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The Confidentiality of Medical Quality Assurance Records

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Introduction

The Department of Defense (DOD) Authorization Act for fiscal year 1987 contains a provision that makes records created in a medical quality assurance (QA) program confidential and precludes participation in quality assurance activities from testifying about the records or about any of the findings, recommendations, evaluations, opinions, or actions taken by the QA activity.2 The statutory privilege, which allows disclosure of QA information only in certain limited situations, is designed to improve the quality of medical care by encouraging a thorough and candid medical peer review process.3 This article will briefly discuss the major provisions of the new law and how it will affect the Army's QA program.

The Army Medical Corps' Quality Assurance Program4 is intended to assure the highest quality of medical care and treatment possible within the available resources. The program encompasses patient care assessment,5 credentialing,6 utilization review,7 and risk management.8 The heart of the program is the process of peer review. Peer review subjects the care and treatment rendered by a particular health care provider to the critical scrutiny of other professionals. The goal is to learn from one's own mistakes and the mistakes of others, and to develop procedures and processes that will minimize the chance of error. As doctors and nurses, as well as other health care providers, improve their individual skills and patch "gaps" in the system, the result will be a continuing improvement in the quality of medical care delivered at the particular facility. The end result, the highest possible quality of medical care, benefits all the patients and potential patients serviced by the medical treatment facility.

As you might imagine, a system such as this produces many files, records, and other information that may be extremely critical of the care rendered in a particular case.9 Disclosing that information to a patient or a patient's attorney seriously hinders the defense of any malpractice claim. To avoid disclosing damaging opinions and information about a colleague's practice of medicine, the participants in the peer review process may be reluctant to scrutinize the medical care as critically as is necessary to reach the laudable goal of the highest quality of care possible. Thus, the risk of public disclosure dilutes the efficacy of the peer review process and damages the public interest in quality medical care.10

Both courts and legislatures have recognized the reluctance among medical professionals to critically review each other's work and have created various privileges to preclude the discoverability and admissibility of information and opinions developed in the peer review process. Prior to

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3Dept of Army, Reg. No. 40-66, Medical Services—Medical Record and Quality Assurance Administration, ch. 9 (31 Jan. 1985) [hereinafter AR 40-66].
4Id. para. 9-7. "Patient care assessment" is a systematic review of medical records and other hospital data sources designed to evaluate the quality of patient care as measured against written assessment criteria developed by the medical staff. The assessment may be performed by committees on a departmental basis or by committees formed according to certain tasks such as tissue review. The process is intended to identify problems or deficiencies in the delivery of health care, establish corrective measures, and monitor the corrective actions. As established by AR 40-66, patient care assessment will include, in addition to the problem identification and correction aspect: a review of medical records for accuracy, timeliness, completeness, clinical pertinence, and adequacy as medico-legal documents; a review of certain specified case outcomes such as hospital incurred trauma, complication, or infection, readmission within 30 days, return to the operating room in the same admission, return for emergency care within 48 hours after emergency or outpatient treatment; and all death cases. Other aspects of patient care assessment include surgical (tissue) review, anesthesia audit, autopsy review, blood utilization review, drug use review, and a review of hospital support services and special units such as emergency rooms, outpatient clinics, and home care programs.
5Id. para. 9-10. "Credentialing" involves the delineation of a given practitioner's privileges to practice medicine or dentistry at a particular facility. All health care providers who are given the authority to make independent decisions to initiate or alter a course of medical or dental treatment will be given individual clinical privileges based upon their training, experience, and the equipment and support available at the medical or dental facility. Residents, interns, and others in training programs are given categorical privileges depending upon their level within the training program. Once granted, individual clinical privileges must be reviewed annually. AR 40-66 contains procedures to summarily limit, suspend, or revoke clinical privileges when the practitioner's conduct such action to protect the health or safety of patients, employees, or others in the facility. In less drastic circumstances, privileges may be limited, suspended, or revoked after the practitioner has been given notice and an opportunity to be heard.
6Id. para. 9-8. "Utilization review" is resource management. The goal is cost containment. Factors such as the appropriateness of admission, services provided, length of stay, discharge planning and practice, and outpatient services are reviewed to assess the prudence with which the facility's resources were utilized. Section 701 of the Authorization Act requires the Secretary to establish by regulation diagnosis related groups (DRGs) as the primary criteria for allocating resources to military medical and dental facilities. DRGs have been used as a resource management tool and as the basis to determine payments under health insurance programs in the civilian sector for some time.
7AR 40-66, para. 9-9. The risk management program is concerned primarily with accident and injury prevention and the reduction of financial loss to the government after an untoward incident has occurred. Each medical facility is required to appoint a risk manager to direct the program. He or she will be an Army Medical Department (AMEDD) officer in the rank of major or above or the civilian equivalent, where possible. The risk manager is responsible for screening incidents that occur in the facility and determining whether they should be reviewed further for risk management purposes. The risk manager serves as the primary point of contact within the medical facility for the claims judge advocate investigating potential and actual claims against the government.
8Merely because a thorough retrospective analysis reveals a "better" or "different" method of handling a particular case does not necessarily mean that the physician deviated from the "standard of care" and committed malpractice.
the passage of the DOD Authorization Act for fiscal year 1987, the protection from discovery of information generated by the Army's QA program was open to question. Attempts to protect the opinions and recommendations of peer review committees from disclosure were based upon a few federal cases as well as some state statutes. 11

