



# Navigating Peer Review and Privileging Across State Lines: Legal Challenges and Practical Solutions

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Presented by

Stephen Kleinman, Epstein Becker & Green, P.C.

Shelli Stoker, VP & Senior Assistant General Counsel, Novant Health, Inc.

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## Agenda



- State law impact on medical staff governance
- Peer review privilege generally
- State peer review privilege variability
- Legal and compliance challenges
- Balancing factors in decision-making
- Strategic approaches to compliance
- Practical considerations and case studies

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# Medical Staff Governance

Bylaws, rules & regs, policies govern the medical staff with content required and informed by –



Medicare  
Hospital and Critical  
Access Hospital (CAH)  
Conditions of  
Participation  
(CoPs)



Hospital / CAH  
accreditation standards  
(ACHC, DNV, TJC)



State laws/regs on  
professional licensure,  
scopes of practice, peer  
review, hospital  
licensure, etc.

## State Law Impact on Medical Staffs

Documents and processes may be standardized in systems with facilities in different states, but some variation will be needed

### Licensure requirements for hospitals and ASCs

- Bylaw content
- Medical staff structure and composition (podiatrists, dentists, APPs?)
- Application processing and timing
- Patient care management (e.g., who can admit, write orders, signing and timing parameters)

### Laws and rules governing medical/ nursing practice and AHPs

- Supervision and collaboration requirements for APPs
- Limitations on prescribing (APPs) and ordering (APPs and AHPs)

### Laws and rules specific to telemedicine

- Privileging requirements
- Consent considerations
- Limitations on prescribing

### Reporting requirements to professional licensure agencies

- Reporting triggers
- Report timing and content

### Peer review legal protections . . . more on that!

# What is a Peer Review Privilege?



## A “legal” privilege is inherently a state law issue

- What constitutes protected peer review is tightly defined by statute and/or case law
- If you know one state’s law, you know one state’s law
- The devil is in the details



## Basic concepts

- Most were enacted in the 1970s in response to the professional liability insurance crisis
- Some states limit the privilege to the hospital setting – others extend to a variety of settings where healthcare is provided

# What is a Peer Review Privilege?



## GENERALLY (*i.e.*, not always)

- Extends immunity from damages for most state claims a practitioner would bring against the hospital and/or peer review participants
- Precludes use of PRI as evidence in civil cases; some states extend protection to criminal cases
- Does not protect information discoverable from other sources
- Courts believe in full and open disclosure of all facts, don’t like privileges, and construe them very narrowly

IF YOU DO NOT RESPECT THE PRIVILEGE, NEITHER WILL THE COURTS

# Why Share Peer Review Information (PRI)?

Enhances patient safety and quality of care

Prevents practitioners with known issues from relocating without scrutiny (“forum shopping”)

Supports informed privileging decisions

Fosters system-wide accountability & transparency

Mitigates legal and regulatory risks

Facilitates operational efficiency

## Sharing PRI – Common Scenarios

PRI is sought to be shared with . . .



**Internal/affiliated stakeholders**  
e.g., HR, affiliated medical groups, etc.



**Other hospitals within a system**  
where the practitioner has privileges



**External stakeholders**  
e.g., licensing bodies, independent medical groups, unaffiliated hospitals conducting credentialing, etc.

# To Share or Not To Share?



Should the information be protected?



Will it be protected? Evaluate and consider:

- What information to share
- How to share the information
- Who will have access to the shared information?
- What purposes will the shared information be used for?



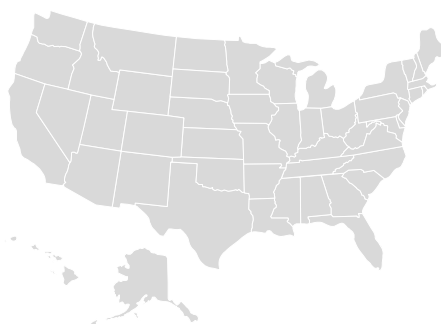
What can be done to mitigate risk/limit exposure (extracting limited information, etc)?

# Understanding State Law Variability

State laws inform procedures around sharing PRI

Consider: (1) what can be shared, (2) with whom, (3) for what purpose / use?

Sharing outside of statutory scope of protections may result in waiver of the privilege



Generally, PRI may be shared between peer review entities for peer review purposes and remain protected, but there is variability in how states define the underlined terms, with some states offering broader protections

**The actual sharing and use of PRI will determine whether PRI is protected by the state's privilege**

# Understanding State Law Variability – Sharing PRI with Hospitals in a System



## Include provisions re sharing PRI between system hospitals in:

- Medical Staff governing documents
- Applications for appointment, reappointment, and/or privileges
- Sharing of information policies or agreements



## Multi-state health systems:

- Document Considerations: Processes for sharing PRI may need to be different for hospitals in each state of operation and reflected in governing documents, policies, and forms (*i.e.*, implementing a one size fits all approach across the system carries risk)
- Cross-State Scenarios: State law variations should be considered before sharing PRI between hospitals in different states (though this issue is uncommon in practice) – consider whether each state’s peer review statute allows for sharing PRI under the circumstances.

