drug legally classified as a controlled substance or as an addictive or dangerous drug for other than medically accepted therapeutic purposes.

N.D. CENT. CODE § 43-17-31 (Supp. 1997).

104. 1997 N.D. LAWS 234.

formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment. Upon receiving a report concerning a licensee *the commission shall*, or on its own motion the commission may, investigate any evidence that appears to show a licensee is or may ~~be medically incompetent, guilty of unprofessional conduct, or mentally or physically incapable of the proper practice of medicine~~ *have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board.* Any person required to report under this section who makes a report in good faith may not be subject to criminal prosecution or civil liability for making the report. *For purposes of any civil proceeding, the good faith of any person who makes a report pursuant to this section is presumed.* A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. *For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct. Any agency or health care institution that violates this section is guilty of a class B misdemeanor. A physician, physician assistant, or radiology technologist who violates this section is subject to administrative action by the North Dakota state board of medical examiners as specified by law or by administrative rule.*[105]

The amendment of section 43-17.1-05.1 by Senate Bill 2301 (which became effective April 18, 1997, because it included an emergency clause) and by House Bill 1135 (which became effective August 1, 1997) created an interesting situation. Accordingly, the Legislative Council attempted to reconcile the inconsistent amendments for the code.[106]

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105. 1997 N.D. LAW 373. House Bill 1135 was filed with the Secretary of State on April 2, 1997.

106. Section 1-02-09.1 states:

> If amendments to the same statute are enacted at the same or different sessions of the legislative assembly, one amendment without reference to another, the amendments are to be harmonized, if possible, so that effect may be given to each. If the amendments are irreconcilable, the latest in date of enactment prevails.

Section 43-17.1-05.1, as "harmonized" by the Legislative Council, now states:

> A physician, a physician assistant, or a fluoroscopy technologist, a health care institution in the state, a state agency, or a law enforcement agency in the state having actual knowledge that a licensed physician, a physician assistant, or a fluoroscopy technologist may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board shall promptly report that information in writing to the commission. A medical licensee or any institution from which the medical licensee voluntarily resigns or voluntarily limits the licensee's staff privileges shall report that licensee's action to the commission if that action occurs while the licensee is under formal or informal investigation by the institution or a committee of the institution for any reason related to possible medical incompetence, unprofessional conduct, or mental or physical impairment. Upon receiving a report concerning a licensee the commission shall, or on its own motion the commission may, investigate any evidence that appears to show a licensee is or may have committed any of the grounds for disciplinary action provided by law or by rules adopted by the board. A person required to report under this section who makes a report in good faith is not subject to criminal prosecution or civil liability for making the report. For purposes of any civil proceeding, the good faith of any person who makes a report pursuant to this section is presumed. A physician who obtains information in the course of a physician-patient relationship in which the patient is another physician is not required to report if the treating physician successfully counsels the other physician to limit or withdraw from practice to the extent required by the impairment. A physician who obtains information in the course of a professional peer review pursuant to chapter 23-34 is not required to report pursuant to this section. A physician who does not report information obtained in a professional peer review is not subject to criminal prosecution or civil liability for not making a report. For purposes of this section, a person has actual knowledge if that person acquired the information by personal observation or under circumstances that cause that person to believe there exists a substantial likelihood that the information is correct. An agency

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N.D. CENT. CODE § 1-02-09.1 (1987).

> or health care institution that violates this section is guilty of a class B misdemeanor. A physician, physician assistant, or radiology technologist who violates this section is subject to administrative action by the North Dakota state board of medical examiners as specified by law or by administrative rule.

E. RETROACTIVITY

Section 6 of Senate Bill 2301, as introduced, stated that "Section 1 of this Act applies retroactively to peer review records created before the effective date of this Act." This provision triggered a controversy by plaintiffs in then-existing actions who complained that the bill would prevent their use of evidence obtained during discovery after the *Trinity Medical Center v. Holum* decision. The House deleted the retroactivity clause.[107]

The retroactivity clause generated two legal memoranda. A memorandum from the staff of the Legislative Council to a senator analyzed this issue and concluded:

> If a constitutional challenge is made regarding the retroactive clause of the bill, the Supreme Court may determine it does not result in a bill of attainder or create an ex post facto law. The success of a challenge based on an unconstitutional infringement of an obligation of contract will depend on the contract and the obligation claimed. The success of a claim that a vested right has been taken without due process will depend on whether the Supreme Court determines that Section 1 [chapter 23-34] is procedural, or whether a right to discovery or evidentiary admission is based on an event that is uncertain.[108]

A staff memorandum to the attorney general also addressed this issue. The staff attorney concluded:

> The medical peer review privilege in current law is expanded under. . . Senate Bill 2301, both in terms of the committees protected by the bill and the records of those committees that are privileged. The bill does not interfere with the separation of powers because the rules of evidence adopted by the Supreme Court expressly authorize the creation of evidentiary privileges by statute. Further, privileged material is not subject

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107. JOURNAL OF THE HOUSE, FIFTY-FIFTH SESSION OF THE LEGISLATURE ASSEMBLY 957 (N.D. 1997).

108. Memorandum from the North Dakota Legislative Council Staff to Senator Lee (Mar. 14, 1997) (on file with the NORTH DAKOTA LAW REVIEW). Again, although this memorandum may not have the same authority as an attorney general's opinion, the memorandum reflects that the issue was addressed before the legislature acted on the bill.

> to the rules of discovery. The bill also will generally not be applied retroactively and thus has no retroactivity problem, except as applied to records that have previously been disclosed, or to pending cases on the effective date of the act in which material has already been introduced that is privileged under the bill.[109]

Concerning the pending actions, the memorandum expressed concern that "the retroactivity clause does raise constitutional questions resulting from its application to cases in which the material has already been introduced or to records that have already [been] disclosed."[110] The memorandum suggested three options to avoid a constitutional problem, and the bill was subsequently amended in accordance with the suggestion. Section 6 of the bill was amended to state: "Section 1 of this Act [chapter 23-34] does not apply in any action that was commenced before the effective date of this Act."[111]

VII. CONCLUSION

Medical peer review in North Dakota was in disarray following *Trinity Medical Center v. Holum*. However, as a result of Senate Bill 2301 and House Bill 1135, medical peer review should again be an effective tool to continually improve the delivery of medical care in the state. The legislation balances a number of public policies including confidentiality versus reports to the Commission on Medical Competency, prospective versus retroactive application of the law, and liability of participants versus protection of persons who participate in good faith. The legislation also prevents potential litigation by the Commission on Medical Competency concerning the Commission's access to peer review records during an investigation of a physician. Although the legislation may require "fine tuning" in subsequent legislative sessions, chapters 23 through 34 of the North Dakota Century Code will be the foundation for professional peer review into the 21st century.

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109. Memorandum from Jim Fleming, Assistant Attorney General, to Heidi Heitkamp, Attorney General (Mar. 24, 1997) (on file with the NORTH DAKOTA LAW REVIEW).

110. *Id.*

111. The definition of "peer review records" was concurrently amended to include the phrase "regardless of when the record is created." JOURNAL OF THE SENATE HOUSE, FIFTY-FIFTH SESSION OF THE LEGISLATURE 1203, 1221 (N.D. 1997); JOURNAL OF THE HOUSE, FIFTY-FIFTH SESSION OF THE LEGISLATURE ASSEMBLY 1379, 1483 (N.D. 1997); 1997 N.D. LAWS 234.