Is Secretive Peer Review Good Or Bad For Patients And Doctors?

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ABSTRACT

This article explores the secrecy provisions in Pennsylvania's Peer Review Protection Act (PRPA) and recent court decisions regarding them. There has been much debate about peer review immunity and confidentiality and whether they are good or bad for patients. This article also explores whether it is good or bad for doctors. The article concludes that the secrecy provisions in the PRPA should be narrowly construed.

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I. BACKGROUND: PENNSYLVANIA'S PEER REVIEW PROTECTION ACT

Pennsylvania's Peer Review Protection Act (PRPA)[2] was enacted in 1974. A key provision provides for "Confidentiality of review organization's records" as follows:

> The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, rec-

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2. 63 P.S. §§425.1 – 425.4.

> ommendations, evaluations, opinions or other actions of such committee or any members thereof: Provided, however, That information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, but the said witness cannot be asked about his testimony before such a committee or opinions formed by him as a result of said committee hearings.[3]

The secrecy provisions in Pennsylvania's Peer Review Protection Act are not beneficial to either doctors or patients and should be narrowly construed.

The essentially secretive nature of the process thus established, and the scope of that secrecy, have been debated since the statute's enactment. The question as to whether secretive peer review is good or bad for patients and doctors has effectively been usurped by the creation of electronic medical records, review investigations, Centers for Medicare & Medicaid Services, Joint Commission on Accreditation of Healthcare Organizations ("JCAHO"), private health insurers, and state government agencies.

The *raison d'être* for secretive peer review has disappeared. Currently, all it does is protect doctors and hospitals who have mistreated patients and gives employers the opportunity to discipline their doctor employees, even when it is not fair so to do. It is time for an overall review of peer review, whether in the context of a hospital setting or as it applies to organizations such as the Pennsylvania Patient Safety Authority.

II. COURT DECISIONS WITH RESPECT TO SECRETIVE PEER REVIEW

It is clear that court decisions within the Commonwealth have construed the secretive process of peer review narrowly, and for good reason. In a recent Pennsylvania Supreme Court case which examined the evidentiary privileges created under the Peer Review Protection Act, *Reginelli v. Boggs*,[4] the Court was careful to interpret the protective provisions and definitions strictly, to limit the individuals and organizations to whom the peer review protection privilege was afforded. *Reginelli* concerned a medical malpractice action involving an alleged misdiagnosis that occurred in a hospital emergency department. The emergency department was staffed by an entity which contracted with the hospital to provide emergency physicians and services. The majority opinion ruled that the contractor was not entitled to invoke the peer review privilege because it was not a "professional health care provider" as that term is defined by the statute. As emphasized by the Court in reaching that conclusion:

> ". . . . evidentiary privileges are not favored, as they operate in derogation of the search for truth." *In re: Thirty-Third Statewide Investigating Grand Jury*, 624 Pa. 361, 86 A.2d 204, 215 (Pa. 2014). As we have stated, "exceptions to the demand for every man's evidence are not lightly created nor expansively construed, for they are in derogation of the search for truth." *Commonwealth vs. Stewart*, 547 Pa. 277, 690 A.2d 195, 197 (Pa. 1997) (quoting *Hutchinson vs. Luddy*, 414 Pa. Super. 606 A.2d 905, 908 (Pa. Super. 1992)).[5]

3. 63.P.S. §425.4.
4. 181 A. 3d 293 (2018).
5. *Id*. at 300.

Moreover, as will be discussed below in Section III, expansive secrecy in pursuit of protecting purported peer review processes does not further the stated objective of the peer review privilege provided under the PRPA to improve the quality of health care and to maintain high professional standards in the medical profession. This purpose was reiterated by the Supreme Court in *Leadbitter v. Keystone Anesthesia Consultants, Ltd.*, which was decided after *Reginelli*:

> The purpose of this privilege system is to improve the quality of healthcare, and . . . it is beyond question that peer review committees play a critical role in the effort to maintain high professional standards in the medical practice.[6]

Leadbitter concerned discovery in a medical negligence lawsuit in which the patient suffered complications following surgery at a hospital. The issue under consideration was whether certain portions of the hospital's credentialing file for the doctor who performed the surgery were protected from discovery under the Peer Review Protection Act and the federal Health Care Quality Improvement Act.[7] Justice Saylor wrote the majority opinion which primarily dealt with interpreting the statutory definition of "peer review," which provides:

> "PEER REVIEW" means the procedure for evaluation by professional health care providers of the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, claims review, and the compliance of a hospital, nursing home or convalescent home or other health care facility operated by a professional health care provider with the standards set by an association of health care providers and with applicable laws, rules and regulations. . . .[8]

As in *Reginelli*, the Court in *Leadbitter* indicated that peer review protection is framed in terms of "professional health care providers," which in turn is limited to "individuals or organizations who are approved, licensed or otherwise regulated to practice or operate in the health care field" under Pennsylvania law.[9]

The Court in *Leadbitter* further indicated that peer review is "limited to the evaluation of the 'quality and efficiency of services ordered or performed' by a professional health care provider."[10] The confidentiality directive of Section 4 of the PRPA expressly applies to peer review committees and not all review organizations.[11] However, the Court agreed with the hospital's position that "a committee which performs a peer-review function, although it may not be specifically entitled a 'peer review committee', constitutes a review committee whose proceedings and records are protected under Section 4 of the act,"[12] but that protection applies only if and to the extent that it engages in peer review.[13]

At the court of common pleas level, Judge Caffrey of Lehigh County in *Lahr v. Young*,[14] addressed the question of the discoverability of event reports created by a hospital. They were called patient safety reports and noted as "incidents." Judge Caffrey conducted an *in camera* review. At issue was an investigation by the hospital

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6. Leadbitter v. Keystone Anesthesia Consultants, Ltd., 256 A.3d 1164, 1169 (Pa. 2020) (quoting Cooper vs. Delaware Valley Medical Ctr., 654 A.2d 547, 551 (Pa. 1995).
7. 42 U.S.C. §1112(a).
8. 63 P.S.§425.2.
9. *See* 63 P.S. §425.2 (definitions of "peer review" and "professional health care provider").
10. *Leadbitter*, 256 A.3d at 1171 (*citing* Reginelli vs. Boggs, 181 A.3d 293 (Pa. 2018)).
11. *Id.*, at 1177.
12. *Id.*
13. *Id.*
14. Civil No. 2021-C-0010, 2022 Pa. Dist. & Cnty. Dec. LEXIS 2608 (C.P. Lehigh June 21, 2022).

which was supposed to be factual. It was not supposed to be any different than what would ordinarily be contained in medical records.The judge stated that risk management was not part of the investigation and peer review process under the patient safety reporting policy adopted by the Hospital Network in accordance with its Patient Safety Plan, which was put in place pursuant to Section 307 of the Medical Care Availability and Reduction of Error Act ("MCARE").[15] The judge reviewed the Pennsylvania Peer Review Protection Act and determined that because the event reports were not "proceedings and records of a review committee," the event reports consisted of information "otherwise available from original sources." This reasoning, often referred to as the "original source rule," has usually been resorted to in order to avoid the secrecy protections of the Peer Review Protection Act. In *Lahr*, the court found that the record did not establish that the information contained in the event reports was considered during peer review. Therefore, the immunity provided by the PRPA did not apply.

The court also reviewed the confidentiality provision of the MCARE Act, Section 311(a), which states:

> (a) **PREPARED MATERIALS.**—Any documents, materials or information solely prepared or created for the purpose of compliance with section 310(b) or of reporting under section 304(a)(5) or (b) [patient safety authority may contract with entity to collect/analyze data regarding reports of serious events and incidents], 306(a)(2) or (3) [Health Dept. shall receive reports of and investigate serious events and infrastructure failures], 307(b)(3) [patient safety plan shall include system for reporting serious events and incidents], 308(a) [mandatory reporting of serious events and incidents], 309(4) [reports by patient safety officer of investigations], 310(b)(5) [quarterly reports by patient safety committee to governing body regarding serious events and incidents] or 313 [facility reports of serious events and incidents to patient safety authority] which arise out of matters reviewed by the patient safety committee pursuant to section 310(b) or the governing board of a medical facility pursuant to section 310(b) are confidential and shall not be discoverable or admissible as evidence in any civil or administrative action or proceeding. . . .[16]

The MCARE Act provision also contains an "original source" exception:

> . . . Any documents, materials, records or information that would otherwise be available from original sources shall not be construed as immune from discovery or use in any civil or administrative action or proceeding merely because they were presented to the patient safety committee or governing board of a medical facility.[17]

Interpreting Section 311, the *Lahr* court followed *Venosh v. Henzes*, which stated:

> Under the plain language of section 311(a), documents are protected from discovery only if: (1) they were 'solely prepared or created for the purpose of compliance with' the MCARE Act's 'serious events' reporting requirements or the patient safety committee's responsibilities under section 310(b); (2) they 'arise out of mat-

15. 40 P.S. §1303.307.
16. 40 P.S. §1303.311(a). *See also* 40 P.S. §1303.302 which defines "incident" as

> An event, occurrence or situation involving the clinical care of a patient in a medical facility which could have injured the patient but did not either cause an unanticipated injury or require the delivery of additional health care services to the patient. . . .

and "serious event" as

> An event, occurrence or situation involving the clinical care of a patient in a medical facility that results in death or compromises patient safety and results in an unanticipated injury requiring the delivery of additional health care services to the patient.