The leading case in the federal sector on the confidentiality of peer review information is Bredice v. Doctor's Hospital. 12 In Bredice, the plaintiff sought discovery of minutes and reports of any board, committee, or staff member of the defendant hospital concerning the death of plaintiff's decedent. The defendant refused to produce the information and the plaintiff moved the court to compel discovery. The court denied discovery of the requested material and found that the peer review function performed by the committees and staff was essential to improving the quality of medical care and treatment delivered. Furthermore, the court was convinced that "[c]andid and conscientious evaluation of clinical practices [was] a sine qua non of adequate hospital care" and that the public had an overwhelming interest in having the peer review process carried on in confidence so that "the full flow of ideas and advice can continue unimpeded." 13 The privilege from discovery of peer review materials established by Bredice is not absolute, however. The court noted that evidence of extraordinary circumstances could overcome the public's interest and establish sufficient cause to justify disclosure. 14

Subsequent decisions have, more or less, followed Bredice and one can safely say that authority does exist to support the federal common law privilege for self-evaluative materials. 15 In applying the federal common law privilege, the test normally used by the courts to determine if information is subject to discovery entails balancing the public's interest in protecting the confidentiality of the peer review process against the needs of the particular party seeking discovery. If the need for truth outweighs the public's interest in the confidential nature of the relationship that produced the information, discovery is ordered. 16

This "balancing act" presents a problem for the judge advocate called upon to advise a hospital commander concerning the confidentiality of QA information. The question the commander has is not whether there is a privilege, but whether particular documents reflecting the recommendations and opinions of a particular peer review activity will be protected from disclosure. To ensure that the peer review process works and the incident at issue receives thorough and critical scrutiny, this question must be answered before the documents are created. As with any exercise involving the weighing of the public's interest against the interest of an individual litigant, it is difficult to predict, at the time the document or information is created, whether a particular document will withstand a challenge to the privilege. Thus, when the opinions and recommendations are being developed, usually well in advance of litigation, one cannot safely say that they will not be turned over to a plaintiff a year or two down the road. The new statutory privilege will remove some of this uncertainty.

Generally speaking, the new statute does four things. It establishes the confidential and privileged nature of QA information; it prohibits disclosure of the records and testimony concerning the records except in certain specified circumstances; it establishes penalties for unauthorized disclosure; and it provides immunity from civil liability for anyone who, in good faith, participates in or provides information to a person or body engaged in creating or reviewing medical quality assurance records. The legislative history is quite sparse; however, the statute is sufficiently detailed to allow some conclusions to be made concerning its application.

