Utah's Peer Review Law

What does it mean for physician practices?

Utah has care review and peer review statutes that protect certain healthcare related review activities and participants. This includes those activities conducted by any organization of healthcare providers, which includes physician group practices.[1] Many physician practices and clinics, however, don't appreciate the benefits of instituting peer review within their organizations.

Frequently Asked Questions

Why is peer review important?

Peer review is ultimately a way to protect patients and improve the quality of patient care. Having a legally protected and confidential process to conduct peer review encourages healthcare providers to participate in peer review. The peer review law protects both communications and documents created specifically for purposes of peer review as well as peer review participants acting in good faith.

Unlike other states, a primary protection of peer review communications is found in Utah's Rules of Civil Procedure used by courts. Under the Utah care review statute, any person, health facility, or other organization may provide interviews, reports, statements, memoranda, and other data relating to the condition and treatment of any person to "peer review committees." This information may be provided for the evaluation and improvement of hospital and healthcare rendered by hospitals, health facilities or healthcare providers. Any person may also provide information, interviews, reports, statements, or other information relating to the ethical conduct of any healthcare provider to peer review committees.[2]

While "peer review committee" is not further defined by statute, a "healthcare provider" is defined broadly to include any person, partnership, association, corporation, or other facility or institution who renders healthcare or professional services as a hospital, healthcare facility, physician, PA, nurse or other healthcare provider rendering similar care and services relating to or arising out of the health needs of persons or groups of persons, and officers, employees, or agents of any of the above acting in the course and scope of their employment.[3] This would include physician group practices.

Under the care review law, all information, interviews, reports, statements, memoranda, or other data furnished by reason of care review and any finding or conclusions resulting from those studies are privileged communications and are not subject to discovery, use, or receipt in evidence in any legal proceeding of any kind or character.[4]

Under Utah Rule of Civil Procedure 26(b)(2), privileged matters that are not discoverable or admissible in any proceeding of any kind or character include:

> all information in any form provided during and created specifically as part of a request for an investigation, the investigation, findings, or conclusions of peer review, care review, or quality assurance processes of any organization of health care providers as defined in the Utah Health Care Malpractice Act for the purpose of evaluating care provided to reduce morbidity and mortality or to improve the quality of medical care, or for the purpose of peer review of the ethics, competence, or professional conduct of any health care provider.[5]

The legislative note to this 2012 rule amendment indicates that the amended language was "intended to incorporate long-standing protections against discovery and admission into evidence of privileged matters connected to medical care review and peer review into the Utah Rules of Civil Procedure. . . . The language is intended to ensure the confidentiality of peer review, care review, and quality assurance processes and to ensure that the privilege is limited only to documents and information created specifically as part of the processes. It does not extend to knowledge gained or documents created outside or independent of the processes."[6]

[1] Utah Code § 26B-1-229(1)(b); Utah Code § 78B-3-403(13).

[2] Utah Code §26B-1-229.

[3] Utah Code § 26B-1-229(1)(b); Utah Code § 78B-3-403(13).

[4] Utah Code § 26B-1-229(8).

[5] Utah R. Civ. Pro. 26(b)(2).

[6] Belnap v. Howard, 437 P.3d 355, 360 n.18 (Utah 2019).

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While most of us are familiar with peer review in the hospital setting, other healthcare entities, including a physician practice or clinic, can conduct peer review under the law. But many practices don't take advantage of the legal protections under the peer review law. When practices are asked if they discuss cases regularly, have morbidity and mortality conferences, receive patient complaints, or have experience with a physician who may be impaired, often the answer is yes. But when asked whether a practice has a formal peer review process with policies in place to address these activities, often the answer is no.

Without the legal protections afforded by having these policies and procedures in place, conversations, emails, and text messages about a patient's care, a patient complaint, or a provider's professional conduct are not protected under the peer review privilege. They may need to be disclosed in a subsequent lawsuit involving a patient's care.

What does peer review involve?

To conduct peer review pursuant to federal and state law, a physician practice or clinic should adopt and adhere to written policies and procedures governing its peer review committee.[7] That will assist a practice claiming the peer review privilege to show that the information was "provided during and created specifically as part of" peer review or care review "for the purpose of evaluating care provided to reduce morbidity and mortality or to improve the quality of medical care, or for the purpose of peer review of the ethics, competence, or professional conduct of any healthcare provider."[8]

Copic has developed a peer review checklist of what is required under Utah law as well as template peer review policies and procedures to assist practices in establishing their peer review programs. These template policies should be reviewed by an attorney who can add information that is specific to the practice.

