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CODIFYING COMMON LAW: THE SELF-CRITICAL ANALYSIS PRIVILEGE AND THE NEW JERSEY PATIENT SAFETY ACT

*Adam Blander**

INTRODUCTION

In 2004, New Jersey enacted the Patient Safety Act (“the PSA” or “the Act”),¹ requiring hospitals to engage in the “comprehensive reporting of adverse patient events, systematic analysis of their causes, and creation of solutions.”² The Act was grounded in the belief that fostering “a non-punitive culture that focuses on improving processes rather than assigning blame”³ was crucial in promoting disclosure and reporting. As such, it provided that materials developed from a process of “self-critical analysis” not be discoverable nor used as evidence in any subsequent trial or proceeding.⁴

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¹ See Patient Safety Act, N.J. STAT. ANN. § 26:2H-12.23–25 (West 2007 & Supp. 2012).

² *Patient Safety Reporting System*, STATE OF N.J. DEP’T OF HEALTH, <http://www.state.nj.us/health/ps/> (last visited Feb. 20, 2013).

³ N.J. STAT. ANN. § 26:2H-12.24(e).

⁴ *Id.* § 26:2H-12.25(g) (rendering self-critical patient safety documents immune from discovery and not “admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding”).

That certain medical investigations, evaluations, and peer review reports⁵ should be privileged is not a new evidentiary concept. At least since the early 1970s, both federal and state courts have relied on a self-critical analysis exception to the generally liberal rules of the American discovery system to prevent a litigant from gaining access to his adversary's candid assessments of its internal practices, however relevant they might be to that litigant's case.⁶

In some respects, the PSA merely codified an already existing, judge-made, self-critical analysis privilege, which protected medical peer review documents. In fact, the statute text explicitly adopted the holding of *Christy v. Salem*,⁷ an important self-critical analysis case. This Note demonstrates, however, that while prior common law undoubtedly informed the drafters of the PSA, the Act actually created a fairly novel and more expansive self-critical analysis privilege. Quite simply, the values and policy concerns of the emergent "patient safety" movement that inspired the PSA differed from those that encouraged past courts to create and apply the privilege. As a result, these two privileges function quite differently: self-critical analysis under the common law (both in the federal system and in New Jersey) was traditionally a malleable and "qualified" privilege,⁸ applied infrequently and on an ad hoc basis by trial judges in an attempt to balance competing public and private interests during discovery. In contrast, the PSA created a more

⁵ See Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 7 (1999) (defining peer review as "a process by which members of a hospital's medical staff review the qualifications, medical outcomes and professional conduct of other physician members and medical staff applicants to determine whether the reviewed physicians may practice in the hospital and, if so, to determine the parameters of their practice") (citations omitted).

⁶ See, e.g., *Reid v. Lockheed Martin Aeronautics Co.*, 199 F.R.D. 379 (N.D. Ga. 2001); *In re Crazy Eddie Securities Litigation*, 792 F. Supp. 197 (E.D.N.Y. 1992); *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249 (D.D.C. 1970); *McClain v. College Hosp.*, 492 A.2d 991 (N.J. 1985).

⁷ *Christy v. Salem*, 841 A.2d 937 (N.J. Super. Ct. App. Div. 2004). This case will be discussed in further detail in Parts II and III.

⁸ See, e.g., *Bredice*, 50 F.R.D. at 251 (holding medical peer review reports are "entitled to a qualified privilege").

crystallized, unbending, and absolute privilege, which could likely produce more consistent, albeit perhaps less equitable, results in future litigation against hospitals.

Under a PSA regime, trial judges will have less discretion to shape the course of discovery because the relevant question in deciding whether to apply a privilege is no longer one which balances the equities and considers the discoverer's need for the information. Instead, courts will resolve distinctly statutory inquiries: whether a hospital "substantially complied" with the PSA's reporting scheme⁹ or whether the allegedly privileged materials were created "exclusively" for the purpose of complying with the PSA.¹⁰ As a result, there is a danger that the PSA, while well intentioned, will spawn unintended mischief during litigation and may undermine the underlying goal of the Act—to ensure patient safety in New Jersey.

Part I of this Note tracks the development of self-critical analysis doctrine in the federal courts, emphasizing the seminal 1970 case *Bredice v. Doctors Hospital*.¹¹ Part II examines the history of self-critical analysis in New Jersey and where it stood on the eve of the PSA's passage. Part III tells the story of the PSA—why it was needed, how the Legislature and competing interest groups united behind the Act, and how the drafters utilized existing self-critical analysis doctrine in order to further their goals. Part IV shows, through the recent case of *Applegrad ex rel. C.A. v. Bentolila*,¹² how the PSA has unleashed some unforeseen results, in large part because, like with any controversial legislation, interested parties are now asserting novel interpretations of the Act. Part V argues that these consequences are a result of the PSA's misguided attempt to apply its vision of patient safety to the incompatible common law principles of self-critical analysis. This Note proposes a more modest self-critical analysis rule, based not on the laws of privilege but rather on the Subsequent Remedial Measures

⁹ See *Applegrad ex rel. C.A. v. Bentolila*, 51 A.3d 119, 135 (N.J. Super. Ct. App. Div. 2012).

¹⁰ See *id.* at 139.

¹¹ 50 F.R.D. 249.

¹² 51 A.3d 119.

doctrine (commonly referred to as “Rule 407”¹³), which, in practice, would deem self-critical materials inadmissible at trial yet still discoverable. This paradigm strikes a proper balance between the patient’s right to uncover the truth—regardless of any intention to sue—and the public interest in encouraging constant and candid assessments of hospital procedures. Incidentally, this may even further the PSA’s objective of limiting adverse health outcomes.

I. THE DEVELOPMENT OF THE SELF-CRITICAL ANALYSIS PRIVILEGE

Privileges “reflect societal choices that certain relationships (such as those between husbands and wives) or activities (such as seeking legal or medical advice) should be valued above others.”¹⁴ Understood another way, privileges are the product of a principled determination by the privilege creator (typically a legislature or court) that the public would benefit from certain information remaining confidential. As one author succinctly stated, “[S]ociety needs privileges because in their absence, individuals will be discouraged from engaging in certain socially desirable behavior.”¹⁵ A privilege can thus be regarded as a type of public interest carve-out to the discovery process, which otherwise allows for the disclosure of all potentially relevant material.¹⁶

¹³ FED. R. EVID. 407.

¹⁴ Pam Jenoff, *The Case for Candor: Application of the Self-Critical Analysis Privilege to Corporate Diversity Initiatives*, 76 BROOK. L. REV. 569, 576 (2011).

¹⁵ *Id.* at 577. For example, without an attorney-client privilege, a client may be reluctant to speak frankly with her lawyer, and without a doctor-patient privilege, a patient may be reluctant to inform her physician of crucial, yet possibly embarrassing, details of her personal health. Society should (and does) encourage these behaviors, which, respectively, promote justice and improve health outcomes.

¹⁶ *See, e.g.*, FED. R. CIV. P. 26(b)(1) (“Parties may obtain discovery regarding any nonprivileged matter that is relevant to any party’s claim or defense Relevant information need not be admissible at the trial if the discovery appears reasonably calculated to lead to the discovery of admissible evidence.”). Most states have similarly expansive rules. *See, e.g.*, N.Y.

While many privileges are so deeply rooted in our culture that few would question their necessity—the privilege against self-incrimination or the attorney-client privilege, for instance—*all* privileges are controversial in that they prevent a party from uncovering facts likely crucial to its case. As Justice Scalia noted, “[J]ustice . . . is severely harmed by contravention of ‘the fundamental principle that “the public has a right to every man’s evidence.”’”¹⁷ Privileges, the Supreme Court famously admonished, “are not lightly created nor expansively construed, for they are in derogation of the search for truth.”¹⁸ In sum, privileges are unabashedly bold vehicles for policymaking.¹⁹

A. *The Doctrinal Roots of the Self-Critical Analysis Privilege*

The self-critical analysis privilege is rooted in the belief that in certain situations, public policy demands that institutions engage in evaluative internal investigations and discussions in order to pinpoint—and hopefully correct—recurring problems or prior mistakes.²⁰ Because such discussions likely contain embarrassing or damaging information, participants may not

C.P.L.R. 3101(a) (McKINNEY 2005) (“There shall be full disclosure of all matter material and necessary in the prosecution or defense of an action, regardless of the burden of proof . . .”).

¹⁷ *Jaffee v. Redmond*, 518 U.S. 1, 19 (1996) (Scalia, J., dissenting) (quoting 7 JOHN HENRY WIGMORE, EVIDENCE IN TRIALS AT COMMON LAW § 2192 (3d ed. 1940) (quoting Lord Hardwicke)).

¹⁸ *United States v. Nixon*, 418 U.S. 683, 710 (1974).

¹⁹ Because of the extraordinary power that privileges afford, and because they reflect overarching and often controversial policy decisions, the secondary question of *who* has the authority to create a privilege is itself an important public policy inquiry. Privileges in New York, for example, are almost entirely a product of statute. New York courts have traditionally declined to create new privileges. See RICHARD T. FARRELL, PRINCE, RICHARDSON ON EVIDENCE § 5-101 (11th ed. 1995) (“Efforts have been made to induce the courts to create privileges in favor of additional classes of persons, but without success.”).

²⁰ See, e.g., Brad Bacon, Note, *The Privilege of Self-Critical Analysis: Encouraging Recognition of the Misunderstood Privilege*, 8 KAN J.L. & PUB. POL’Y 221, 223 (1999) (“The privilege is premised on the rationale that unimpeded self-criticism serves a social good outweighing the cost of evidentiary exclusion.”).

speak frankly if they know their own self-critical analyses could be discovered by outsiders, or worse, used as evidence against them in a future lawsuit.²¹ Therefore, the argument goes, the contents of these discussions must remain confidential.

The belief that a party should not be compelled to disclose its self-evaluative material is not novel. Such a rationale is embedded in two well-recognized and existing protections: (1) the attorney-client privilege and (2) the work-product doctrine. The attorney-client privilege ensures the “full and frank communication between attorneys and their clients and thereby promote[s] broader public interests in the observance of law and administration of justice.”²² A broad attorney-client privilege thus encourages a form of self-critical analysis.²³ The work-product doctrine, articulated in *Hickman v. Taylor*²⁴ and now codified in Rule 26(b)(3) of the Federal Rules of Civil Procedure, prevents a party from discovering documents that were prepared in “anticipation of litigation.”²⁵ The doctrine promotes the adversarial system, and more generally ensures fairness, by preventing a party from unjustly benefiting from the hard work of its adversary.²⁶ Importantly, the work-product

²¹ See generally 1 DAVID M. GREENWALD ET AL., TESTIMONIAL PRIVILEGES § 1:120 (3d ed. 2005 & Supp. 2012).

²² *Upjohn Co. v. United States*, 449 U.S. 383, 389 (1981). In *Upjohn*, the Supreme Court recognized that robust attorney-client privilege encourages corporate entities to investigate and root out possible illegal activities within their own ranks.

²³ See, e.g., Stuart E. Rickerson, *The Privilege of Self-Critical Analysis: How to Raise It and Use It*, 58 DEF. COUNS. J. 504, 507 (1991) (stating that *Upjohn* “could have become the cornerstone of the critical self-examination privilege”). An implicit assumption in both attorney-client and self-critical analysis privilege is what might be called the proactive “nip it in the bud” approach, where reliance on forward-looking internal compliance approaches produces higher degrees of conformity with the law and is therefore more efficient and desirable than post hoc deterrents and remedies through the imposition of civil or criminal liability.