QA Information Is Confidential and Privileged

The heart of the statute is the broad declaration that "quality assurance records . . . are confidential and privileged . . . [and] . . . may not be disclosed to any person or entity . . ." by the specific exceptions within the statute. 17 Thus, the language of the statute not only creates the privilege but also establishes the extent of the privilege. The weighing of competing interests to determine the discoverability of documents under the federal common law privilege is no longer the test that determines the scope of the privilege. If the information in question falls within the definition of "quality assurance records" its releasability is determined by the statute, not by a court's notion of the relative weight of various competing interests. Furthermore, apparently not satisfied with the protection from

11 Under Fed. R. Evid. 501, the privilege of a witness, person, government, or other entity, is determined by the principles of the common law as they may be interpreted by the federal courts in light of reason and experience. In civil cases, when state law provides the rule of decision, such as a diversity action, Rule 501 directs that state law provide the rule of privilege as well. Scott v. McDonald, 70 F.R.D. 568 (N.D. Ga. 1976). Cases brought against the United States under the Federal Tort Claims Act, 28 U.S.C. §§ 1346(b), 2671–2680 (1982) look to state law to determine the liability of the government. In this instance, however, state law is adopted and becomes federal law for the purpose of Fed. R. Evid. 501 and the federal common law of privilege applies. See Whitman v. United States, 108 F.R.D. 5, 6 (D.N.H. 1985) (federal common law applied in an FTCA case); Mewborn v. Heckler, 101 F.R.D. 691, 693 (D.D.C. 1984) (federal common law applied in an FTCA case); Perrignon v. Bergen Brunswig Corp., 77 F.R.D. 455, 459 (N.D. Cal. 1978) ("in non-diversity jurisdiction civil cases, federal privilege law will generally apply"). In interpreting the principles of the common law "in light of reason and experience" as required by Fed. R. Evid. 501, the federal courts will consider the state privilege rules and their underlying policies. The federal courts are not, however, required to apply the state rule. Robinson v. Magovern, 83 F.R.D. 79 (W.D. Pa. 1979).


13 Id. at 250.

14 Id. at 251.


17 10 U.S.C. § 1102(a).
disclosure afforded by exemption b(5) of the Freedom of Information Act (FOIA). 18 Congress expressly declared that medical quality assurance records may not be disclosed under FOIA. 19

At this point, it is probably safe to assume that much of the future litigation under the statute will center around whether the records or information at issue are “quality assurance records” within the meaning of the statute. A “medical quality assurance record” is defined as “the proceedings, records, minutes, and reports that emanate from quality assurance program activities.” 20 A “medical quality assurance program” within the meaning of the statute is “any activity carried out . . . to assess the quality of medical care.” 21 The statute specifically includes within the definition of quality assurance program any activity designed to assess the quality of medical care carried out or conducted by individuals, committees, or other review bodies responsible for credentialing, infection control, patient care assessment, medical records, health resources management review, and identification and prevention of medical or dental incidents and risks. 22

To fully appreciate the breadth of the statute’s coverage, one need only compare the new federal law with some of the state statutory schemes. As a general rule, the state privileges are rather narrowly drawn and do not extend to all quality assurance information and activities. The federal law, on the other hand, is quite comprehensive and encompasses all aspects of the Army’s current Quality Assurance Program.

While virtually all statutes offer some degree of protection to the opinions and recommendations of a peer review committee, the actions taken after the peer review process is completed are not always afforded confidentiality. The Illinois statute is a good example. 23 In Gleason v. St. Elizabeth Medical Center, 24 the plaintiff alleged that the defendant hospital was negligent in allowing her physician operating privileges. To press her claim against the hospital, the plaintiff sought to discover what action the hospital took after information concerning the doctor’s past medical practice came to light through depositions taken in several malpractice cases. In interpreting the Illinois statute, the court found that the peer review process was privileged but that any action taken as a result of the process was outside the protection of the statute. More recently, the Illinois Supreme Court agreed with the Gleason analysis in upholding a civil contempt citation against a hospital that refused to answer interrogatories concerning the action it had taken to limit or suspend a physician’s privileges. 25

The federal statute, on the other hand, protects not only the “proceedings, records, minutes, and reports” 26 of a quality assurance program, but also precludes any individual who reviews or creates QA records or who participates in a proceeding that reviews or creates the records, from testifying “with respect to any finding, recommendation, evaluation, opinion, or action taken by such person or body.” 27 The presence of the “action taken” language in the federal statute makes a compelling argument that the mantle of confidentiality created by Congress covers the corrective action as well as the peer review process itself.