40 P.S. §1303.302.
17. *Id.*

> ters reviewed by the patient safety committee . . . or the governing board' pursuant to section 310(b); and (3) they are not otherwise available "from original sources."[18]

Although the event reports in *Lahr* were prepared solely for compliance with §308(a) of the MCARE statute,[19] the court determined that the reports did not arise out of matters reviewed by a patient safety committee pursuant to §310(b),[20] which meant they were not immune from discovery, and whether the reports were discoverable because they included "information that would otherwise be available from original sources" was a moot issue. Judge Caffrey found that the material must be produced.[21]

Event reports should not be shielded from discovery by the MCARE Act as they consist of information that is otherwise available from original sources. Event reports consist solely of objective data and information contained in the patient's medical records and other non-confidential sources of information. The reports are strictly factual descriptions of the event, time and place of the event, persons involved in the event and witnesses to the event. What is contained within these event reports, while not opinions on issues relevant to liability, may still be very valuable in terms of discovery.

III. PEER REVIEW IMMUNITY AND CONFIDENTIALITY DOES NOT ADEQUATELY SERVE THE OBJECTIVE OF IMPROVING THE QUALITY OF HEALTHCARE

The question as to whether peer review immunity is in the public interest was thoroughly addressed in an article authored by both a medical professional and legal professionals. Michael Benson, MD, Jordan Benson, CPA, JD, and Mark Stein, JD, PhD, addressed both the Health Care Quality Improvement Act ("HCQIA") and state laws with respect to keeping peer review secret from patients in an article in the Northwestern Journal of Law and Social Policy entitled "Hospital Quality Improvement: Are Peer Review Immunity, Privilege, Confidentiality in the Public Interest?"[22]

The authors concluded that the current system impedes quality improvement in health care.[23] There are many reasons why secretive peer review is inconsistent with patient safety. "One major element of the current system that predisposes it to error is the use of internal, self-interested reviewers. The second element is the array of federal and state legal protections for peer review that throw a blanket of secrecy

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18. Venosh v. Henzes, 31 Pa.D&C. 5th 411, 432 (C.P. Lackawanna County) *aff'd*, 105 A.3d 788 (Pa. Super. 2014) (non-precedential memorandum opinion).
19. 40 P. S. §1303.308(a).
20. 40 P. S. §1303.310(b).
21. Lahr v. Young, Civil No. 2021-C-0010, 2022 Pa. Dist. & Cnty. Dec. LEXIS 2608, *11-12 (C.P. Lehigh June 21, 2022). *See also Wakeem Ford-Bey v. Professional Anesthesia Services of North America*, No. 2017-02996 (C.P. Montgomery March 23, 2022) (Saltz, J.), currently on appeal to the Superior Court, Docket No. 162 EDA 2022, in which the hospital objected under section 311 of the MCARE Act, 40 P.S. §1303.311, to plaintiff's discovery request for notes made by the Hospital's patient safety director prepared during a root cause analysis of the underlying alleged malpractice. The hospital's investigation was not conducted solely for the purpose of complying with the patient safety reporting requirements of the MCARE Act, and there was no evidence that the safety director's investigation was ever reviewed by the patient safety committee or board of trustees in compliance with section 310(b) of the Act, 40 P.S. §1303.310(b). The hospital failed to show that the patient safety committee had been established in compliance with the MCARE Act. The court therefore granted plaintiff's motion to compel.
22. Michael D. Benson, Jordan B. Benson and Mark S. Stein, *Hospital Quality Improvement: Are Peer Review Immunity, Privilege, Confidentiality in the Public Interest?*, 11 NW. J. L. & SOC. POL'Y 1, 1-27 (2016) (hereinafter "NORTHWESTERN JOURNAL").
23. NORTHWESTERN JOURNAL, *supra* note 22, at 1.