²⁴ *Hickman v. Taylor*, 329 U.S. 495 (1947).

²⁵ FED. R. CIV. P. 26(b)(3)(A).

²⁶ Sherman L. Cohn, *The Work-Product Doctrine: Protection, Not Privilege*, 71 GEO. L.J. 917, 943 (1983). The doctrine serves a more forward-thinking goal as well: the quality of attorney work product would suffer if such material were easily obtainable by adversaries. See *id.* at 919–

doctrine is a protection, *not* a privilege: a court will order discovery if a litigant asserts a “substantial need” for the materials,²⁷ although “mental impressions, conclusions, opinions, or legal theories of a party’s attorney or other representative” are always protected.²⁸

These “attorney-based protections,” however, do not extend to more general self-critical materials.²⁹ Most courts have interpreted the “anticipation of litigation” standard of the work-product doctrine fairly narrowly, protecting only work product prepared by an attorney in response to an actual event that could reasonably give rise to litigation.³⁰ As one commentator noted, many self-critical procedures and studies are designed to *prevent* litigation and thus would “not possess the requisite tie to litigation to invoke work-product protection.”³¹ The attorney-client privilege, on the other hand, only protects confidential communications between an attorney and her client.³² Information acquired by an attorney from other sources, including third parties, is not protected, however “confidential” it may seem in the colloquial sense of the term.³³ In sum, neither

20; *see also Hickman*, 329 U.S. at 516 (“Discovery was hardly intended to enable a learned profession to perform its functions either without wits or on wits borrowed from the adversary.”).

²⁷ FED. R. CIV. P. 26(b)(3)(A) provides that the discovering party can overcome the protection if it “shows that it has substantial need for the materials to prepare its case and cannot, without undue hardship, obtain their substantial equivalent by other means.”

²⁸ FED. R. CIV. P. 26 (b)(3)(B).

²⁹ Patricia L. Andel, *Inapplicability of the Self-Critical Analysis Privilege to the Drug and Medical Device Industry*, 34 SAN DIEGO L. REV. 93, 98–103 (1997).

³⁰ *See* FED. R. CIV. P. 26 advisory committee’s note (“Materials assembled in the ordinary course of business, or pursuant to public requirements unrelated to litigation, or for other nonlitigation purposes are not under the qualified immunity provided by this subdivision.”); *see also Janicker v. George Washington Univ.*, 94 F.R.D. 648, 650 (D.D.C. 1982) (“The fact that a defendant anticipates the contingency of litigation resulting from an accident or an event does not automatically qualify an ‘in house’ report as work product.”).

³¹ Andel, *supra* note 29, at 103.

³² *Id.* at 99.

³³ *Id.* at 100; *see also* FARRELL, *supra* note 19, § 5-101 (quoting 7

the attorney-client privilege nor the work-product doctrine can ensure the confidentiality of self-critical materials. What is needed is a distinct self-critical analysis privilege.

B. Bredice v. Doctor's Hospital

*Bredice v. Doctors Hospital*³⁴ is often acknowledged as the first case in which a court recognized a common-law self-critical analysis privilege.³⁵ Ms. Bredice, in her medical malpractice action, sought discovery of the minutes from medical board meetings convened by the defendant hospital concerning the treatment received by her late husband.³⁶ The court observed that these meetings, which evaluated the performance of medical staff, were required by the Joint Commissions on Accreditation of Hospitals and existed for the “sole” purpose of improving care.³⁷ The court continued:

[T]hese meetings are essential to the continued improvement in the care and treatment of patients. Candid and conscientious evaluation of clinical practices is a *sine qua non* of adequate hospital care. To subject these discussions and deliberations to the discovery

WIGMORE, *supra* note 17, § 2286) (“No pledge of privacy, nor oath of secrecy can avail against demand for the truth in a court of justice.”). Particularly within the context of internal compliance efforts, such as in *Upjohn*, disclosure to *anyone* outside the agency of the party, including to government agencies, may constitute a waiver of the privilege. *See In re Steinhardt Partners*, 9 F.3d 230, 235–36 (2d Cir. 1993) (deeming company’s voluntary submission of materials a waiver); Andel, *supra* note 29, at 100. Further, the privilege “does not apply when the in-house attorney, who regularly wears several hats, is performing work that requires management expertise rather than work that requires legal acumen.” Andel, *supra* note 29, at 101.

³⁴ *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249 (D.D.C. 1970).

³⁵ Jenoff, *supra* note 14, at 580 (“[I]n *Bredice*, a court recognized for the first time that there was a strong public interest in allowing the free discussion of information in socially useful critical self-examination, and that if discovery of such materials were allowed, the flow of information would halt.”).

³⁶ *Bredice*, 50 F.R.D. at 249.

³⁷ *Id.* at 250.

process, without a showing of exceptional necessity, would result in terminating such deliberations. Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit.³⁸

The court therefore reasoned that there was an "overwhelming public interest" in keeping these staff meetings confidential "so that the flow of ideas and advice [could] continue unimpeded."³⁹ The court further noted that "what someone . . . at a subsequent date thought of these acts or omissions is not relevant to the case."⁴⁰ For both of these reasons, the court concluded that the meetings "are entitled to a qualified privilege."⁴¹

C. Doctrinal Disputes: How Far Should the Privilege Extend?

Bredice predated Federal Rule of Evidence 501 (promulgated in 1974), which created a new framework for federal courts to determine when to recognize new privileges.⁴² While one could

³⁸ *Id.*

³⁹ *Id.* at 251.

⁴⁰ *Id.* (alteration in original) (quoting *Richards v. Me. Cent. R.R.*, 21 F.R.D. 590 (D. Me. 1957)) (internal quotation marks omitted). This contention is highly questionable. FED. R. CIV. P. 26(b) allows for the discovery of materials "reasonably calculated to lead to the discovery of admissible evidence." Documents compiled in the wake of an adverse patient occurrence are almost *certain* to include relevant evidence, particularly the identity of witnesses, and will likely serve, in the words of James F. Flanagan, as a crucial "'road map' of the events" for the discoverer. James F. Flanagan, *Rejecting a General Privilege for Self-Critical Analyses*, 51 GEO. WASH. L. REV. 551, 558 (1983). "Any evaluation of the self-critical report . . . must start with the fact that it is undeniably relevant and of assistance in resolving the case." *Id.*

⁴¹ *Bredice*, 50 F.R.D. at 251.

⁴² See FED. R. EVID. 501 ("The common law—as interpreted by United States courts in the light of reason and experience—governs a claim of privilege unless any of the following provides otherwise: the United States Constitution; a federal statute; or rules prescribed by the Supreme Court. But in a civil case, state law governs privilege regarding a claim or defense for

question whether a *Bredice* holding would survive under a Rule 501 regime, many courts have since relied on *Bredice* to shield “self-critical” medical peer reviews.⁴³ In fact, medical peer reports, along with internal disciplinary investigations⁴⁴ and certain types of equal employment opportunity reports,⁴⁵ constitute the three types of documents most often afforded self-critical analysis protection. The common denominator in all these cases is a court’s determination that the public interest in encouraging candid analysis outweighs the litigant’s right to that information.

Self-critical analysis has been litigated almost entirely at the trial court level.⁴⁶ “Rely[ing] on their inherent power to control discovery,”⁴⁷ trial judges have applied the privilege on an ad hoc basis, creating what one commentator has referred to as a “confusing body of case law” with inconsistent results.⁴⁸ The

which state law supplies the rule of decision.”); FED. R. EVID. 501 advisory committee’s note.

⁴³ Andel, *supra* note 29, at 105–06.

⁴⁴ Note, *The Privilege of Self-Critical Analysis*, 96 HARV. L. REV. 1083, 1088 (1983) (citing, as examples, investigations conducted by railroad companies following an accident in order to “discipline any culpable employees and ultimately to improve the railroad’s safety” and police department investigations “when, following an arrest or shooting, a plaintiff has either alleged a civil rights violation or asserted a wrongful death claim”).

⁴⁵ *Id.* at 1089–90 (describing government contractors’ obligation under Title VII of the Civil Rights Act of 1964 to file documents that “candid[ly]” evaluate their own nondiscrimination procedures).

⁴⁶ See Note, *Making Sense of Rules of Privilege Under the Structural (Il)logic of the Federal Rules of Evidence*, 105 HARV. L. REV. 1339, 1352 n.74 (1992) [hereinafter *Making Sense of Rules of Privilege*].

⁴⁷ Flanagan, *supra* note 40, at 575.

⁴⁸ GREENWALD ET AL., *supra* note 21, § 1:119. Adding to the confusion, federal courts often treat privileges as matters of “substance” (rather than procedure) under an *Erie* analysis and therefore defer to the privilege law in the state in which they sit. See, e.g., *Lawson v. Fisher-Price, Inc.*, 191 F.R.D. 381, 382 (D. Vt. 1999) (“[T]his Court applies state law in determining whether a privilege for self-critical analysis exists.”); see also *Spencer Sav. Bank, SLA v. Excell Mortg. Corp.*, 960 F. Supp. 835, 836 (D.N.J. 1997) (“[A] federal court may ‘resort to state law analogies for the development of a federal common law of privileges in instances where the

deferential “abuse of discretion” standard governing appeals of trial court discovery rulings,⁴⁹ as well as parties’ inability in many jurisdictions to appeal discovery rulings until a “final” judgment, have resulted in a dearth of guidance from appellate courts, which, in turn, has created more unpredictability.⁵⁰ As a result, “some jurisdictions have cases with conflicting outcomes that are barely recognizable.”⁵¹ Many courts have also simply rejected the privilege outright.⁵²

The privilege’s lack of coherence has forced observers to grapple with the basic question of whether the self-critical analysis should be an “absolute” relational privilege of the attorney-client or doctor-patient type or rather an equitable tool of trial judges to ensure fairness during discovery and thus more similar to protections like the work-product doctrine. Despite the inconsistent application of the privilege, one influential *Harvard Law Review* Note discerned three overarching principles to the application of the privilege in certain scenarios. First, the privilege seeks to prevent the “dual chilling effect” discovery would unleash: “the direct chilling effect on the institutional or individual self-analyst . . . [which] operates to discourage the analyst from investigating thoroughly and frankly or even from investigating at all,”⁵³ as well as the chilling effect upon the data-“supplier,” which “discourage[s] individuals from coming

federal rule is unsettled.” (quoting *Wm. T. Thompson Co. v. Gen. Nutrition Corp.*, 671 F.2d 100, 104 (3d Cir. 1982)).

⁴⁹ *See, e.g.*, *Dowling v. Am. Haw. Cruises*, 971 F.2d 423, 425 (9th Cir. 1992).

⁵⁰ *See* GREENWALD ET AL., *supra* note 21, § 1:119.

⁵¹ *Id.*

⁵² *Id.* (“The privilege is defined differently in different jurisdictions, but in most cases the courts have found that the privilege did not apply to facts before them.”).

⁵³ *The Privilege of Self-Critical Analysis*, *supra* note 44, at 1091–92.