Some state courts have interpreted their statutes as only protecting quality assurance activities when performed by regularly constituted committees of the hospital whose duty it is to review and evaluate the quality of care in question. 28 Under this view, protected QA activities are rather limited and formalized. Unless the documents, records, or information were either created by a formal committee or done at the specific request or direction of a committee, the privilege does not attach. 29 In enacting the federal statute, Congress apparently recognized the shortsightedness of this approach and extended confidentiality to QA “activities,” 30 not just QA committees. The statute specifically envisions QA activities being carried out by individuals apart from a committee arrangement. 31 This should allow the Surgeon General and hospital commanders some flexibility in accomplishing peer review. For example, a medical facility may only have one or two specialists in a particular discipline. In order to assess the quality of their care, a consultant from another facility can be called upon to review their cases. The fact that the consultant is an individual and not a “committee” of the facility involved will not remove the documents, information, and opinions from the protection of the statute. 32

A document that can be extremely useful to a plaintiff, and one that may initiate the peer review process, is the

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19 10 U.S.C. § 1102(f). This provision invokes exemption b(3) of FOIA which exempts from mandatory disclosure records that are specifically exempted from release by statute. 5 U.S.C. § 552(b)(3) (1982).
20 Id. § 1102(j)(2).
21 Id. § 1102(j)(1).
22 Id.
27 Id. § 1102(b)(2) (emphasis added).
29 See, e.g., Jordan v. Court of Appeals, 701 S.W.2d 644 (Tex. 1985) (protected documents are those prepared by or at the direction of a committee for committee purposes).
31 See Gutierrez v. United States, No. EP–83–CA–116 (W.D. Tex. Discovery Order Apr. 11, 1984) (report prepared by Surgeon General’s consultant containing review of Army doctor’s medical practice not protected under either Texas statute or federal common law privilege because the consultant was not a “committee”).

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hospital incident report. Designed to bring an unusual occurrence or incident to the immediate attention of supervisory personnel, these reports are usually prepared by the nursing staff and forwarded through channels to the person responsible for taking corrective action. Because they are not prepared by "committees" they may fall outside the protection of a narrowly drawn statute. Most cases dealing with the discoverability of incident reports resolve the issue on either the attorney-client privilege or the work-product doctrine. The short-comings of both of these theories are illustrated by the decision in St. Louis Little Rock Hospital v. Gaertner. The underlying case was a medical malpractice action for the wrongful death of an alcoholic and chemically dependent patient who committed suicide by drinking a bottle of toilet bowl cleanser that was left in her hospital room. In support of their claims, plaintiffs sought to discover the hospital incident report prepared by a nurse as required by the hospital's safety manual. The hospital objected to the requested discovery and asserted both the work-product doctrine and the attorney-client privilege. The court found that the work-product doctrine was not available because the incident report was prepared as part of the hospital's program to prevent future incidents and losses and not in anticipation of litigation. The attorney-client privilege did not protect the document from discovery because the court found that the form was not prepared for the purpose of seeking professional legal advice, but was created in the ordinary course of business as a means of accident prevention.

Under the Army QA program, whenever an “incident” occurs a report of unusual occurrence must be prepared and forwarded to the head of the department within twenty-four hours of the incident and should reach the risk manager within forty-eight hours. Depending upon the nature of the incident, the claims judge advocate may or may not receive the report. Neither the attorney-client privilege nor the work-product doctrine offers much hope of protecting the report from discovery. Because it is prepared at the time the incident is first discovered and well before any claim has been asserted, the report is not prepared “in anticipation of litigation or for trial” and does not qualify for work-product protection.