The federal HCQIA law applies to both hospitals and group medical practices that provide healthcare services and follow a formal peer review process for the purpose of furthering quality healthcare.[9]

Federal HCQIA grants immunity from damages liability with respect to actions taken by professional review bodies, to the review body, any member or staff to the body, contractors, and participants, provided the action was taken:

- In the reasonable belief that it was in the furtherance of quality healthcare,
- After making a reasonable effort to obtain the facts of the matter,
- After adequate notice and hearing procedures are afforded to the physician involved, and
- In the reasonable belief that the action was warranted by the facts after a reasonable effort to obtain facts and after following procedures that are fair to the physician under the circumstances.[10]

Any person who provides information to a professional review body regarding the competence or professional conduct of a physician is not liable in damages under any state or federal law, as long as that person does not knowingly provide false information.[11]

Utah's peer review immunity provisions are very similar to HCQIA. Under Utah's peer review law, healthcare providers serving on committees established to evaluate and improve the quality of healthcare or determine whether provided healthcare was necessary, appropriate, properly performed, or provided at a reasonable cost are immune from liability with respect to deliberations, decisions, or determinations made or information furnished in good faith and without malice.[12] A healthcare entity conducting or sponsoring the review is immune from liability arising from participation in a review of a healthcare provider's professional ethics, medical competence, moral turpitude, or substance abuse.[13]

Ideally, medical practices will address any issues through peer review *before* they reach the stage where they determine that a physician is unsafe to practice. In Utah, licensed healthcare facilities that grant privileges to, or otherwise permit a licensed healthcare provider to practice within the facility have reporting obligations to

[7] 42 U.S.C. § 11112; 45 C.F.R.§ 60.3.

[8] Utah R. Civ. Pro. 26(b)(2).

[9] 42 U.S.C. 11151(4).

[10] 42 U.S.C. § 11111(a)(1); 42 U.S.C. § 11112(a).

[11] 42 U.S.C. § 11111(a)(2).

[12] Utah Code § 58-13-4(2)(a)(ii).

[13] Utah Code § 58-13-5(7).

the Division of Professional Licensing (DOPL), including the following events within 60 days:

- terminating or restricting privileges for cause to engage in any act or practice related to practice as a licensed healthcare provider;
- subjecting a licensed healthcare provider to disciplinary action for a period of more than 30 days;
- a finding that a licensed healthcare provider has violated professional standards or ethics;
- a finding of incompetence in practice as a licensed healthcare provider; or
- a finding that a licensed healthcare provider is engaged in abuse of alcohol or drugs.[14]

The reporting requirements apply to "healthcare facilities," which does not include the offices of private physicians, except it does include an abortion clinic.[15]

For DOPL regulated licensees, unprofessional conduct includes:

- engaging in conduct, including the use of intoxicants or drugs, to the extent that the conduct could reasonably impair the ability of the licensee to safely engage in the profession;
- practicing a profession despite being physically or mentally unfit to do so; and
- practicing through gross incompetence, gross negligence, or a pattern of incompetency or negligence.[16]

Under the Medical Practice Act and Osteopathic Medical Practice Act regulations, it is also unprofessional conduct to violate the AMA Code of Medical Ethics, which is incorporated by reference.[17] Under the AMA ethics opinions, physicians should intervene with respect and compassion when a colleague is not able to practice safely.[18] Physicians who become aware of or strongly suspect that conduct threatens patient welfare should report directly to the state licensing board when the conduct poses an immediate threat to the health and safety of patients or violates state licensing provisions.[19]

Peer review allows a more full and fair assessment of a provider, and an opportunity for them to address any educational deficiencies or behavioral health issues so they can practice safely and don't need to be reported to the medical board. Addressing substance use disorders proactively is encouraged in Utah through the Utah Professionals Health Program (UPHP). The UPHP administered by DOPL is a confidential, voluntary alternative to public disciplinary action for licensees with substance use disorders.[20] The program is not eligible to a licensee who has harmed a patient by providing care below the expected standard that resulted in an adverse consequence for the patient.[21] A licensee who participates in UPHP and adheres to the UPHP Participation Standards can receive treatment and monitoring confidentially. This is subject to the conditions when the UPHP may be required to report to DOPL, such as for noncompliance with the standards.[22]

While it is very unlikely that a provider's care will rise to the level of reporting an adverse professional review action to the medical board, a practice's policy needs to address the due process requirements under federal HCQIA.[23] This allows for a fair hearing for the provider if a peer review committee recommends that the practice's governing board take an adverse professional review action.