Fear of lawsuits, however, is not the only cause for hesitancy on the part of self-analysts. If an individual self-analyst is asked by his superiors to conduct an internal analysis, the individual may temper his criticism out of a fear that reprisals will result if the analysis ultimately leads to liability or adverse publicity for the employer.

Id. at 1092.

forward with relevant information.”⁵⁴ The second principle is that evaluations and opinions in self-critical materials are protected from discovery but the underlying facts upon which these opinions are based are not,⁵⁵ a distinction which the Note criticized, observing that “chilling effects of disclosure often operate on facts as well as evaluations.”⁵⁶ The third principle is that the privilege is not “absolute,” meaning it is applied on a case-by-case basis, and, even when applied, may be overcome if a party shows “exceptional need” for the material.⁵⁷ The Note likewise criticized this principle, advocating for a more absolutist privilege approach, analogous to the attorney-client context, in which judges decline to “weight the equities” in determining whether to apply the self-critical analysis privilege.⁵⁸ For much the same reason, the Note criticized the “exceptional need” concession: “The more crucial the material is to the [discoverer’s] case, the more likely it is to be the type of material that the privilege was designed to protect.”⁵⁹ The Note therefore criticized courts for “fail[ing] to give the privilege sufficiently broad application to effectuate the important policies underlying it.”⁶⁰

In contrast, James F. Flanagan, in *Rejecting a General Privilege for Self-Critical Analyses*, asserted that self-critical analysis is not an “evidentiary privilege” and should instead be regarded as “an exercise in discretionary protection founded in the court’s power over discovery.”⁶¹ Self-critical analysis is thus

⁵⁴ *Id.* at 1092. “Without the privilege, as the risk of liability for the institution increases, the likelihood that witnesses will come forward decreases.” *Id.*

⁵⁵ *Id.* at 1093–94. This same distinction exists in work-product doctrine. See FED R. CIV. P. 26(b)(3)(B) (protecting “mental impressions, conclusions, opinions, or legal theories”); *Hickman v. Taylor*, 329 U.S. 495, 510 (1947) (recognizing that thoughts are “inviolable” and “outside the arena of discovery”).

⁵⁶ *The Privilege of Self-Critical Analysis*, *supra* note 44, at 1095.

⁵⁷ *Id.* at 1096–97.

⁵⁸ *Id.* at 1098.

⁵⁹ *Id.* at 1099.

⁶⁰ *Id.* at 1100.

⁶¹ Flanagan, *supra* note 40, at 576.

similar to the work-product doctrine, which protects certain materials from discovery absent a showing of “sufficient need.”⁶² Flanagan concedes that protecting medical peer reviews from malpractice plaintiffs is necessary, recognizing that “a failure to ensure [their] confidentiality will diminish the[ir] quality.”⁶³ Yet he also observes that many states nevertheless protect these reports in the form of “peer review statutes,” which, unlike a general self-critical analysis rule, “provide sufficient exceptions so that no litigant will be seriously prejudiced because he cannot discover who was present or what occurred during a relevant review proceeding.”⁶⁴ Flanagan thus concludes that while self-critical analysis may be a worthwhile public policy, it is undeserving of an unqualified privilege.⁶⁵

D. The Current State of Self-Critical Analysis

While the self-critical analysis doctrine has likely informed many medical peer-review statutes,⁶⁶ it has certainly not gained recognition as a general privilege. Instead, the privilege has been maintained as an equitable tool for trial courts to shield documents not otherwise protected by the attorney-client privilege or work-product doctrine.⁶⁷ There is little agreement

⁶² *Id.* at 575.

⁶³ *Id.* at 576.

⁶⁴ *Id.* at 577. As discussed *infra* Parts II & III, New Jersey is one of the few states in which medical peer-review protections are *not* derived from statute, but rather from decisional law (the exception being the “utilization review” privilege, see *infra* Parts II & III).

⁶⁵ Flanagan, *supra* note 40, at 582 (“At best there are compelling reasons for courts to consider requests for discovery of peer reviews, to weigh alternatives, and to seek the least harmful means of disclosure.”).

⁶⁶ GREENWALD ET AL., *supra* note 21, § 1:121 (“State law relating to privileges is often governed by statute, and many states have statutes adopting forms of a self-evaluative privilege in a very limited context. For example, most states afford some confidentiality to medical peer reviews of patient care.”).

⁶⁷ *Id.* (observing that “in order to provide additional protection [aside from the attorney-client and work-product protections], some courts have recognized [the self-critical analysis privilege] to protect institutional self-analysis from outside discovery”).

even in those three areas where courts typically apply the privilege.⁶⁸ For example, one court observed that employment discrimination cases “are all over the map on whether the self-evaluative privilege exists,” noting that “[t]he privilege is a creature of the state trial courts, and there is little uniformity of law even within particular states.”⁶⁹ Even courts recognizing a self-critical analysis privilege have mostly found it did not apply in the cases before them.⁷⁰

The Supreme Court’s decision in *University of Pennsylvania v. EEOC*,⁷¹ which declined to recognize a peer-review privilege, was a discernible setback for the self-critical analysis movement. The University of Pennsylvania, defendant in a Title VII discrimination suit, refused to turn over tenure review files, arguing that courts should embrace a “common law” peer review privilege under Federal Rule of Evidence 501.⁷² The Court held that “although Rule 501 manifests a congressional desire . . . [to] provide the courts with flexibility to develop rules of privilege on a case-by-case basis . . . we are disinclined to exercise this authority expansively.”⁷³ The University’s peer review claim was, at its core, one of self-critical analysis. Both privileges posit that society should encourage the frank evaluations of experts in a given field on matters of public import, even at the expense of denying individual litigants access to plainly relevant materials.⁷⁴ The Court’s rebuff of the University’s policy rationale thus foreclosed a similar self-critical analysis defense in the future. As such, subsequent

⁶⁸ See *supra* notes 44–45 and accompanying text.

⁶⁹ *Walker v. Cnty. of Contra Costa*, 227 F.R.D. 529, 532 (N.D. Cal. 2005); see also *Siskonen v. Stanadyne, Inc.*, 124 F.R.D. 610, 611 (W.D. Mich. 1989) (observing self-critical analysis law in federal discrimination cases to be “in disarray”).

⁷⁰ See GREENWALD ET AL., *supra* note 21, § 1:119.

⁷¹ *Univ. of Pa. v. EEOC*, 493 U.S. 182 (1990).

⁷² *Id.* at 188–89.

⁷³ *Id.* at 189 (citations omitted).

⁷⁴ See, e.g., *Making Sense of Rules of Privilege*, *supra* note 46, at 1352 n.75 (observing that the academic peer review privilege “center[s] upon many of the same normative and empirical arguments that dominate the self-critical analysis privilege area”).

courts have relied on *University of Pennsylvania* to reject a self-critical analysis privilege.⁷⁵

Today, many courts rely on the four-part test articulated by the Ninth Circuit in *Dowling v. American Hawaii Cruises*,⁷⁶ which held that a party asserting the privilege must show that:

“[1] the information must result from a critical self-analysis undertaken by the party seeking protection; [2] the public must have a strong interest in preserving the free flow of the type of information sought; [3] the information must be of the type whose flow would be curtailed if discovery were allowed.” . . . [And 4, that the document] was prepared with the expectation that it would be kept confidential, and has in fact been kept confidential.⁷⁷

In *Dowling*, the court allowed the plaintiff, in his personal injury action under the Jones Act,⁷⁸ to discover the factual content of the defendant cruise ship’s preaccident safety committee meeting minutes, reasoning that “organizations have many incentives to conduct such reviews that outweigh the harm that might result from disclosure,” such as fear of other lawsuits or simply “to avoid developing a reputation for having an unsafe premises.”⁷⁹

Altogether, the federal courts have generally declined to extend application of the self-critical analysis doctrine.⁸⁰ Despite

⁷⁵ Jenoff, *supra* note 14, at 585 (observing that the majority of lower courts have “seemed to take *University of Pennsylvania* as a broad mandate to reject the self-critical analysis privilege” in the employment context).

⁷⁶ *Dowling v. Am. Haw. Cruises, Inc.*, 971 F.2d 423 (9th Cir. 1992).

⁷⁷ *Id.* at 426 (citations omitted) (quoting *The Privilege of Self-Critical Analysis*, *supra* note 44, at 1086).

⁷⁸ The Jones Act, also known as the Merchant Marine Act of 1920, empowers injured seamen with a tort remedy. 46 U.S.C. § 30104 (2011) (“A seaman injured in the course of employment . . . may elect to bring a civil action at law . . .”).

⁷⁹ *Dowling*, 971 F.2d at 426. Remanding the case, the court did not explicitly rule on whether opinions and conclusions would still be protected. *Id.* at 427.

⁸⁰ See GREENWALD ET AL., *supra* note 21, § 1:119.

the best efforts of the defendants' bar and corporate counsel,⁸¹ the dream of a broad and impenetrable general privilege, as articulated in the Harvard Note, has not been realized.

II. SELF-CRITICAL ANALYSIS IN NEW JERSEY

Because the Patient Safety Act referred by name to self-critical analysis, and because the statute itself explicitly incorporated the holding of *Christy v. Salem*,⁸² an important self-critical analysis case which itself was the culmination of two decades of common law development, it is crucial to understand the status of the doctrine in New Jersey prior to passage of the PSA. New Jersey courts, much like the federal courts, have approached the privilege with caution, recognizing it only in limited situations.

A. *The Lead-Up to Christy*

Christy represents a synthesis of two separate streams of case law—those that confront the self-critical analysis privilege within the context of medical peer reviews, and those that deal with the privilege more generally. The most important case, *Payton v. New Jersey Turnpike Authority*,⁸³ was the latter type. *Christy* could be understood as an application of *Payton* in the medical context. To appreciate the relevance of *Christy*, a very brief

⁸¹ For example, the Federation of Defense and Corporate Counsel, a trade group “dedicated to representation of insurers and corporations,” FED’N DEF. & CORP. COUNS., <http://www.thefederation.org/> (last visited Feb. 21, 2013), recently published an article in their quarterly journal advocating for formal adoption of the privilege, Kurtis B. Reeg & Mathew A. Temper, *The Self-Critical Analysis Privilege: It Is Time for Formal Adoption*, 62 FED’N DEF. & CORP. COUNS. Q. 80 (2011).

⁸² The statute provides that “[n]othing in this act shall be construed to increase or decrease the discoverability, in accordance with *Christy* . . . of any documents, materials or information if obtained from any source or context other than those specified in this act.” N.J. STAT. ANN. § 26:2H-12.25(k) (West 2007) (citation omitted). For much more on this, see *infra* Part III.

⁸³ *Payton v. N.J. Tpk. Auth.*, 691 A.2d 321 (N.J. 1997).

historical sketch of self-critical analysis in New Jersey is in order.

The first case to grapple with the privilege was *Wylie v. Mills*,⁸⁴ a lawsuit arising out of an automobile accident, where a defendant utility company sought protection of a document titled “[City of] Elizabeth Electric Transmission & Distribution Committee Investigation—Automobile Accident,” which purported to “determine whether [the defendant] should alter its procedures to avoid future injuries to employees.”⁸⁵ While the court summarily rejected the defendant’s contention that the document was protected under a work-product or attorney-client privilege, it found defendant’s assertion of the “nascent” self-critical analysis protection to be a “more formidable and persuasive argument.”⁸⁶ Citing *Bredice*, the court determined that “confidentiality and the ‘public need for confidentiality’ are the *sine qua non* of effective internal self-critical analysis”⁸⁷ and protected the evaluative portions of the report while ordering disclosure of the factual portions.