To be protected under the attorney-client privilege, the document must be prepared for the purpose of obtaining legal advice. The DA Form 4106, however, is routed through non-lawyer supervisors before it gets to an attorney and, in fact, may never be seen by an attorney at all. Under these circumstances, a court could easily find that the primary purpose for preparing the document was future accident prevention and not to obtain legal advice. Absent this crucial element, the attorney-client privilege will not protect these reports from discovery.

The uncertainty surrounding the privileged status of the incident report is eliminated by the federal statute. Under the new law, a medical quality assurance program activity specifically includes activities carried out to identify and prevent medical or dental incidents and risks. The DA Form 4106 serves just such a purpose and is a report emanating from a quality assurance program activity within the meaning of the statute.

Reports and documents prepared by infection control committees have been discoverable under some state laws, but are privileged under the DOD confidentiality statute. In Davidson v. Light, the court allowed discovery of a report containing mixed factual and opinion information prepared by a hospital infection control committee. In distinguishing Bredice, the court said that the mixture of fact and opinion in the report indicated that the document was prepared as part of the patient's ongoing medical care and was not a retrospective review of treatment rendered in the past.

The same result was reached by the New Jersey Superior Court in Young v. King, an action alleging that plaintiff's decedent died due to the defendant's failure to properly diagnose and treat a staph infection. Plaintiff, as well as four physician co-defendants, sought an order compelling the hospital to produce records of the Medical Record and Audit Committee, the Tissue Committee, the Medical Council, and the Infection Control Committee. In construing the New Jersey statute, the court found that the only committee that enjoyed an immunity from discovery was the Utilization Review Committee. The hospital's argument that the statute "inferentially" protected all peer review committees was rejected and discovery was ordered. Should a similar case arise out of a DOD medical treatment facility under the Federal Tort Claims Act, the statutory definition of quality assurance program in the new federal statute, which includes infection control committees, committee members, medical record review, and resources management review, would apply and protect the information.

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33 682 S.W.2d 146 (Mo. Ct. App. 1984).

34 An "incident" is "any unintended or unexpected result that arises from human error or mechanical malfunction during patient care." AR 40-66, para. 9-9d.

35 Dep't of Army, Form No. 4106, Report of Unusual Occurrence (June 1973) [hereinafter DA Form 4106].

36 See Fed. R. Civ. P. 26(b)(3). Even if a document qualifies for protection under the work-product doctrine, it can still be discovered if the party seeking discovery can establish "a substantial need of the materials in the preparation of his case and that he is unable without undue hardship to obtain the substantial equivalent of the materials by other means." Id.

37 The requirement to prepare a DA Form 4106 is part of the Risk Management Program. According to the regulation, "Risk Management... is concerned with accident and injury prevention and the lowering of financial losses after an incident has occurred; [i]t will identify problems or potential risk circumstances that must be eliminated or reduced to prevent accident and injury." AR 40-66, para. 9-9a.

38 10 U.S.C. § 1102(1).


41 10 U.S.C. § 1102(1).
Another significant difference between the new federal statute and the common law privilege and some state statutes is that the federal privilege is not qualified. In establishing the common law privilege, the Bredice court created only a qualified privilege and held that evidence of extraordinary circumstances would overcome the public's interest in confidential peer review. The protection afforded peer review documents by several state statutes is also qualified and discovery is allowed under certain conditions.

