

SENATE, No. 527

STATE OF NEW JERSEY
211th LEGISLATURE

PRE-FILED FOR INTRODUCTION IN THE 2004 SESSION

Sponsored by:

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SYNOPSIS

"New Jersey Patient Safety Act;" makes self-critical analysis by health care facility privileged information.

CURRENT VERSION OF TEXT

Introduced Pending Technical Review by Legislative Counsel.



1 AN ACT concerning self-critical analyses by health care facilities and
2 supplementing Title 26 of the Revised Statutes.

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4 **BE IT ENACTED** by the Senate and General Assembly of the State
5 of New Jersey:

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7 1. This act shall be known and may be cited as the "New Jersey
8 Patient Safety Act."

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10 2. The Legislature finds and declares that:

11 a. It is in the public interest, and in the interest of patient safety,
12 for health care facilities to conduct internal voluntary reviews of their
13 practices for the purpose of discovering or correcting any practices
14 that do not comply with recognized industry standards in order to
15 prevent medical errors in the future;

16 b. If, however, these self-critical analyses conducted by health care
17 facilities are made available to third parties other than regulators and
18 peer review organizations, this can potentially result in the liability of
19 health care facilities to these third parties; and, if that occurs, the
20 health care facility may be discouraged from making these additional
21 efforts and from sharing these results with regulators;

22 c. The resulting fear of self-incrimination may affect the health care
23 community in a manner that would hinder the open and honest
24 discussions that need to occur in order to improve the quality of care;
25 however, a legal structure that promotes self-policing programs can
26 achieve improvements in quality of care and serve to prevent medical
27 errors in the future;

28 d. Health care facilities, health care professionals, peer review
29 organizations, patients, consumers and the State have a vested interest
30 in improving the delivery of patient care; and it is recognized that such
31 improvement can occur only through the collection, analysis and
32 reporting of data;

33 e. When health care facilities and health care professionals are
34 focused on improving the quality of patient care, they must have
35 adequate assurances that information discussed will not be disclosed
36 or compelled to be produced in any civil, administrative or other non-
37 criminal proceeding;

38 f. It is, therefore, declared to be the public policy of this State to
39 encourage health care facilities and health care professionals to
40 undertake self-critical analysis and institute corrective action
41 programs, when appropriate, by protecting these self-critical analyses
42 from third parties other than regulators and peer review organizations;
43 and, to that end, these self-critical analyses are to be considered
44 privileged, and not to be considered public records or public
45 documents subject to inspection or examination under any statutory or
46 common law, except to the regulator; and

1 g. It is the purpose of the public policy declared by this act to
2 create a non-punitive environment that will ultimately improve patient
3 safety and improve the quality of health care delivered to citizens
4 throughout the State.

5
6 3. As used in this act:

7 "Accrediting body" means the Joint Commission on Accreditation
8 of Healthcare Organizations or another organization that accredits
9 health care facilities and is recognized as an accrediting body by the
10 federal or State government.

11 "Adverse event" means an untoward, undesirable and usually
12 unanticipated event that may result in an injury to a patient resulting
13 from a health care provider's medical management, rather than the
14 patient's underlying condition.

15 "Department" means the Department of Health and Senior Services.

16 "Health care facility" means a health care facility as defined in
17 section 2 of P.L.1971, c.136 (C.26:2H-2).

18 "Health care provider" means an individual or entity, which, acting
19 within the scope of its licensure or certification, provides health care
20 services, and includes, but is not limited to, a physician, dentist, nurse
21 or other health care professional whose professional practice is
22 regulated pursuant to Title 45 of the Revised Statues, and a health
23 care facility.

24 "Medical error" means an adverse event, health care-related error,
25 medication-related error or sentinel event.

26 "Peer review organization" means the Joint Commission on
27 Accreditation of Healthcare Organizations or another national
28 accreditation body, or a panel, committee or organization, which
29 engages in or utilizes peer reviews, and gathers and reviews
30 information, relating to the care and treatment of patients in order to
31 ensure professional competence in the review of services. "Peer
32 review organization" specifically includes a hospital medical staff
33 committee that has the responsibility to evaluate and improve the
34 quality of care in a hospital.

35 "Self-critical analysis" means confidential, critical, evaluative or
36 deliberative reports, opinions or materials prepared by a health care
37 facility and its staff in connection with a medical error.

38 "Sentinel event" means an unexpected occurrence involving death
39 or serious physical or psychological injury, or risk thereof. Serious
40 injury specifically includes loss of limb or function.

41
42 4. a. A self-critical analysis shall be privileged, and neither it nor
43 its existence shall be discoverable or admissible as evidence in any
44 legal action or administrative proceeding of any nature involving the
45 health care facility and its staff that prepared the self-critical analysis.

46 b. The submission of any information regarding medical errors or

1 unexpected occurrences to the department, a peer review organization,
2 an accrediting body, or a federal or State agency shall be protected
3 from disclosure to any person or entity by any method, including, but
4 not limited to, subpoena, discovery, introduction of evidence,
5 testimony or any other form of disclosure in connection with any
6 federal or State civil, criminal or administrative proceeding.