One year later, in 1985, the New Jersey Supreme Court, in *McClain v. College Hospital*, expounded upon *Wylie*’s discussion of the privilege.⁸⁸ Within the context of medical peer reviews, the court ruled that the plaintiff/discoverer must show particularized need that outweighs the public interest in confidentiality of the investigative proceedings, taking into account (1) the extent to which the information may be available from other sources, (2) the degree of harm that the litigant will suffer from its unavailability, and (3) the possible prejudice to the agency’s investigation.⁸⁹

⁸⁴ *Wylie v. Mills*, 478 A.2d 1273 (N.J. Super. Ct. Law Div. 1984). A Westlaw search reveals this to be the first New Jersey case in which a court either used the phrase “self-critical analysis” or cited *Bredice*.

⁸⁵ *Id.* at 1275.

⁸⁶ *Id.* at 1276.

⁸⁷ *Id.* at 1277.

⁸⁸ *McClain v. Coll. Hosp.*, 492 A.2d 991, 997–98 (N.J. 1985).

⁸⁹ *Id.* at 993.

Guided by the United States Supreme Court's decision in *EPA v. Mink*,⁹⁰ which held that factual material could be "severed" and thus disclosed from otherwise privileged documents, the court remanded the case and ordered an in camera inspection of the documents, holding that "strictly factual" contents be disclosed but that "matters of opinion or conjecture" be entitled to a "higher degree of protection."⁹¹

In *Bundy v. Sinopoli*,⁹² the court noted that the legislature created a privilege for a hospital's "utilization review committee" reports⁹³ and also provided broad immunity for participants' statements made during the peer review process⁹⁴ yet also observed that "[t]he Legislature has *not* . . . provided for a privilege regarding the information contained within the Peer Review process."⁹⁵ The court nonetheless held the evaluations therein were "absolutely protected" under the "common law" self-critical analysis doctrine enunciated under *Wylie* and *McClain*.⁹⁶

Finally, the New Jersey Supreme Court in *Payton* scaled back *Wylie*'s and *Bundy*'s broad interpretation of the privilege. *Payton*, in the course of her sexual harassment suit, sought to discover the minutes of the "executive session" her employer convened in response to allegations of harassment.⁹⁷ The court was confronted with two competing public interests, both of which further the same goal of limiting incidents of sexual harassment: "disclosure to ensure that employers maintain effective sexual-harassment procedures and nondisclosure to

⁹⁰ *EPA v. Mink*, 410 U.S. 73 (1973).

⁹¹ *McClain*, 492 A.2d at 1000.

⁹² *Bundy v. Sinopoli*, 580 A.2d 1101 (N.J. Super. Ct. Law Div. 1990).

⁹³ These documents, resulting from peer review, are created as a condition of receiving federal funding under the Social Security Act. *See id.* at 1104. The privilege is embodied in N.J. STAT. ANN. § 2A:84A-22.8 (West 2011).

⁹⁴ *Bundy*, 580 A.2d at 1106. This immunity protects participants from defamation claims. *See, e.g.,* *Bainhauer v. Manoukian*, 520 A.2d 1154 (N.J. Super. Ct. App. Div. 1987).

⁹⁵ *Bundy*, 580 A.2d at 1105.

⁹⁶ *Id.* at 1106.

⁹⁷ *Payton v. N.J. Tpk. Auth.*, 691 A.2d 321, 325 (N.J. 1997).

enable employers to maintain effective procedures that encourage reporting and candid statements by all involved.”⁹⁸ The court concluded that self-critical analysis was “not qualitatively different from other confidential information, and thus [did] not require the protection of a broad privilege.”⁹⁹ *Payton* therefore clarified that self-critical analysis was, at most, an occasional bulwark against discovery.¹⁰⁰

B. *Christy v. Salem*

On February 17, 2004, the Appellate Division decided *Christy v. Salem*.¹⁰¹ In *Christy*, the plaintiff, in his medical malpractice action, sought the defendant hospital’s peer review report after learning that an x-ray material to his claims went missing and following the depositions of several physicians which “resulted in [alleged] discrepancies . . . concerning [how] events unfolded at the hospital.”¹⁰² The court noted that the “conditional” privilege established in *Payton* empowered trial courts to protect confidentiality “short of suppression” through techniques such as “redaction, issuance of confidentiality or gag orders, and sealing of portions of the record.”¹⁰³ The court recognized that “here, unlike *Payton* [which implicated the ‘public interest’ of preventing sexual harassment], we are required to balance the private interest of a patient against the public interest of a hospital”¹⁰⁴ and concluded that “plaintiff’s interest in disclosure does not the have the ‘strong . . . reflection of important public policies, to outweigh . . .

⁹⁸ *Id.* at 329.

⁹⁹ *Id.* at 331.

¹⁰⁰ *Id.*

¹⁰¹ *Christy v. Salem*, 841 A.2d 937 (N.J. Super. Ct. App. Div. 2004). *Christy* was decided following the January 26, 2004 hearings before the New Jersey Senate Health, Human Services and Senior Citizens Committee on the proposed PSA legislation, but prior to the March 4, 2004 committee hearings in the General Assembly. See *infra* Part III.

¹⁰² *Christy*, 841 A.2d at 938.

¹⁰³ *Id.* at 940 (quoting *Payton v. N.J. Tpk. Auth.*, 691 A.2d 321, 330 (N.J. 1997)).

¹⁰⁴ *Id.*

confidentiality concerns under most, if not all, circumstances.’”¹⁰⁵ On the other hand, the court cited a section from the New Jersey statute commonly referred to as the “Patient Bill of Rights”¹⁰⁶ as support for the proposition that patients have a “right to know . . . what happened to them while in a hospital.”¹⁰⁷

Defendants and amicus curiae New Jersey Hospital Association (“NJHA”) argued that if the court allowed disclosure of factual materials, it would lead hospitals to simply exclude them in future peer review documents.¹⁰⁸ The court rejected this contention as “contrary to the reasoning in both *McClain* and *Payton*,”¹⁰⁹ questioning whether facts, which “provide the basis” for self-critical analysis, would be excluded “simply because [they are] discoverable.”¹¹⁰ Defendants also argued that plaintiff in any event failed to show a “compelling need” for the reports, to which the court responded that “[t]he availability of relevant facts from multiple sources has never in and of itself prevented discovery It is not unusual to find subtle differences in both testimony and documented facts, which support an argument bearing on credibility.”¹¹¹ The court therefore held that the plaintiff need not make a showing of compelling need to access the factual material of the documents and ordered their disclosure. The court even ordered disclosure of a so-called “deliberative” portion concerning the inability of the committee to reach a resolution on an issue due to “missing information” because the court believed it could reasonably lead to discovery.¹¹²

¹⁰⁵ *Id.* (alteration in original) (quoting *Payton*, 691 A.2d at 333).

¹⁰⁶ See N.J. STAT. ANN. § 26:2H-12.8(c) (West 2007) (empowering a patient with the right “[t]o obtain from the physician complete, current information concerning his diagnosis, treatment, and prognosis in terms he can reasonably be expected to understand”).

¹⁰⁷ *Christy*, 841 A.2d at 940.

¹⁰⁸ *Id.* at 939.

¹⁰⁹ *Id.* at 941.

¹¹⁰ *Id.* at 942.

¹¹¹ *Id.* at 941–42.

¹¹² *Id.* “We are convinced that [defendants] would not be prejudiced by disclosure, notwithstanding its deliberative nature, because the peer review

Nonetheless, the court refused to allow discovery of the committee's opinions and fact-findings. First, the court felt that the plaintiff did not demonstrate a compelling need for disclosure because he already "obtained and supplied opinions from three separate experts supporting his claim of medical malpractice."¹¹³ Second, the court noted that justifications for disclosure were based on allegations of the factual discrepancies, and having inspected the documents in camera, the court was "convinced" that by allowing disclosure of the other material, "[the] plaintiff's compelling needs [had] been addressed."¹¹⁴ The court further ruled that the committee's factual findings were "of no use to plaintiff, as such findings are within the sole province of the jury" and that "disclosure might discourage a peer review committee from making factual findings because such findings often include a determination of what is credible."¹¹⁵

Because the PSA explicitly referenced (without comment) the holding in *Christy*, it is worth asking: what *was* the holding? On a basic level, it reaffirmed two basic and interrelated principles of self-critical analysis: first, that facts are generally discoverable; and second, that privileged material can nonetheless be discovered upon a showing of "substantial" or "compelling" need. In short, the privilege is qualified.¹¹⁶ Nonetheless, it is possible that *Christy* did *not* have any discernible holding but was instead a series of fact-sensitive rulings—a good faith attempt to balance the competing interests and equities of rival discovery claims. The *Christy* court happened to conclude that the plaintiff demonstrated a compelling need to discover factual materials. One cannot be sure that the *Christy* court would reach the same conclusion in only slightly different circumstances. For example, the plaintiff in *Christy* was denied discovery of the evaluative materials

committee has itself been unable to resolve the issue due to the missing information, the possible whereabouts of which is described in the subject sentence." *Id.* at 942.

¹¹³ *Id.*

¹¹⁴ *Id.*

¹¹⁵ *Id.* at 942–43.

¹¹⁶ The references to *Christy* during the Senate hearings seem to subscribe to this reading. *See infra* Part III.

because the court was “convinced” that his compelling needs were addressed through disclosure of the factual documents. How would the court rule if, next time, it was “convinced” that the *evaluations*, and *not* the factual material, were more likely to meet a plaintiff’s needs? *Christy* should have even less precedential value considering that the documents at issue were confidential, inspected in camera, and without description in the decision. One must therefore consider the possibility that *Christy* was simply an application of existing self-critical analysis doctrine, specifically the *McClain* and *Payton* rules. Perhaps the court never intended to make new law.¹¹⁷

III. THE PATIENT SAFETY ACT

A. *The Patient Safety Movement*

The PSA is New Jersey’s response to the relatively recent healthcare discipline known as “patient safety,” which examines the institutional problems in complex healthcare systems that cause medical errors.¹¹⁸ The discipline stresses that the vigilant

¹¹⁷ Judge Raymond A. Reddin, the trial Judge in *Applegrad ex rel. C.A. v. Bentolilia*, see *infra* Part IV, raised a related point during oral arguments:

Cases are not firmly rooted in cement. They change. They are modified So, what happens to this Patient Safety Act if the Supreme Court either expands *Christy*, reduces the scope of *Christy*, overrules *Christy*? Does not the legislature then have to say, we read what the Supreme court did in this decision and notwithstanding that, okay, forget what we said about *Christy*, now we say the holding in whatever this new case is doesn’t change anything? [D]id not the legislature posit the Patient Safety Act on something that isn’t strong footed? I mean, did they anchor the boat to something that may not be there tomorrow?

Stenographic Transcript of Proceeding Hearings, September 7, 2011, at 14–16, *Applegrad ex rel. C.A. v. Bentolila*, No. PAS-L-908-08 (N.J. Super. Ct. Law Div. Sept. 26, 2011).