QA Information May Not Be Disclosed

The second major accomplishment of the statute is the express prohibition against disclosure of the records and the preclusion of testimony concerning the records or the findings, recommendations, evaluations, opinions, or actions taken by a QA activity by any person who reviews, creates, or participates in any proceeding that reviews or creates QA records, except as specified in the statute itself. Significantly, the statute does not just preclude a witness from compulsory testimony; it precludes even voluntary testimony. The statute provides that an individual "may not be permitted or required to testify in any judicial or administrative proceeding." This language should preclude decisions like Whitman v. United States, where the court held that the voluntary disclosure of certain information during a deposition waived the privilege. The Whitman plaintiff alleged that negligent surgery by Air Force physicians resulted in facial paralysis. During the pre-trial deposition of one of the Air Force physicians, testimony was elicited concerning the peer review committee meeting. The doctor testified that the meeting was held about two months after the surgery, identified the individuals present, and disclosed that an outside specialist reviewed the information developed by the committee and concluded that he "didn't think the job was too good." The plaintiff requested production of the record of the peer review committee meeting and sought an order to compel discovery when the government asserted the self-evaluative privilege. The magistrate, relying on Bredice, denied the motion to compel. The district court found that the testimony of the doctor at his deposition constituted a waiver of the privilege and ordered the record disclosed.

The Supreme Court of California reached a similar result in ruling that under California law, a member of a peer review committee may waive the confidentiality afforded peer review activities and voluntarily reveal the substance of peer review proceedings. The case, West Covina Hospital v. Superior Court, involved a malpractice action brought against a hospital for negligently granting surgical privileges to the plaintiff's surgeon and for retaining him on the medical staff when they knew or should have known that he was incompetent. The plaintiff intended to call as a witness a member of the hospital committee that evaluated the surgeon's application for operating privileges. The trial court, over the objection of the hospital, ruled that the California statute providing that a hospital committee member may not be "required" to testify did not preclude the voluntary testimony of the committee member. Upon the hospital's petition for an order to compel the trial court to reverse its ruling and exclude the testimony, the appellate court found that allowing voluntary testimony would "punch a judicially created and legislatively unintended hole in the crucial shield of confidentiality provided to medical staff committees in medical malpractice actions [and] would directly contravene the vital policy underlying that immunity." The California Supreme Court reversed. The statute in question, the court found, clearly precluded compulsory testimony but made no mention of voluntary testimony. The court concluded that if the legislature intended to prohibit voluntary testimony it would have done so specifically. Responding to the underlying public policy to encourage medical peer review by providing confidentiality, the court determined that by immunizing members of hospital committees from compulsory process for their committee work, it would be easier to attract doctors to serve on the committees, thereby fostering peer review.

The new federal statute, unlike the California law and the common law privilege, precludes any disclosure of QA records except as provided by the statute. Records or information covered by the federal law can be disclosed only if one of the exceptions specified in the statute applies. Even if an adverse party in litigation obtains a copy of a QA record, the statute still prohibits its use in the case. The new law specifically provides that QA records may not be "subject to discovery or admitted into evidence," except as provided by the statute. Thus, the concept of waiver that appears in some state provisions and in the federal common law rule has not been incorporated into the federal statute.

The circumstances under which either the records may be disclosed or a person may testify as to the records are rather limited by the new law. The statute allows disclosure to federal or private agencies performing licensing or accreditation functions regarding DOD facilities or conducting required monitoring of DOD health care facilities. This will allow the Joint Commission on Accreditation of Hospitals (JCAH) access to the QA files of

44 10 U.S.C. § 1102(b)(2) (emphasis added).
46 Id. at 8.
50 10 U.S.C. § 1102(a) & (b).
51 Id. § 1102(b)(1) (emphasis added).
52 Id. § 1102(c)(1)(A).
DOD hospitals that are undergoing accreditation inspection.

The statute also allows release of QA records to an administrative or judicial proceeding brought by a current or former DOD health care provider concerning the termination, limitation, or suspension of the health care provider’s clinical privileges. Basic fairness dictates that the affected practitioner have access to the information relied upon and the rationale for a decision to curtail or terminate his or her clinical privileges.

QA records may also be disclosed to governmental boards, agencies, or professional health care societies if needed to perform licensing, credentialing, or monitoring of the professional standards of any present or former member or employee of DOD. Similarly, disclosure is permitted when the records or information are requested by another hospital or medical treatment facility and are needed to assess the professional qualifications of a current or former DOD health care provider. These types of disclosures are consistent with the goal of providing quality health care. Certainly, professional societies charged with the responsibility of certifying a particular physician as a “specialist” in a given discipline should have access to peer review information concerning the physician’s practice. By the same token, when a health care provider seeks staff privileges at a hospital, the hospital should be allowed to make a decision based upon all of the information available concerning the applicant, including his or her track record at other facilities. Indeed, the failure to make inquiry or consider such information can give rise to liability on the part of the health care facility.