and immunity over the process, preventing scrutiny and thwarting legitimate challenges."[24] These features often result in either improperly severe and arguably "sham" discipline of physicians, which can wrongfully impede and damage the ability of good physicians to practice medicine or, on the other side of the spectrum, improperly lenient discipline and underreporting—or even lack of reporting altogether—of physician misconduct/bad patient outcomes.[25]

Outside reviews have generally proven themselves to be much more useful and are not protected by most state laws when it comes to revealing their contents to patients and doctors. "An increased use of external reviewers would likely improve the quality of peer review not only because of the avoidance of bias, but because external reviewers will be compensated at market rates. Internal peer reviewers are generally uncompensated, peer review is a duty they must fulfill in order to maintain staff privilege at the hospital. . . ."[26] This likely results in the process being "shortchanged on time and effort."[27] *Id*. As stated in the Northwestern Journal article:

> Hopefully, the removal of immunity, privilege and confidentiality would lead eventually to the creation of a cadre of professional, compensated, and specifically trained and credentialed peer reviewers. If there were an accrediting organization for peer reviewers, it would probably be best for that organization to select the external reviewers for each case, rather than leaving that function in the hands of the hospital. External selection of the external reviewers would further minimize the ability of hospitals to manipulate the results of the review process.[28]

The reports of the Pennsylvania Patient Safety Authority to the Legislature, as required by statute,[29] highlight the underreporting of medical errors, both incidents and serious events. The major incentive for underreporting is the shroud of secrecy and immunity surrounding the peer review process which makes it too easy for hospitals to violate their reporting obligations without detection.[30] Serious peer review undertaken by external reviewers, the Northwestern Journal article points out, may increase the reporting of well-founded cases of physician negligence and decrease those without support. As the conclusion notes:

> The well-intended immunity from civil liability for peer review established by the HCQIA, along with state immunity, privilege, and confidentiality, have the paradoxical effect of shielding hospital quality improvement processes from outside scrutiny and discouraging mandated reporting of adverse actions against hospital physicians. These legal protections should be removed. The resulting market forces can be expected to create a more credible and robust peer review process that will result in improved hospital quality and reporting. It is both ironic and unsettling that the court system—with its use of discovery available to all parties

24. *Id*. at 2.
25. *See id*. at 2, and 8-11, 12-14.
26. *Id*. at 17.
27. *Id*.
28. *Id*. at 18. Professor Eleanor Kinney has suggested that Quality Improvement Organizations (QIOs) provide external reviewers. *See* Eleanor D. Kinney, *Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?*, 13 MICH. ST. U. J. MED & L. 57, 84-85 (2009). "QIOs are physician-dominated organizations [that] conduct reviews of the quality of medical care provided to Medicare beneficiaries." *Id*. at 84. However, the authors of the Northwestern Journal article, believe that these organizations, as part of the Medicare system are too focused on issues of cost to reliably fill the role of selecting external reviewers. *See*, NORTHWESTERN JOURNAL, *supra* note 22, at n.137.
29. 40 P.S. §1303.304(c).
30. *See*, NORTHWESTERN JOURNAL, *supra* note 22, at 13, *See also*, Teresa M. Waters, et al., *The Role of the National Practitioner Data Bank in the Credentialing Process*, 21 AM. J. MED. QUALITY 30, 38 (2006) (State statutes providing for confidentiality "make it extremely difficult to hold institutions accountable for meeting reporting requirements").

> and compensated medical experts that practice in the same field as the care provider—creates a more credible peer review product than the health care industry. . . . it would be better for this level of effort to occur first as a hospital activity rather than in the courts. Repeal of peer review immunity, privilege, and confidentiality is a large and necessary first step.[31]

IV. HOW SECRECY IN PEER REVIEW AFFECTS PATIENTS

It is typically asserted that the Pennsylvania Peer Review Protection Act, and similar statutes, were intended to improve the quality of care.[32] Wendy O'Connor, writing from the defense perspective, in her article, "The Peer Review Protection Act ("PRPA"): Looking Back, Looking Ahead," reiterates the notion of the early cases interpreting the PRPA that the immunity afforded for those involved in the peer review process would encourage "free and frank discussion by review organizations" and avoid the threat of civil liability which may occur if, in essence, the patient knew the truth.[33]

To the extent that patients who learn the truth with respect to their medical care may become involved in the subsequent litigation, there is an argument made by the medical industry that this would create additional litigation or undermine the process of legitimate review of physician or hospital misconduct. Such reasoning is fundamentally unsound. The opposite argument has more support in reality. Keeping secrets from patients when medical care is substandard, encourages patients to seek legal counsel in order to pursue necessary discovery, which may ultimately bring the relevant facts to the fore. One system of truth-seeking could be hospital peer review, if it is done adequately and openly. The other approach is resort to the courts, which can be expensive and time consuming.