The practice should identify what peer review activities fall within the policy. Some examples include the review of:

- patient safety incidents, including near-misses,
- unscheduled patient returns,
- patient complaints,
- cases identified through screening by quality indicators,
- reported unprofessional conduct, and
- concerns regarding a possible impaired provider.

[14] Utah Code § 58-13-5(3).
[15] Utah Code § 26B-2-201(13).
[16] Utah Code § 58-1-501(2).
[17] Utah Code § 58-1-203(1)(e); Utah Admin. Code r.156-67-502(14); Utah Admin. Code r.156-68-502(13).
[18] AMA Ethics Opinion 9.3.2 Physician Responsibilities to Colleagues with Illness, Disability, or Impairment.
[19] AMA Ethics Opinion 9.4.2 Reporting Incompetent or Unethical Behaviors by Colleagues.
[20] Utah Code § 58-4a-103(2)(a); UPHP What Does a Confidential Program Mean? (commerce.utah.gov)
[21] Utah Admin. Code r.156-4a-103a(2)(a).
[22] Utah Admin. Code r.156-4a-105(4); Utah Admin. Code r.156-4a-111(3).
[23] 42 USC § 11111(a)(1); 42 USC § 11112(a).

Implementing Peer Review at Your Medical Practice

Practices that have successfully utilized peer review and had positive experiences share common themes. Foremost, these practices have developed a culture of understanding that the purpose of peer review is not to hinder or punish practitioners. Instead, they believe it allows them to continually improve the quality of care, treatment, and services provided as well as protect the safety of the patients they treat and ensure the best possible outcomes.

When implementing peer review, it can be important to dispel a common misunderstanding among physicians that all reviews of a physician will be reported to the medical board. The reality is that they are reported only if:

- the findings of an investigation indicate that a physician lacks competence, or has exhibited inappropriate professional conduct **AND**
- the professional review committee recommends an action to adversely affect the person's membership or privileges with the practice **AND**
- after a fair hearing process, the governing board takes a *final professional review action* that adversely affects the clinical privileges of the physician for more than 30 days or accepts the surrender of clinical privileges while the physician is under investigation or in return for not conducting such an investigation or proceeding.[24]

Recommendations for additional education or treatment for behavioral health issues where there is no final adverse action would *not* need to be reported. Knowing this enhances the participation of clinicians. The case study below is an example of how peer review facilitated a practice's improving its patient safety.

Case Study

A middle-aged patient complaining of persistent hacking cough a week after recovering from influenza was worked into a busy clinician's schedule during the afternoon. The patient was evaluated and treated with a codeine cough suppressant and told to return if symptoms worsened. Just five hours later, the patient felt much worse and went to the emergency department and was diagnosed with bi-lobar pneumonia and admitted to the ICU due to hypoxia, hypotension, and presumed sepsis.

The peer review committee at the clinic reviewed the medical care and noted that vital signs had not been performed at the time of the clinic visit. Although there is no way to know definitively whether the vital signs would have been abnormal, they presumably would have been and could have provided a clue that the patient was more severely ill than he appeared. The peer committee investigated further and learned that vital signs had not been performed on nearly half of acute visits not just for this doctor, but clinic wide. They discovered a workflow challenge for acute visits that made it difficult for medical assistants to check vital signs, and this system failure was subsequently corrected. Now, nearly 100% of acute visits to the clinic have vital signs checked, which almost certainly has improved patient safety and outcomes.

In this case, and in many other examples, peer review protections have helped physician practices and clinics, with physicians' buy-in and assistance, identify and address problems to prevent adverse patient outcomes. The medical literature is rich with examples where proactive peer review, such as in the case above, and a culture of patient safety have resulted in a reduction in medical liability claims.

Many practices have found that the protections under peer review promote a culture of patient safety and continuous improvement, and when the practices work to educate their practitioners about how and why the peer review process works, they can help facilitate use of this valuable tool.

[24] 42 U.S.C. § 11133(a); 42 U.S.C. § 11151(9).