The federal statute also allows disclosure to officers, employees, and contractors of DOD who have need for QA information in the performance of their official duties. Under this provision, claims officers, criminal investigators, the Inspector General, and others may gain access to QA information in the performance of their official duties. Access to QA information by criminal investigators is controversial within the medical profession and opponents of this particular use of QA information almost precluded the draft legislation from ever leaving the Pentagon. In view of the strong feelings about this issue, implementing regulations promulgated by the Secretary of Defense could establish procedures to review requests for information and remove the access decision from the discretion of the individual investigator. By placing the decision in the hands of a senior commander, both the needs of the medical profession and the needs of the criminal investigator could be balanced in determining whether disclosure would serve the best interests of the agency.

While DOD law enforcement personnel can gain access to QA information based upon a need to know in the performance of their official duties, civilian agencies charged with enforcement of criminal or civil laws may obtain QA records only if they are charged under “applicable law with the protection of the public health or safety, [and] if a qualified representative of... [the] agency makes a written request that such record or testimony be provided for a purpose authorized by law.” Similarly, disclosure may be made in an administrative or judicial proceeding brought by the civilian agency to protect the public health or safety. Disclosure under this exception may arise in a state prosecution for the unauthorized or unlicensed practice of medicine or in an action to revoke a license to practice medicine issued by the state.

Once disclosure of privileged information occurs, the protection of the statute is not lost. The records of the QA activity or testimony given concerning the QA process remains confidential and further disclosure may be made only as specifically provided. This prohibition against disclosure is not limited to participants in the peer review process, but extends to any “person or entity having possession of or access” to QA records or testimony. Furthermore, the nature of the initial disclosure is irrelevant; the statute simply precludes disclosure “in any manner or for any purpose except as provided in this section.” Thus, if information is “leaked” or inadvertently disclosed, the recipient of the unauthorized disclosure is precluded from further disclosure.

Penalties for Unauthorized Disclosure

To underscore the seriousness with which Congress views the peer review function, the federal statute provides for penalties for unauthorized disclosures of QA information. Penalties range from a $3,000 fine for a first offense of willful disclosure of a QA record to a $20,000 fine for subsequent violations. The penalty provisions apply to “[a]ny person” and will reach not only the government employee who makes an unauthorized disclosure, but will also apply to recipients of authorized and unauthorized releases who make further disclosure of the privileged information.

An important task in implementing the new law will be to inform both medical and administrative personnel of the

53 Id. § 1102(c)(1)(B).
54 Id. § 1102(c)(1)(C).
55 Id. § 1102(c)(1)(D).
56 See, e.g., Johnson v. Misericordia Community Hospital, 301 N.W.2d 156 (Wis. 1981).
58 While this approach reintroduces a degree of uncertainty inherent in any “balancing act” (see supra test accompanying notes 15–16), at least the weighing of the competing interests can be done by a senior military commander and not a civilian judge.
60 Id. § 1102(c)(1)(G).
61 Id. § 1102(e).
62 Id.
63 Id.
64 Id. § 1102(k).
65 Id.
consequences of an unauthorized disclosure of QA information. Before a fine can be assessed for an unauthorized disclosure, the statute requires a willful disclosure with knowledge that the record is a QA record. The local judge advocate should make certain that every one who may even remotely come in contact with quality assurance information is aware of its confidential nature and the penalties for unauthorized disclosure. Lectures and briefings should be conducted and consideration should be given to labeling all QA documents as such. Included in any label should be a warning that unauthorized disclosure carries a $3,000 fine. Prominently marking QA documents in this manner will not only establish the element of knowledge necessary to impose a fine, but also will serve as an ever-present reminder of the consequences of improper disclosure. This should foster an attitude of caution on the part of personnel charged with the creation and maintenance of QA files, records, and information. Perhaps this ounce of prevention will be better than several pounds of cure. Of course, labeling documents as QA records will also require the Army and the other services to make a conscious determination as to what is and what is not a QA record, an exercise that will require a careful view of the entire QA program. If implementing directives require all QA records to be labeled as such, we will be hard-pressed to convince a court later on that a non-labeled document is really a QA record that we just overlooked.