¹¹⁸ See Linda Emanuel et al., *What Exactly Is Patient Safety?*, in 1 ADVANCES IN PATIENT SAFETY: NEW DIRECTIONS AND ALTERNATIVE APPROACHES 4 (Kerm Henriksen et al. eds., 2008), available at http://www.ahrq.gov/downloads/pub/advances2/vol1/Advances-Emanuel-Berwick_110.pdf (defining patient safety both as “a discipline in the health care sector that applies safety science methods toward the goal of achieving a

patrolling, reporting, and analysis of healthcare phenomena—particularly adverse incidents (such as the event giving rise to the peer review in *Bredice*) and so-called “near misses”—will allow providers and policymakers to locate, and ultimately fix, the mechanisms that allowed for the error in the first place.¹¹⁹

The 1999 Institute of Medicine Report, *To Err is Human: Building a Safer Health System*, which alarmingly estimated that between 44,000 and 98,000 Americans died each year as a result of preventable medical errors,¹²⁰ effectively launched the Patient Safety Movement in America.¹²¹ Within months of publication, President Clinton called for the creation of nationwide error-reporting systems and mandated the introduction of patient safety programs for hospitals participating in Medicare.¹²² Federal and state agencies, hospitals, and other health providers followed suit, initiating mandatory reporting systems, improved health records systems, and other policies attempting to root out errors in medicine.¹²³ In 2005, Congress passed the Patient Safety and Quality Improvement Act of 2005 (“PSQIA”),¹²⁴ which created Patient Safety Organizations (“PSOs”) “to collect, aggregate, and analyze confidential information reported by health care providers” on a privileged and confidential basis, for analysis of

trustworthy system of health care delivery” and as “an attribute of health care systems; it minimizes the incidence and impact of, and maximizes recovery from, adverse events”).

¹¹⁹ See *id.* at 2, 5–6; see also N.J. STAT. ANN. § 26:2H-12.24(d) (West 2007 & Supp. 2012); George J. Annas, *The Patient’s Right to Safety—Improving the Quality of Care Through Litigation Against Hospitals*, 354 NEW ENG. J. MED. 2063, 2065 (2006).

¹²⁰ NAT’L RESEARCH COUNCIL, *TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 1* (2000).

¹²¹ See Bob Wachter, *The Patient Safety Movement Turns Ten*, HEALTH CARE BLOG (Dec. 2, 2009), <http://thehealthcareblog.com/blog/2009/12/02/the-patient-safety-movement-turns-ten/>.

¹²² Fred Charatan, *Clinton Acts to Reduce Medical Mistakes*, 320 BRIT. MED. J. 597, 597 (2000).

¹²³ See generally Lucian Leape & Don Berwick, *Five Years After To Err Is Human: What Have We Learned?*, 293 JAMA 2384 (2005).

¹²⁴ The Patient Safety and Quality Improvement Act of 2005, Pub. L. 109-41, 119 Stat. 424 (codified in scattered sections of 42 U.S.C.).

patient safety events.¹²⁵ New Jersey sought to create a similar patient safety regime.

B. The New Jersey Patient Safety Act

The New Jersey Patient Safety Act was, in part, a response to revelations that a New Jersey nurse named Charles Cullen had administered lethal doses of medication to over forty patients under his care over a several-year period at roughly a dozen different facilities.¹²⁶ The PSA's drafters believed that a more robust centralized reporting system could have sooner uncovered Mr. Cullen's crimes.¹²⁷

The portion of the Act entitled "Findings, declarations relative to patient safety" accurately summed up some basic tenets of the patient safety movement.¹²⁸ Readers should take

¹²⁵ *The Patient Safety and Quality Improvement Act of 2005*, AGENCY FOR HEALTHCARE RESEARCH & QUALITY (June 2008), <http://www.ahrq.gov/qual/psoact.htm>. The agency specifically cites the Institute of Medicine Report as the impetus for the bill.

¹²⁶ Senator Joseph F. Vitale, Chairman of the Senate Health and Human Services and Senior Citizens Committee, remarked during committee hearings that "this [bill] is, in part, due to the recent revelations of Charles Cullen, who has professed to have killed at least 40 individuals under his care." *Testimony on the Patient Safety Act: Hearing on S.B. 557 Before the S. Comm. on Health, Human Servs. & Senior Citizens*, 211th Leg., 2004–2005 Sess., at 2 (N.J. 2004) [hereinafter *Senate Hearing*]. In 2006, Cullen pleaded guilty to twenty-nine counts of murder and six counts of attempted murder in New Jersey and Pennsylvania courts. Sophie Sohn & Allan Chernoff, *Killer Nurse Gets 11 Life Sentences*, CNN JUSTICE (Mar. 10, 2006, 11:11 AM), http://articles.cnn.com/2006-03-02/justice/killer.nurse_1_cullen-names-killer-nurse-john-shanagher?_s=PM:LAW.

¹²⁷ See *Senate Hearing*, *supra* note 126, at 31 (testimony of U.S. Senator Frank Lautenberg's Office) (commending the committee "for convening this important hearing to discuss recommendations to improve the integrity and safety of our health-care system in the wake of the tragic murders carried out by Charles Cullen"); *id.* at 41 (testimony of David Knowlton, Chairman, New Jersey Health Care Quality Institute) ("[I]n the Cullen case, there were people who had concerns, but they—if they're a nurse, they [first] have to report it to a supervisor. . . . [T]he new bill that you've just approved . . . would provide immunity.").

¹²⁸ N.J. STAT. ANN. § 26:2H-12.24 (West 2007 & Supp. 2012).

special note of subsection (e), as it seems to address medical malpractice litigation:

The Legislature finds and declares that:

a. Adverse events, some of which are the result of preventable errors, are inherent in all systems, and . . . the great majority of medical errors result from systems problems, not individual incompetence; . . .

e. To encourage disclosure of these events so that they can be analyzed and used for improvement, it is critical to create a non-punitive culture that focuses on improving processes rather than assigning blame. Health care facilities and professionals must be held accountable for serious preventable adverse events; however, punitive environments are not particularly effective in promoting accountability and increasing patient safety, and may be a deterrent to the exchange of information required to reduce the opportunity for errors to occur in the complex systems of care delivery. Fear of sanctions induces health care professionals and organizations to be silent about adverse events, resulting in serious under-reporting; and

f. By establishing an environment that both mandates the confidential disclosure of the most serious, preventable adverse events, and also encourages the voluntary, anonymous and confidential disclosure of less serious adverse events, as well as preventable events and near misses, the State seeks to increase the amount of information on systems failures, analyze the sources of these failures and disseminate information on effective practices for reducing systems failures and improving the safety of patients.¹²⁹

To further these legislative goals, the Act mandated healthcare facilities to report every “serious preventable adverse event” to the Department of Health and Senior Services¹³⁰ and to

¹²⁹ *Id.*

¹³⁰ *Id.* § 26:2H-12.25(c).

notify patients of such occurrences “in a timely fashion.”¹³¹ Crucially, the Act provided that:

Any documents, materials or information developed by a health care facility *as part of a process of self-critical analysis* conducted pursuant to subsection b. of this section . . . shall not be . . . subject to discovery or admissible as evidence or otherwise disclosed in any civil, criminal or administrative action or proceeding¹³²

As indicated earlier, the Appellate Division decided *Christy* while the Patient Safety bill was already in the midst of discussions at the committee level. The drafters of the PSA added subsection (k), in an attempt to clarify the new privilege it had just created: “Nothing in this act shall be construed to increase or decrease the discoverability, in accordance with *Christy v. Salem* . . . of any documents, materials or information if obtained from any source or context other than those specified in this act.”¹³³

This late addition of subsection (k) was the product of extensive negotiations with Senate and Assembly members and representatives from both NJHA and the Association of Trial Lawyers of America—New Jersey (“ATLA-NJ”) immediately prior to the Assembly hearing.¹³⁴ Evidently, and somewhat

¹³¹ *Id.* § 26:2H-12.25(d).

¹³² *Id.* § 26:2H-12.25(g) (emphasis added).

¹³³ *Id.* § 26:2H-12.25(k).

¹³⁴ Drew Britcher, in the NJAJ amicus brief in *Applegrad* noted that:

[O]n the day that the General Assembly Health Committee was to entertain the bill, the hearing of testimony regarding the bill was held until certain amendments, namely the provision concerning *Christy* . . . were presented with the assistance of the Office of Legislative Services. Indeed, the discussions concerning the inclusion of a specific case reference were so lengthy that they warranted a comment by the Assembly Health Committee Chairperson, the Honorable Loretta Weinberg that “we just completed the longest recess in the history of committee meetings.”

Brief on Behalf of New Jersey Association for Justice (NJAJ) at 3, *Applegrad ex rel. C.A. v. Bentolila*, No. PAS-L-908-08 (N.J. Super. Ct. Law Div. Sept. 26, 2011).

surprisingly, both NJHA and ATLA-NJ found *Christy*'s holding acceptable and lobbied for its inclusion in the PSA before agreeing to publicly support the legislation. All sides professed satisfaction. Elizabeth Ryan, General Counsel of NJHA, referring to the bill as “landmark legislation,” thanked the committee for “preserving” *Christy*, a case “very important to the provider community.”¹³⁵ Drew Britcher of ATLA-NJ likewise applauded *Christy*'s codification.¹³⁶

That the PSA secured the endorsement of two oft-adverse interest groups was not lost on the bill's drafters. Sitting between Ms. Ryan and Mr. Britcher, sponsor Senator Joseph Vitale proclaimed that “we're here together in accord over this bill.”¹³⁷ Clifton Lacy, Commissioner of the Department of Health and Senior Services, emphasized the need for additional protections, citing to a National Association of State Health Policy report indicating that, of the twenty-one states with legislation mandating the reporting of medical errors, New Jersey was alone in not also legislating a peer-review privilege.¹³⁸ Commissioner Lacy asserted that “the focus on finding who did wrong rather than why things go wrong is the major obstacle in improving safety across this country,”¹³⁹ and commended the bill for “shield[ing] self-critical analysis from discovery but maintain[ing as] discoverable all that is now discoverable.”¹⁴⁰ The PSA passed both houses soon thereafter, was signed into law by Governor Jim McGreevey on April 27, 2004, and went into effect on October 24 of that year.¹⁴¹

¹³⁵ *Legislative Hearing on Patient Safety Act Before the Gen. Assemb. Comm. on Health, Human Servs. & Senior Citizens*, 211th Leg., 2004–2005 Sess., at 7 (N.J. 2004) [hereinafter *Assembly Hearing*].

¹³⁶ *See id.* at 22–23 (praising the “preservation of the discoverability . . . reconfirmed recently by our courts,” which “draw[s] an important balance between the absolutely vital aspect of trying to identify medical error . . . while at the same time recognizing . . . [that] the patient does need to know what has happened to them”).

¹³⁷ *Id.* at 2.

¹³⁸ *Id.* at 19–20.

¹³⁹ *Id.* at 15.

¹⁴⁰ *Id.* at 19.