Thus, unfortunately, lawyers are put in the position of conducting the real "root cause analysis." This author was involved in the drafting of the MCARE Act and, in particular, the creation of the Patient Safety Authority and served on the Patient Safety Authority. This author, along with two major hospital CEOs in Pennsylvania, expressed the view at the first Pennsylvania Patient Safety Authority retreat, and at times thereafter, that lawyers pursuing legal claims for substandard medical care are in fact conducting the peer review that hospitals should be doing. The Patient Safety Authority has not seen fit to release the content of serious event or incident reports, relying upon statutory protection within the Act creating the Patient Safety Authority.[34]

It is understood that the PRPA does not protect from disclosure information "generated by an entity which is not a 'professional heath care provider,' where the focus of the investigation is not to improve the quality of health care providers' delivery of medical care."[35] It makes little sense, in logic, to permit so-called "external" or non-PRPA investigations to be released to the patient, but to shield a narrow class of revelation which may be key to patient safety. The concept of a more open and transparent medical healthcare system has been addressed by the federal establishment as well in the promulgation of the recent so-called "open notes" rule.[36] This recent development is discussed in an article in The Atlantic, "Do You Really Want

31. NORTHWESTERN JOURNAL, *supra* note 22, at 20-21.
32. *See* Wendy O'Connor, "The Peer Review Protection Act ('PRPA'): Looking Back, Looking Ahead," 87 PA. BAR ASSOC. Q. 49 (2016).
33. *Id*. at 50.
34. 40 P.S. §1303.311(d).
35. O'Connor, *supra* note 32, at 61.
36. 85 FR 25642 (May 1, 2020). The effective date of the rule was later extended to April 5, 2021.

to Read What Your Doctor Writes About You?"[37] According to the author of the article, physicians and even the AMA have backed off their opposition to sharing key information with patients.

The goal of lifting this shroud of secrecy surrounding peer review investigations leads to the conclusion argued herein that the PRPA should be narrowly construed.

The number of preventable medical deaths and serious events have not declined appreciably in Pennsylvania notwithstanding the creation of Pennsylvania's Patient Safety Authority and similar entities on the federal level and in other states. The Pennsylvania Patient Safety Authority was established in 2002 as a result of findings by the Institute of Medicine in its landmark report: *To Err is Human: Building a Safer Health System*.[38] Although a majority of members of the Patient Safety Authority are health related professionals, the Authority has nevertheless documented a huge number of event reports of medical mistakes and adverse healthcare outcomes in hospitals. These consist of both "incidents" and "serious events."[39] Medical facilities are obligated by statute to report "serious events" to the Pennsylvania Department of Health and the Patient Safety Authority is required to provide a general report regarding these events to the legislature on a yearly basis.[40]

In spite of secretive peer review and its argued-for benefits in connection with patient safety, the data reflect a substantial number of medical errors reported by the Patient Safety Authority in its annual reports to the Legislature. The Patient Safety Annual Report for 2020 indicated that there were 278,548 total reports: 270,180 incidents and 8,368 serious events.[41] The most recent Patient Safety Annual Report for the year 2021 stated that there were 288,882 total reports: 279,840 incidents and 9,042 serious events.[42]

The Administrative Office of the Pennsylvania Courts has kept count of filed medical malpractice cases within the Commonwealth. As of 2020, the latest year for which the Court has published records, the AOPC has reported 1,476 medical malpractice filings for the year 2020.[43]

There is a very low correlation in the Commonwealth between the number of incidents and serious events in hospitals and the number of medical malpractice cases filed. One of the reasons for this is the great difficulty in obtaining information concerning hospital errors, why they occur, and who is responsible. It is quite clear that secretive peer review not only fails to enhance patient safety, but also makes recovery of legitimate claims difficult and sometimes impossible.

Serious and substantial problems exist in hospitals in the Commonwealth and there is no apparent relationship between secretive peer review and safety. Secrecy with respect to medical errors tends to prevent cooperation by medical professionals with patients and their families in addressing the shortcomings of medical institutions in order to enhance patient safety.

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37. Zoya Qureshi, *Do You Really Want to Read What Your Doctor Writes About You?*, The Atlantic (November 15, 2022) (© 2022 The Atlantic Monthly Group).