# Understanding State Law Variability – What Information May Be Shared (what’s protected)?

## *Information prepared by a PRC? Information provided to a PRC?*



Ala. Code § 6-5-333(D) – “All information, interviews, reports, statements, or memoranda **furnished** to any [medical peer review] committee as defined in this section, and any findings, conclusions, or recommendations **resulting from** the proceedings of such committee are declared to be privileged.”



Ariz. Rev. Stat § 36-445.01 – “All proceedings, records and materials **prepared in connection with** the reviews provided for in §36-445, including all peer reviews of individual healthcare providers practicing in and applying to practice in hospitals or outpatient surgical centers and the records of such reviews, are confidential and are not subject to discovery” unless expressly exempt.



N.M. Stat. Ann. § 41-9-5(A) – “[A]ll data and information **acquired by** a review organization in the exercise of its duties and functions shall be held in confidence and shall not be disclosed to anyone except to the extent necessary to carry out one or more of the purposes of the review organization or in a judicial appeal from the action of the review organization.”



N.C. Gen. Stat. § 90-21-22A(c) – “The **proceedings** of a medical review or quality assurance committee, the **records and materials it produces**, and the **materials it considers** shall be confidential . . .”

## Understanding State Law Variability – With Whom May PRI Be Shared?

*To maintain protections, PRI must be shared between entities recognized under the laws of each state implicated in the scenario*

**Common variations by state include:**

**Settings where peer review entities are legally recognized** (e.g., hospital, medical group)

- Wisconsin extends protections to “health care providers” to include individual licensed practitioners, health facilities, and parent, subsidiary, or affiliate organizations of health facilities and business entities. Wis. Stat. § 146.381(1)(b).
- North Carolina extends protections to individual licensed practitioners, patient safety organizations, ambulatory surgery centers, and licensed hospitals. N.C. Gen. Stat. § 90-21-22A(c)

**Individuals/entities to whom protections extend** (PRCs, employers, administrators, etc.)

- Kansas protections indicate “[a] peer review committee or officer may report to and discuss its activities, information and findings **to other peer review committees or officers or to a board of directors or an administrative officer of a healthcare provider** without waiver of the privilege.” Kan. Stat. Ann. § 65-4915(e)
- Wisconsin protections indicate “[i]nformation acquired in connection with the review or evaluation of health care services may be disclosed, and the records of such a review or evaluation released, to any of the following persons . . . (1) the employer of a health care provider . . . (2) the parent, subsidiary, or affiliate organization of a health care provider, or (3) the parent, subsidiary, or affiliate organization of the employer of a health care provider . . .”

## Sharing PRI With Hospital Affiliated Medical Groups

Whether privilege applies at the “employment” level depends upon state laws and interpretive case law



**E.g., in Ohio**, it applies to all health care entities that conduct professional credentialing/quality review activities involving provider competence, professional conduct, or quality of care



**E.g., in Kentucky**, protections only apply in the hospital setting (if at all)



**E.g., in South Carolina**, protection applies to PRI shared with hospital parent or subsidiaries, other hospitals in a system, employees, agents, etc.



**If protected, then the process considerations re sharing PRI within systems generally apply**

## Understanding State Law Variability – For What Purpose May PRI Be Shared?



**State statutes typically limit use to peer review, credentialing, and quality assurance purposes and may withdraw protections if PRI is used for broader purpose (employment decisions, education, risk management, etc.)**

*E.g.*, Ohio Rev. Code 2305.252(A) (“Nothing in this section precludes health care entities from sharing information, documents, or records that were produced or presented during proceedings of a peer review committee or created to document them as long as the information, documents, or records are used only for peer review purposes.”)



**Some states specifically allow PRI to be used for other purposes (making employment decisions), or permit sharing to certain entities without limiting purpose**

*E.g.*, S.C. Code Ann. § 44-7-392 “The proceedings and data, documents, records, and information described in subsection (A)(1) may be shared with a parent corporation, subsidiaries, other hospitals in the health care system, directors, officers, employees, and agents of the hospital and, if shared, remain confidential.”