¹⁴¹ *See* Press Release, N.J. Gov. Jim McGreevey, McGreevey Signs

IV. DUELING INTERPRETATIONS, UNINTENDED MISCHIEF

A. *Applegrad ex rel. C.A. v. Bentolila*

Despite the good feelings on all sides surrounding the passage of the statute, a glaring inconsistency existed in the PSA: subsection (g) provided—without exception or ambiguity—that the materials developed as a process of self-critical analysis “shall not be subject to discovery or admissible as evidence,” while subsection (k) codified *Christy*, which provided for the disclosure of certain self-critical materials. The Appellate Division was confronted with this dilemma in *Applegrad ex rel. C.A. v. Bentolila*, where plaintiffs Esther and Gedalia Applegrad, on behalf of their infant child “C.A.,” alleged medical malpractice against Valley Hospital (“Valley”) for the brain damage and oxygen deprivation sustained by C.A. during delivery.¹⁴² During discovery, Valley withheld six documents, which it asserted were absolutely privileged.¹⁴³ The motion judge sided with Valley, ruling that the PSA was a “legislative overruling” of *Christy* and that the materials were fully protected from disclosure.¹⁴⁴

On appeal, the Appellate Division noted that “[a]lthough not specifically mentioned in *Christy*, several regulatory and professional standards existed before . . . adoption of the PSA

Landmark Law Protecting NJ’s Families (Apr. 27, 2004), http://web.archive.org/web/20041116163012/http://www.state.nj.us/cgi-bin/governor/njnewsline/view_article_archives.pl?id=1884; *Medical Errors and Patient Safety – New Jersey*, QUALITY & PATIENT SAFETY, http://qups.org/med_errors.php?c=individual_state&s=31&t=1 (last visited Feb. 24, 2013).

¹⁴² *Applegrad ex rel. C.A. v. Bentolila (Applegrad I)*, No. L-0908-08, 2011 WL 13700, at *1 (N.J. Super. Ct. App. Div. Jan. 5, 2011).

¹⁴³ *Id.* at *2. Valley identified those documents: “Occurrence Report; Director of Patient Safety Post Incident Analysis; Department of Risk Management Request for Quality Assurance Review; Mother/Baby Quality Assurance/Performance Improvement Review; Department of OB/GYN Quality Assurance Response; and Utilization Review Committee, Quality Assessment and Improvement Subcommittee of the Department of OB/GYN.” *Id.*

¹⁴⁴ *Id.* at *4. Initially, the judge ordered disclosure of two documents but changed course following an ex parte meeting with defense counsel, who for the first time asserted privilege under the PSA. *Id.*

. . . that pertain to the activities of hospitals in engaging in forms of internal self-assessments and reporting[,] some or all . . . apparently continu[ing] to this day.”¹⁴⁵ The question, therefore, was, how did the PSA alter existing law?

Valley and amicus NJHA argued that the PSA represented a “sweeping change in the law of privilege, . . . insulat[ing] from disclosure a wide range of documents and information that previously may have been subject to disclosure.”¹⁴⁶ On that view, subsection (k) simply clarified that documents *not* produced pursuant to the PSA would still be subject to a *Christy* analysis and remain partially discoverable.¹⁴⁷ Plaintiffs and amicus New Jersey Association for Justice (formerly ATLA-NJ)¹⁴⁸ argued that “*Christy*’s factual/evaluative distinction still applies to documents generated under the PSA”¹⁴⁹ and that, at any rate, the privilege should not apply because there was no proof that Valley actually reported the Applegrad event to state officials pursuant to the Act.¹⁵⁰

Nonetheless, the court eschewed answering any of these “interpretative issues” due to what it felt were “especially troublesome” “uncertainties” in the record regarding why and how these withheld documents actually came into being¹⁵¹:

¹⁴⁵ *Id.* at *7. For example, the court observed that the Legislature directed hospitals to develop “peer review quality assurance processes” but pointedly did *not* provide that such documents be privileged. Also, hospitals, in accordance with guidelines established by the Joint Commission on Accreditation of Healthcare Organizations, had already engaged in “self-critical analysis procedures” to determine the “root cause” of adverse occurrences. *Id.* at *6.

¹⁴⁶ *Id.* at *8. It is worth remembering that NJHA supported the Patient Safety bill *because of*, not in spite of, the “preservation” of *Christy*. *See supra* Part III.

¹⁴⁷ *Applegrad I*, 2011 WL 13700, at *8. NJHA specifically cited the preservation of *Christy* as grounds for supporting the PSA at the General Assembly hearing. *See supra* Part III.

¹⁴⁸ NJAJ was represented by Drew Britcher, former president of ATLA-NJ, who testified at the General Assembly hearing. *See supra* Part III.

¹⁴⁹ *Applegrad I*, 2011 WL 13700, at *8.

¹⁵⁰ *Id.*

¹⁵¹ *Id.* at *8, *9.

One of the documents . . . bears a heading of “Occurrence Report,” with no further explanatory label or statutory cross-reference. Another one . . . contains a boxed legend on its first page citing the PSA, stating that “This Quality Assurance Document was created and is protected in accordance with N.J.S.A. 26:2H-12.23 et seq.” Two of the documents . . . bear a different heading with no statutory citation: “CONFIDENTIAL RISK MANAGEMENT / QUALITY ASSURANCE DOCUMENT.” Another document . . . contains no label and is on business letterhead. Lastly, the document dated September 10, 2007 bears this heading: “CONFIDENTIAL AND PRIVILEGED Pursuant to N.J.S.A. 2A:84A[-]22.8,” the utilization review statute.¹⁵²

The court exclaimed that “mere labeling of a hospital document does not necessarily control its legal classification.”¹⁵³ The court also noted Valley’s inability to explain how self-critical “organizational structures and processes” actually changed in the wake of the PSA’s enactment.¹⁵⁴ The court therefore remanded the case, directing Valley to explain in greater detail “the internal processes within the hospital that generated each document, and how those processes relate to . . . other standards apart from the PSA.”¹⁵⁵

Finally, and most curiously, the court suggested in a footnote that the PSA’s “restriction on evidential admissibility in the courts” may have improperly limited the judiciary’s powers in violation of the New Jersey Constitution and that the Legislature “apparent[ly] fail[ed] to follow the proscribed procedures for the adoption of evidence rules under the Evidence Act of 1960.”¹⁵⁶

¹⁵² *Id.* at *9. A seemingly exasperated court exclaimed, “[W]e are unsure what to make of this hodgepodge of labels.” *Id.*

¹⁵³ *Id.*

¹⁵⁴ *Id.* For example, the record was silent on how the functions and authority of Valley’s “Patient Safety Director” (created pursuant to the PSA) corresponded to the other “related ongoing [peer-review] operations within the hospital.” *Id.*

¹⁵⁵ *Id.* at *11.

¹⁵⁶ *Id.* at *8 n.8; see N.J. CONST. art. VI, § 11, cl. 3 (providing that

However, the court declined to comment further because neither party challenged the PSA on separation of powers grounds.¹⁵⁷

B. Remand: Judge Reddin's Opinion

On remand, Valley asserted that only two out of six documents were deserving of PSA protection: a summary of a roundtable discussion convened by the hospital's Director of Patient Safety to engage in a self-critical analysis of the Applegrad occurrence ("DV2") and a document which memorialized specific activities conducted following the roundtable discussion ("DV5").¹⁵⁸ Following in camera inspection, testimony of hospital officials, and several days of oral arguments, the trial judge, the Honorable Raymond A. Reddin, delivered an oral ruling.¹⁵⁹ While recognizing "some inconsistency between *Christy* and the language of the statute,"¹⁶⁰ he nonetheless ruled that the intent of the PSA was to allow individuals to "speak freely without a fear of retribution" and therefore the self-critical analysis documents created pursuant to the Act were "entitled to a full privilege and no *Christy* analysis is warranted."¹⁶¹ Nonetheless, the judge held this absolute

"[t]he Supreme Court shall make rules governing the administration of all courts in the State and, subject to the law, the practice and procedure in all such courts"). The Evidence Act, N.J. STAT. ANN. §§ 2A:84A-33-34 (West 2011) mandates special procedures to ensure that rules of evidence be adopted only through the joint collaboration of all three branches of government. *See State v. Byrd*, 967 A.2d 285, 294-97 (N.J. 2009) (discussing the history of and rationale for the Rules of Evidence).

¹⁵⁷ *Applegrad I*, 2011 WL 13700, at *8.

¹⁵⁸ *See Applegrad ex rel. C.A. v. Bentolila (Applegrad II)*, 51 A.3d 119, 129 (N.J. Super. Ct. App. Div. 2012) ("Defendants, on reflection, modified their earlier position that all of the withheld documents were privileged under the PSA, and instead limited their claims of PSA confidentiality to exhibits DV2 and DV5."). *See* subheadings "DV2" and "DV5," *id.* at 132-33, detailing the purpose of each document.

¹⁵⁹ Stenographic Transcript of Proceedings Decision, Sept. 12, 2011, *Applegrad ex rel. C.A. v. Bentolila*, No. PAS-L-908-08 (N.J. Super. Ct. Law Div. Sept. 26, 2011) [hereinafter Sept. 12 Record].

¹⁶⁰ *Id.* at 26.

¹⁶¹ *Id.* at 31.

privilege be construed narrowly.¹⁶² As such, the judge ordered the disclosure of the names of the participants and the date of the discussion in DV2.¹⁶³ He also ruled that the statute was not unconstitutionally vague and that because “[the] Legislature showed respect to the Supreme Court” in acknowledging *Christy*, the PSA did not violate separation of powers principles.¹⁶⁴

The judge then turned to the documents in question. Having interpreted the PSA to create a full privilege, the judge was left to fashion an appropriate test for when to actually *apply* the privilege. The judge concluded that, notwithstanding Valley’s failure to report the incident, Valley had prepared DV2 in “good faith” and “substantial[ly] compli[ed]” with the PSA, and thus was entitled to the protections of the statute.¹⁶⁵ Nonetheless, the judge suggested that the eventual trial judge, as “gatekeeper,” should have a copy of the confidential documents to ensure that no eventual witness gives testimony contradicting the document because “the court can never function in a way [allowing the presentation of] improper testimony.”¹⁶⁶ The judge reasoned that this caveat was simply a matter of judicial “integrity.”¹⁶⁷ On the other hand, the judge found DV5 to be a “Risk Management” or

¹⁶² *Id.* at 50–51.

¹⁶³ As support, the judge cited a prior New Jersey case ordering an attorney to reveal the address of a client, attorney-client privilege notwithstanding. *See id.* at 52–53 (citing *Horon Holding Corp. v. McKenzie*, 775 A.2d 111 (N.J. Super. Ct. App. Div. 2001)). That the judge felt compelled to utilize case precedent dealing with an entirely different privilege should indicate the novelty of the legal questions presented in *Applegrad*.

¹⁶⁴ *Id.* at 39.

¹⁶⁵ *Id.* at 51. If, on the other hand, the judge detected “bad faith or fraud or concealment or a cover up [The protection] could be lost and the sanction should be beyond [the hospital] paying a fine. Paying a fine does nothing to the person who had treatment and had a concealment occur” *Id.*

¹⁶⁶ *Id.* at 61–62.

¹⁶⁷ *Id.* The judge also suggested the appointment of a “discovery master” to monitor the process and to “see if there’s any problems that are later developed.” Stenographic Transcript of Proceedings Supplemental Decision at 24, Sept. 14, 2011, *Applegrad*, No. PAS-L-908-08 [hereinafter Sept. 14 Record].