38. Kohn KT, Corrigan JM, Donaldson MS, eds., *To Err is Human: Building a Safer Health System*, U.S. Institute of Medicine Committee on Quality of Health Care in America (National Academy of Press 1999).

39. 40 P.S. §1303.302.

40. 40 P.S. §1303.304.

41. Patient Safety Authority 2020 Annual Report, *available at* http://patientsafety.pa.gov.

42. Patient Safety Authority 2021 Annual Report, *available at* http://patientsafety.pa.gov.

43. "Pennsylvania Medical Malpractice Case Filings 2000-2020," Table 1 (Prepared December 2, 2019), *available at* Medical Malpractice Statistics Research & Statistics News & Statistics Unified Judicial System of Pennsylvania (pacourts.us). *See* 152139-pennsylvaniamedicalmalpracticecaSefilngs2000-2020.pdf (pacourts.us).

Secretive peer review does not serve the public interest, it has the effect of denying claimants their right to redress, and it ultimately raises the cost of health care to everyone.

V. HOW PEER REVIEW SECRECY AFFECTS DOCTORS

On the federal level, the Health Care Quality Improvement Act ("HCQIA"),[44] seeks to encourage physicians to participate in peer review by providing limited immunity, much like the state peer review system. There has been much criticism of the HCQIA by doctors, however, because it protects hospitals and peer reviewers from liability for money damages for actions taken in a professional review proceeding regarding the physician's hospital privileges that meet the reasonableness and fairness standards of the Act.[45] Doctors and their advocates are greatly concerned that peer review, and its secretive components, are injurious to physicians. The Northwestern Journal article asserts that "a considerable body of evidence has grown appearing to demonstrate that the current federal-state regulatory scheme shields the peer review process from challenge and scrutiny."[46] It is alleged that courts protect unjustified peer review actions and reach conclusions that are neither doctor nor patient friendly. In particular, the medical community is agitated about the deference given to peer reviewers because an inaccurate peer review subjects both physician and patient to possible negative consequences. The "presumption" of immunity in connection with peer review which affects physicians adversely is one of the greatest components of physician stress. According to some, "[t]he federal courts [interpreting the HCQIA] have destroyed the careful balance Congress struck . . . by replacing the objective reasonableness standards of §11112(a) with a deferential standard of review that accepts as reasonable any facially plausible belief the peer reviewers could have subjectively entertained, however objectively unreasonable."[47]

Certainly, physicians deserve a fair hearing and due process, but their patients do not deserve anything less. One can argue that there is a difference between unfair peer review as it impacts doctors, as opposed to patients attempting to find out the etiology of the serious events which have occurred to them. However, the question is one of secrecy, immunity, and who benefits by keeping information undisclosed with respect to the quality of medical care. In both cases, physician and patient seek the truth and should be entitled in modern society to a complete understanding of the medical care rendered, particularly if a serious event has occurred. The best safeguard for quality care improvement is transparency.

VI. CONCLUSION

Both doctors and patients find the peer review process flawed by its current secretive nature. It serves the interests of neither group well and ultimately fails to promote the stated goal to improve the quality of healthcare. Perhaps most importantly, the data from the Pennsylvania Patient Safety Authority demonstrates that the amount of preventable medical deaths and serious events has not declined appreciably. The reports of the Patient Safety Authority, in its legislatively mandated

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44. 42 U.S.C. §11112(a).
45. *See* Nicholas Kadar, "How Courts are Protecting Unjustified Peer Review Actions Against Physicians," 16 JOURNAL OF AMERICAN PHYSICIANS AND SURGEONS 1, 17 (Spring 2011).
46. Northwestern Journal, *supra* note 22, at 9.
47. Kadar, *supra* note 45, at 18.

accounting to the Commonwealth, do not show any drop in the number of such events.

When it comes to trusting a blind process in terms of efficacy or utility, skepticism in pursuit of truth is a wise person's pumice. In the words of President Kennedy:

> The very word "secrecy" is repugnant in a free and open society; and we are as a people inherently and historically opposed . . . to secret proceedings. We decided long ago that the dangers of excessive and unwarranted concealment of pertinent facts far outweighed the dangers which are cited to justify it.[48]

While some degree of confidentiality may be necessary to carry out effective peer review, the conclusion seems inescapable that the goal of improving the quality of healthcare is more likely to be achieved when the statutory secrecy protections are narrowly construed.

48. John F. Kennedy speech to the American Newspaper Publishers Association, April 27, 1961.