7 c. A person who participates in the preparation, writing or
8 submission of a self-critical analysis, medical error report or any other
9 report regarding an unexpected occurrence to the department, or to a
10 peer review organization, accrediting body, or other State or federal
11 agency:

12 (1) shall not be compelled to give answers to any questions or
13 provide testimony regarding the existence, contents or conclusions of
14 any such analysis or report; and

15 (2) shall not be liable in damages to any person for any action
16 taken or recommendation made within the scope of the person's
17 function, if the action or recommendation was taken or made without
18 malice and in the reasonable belief, after reasonable investigation, that
19 such action or recommendation was warranted based upon the facts
20 disclosed.

21 d. A peer review organization may voluntarily disclose self-critical
22 analyses to another peer review organization without waiving any
23 privilege set forth in this act.

24 e. No person shall use any information privileged pursuant to this
25 act to discover any other information, and any information so
26 discovered shall be inadmissible in any action or proceeding. If a court
27 of competent jurisdiction determines that any information is not
28 privileged, it shall, by the entry of appropriate protective orders,
29 ensure that the information is disclosed only to the extent required for
30 the proper conduct of the action or proceeding.

31 f. Nothing in this act shall be construed to limit, waive or abrogate
32 the scope or nature of any statutory or common law privilege,
33 including, without limitation, the work product doctrine and the
34 attorney-client privilege.

35 g. No regulatory agency shall adopt a rule for the purpose of
36 circumventing the privilege established in this act by requiring
37 disclosure of a self-critical analysis or any other report prepared as the
38 result of a peer review process.

39 h. Nothing in this act shall be construed to permit a third party
40 which is not a federal, State or local government agency access to any
41 self-critical analysis or any report prepared by a peer review
42 organization; however, a federal, State or local government agency
43 shall only be provided such access if it agrees in writing to be bound
44 by the provisions of this act.

45 i. The following materials shall not be considered privileged
46 pursuant to this act merely because they are utilized or incorporated

1 in a self-critical analysis:

2 (1) information obtained by observation, sampling, examining,
3 auditing or monitoring by any regulatory agency;

4 (2) information obtained from a source independent of the self-
5 critical analysis review; and

6 (3) information exchanged by and among the department and other
7 appropriate regulatory agencies pursuant to an agreement between or
8 among those agencies.

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10 5. This act shall take effect immediately.

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STATEMENT

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15 This bill provides that information derived from self-critical
16 analyses by licensed health care facilities is to be considered privileged
17 information.

18 In 1999, the Institute of Medicine reported that up to 98,000 deaths
19 attributable to medical errors may occur nationally each year, and a
20 2000 Health Care Financing Administration study ranked New Jersey
21 48th in performance measures related to patient care and safety.
22 While alarming, this report served to educate the public and provider
23 community about New Jersey's performance relative to its peer states.
24 The report further served to encourage hospitals and physicians to
25 closely examine their medical practices and to learn from their medical
26 mistakes, which is the most effective process for reducing unintended
27 adverse patient outcomes. However, national studies and the
28 experience of states throughout the country demonstrate that this
29 process of sharing, learning and improving performance can only occur
30 if it is voluntary, confidential and absent any punitive action.

31 This bill would allow health care facilities to continue to engage in
32 open and frank discussions without fear of self-incrimination, which
33 is necessary to improve health care practices and patient safety.
34 Recognizing that health care facilities, health care professionals, peer
35 review organizations, consumers and the State have a vested interest
36 in improving the delivery of patient care, this bill is intended to
37 encourage a systemic review of medical errors occurring in health care
38 facilities in New Jersey. To facilitate this process, this bill would
39 provide protection for health care facilities and their provider staff for
40 the reporting, collection and analysis of adverse events so that staff
41 are encouraged to voluntarily report these events, and to perform self-
42 critical analyses and improve care processes when something goes
43 awry in their institution. By so doing, this bill would prevent facilities
44 and staff from facing the chilling effect that having to turn over such
45 information to a plaintiff's attorney would have upon performing this
46 kind of analysis.

1 This bill would not preclude an aggrieved party from pursuing
2 litigation and engaging in the normal discovery process. Aggrieved
3 parties would still be able to obtain the same information that they are
4 currently allowed to receive (e.g., obtaining medical records, and
5 deposing physicians, nurses and other medical practitioners). A self-
6 critical analysis involves an evaluation of the facts and a discussion of
7 opinions and recommendations on how to improve the quality of care
8 and prevent future adverse events. All facts related to the adverse
9 event would continue to be available through the normal discovery
10 process. This bill is intended to protect the opinions expressed
11 through the self-critical analysis process, because these opinions
12 should never be considered factual or construed as such. Failure to
13 enact this protection would have a chilling effect upon open and frank
14 discussions for fear of having one's opinions used against a peer, or the
15 possibility of self-incrimination.

16 Although regulations exist that require hospitals to report adverse
17 events, such reporting has been minimal, in large part due to the fear
18 of regulatory and legal action that may be taken against a hospital. In
19 order to address these problems and improve patient care in health
20 care facilities, peer review and accreditation organizations and
21 regulatory agencies responsible for monitoring the quality of care
22 provided by those facilities must be allowed to receive medical error
23 data without subjecting that data and the facilities that provide it to
24 disclosure. This bill would encourage health care facilities to report
25 adverse events and other medical errors to these monitoring entities
26 without fear of disclosure of confidential, self-critical analyses.

27 This bill is modeled in part on the provisions of P.L.1999, c.183
28 (N.J.S.A.17:23C-1 et seq.), which was enacted in order for insurance
29 carriers in this State to be able to conduct internal reviews and audits
30 of their operations, practices and procedures for the purpose of
31 discovering, correcting and preventing continuing and more serious
32 violations.