“Quality Assurance document,” developed independent of the PSA and was therefore subject to a *Christy* analysis.¹⁶⁸

Remarkably, the judge found that the PSA “has done nothing to change the pre-Patient Safety Act statutes and regulations All the Patient Safety Act does is encourage more reporting and how things are reported to create an atmosphere of trust.”¹⁶⁹ Specifically with regard to Valley, the court found no “tremendous difference in the way [it] investigated incidents before and after the [PSA].”¹⁷⁰

Both parties appealed different aspects of Judge Reddin’s ruling.¹⁷¹ Judge Reddin remarked that the “entire medical community” and the “lawyers associated with it” are “looking to see if this statute is going to be validated or invalidated [and] . . . if there really will be confidentiality.”¹⁷²

C. Appellate Decision: Discarding “Substantial Compliance” for “Exclusivity”

On August 9, 2012, in *Applegrad ex rel. C.A. v. Bentolila*, the Appellate Division held that the PSA’s “repeated emphasis on confidentiality . . . cannot be reconciled with plaintiffs’ claim

¹⁶⁸ Sept. 14 Record, *supra* note 167, at 16.

¹⁶⁹ *Id.* at 12.

¹⁷⁰ *Id.* at 6.

¹⁷¹ Plaintiffs in particular argued that the trial judge’s interpretation of the PSA would render it unconstitutional—if the PSA did indeed create an absolute self-critical analysis privilege, it thus constituted a legislative overruling of *Payton*, in which the Supreme Court declined to recognize one. The trial court therefore “should have rejected . . . that the legislature could so cavalierly and vaguely create a new privilege [I]f the Legislature did [so] . . . without consultation with the Court,” it was in violation of the Constitution and the Evidence Act. Plaintiffs/Appellants’ Merit Brief at 37–38, *Applegrad ex rel. C.A. v. Bentolila (Applegrad II)*, 51 A.3d 119 (N.J. Super. Ct. App. Div. 2012). The New Jersey Supreme Court, to date, has not ruled on whether *Christy* was correctly decided. Certification in *Applegrad* was granted on December 6, 2012, and the court will hear argument later this year. One likely issue is whether the court will be “bound” by the Appellate Division’s holding in *Christy*, now that the Legislature has enshrined it in the PSA.

¹⁷² Sept. 12 Record, *supra* note 159, at 62–63.

that the PSA's non-disclosure protections must yield to the exceptions set forth in *Christy*.¹⁷³ As for the inclusion of subsection (k), the court reasoned that

[T]he Legislature appears to have adopted a dual approach, i.e., (1) treating materials exclusively developed under the PSA as subject to the PSA's specific confidentiality terms; and (2) treating other internal materials that are not exclusively developed under the PSA pursuant to the residual common-law standards set forth in *Christy* or other law.¹⁷⁴

The court thus held that "the PSA extends absolute confidential protection to 'all documents . . .' developed exclusively . . . through the PSA process."¹⁷⁵ The court made clear the privilege existed "regardless of a plaintiff's asserted need for disclosure and regardless of whether the documents contain factual information in addition to subjective opinions."¹⁷⁶

However, the court issued a crucial caveat:

If, however, such items have been created or developed through some other "source or context," then they are obtainable under the criteria governing such alternative situations. . . . Thus, if a participant in the PSA process obtains facts or opinions from other sources or contexts, such as peer-review material from the facility's continuous quality improvement program, those facts or opinions are not transformed into inaccessible "PSA materials."

The confidentiality of a particular fact or opinion under the PSA therefore hinges upon an *exclusivity test*, requiring the court to consider whether the item was developed solely under the procedures set forth in the PSA, or whether the item had an independent genesis.¹⁷⁷

¹⁷³ *Applegrad II*, 51 A.3d at 138.

¹⁷⁴ *Id.* at 138-39.

¹⁷⁵ *Id.* at 139 (quoting N.J. STAT. ANN. §§ 26:2H-12.25(f)-(g) (West 2007 & Supp. 2012)).

¹⁷⁶ *Id.* at 123.

¹⁷⁷ *Id.* at 139 (emphasis added).

The court also made clear that “nothing in the PSA insulates the underlying facts relating to a patient mishap, *if those facts can be learned from an independent source.*”¹⁷⁸ Rather, the PSA protects the committee’s self-critical *communications*.¹⁷⁹ The court also warned that its “construction of the PSA is not an invitation to health care providers to shield information that was previously accessible under *Christy* or under other law by indiscriminately labeling such formerly accessible items as ‘PSA material’” or “to evade the limitations of [the Act] by giving job titles to hospital personnel such as ‘PSA officers’ when, in fact, they are performing functions that are not truly covered by the PSA.”¹⁸⁰ Echoing its statement a year earlier enshrining substance over form,¹⁸¹ the court focused its inquiry on “the actual functions and activities involved, rather than the nomenclature adopted.”¹⁸²

Applying these principles to the documents at hand, the Appellate Division proceeded to *reverse* Judge Reddin’s rulings, determining that DV2 should be made available to the plaintiffs.¹⁸³ The court also upheld the constitutionality of the

¹⁷⁸ *Id.* at 140 (emphasis added). “For example, if counsel for a medical malpractice plaintiff deposes employees within the hospital having personal knowledge about a patient’s care, those witnesses cannot refuse to answer factual questions because those same facts also had been made known to the hospital’s patient safety committee.” *Id.*

¹⁷⁹ *Id.* (“[W]hat the PSA guards against is the disclosure of *communications* made within the PSA process itself, including the self-critical and deliberative analyses that are undertaken by a patient safety committee.” (emphasis added)).

¹⁸⁰ *Id.* at 140–41.

¹⁸¹ See *Applegrad ex rel. C.A. v. Bentolila (Applegrad I)*, No. L-0908-08, 2011 WL 13700, at *9 (N.J. Super. Ct. App. Div. Jan. 5, 2011) (holding that the “mere labeling of a hospital document does not necessarily control its legal classification . . . just as the stamping of a document as ‘attorney-client’ or ‘work-product’ does not ensure that the privilege was appropriately invoked”).

¹⁸² *Applegrad II*, 51 A.3d at 141.

¹⁸³ *Id.* While conceding that the hospital attempted to comply with the Act “in good faith,” the court was specifically troubled by the fact that the roundtable discussion was staffed by nonphysicians and that the committee chose not to refer the matter to the Patient Safety Committee, despite the gravity of the incident implicating physician error. *Id.* at 144.

PSA (essentially answering the question it raised a year earlier), noting that “the Legislature has codified other evidentiary privileges in the past without the Judiciary’s involvement” and that “[g]iven this backdrop of constitutional and legal history, we decline to pronounce the confidentiality provisions in the PSA an invalid exercise of legislative power.”¹⁸⁴

Defendants filed a motion for leave to appeal to the New Jersey Supreme Court, arguing that the Appellate Division’s holding, which in their view imposed additional restrictions on providers, should not apply retroactively to the specific documents at issue in *Applegrad*.¹⁸⁵ Tellingly, and quite understandably, defendants did *not* appeal the Appellate Division’s overall interpretation of the statute.¹⁸⁶ The recognition of an “absolute” PSA privilege will remain the law of the land, for now.¹⁸⁷

¹⁸⁴ *Id.* at 145–46; *see also id.* at 146 (“[T]he ultimate assessment of this constitutional question is best reserved to the Supreme Court, as the final arbiter of the boundaries among our three branches of State government.”).

¹⁸⁵ *See* Brief of Defendants-Appellants in Support of Motion for Leave to Appeal at 1–2, *Applegrad ex rel. C.A. v. Bentolila*, No. A-1261-11T1 (N.J. Dec. 4, 2012).

¹⁸⁶ *See* Alicia Gallegos, *Patient Safety Law Protects Some Documents in Court Case*, AM. ASS’N MED. NEWS (Aug. 29, 2012), <http://www.ama-assn.org/amednews/2012/08/27/prsd0829.htm> (quoting *Applegrad* defense attorney stating that she was “gratified that the court upheld the privilege” and that “[i]t was wonderful to see that what hospitals, physicians and nurses had been concerned about for decades has the ability to go forward [and] improve health care”).

¹⁸⁷ In December 2012, the New Jersey Supreme Court granted defendants’ motion for leave to appeal. *Applegrad ex rel. C.A. v. Bentolila*, 2012 N.J. LEXIS 1257 (N.J. 2012). Because the issue of “retroactivity” presented to the court is a fairly narrow one, NJHA is no longer involved as amicus in the case. E-mail from Ross Lewin, Drinker Biddle & Reath, LLP, to author (Oct. 17, 2012) (on file with author).

V. CONCLUSIONS

A. An Analytical Misfit in the Family of Privileges

The drafters of the PSA should have foreseen that their self-critical analysis privilege, by its own terms, was destined to unleash trouble. As argued in Parts I and II of this Note, the self-critical analysis privilege, as applied in both the federal system and New Jersey, was always “qualified.” Hence, courts assessed self-critical analysis on a case-by-case basis. The privilege could be overcome through the showing of a litigant’s exceptional need, and even if applied in a given case, the privilege would not protect facts from disclosure. This dynamic is in stark contrast to long-established “unqualified” privileges, such as the attorney-client or spousal varieties, in which courts refuse to allow for compromise, no matter how compelling the need, correctly recognizing that allowing for equitable “exceptions” would undermine the underlying relationships the privilege was designed to protect.

This Note therefore suggests that much of the controversy surrounding self-critical analysis is rooted in its unfortunate and erroneous description as a “privilege,” when a much more accurate descriptor would be “protection.” In determining whether a piece of evidence is privileged, a court should *not* consider the hardship an opposing party may endure. A thorough balancing of the positive and negative practical outcomes of recognizing a privilege is surely a crucial undertaking, but this must occur at the initial privilege-creating stage, not during its application.¹⁸⁸ As the *Upjohn* Court succinctly stated, “an uncertain privilege, or one which purports to be certain but results in widely varying applications by the courts, is little better than no privilege at all.”¹⁸⁹

New Jersey and federal courts simply have not approached self-critical analysis doctrine with this level of deference. The “uncertainty” endemic to any qualified privilege has been one of

¹⁸⁸ See *supra* Part I. See generally *The Privilege of Self-Critical Analysis*, *supra* note 44, at 1097–99.

¹⁸⁹ *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981).

the defining characteristics of self-critical analysis. For example, the *Dowling* court declined to extend self-critical analysis protection to the defendant's safety-review documents because they "will be *invaluable to a plaintiff* attempting to prove that his injury was caused by the company's negligent failure to make safe a hazardous condition."¹⁹⁰ (One could hardly imagine a court ordering disclosure of attorney-client or confidential psychiatric material because it would be "invaluable" to an adversary's case.) Even the *Bredice* court, which applied the privilege—and which, incidentally, referred to it as "qualified"—did so because it felt plaintiff failed to show "good cause" to discover the materials.¹⁹¹ For the self-critical analyzer to confidently predict whether a hypothetical discoverer will successfully argue "good cause" in front of a randomly chosen judge or magistrate seems next to impossible.

Similarly, in New Jersey, the three-part balancing test established in *McClain* emphasized the discoverer's "particularized need" for the self-critical materials,¹⁹² while *Payton* emphasized the court's role in overseeing an "exquisite weighing process" in determining whether to shield documents.¹⁹³ For example, in *Christy*, the court refused disclosure of opinions of the committee, noting that the plaintiff had already retained experts to support his medical malpractice claim, but allowed for discovery of other portions which it believed could reasonably lead to discovery and which would not prejudice defendant. Finally, the current approach in the District of New Jersey, which borrows from both New Jersey and federal law, employs a six-part self-critical analysis test, which emphasizes equity balancing at virtually every stage.¹⁹⁴

¹⁹⁰ *Dowling v. Am. Haw. Cruises*, 971 F.2d 423, 427 (9th Cir. 1992) (emphasis added).