## Strategic Approaches to Compliance – Medical Staff Bylaws

Include provisions in each affiliated hospital's medical staff bylaws that:

- Allow sharing of PRI across system affiliates
- Refer to a system-wide policy for parameters



### Bylaws Provisions

Keep sharing provisions basic, while incorporating references to an external, system-wide policy that can be supplemented hospital policy



### Address Conflicts

In event of conflict between hospital bylaws and system-wide policy, individual hospital bylaws govern



## Strategic Approaches to Compliance – System-Wide Policy



**A system-wide PRI sharing policy should align with state law and include, at a minimum:**

- List of affiliates that will share PRI (including affiliated medical groups if applicable and permitted)
- Clear definition of PRI to be shared
- List of events that trigger sharing
- Clear restrictions and procedural steps for sharing (generally PRC to PRC)
- Restrictions on who can access shared PRI
- List of purposes for which shared PRI may be used
- Sanctions for noncompliance

## Strategic Approaches to Compliance – System-Wide Policy



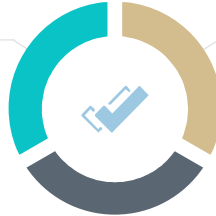
**What information should be shared? Options include . . .**

- When a practitioner's application for appointment, reappointment, or privileges is denied
- When a practitioner's appointment or privileges are limited, suspended, or terminated
- Voluntary resignation of Medical Staff appointment/privileges while under investigation or to avoid investigation
- Practitioner who is subject to a formal corrective action investigation
- Failure by a Practitioner to successfully complete an FPPE for quality-of-care concerns
- A Practitioner who enters into an informal remediation plan
- A Practitioner who receives a "care inappropriate" rating on a predetermined number of cases
- When a hospital learns a practitioner is the subject of an investigation by a government entity
- When a hospital learns that a practitioner is the subject of an investigation by any other quality review organization or professional society
- Aggregate data compiled by utilization review or quality improvement committees of any of the affiliated hospitals
- Other statistical data created by a PRC useful for quality improvement activities

## Strategic Approaches to Compliance – Physician Applications for Appointment & Reappointment



Include provision that addresses the system-wide information sharing policy to put applicants on notice of the policy



Include condition that applicant accepts that the medical staff will share PRI with system affiliates, which may form the basis for corrective action



**Example Provision:** By submitting this application, the applicant acknowledges that the Hospital and Affiliate Hospitals are part of a healthcare system and that information is shared among the Hospital and Affiliate Hospitals. As a condition of appointment and/or grant of Privileges, the applicant recognizes and understands that any and all information (including peer review information) relative to his/her appointment and/or exercise of Privileges maintained, received, and/or generated by the Hospital or Affiliate Hospitals may be shared among the Hospital and Affiliate Hospitals. The applicant further understands that this information may be used as part of the respective Hospital's/Affiliate Hospital's quality improvement activities and can form the basis for corrective action.

## Strategic Approaches to Compliance – Medical Staff Bylaw Content

### 1. Grant of Immunity

By requesting an application and/or applying for Appointment, Reappointment, or Clinical Privileges, the individual expressly accepts the conditions set forth in this Section:

To the fullest extent permitted by law, the individual releases from any and all liability, extends immunity to, and agrees not to sue the Medical Center or the Board, its Medical Staff, any Medical Staff Member, Advanced Practice Professional, or Board member, their authorized representatives, and third parties who provide information for any matter relating to Appointment, Reappointment, Clinical Privileges, or the individual's qualifications for the same. This immunity covers any actions, recommendations, communications, and/or disclosures involving the individual that are made, taken, or received by any entities or individuals named above in the course of credentialing and peer review activities. This immunity also extends to any reports that may be made to government regulatory and licensure boards or agencies pursuant to federal or state law.



## Strategic Approaches to Compliance – Medical Staff Bylaw Content

### 2. Authorization to Obtain Information

By requesting an application and/or applying for Appointment, Reappointment, or Clinical Privileges, the individual expressly accepts the conditions set forth in this Section:

The individual specifically authorizes the Medical Center, its Medical Staff, Medical Staff Leaders, and their authorized representatives (1) to consult with any third party who may have information bearing on the individual's professional qualifications, credentials, clinical competence, character, ability to perform safely and competently, ethics, behavior, or any other matter reasonably having a bearing on his or her qualifications for initial and continued Appointment and/or Clinical Privileges, and (2) to obtain any and all communications, reports, records, statements, documents, recommendations or disclosures of third parties that may be relevant to such questions. The individual also specifically authorizes these third parties to release this information to the Medical Center, its Medical Staff, Medical Staff Leaders, and their authorized representatives upon request. Further, the individual agrees to sign necessary consent forms to permit a consumer reporting agency to conduct a criminal background check on the individual and report the results to the Medical Center.