Civil Immunity for Participants in QA Activities

The fourth major component of the federal statute is the grant of qualified immunity to participants in quality assurance activities. The statute provides one who participates in or provides information to a quality assurance activity immunity from civil liability "if the participation or provision of information was in good faith based on prevailing professional standards at the time the medical quality assurance program activity took place." 66 In view of other immunities available to military members and federal civilian employees for actions taken within the course and scope of their employment, this provision may not seem important. 67 It does, however, serve to immunize individuals who are not government employees, such as patients, civilian physicians, and others who might be asked to provide information to a peer review activity. As long as the information was provided in good faith, the individual will be immune from liability for defamation and other civil actions.

66 Id. § 1102(g).
68 10 U.S.C. § 1102(b).
71 Dept’t of the Army Message 161200Z Oct 85, subject: Command Management and Reporting Requirements of Serious Incidents Resulting From Potentially Substandard Care; reprinted in Dept’t of the Army Message 091713Z Jun 86, subject: Command Management and Reporting Requirements of Serious Incidents Resulting From Potentially Substandard Care.
72 Id.
73 10 U.S.C. § 1102(b).
Conclusion

Congress has provided military medicine with a comprehensive privilege for QA information to ensure that medical peer review can be carried out with maximum confidentiality. The statute fills holes in the common law privilege previously relied upon to protect QA information from discovery and covers documents and information beyond the scope of many states’ peer review privilege laws. To take full advantage of the statute, the services should conduct a detailed review of their entire QA operation and bring all ancillary investigations and activities under the auspices of the established QA program. Having provided the shield of confidentiality, Congress will no doubt expect the military to carry out medical quality assurance programs thoroughly and aggressively. The candid peer review fostered by the new law will improve the quality of medical care by identifying and either training or eliminating the substandard practitioner and by correcting systemic errors. The ball is now in the doctor’s court.

Witnesses: The Ultimate Weapon

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Introduction

Contested issues, whether occurring during the motions, findings, or sentencing stages of a court-martial, are usually won or lost based upon the witnesses who testify for each side. Good advocates generally litigate only close issues because those that are clear are usually resolved out-of-court through alternative disposition negotiations or pretrial agreements. No case can be stronger than the witnesses who support it, and no amount of skillful oratory can resurrect a case doomed by the weaknesses of its witnesses. This article is designed to help judge advocates prepare the defense or prosecution of a court-martial by focusing on the most critical players in that drama. The case itself is usually created by its facts and circumstances before the attorney ever hears of it. The trial lawyer then becomes its “producer, director, and narrator.” One’s skills as a “narrator” are shaped by innate abilities, courses in advocacy, and trial experiences themselves. This article will hone the trial lawyer’s skill in “producing and directing” the performance of the “actors” by presenting a methodology for finding, preparing, and presenting these “stars” of the “play.”

The techniques discussed here are only guidelines and, of course, are not applicable to every situation. Like all “rules,” they are subject to exception based on unusual circumstances or one’s unique style. Arguments of counsel are not evidence, and physical or documentary evidence rarely possesses the great power of persuasion that can be found on the face, heard in the voice, and seen in the eyes of a trial lawyer’s ultimate weapon—the witness!

The Search for Witnesses

The first place to look for witnesses is in the case file itself, which will list and usually include statements or summaries of statements from the witnesses that the command and the investigative agency consider to be material.

1 Model Code of Professional Responsibility Canon 7 (1980).
2 ABA Standards for Criminal Justice 1.1(c) (2d ed. 1980).
5 United States v. Tangpuz, 5 M.J. 426 (C.M.A. 1978); Mil. R. Evid. 403.