## Strategic Approaches to Compliance – Medical Staff Bylaw Content

### 3. Authorization to Release Information

By requesting an application and/or applying for Appointment, Reappointment, or Clinical Privileges, the individual expressly accepts the conditions set forth in this Section:

The individual also authorizes the Medical Center, its Medical Staff, and their authorized representatives to release information to (i) other hospitals, health care facilities, managed care organizations, and their agents when information is requested in order to evaluate his or her professional qualifications for Appointment, Clinical Privileges, and/or participation at the requesting organization/facility, (ii) persons or entities external to the Medical Center that are assessing my professional qualifications, competence, or health pursuant to a review that I have been notified is occurring under applicable Medical Center or Medical Staff policies, and (iii) any government regulatory and licensure boards or agencies pursuant to federal or state law. The disclosure of any Peer Review Information in response to such inquiries does not waive any associated privilege, and any and all such disclosures will be made with the understanding that the receiving entity will only use such Peer Review Information for Peer Review purposes.

## Strategic Approaches to Compliance – Medical Staff Bylaw Content

### 4. Authorization to Share Information with Facilities within the System

By requesting an application and/or applying for Appointment, Reappointment, or Clinical Privileges, the individual expressly accepts the conditions set forth in this Section:

The individual specifically authorizes each hospital, health care facility, or other organization that provides health care services and which is under common ownership, control, or management with the Medical Center (hereinafter “facilities within the System”) to share credentialing, peer review, and other information and documentation pertaining to the individual’s clinical competence, professional conduct and health. This information and documentation may be shared at any time, including, but not limited to, any initial evaluation of an individual’s qualifications, any periodic reassessment of those qualifications, or when a question is raised about the individual.



## Balancing Factors for Decision-Making



### The Real Risk = Not Sharing Critical Information

- Legal risk is often overstated – especially when weighed against potential patient harm
- Failing to disclose issues about problematic providers (e.g., “Dr. Death”) can be catastrophic
- Waiving privilege maybe necessary to fulfill legal/ethical duties (e.g., immediate risk to patient safety)
- Courts and regulators favor transparency over concealment in cases involving serious risk

### Risk Varies by State Law

- The primary legal risk: if information is shared improperly, it may lose privilege and be discoverable
- Sharing externally may jeopardize peer review immunity protections

### Balancing Strategy: Thoughtful, Purposeful Sharing

- Ensure disclosures are tied to quality, credentialing, or patient safety
- Use written agreements/policies to define scope and preserve protections

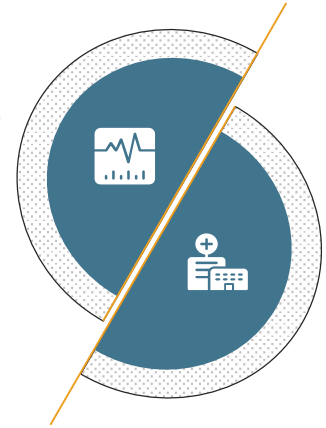
# Strategic Approaches to Compliance – Other Considerations

## When to apply state law vs. federal law

Patient Safety Quality Improvement Act (PSQIA) – Creates a program through which health care providers (not less than 2) can voluntarily report information relating to safety events to a Patient Safety Organization (PSO) in a privileged and confidential basis for the aggregation and analysis of patient safety events

## Distinct Goals

- PSQIA: development of protected environment in which to assess patient safety events and to **submit that information to a PSO to aggregate and report back to its participants** as a means of improving care
- Peer Review: development of protected environment to assess patient care **and take action with respect to providers (and individuals and entities) at the health care entity level** as a means of improving care



# Strategic Approaches to Compliance – Other Considerations

Instead of sharing peer review files, consider whether information can be:

- Accessed via an original source
- Extracted or summarized

Consider Bylaws standardization and consistency of action provisions

Tailor disclosure based on the nature of the information (can entity-level trends, which carry less legal exposure, serve the same purpose?)

***Design sharing protocols to preserve privilege where possible, but don't let fear of risk obscure the obligation to act in the interest of patient safety***



# Case Study #1

## *What Would You Do?*

Physician has appointment and privileges at two hospitals within a health system. Hospital A is located in Ohio, and Hospital B is located in Kentucky. He/she is summarily suspended at Hospital A but continues to practice at Hospitals B.

- What is the result?
- What happens if no information is shared, and the Physician injures a patient at a Hospital B after being summarily suspended by Hospital A?

# Case Study #2

## *What Would You Do?*

Physician has privileges at three hospitals within a system; each located in a different state. He is currently under formal corrective action investigation at Hospital A. Physician resigns while under investigation from Hospital A and continues to practice at Hospitals B and C. Physician subsequently is the subject of a formal corrective action investigation at Hospital B and again resigns while under investigation but continues to practice at Hospital C.

- What is the result?

## Case Study #3

### *What Would You Do?*

The medical group's human resource department uses the information obtained from the Medical Staff President(s) at the system hospital(s) where Dr. A practices as the basis of a medical group employment action related to Dr. A.

- What is the result?

## Presenters



### **Steve Kleinman**

Epstein Becker & Green, P.C.  
Member of the Firm  
614.872.2410



### **Shelli Stoker**

Novant Health, Inc.  
VP & Senior Assistant General Counsel



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