¹⁹¹ *Bredice v. Doctors Hosp., Inc.*, 50 F.R.D. 249, 251 (D.D.C. 1970) ("Absent evidence of extraordinary circumstances, there is no good cause shown requiring disclosure of the minutes of these meetings.").

¹⁹² *McClain v. College Hosp.*, 492 A.2d 991, 993 (N.J. 1985).

¹⁹³ *Payton v. N.J. Tpk. Auth.*, 691 A.2d 321, 331 (N.J. 1997) (quoting *Loigman v. Kimmelman*, 505 A.2d 958, 964 (N.J. 1986)) (internal quotation marks omitted).

¹⁹⁴ *See, e.g., Bracco Diagnostics, Inc. v. Amersham Health Inc.*, No. 04-

This sampling of several self-critical analysis approaches shows that courts do *not* treat it like a privilege. A true “privilege” subject to such a murky and fact-sensitive post hoc inquiry would seemingly deter the self-critical analyst from the outset.¹⁹⁵ Rather, self-critical analysis is better understood as analogous to the work-product doctrine, which offers *protections* against discovery of certain material but will not overcome a discoverer’s showing of “substantial” or “compelling” need.¹⁹⁶

In legislating that the self-critical materials would not be discoverable in “any” litigation, thus creating an unbending rule that did not have built-in “substantial need” exceptions or fact/evaluation distinctions, the drafters of the PSA rested on the unfounded premise that the self-critical analysis protection could be codified like any other privilege. As such, they morphed a flexible common law rule of discovery into an inflexible statutory mandate.¹⁹⁷

B. Reforming Tort Law Through Evidence Law

The PSA drafters also acted from the well-intentioned yet mistaken belief that their vision of a patient safety regime could be reconciled with both the liberal rules of civil discovery, in which absolute privileges are disfavored, and the traditional American tort model, in which medical errors are deterred

6025, 2006 WL 2946469, at *3 (D.N.J. Oct. 16, 2006) (“When analyzing whether the self critical analysis privilege is applicable, a court must balance (1) whether the information is the result of a self critical analysis undertaken by the party seeking protection, (2) the extent to which the information is available from other sources, (3) the degree of harm the litigant will suffer from the information’s unavailability, (4) the possible prejudice to the party asserting the privilege, (5) the public interest in preserving the free flow of the type of information sought, and (6) whether the information is of the type whose flow would be curtailed if discovery were allowed.”).

¹⁹⁵ *Upjohn Co. v. United States*, 449 U.S. 383, 393 (1981).

¹⁹⁶ *See* Flanagan, *supra* note 40, at 575.

¹⁹⁷ *See* 6 JAMES WM. MOORE ET AL., MOORE’S FEDERAL PRACTICE ¶ 26.48 (3d ed. 1999 & Supp. 2013) (“That judicial decisions have been uneven both in their willingness to recognize a privilege for self-critical analysis and in their ability to define its scope is a predictable consequence of its common law roots.”).

through fear that an injured patient, empowered with broad discovery rights, will bring suit. Patient safety, as a legal principle, is adverse to private tort litigation because the former seeks to improve overall health outcomes for patients at the expense of an individual patient's discovery rights, while the latter supports the belief that allowing a patient to discover the truth of what happened in *her* case will improve overall outcomes. As Commissioner Lacy testified in his endorsement of the PSA, "the focus on finding *who* did wrong rather than *why* things go wrong is the major obstacle in improving safety across this country."¹⁹⁸ One could dismiss the Commissioner's opinions during committee hearings as irrelevant in evaluating legislative intent.¹⁹⁹ But there is no escaping that the "Findings and Declarations" portion of the statute itself called for combating "punitive environments," which it contended "are not particularly effective in promoting accountability and increasing patient safety, and may be a deterrent to the exchange of information."²⁰⁰ The inclusion of these portions in the bill reflects the underlying policy judgments of the bill's drafters to create a *complete* self-critical analysis privilege.²⁰¹ Supporters of the bill should have anticipated the Act would frustrate a plaintiff/patient's opportunity to access relevant evidence.

To be sure, the Legislature attempted to placate various interest groups by including the reference to *Christy* in the actual statute text, implying the privilege would maintain its common law qualified status.²⁰² But as both Judge Reddin and the Appellate Division have made clear, the principles embedded in *Christy* are simply inconsistent with the overall intent of the

¹⁹⁸ See *Assembly Hearing*, *supra* note 135, at 15 (emphasis added).

¹⁹⁹ Justice Scalia put the matter rather bluntly in *Zedner v. United States*, 547 U.S. 489, 511 (Scalia, J., concurring): "[T]he use of legislative history is illegitimate and ill advised in the interpretation of any statute."

²⁰⁰ N.J. STAT. ANN. § 26:2H-12.24(e) (West 2007 & Supp. 2012).

²⁰¹ See, e.g., *Applegrad ex rel. C.A. v. Bentolila (Applegrad II)*, 51 A.3d 119, 138 (N.J. Super. Ct. App. Div. 2012) (observing that § 26:2H-12.24 expresses "clear policy objectives to provide greater incentives . . . to disclose mishaps and perceived risks to patient safety" and is thus incompatible with the "balancing criteria of *Christy*").

²⁰² See *supra* Part III.

PSA.²⁰³ A review of both the legislative history and the plain meaning of the statute indicates that applying a *Christy*-like qualified privilege to PSA materials would thwart the Act's explicit goal to afford such documents the simple yet absolute cloak of confidentiality. The only fair conclusion is that, while individual drafters or supporters of the bill may have hoped otherwise, the PSA has limited a patient/plaintiff's "private right" of discovery²⁰⁴ in its attempt to further the broader societal good of improving patient safety.

Understood another way, the Legislature has unleashed a subtle brand of tort reform.²⁰⁵ Proponents of reform argue that an aggressive tort system, which in theory purports to deter unsafe practices and conduct, can actually yield perverse incentives. In the healthcare context, providers will rationally be reluctant to engage in conduct benefitting the patient's or public's interest (such as error-reporting) if it could foreseeably expose them to liability.²⁰⁶

²⁰³ See *Applegrad II*, 51 A.3d at 146–47 (holding that PSA's "repeated emphasis on confidentiality cannot be reconciled with plaintiffs' claim that the PSA's non-disclosure protections must yield to the exceptions set forth in *Christy*"); Sept. 12 Record, *supra* note 159, at 31 (holding that PSA documents are "entitled to a full privilege and no *Christy* analysis is warranted").

²⁰⁴ See *Christy v. Salem*, 841 A.2d 937, 940 (N.J. Super. Ct. App. Div. 2004) (referring to a medical-malpractice plaintiff's right to discovery as a private interest, which, unlike those of a civil rights plaintiff, "does not have the 'strong . . . reflection of important public policies'" (alteration in original) (quoting *Payton v. N.J. Tpk. Auth.*, 691 A.2d 321, 333 (N.J. 1997))).

²⁰⁵ See BLACK'S LAW DICTIONARY (9th ed. 2009) (defining tort reform as "[a] movement to reduce the amount of tort litigation, usu. involving legislation that restricts tort remedies or that caps damages awards (esp. for punitive damages)" and noting that "[a]dvocates of tort reform argue that it lowers insurance and healthcare costs and prevents windfalls, while opponents contend that it denies plaintiffs the recovery they deserve for their injuries").

²⁰⁶ See generally David A. Hyman & Charles Silver, *The Poor State of Health Care Quality in the U.S.: Is Malpractice Liability Part of the Problem or Part of the Solution?*, 90 CORNELL L. REV. 893, 909–14 (2005) (discussing the "conventional wisdom" that "malpractice liability impedes efforts to improve patient safety"). As one nursing expert put it, "The threat

Clearly, this same argument serves not only as a rationale for traditional tort reform, but also for strong self-critical analysis protection. While the majority of tort reform has focused on limiting a defendant's exposure to damage awards, often through the institution of a noneconomic recovery cap²⁰⁷ or through the abolishment of common law joint and several liability,²⁰⁸ the PSA seeks to redress the perceived excesses of the tort system through utilizing rules of evidence. Therefore, in a typical tort reform jurisdiction, a healthcare provider (and its insurer or indemnifier) could rest assured that damages would not exceed a specified sum per accident. The PSA's self-critical analysis protection, on the other hand, does not limit liability per se. Instead, it attempts to further the goal of both the tort reform and the patient safety movements—encouraging the reporting of errors—by rendering such reports immune to discovery.

C. What Has Changed—And What Will Change—Under the PSA?

The PSA's privilege was predicated on the finding that self-critical analysis could not occur without complete confidentiality.²⁰⁹ Admittedly, the belief that providers fail to

of medical malpractice litigation is one of the most obvious barriers to the improvement of patient safety. . . . These risks also serve as disincentives to participate in improvement strategies to reduce the risk of error." *Id.* at 911 (quoting Beverly Jones, *Nurses and the "Code of Silence,"* in *MEDICAL ERROR: WHAT DO WE KNOW? WHAT DO WE DO?* 84, 91–92 (Marilynn Rosenthal & Kathleen Sutcliffe eds., 2002)).

²⁰⁷ See *Noneconomic Damages Reform*, AM. TORT REFORM ASS'N, <http://www.atra.org/issues/noneconomic-damages-reform> (last visited Feb. 24, 2013) (identifying statutory reforms enacted by state).

²⁰⁸ See, e.g., *Joint and Several Liability Rule Reform*, AM. TORT REFORM ASS'N, <http://www.atra.org/issues/joint-and-several-liability-rule-reform> (last visited Feb. 24, 2013) (identifying statutory reforms enacted by state).

²⁰⁹ See N.J. STAT. ANN. § 26.2H-12.24(2)(f) (West 2007 & Supp. 2012) (creating "confidential disclosure" processes, thus providing the State with a means to "increase the amount of information on systems failures, analyze the sources of these failures and disseminate information on effective practices for reducing systems failures"); *Applegrad ex rel. C.A. v. Bentolila*

report errors out of fear of liability, in the words of one public health scholar, “is plausible and has intuitive appeal.”²¹⁰ Still, there is reason to be skeptical. One 2005 study found an absence of “any rigorous evidence show[ing] that fear of malpractice lawsuits discourages error reporting” and that “contrary to the conventional wisdom, malpractice liability itself has the potential to kick-start quality improvement.”²¹¹ For example, rocketing malpractice premiums in the 1980s (due to anesthesia-related deaths) impelled the American Society of Anesthesiologists to launch an aggressive “patient safety campaign” to study incidents of medical errors in the field.²¹² “By the early 1980s, anesthesiologists recognized that something drastic had to be done if they were going to continue to be insured,” recalled the leader of this movement.²¹³ The campaign, while costly, proved remarkably successful and has caused an astonishing ten-to-twenty-fold decrease in deaths over the past few decades.²¹⁴

Further, failure to report errors may simply be a deeply rooted cultural phenomenon rather than an economically rational response to fears of liability. For example, one health scholar cited to a survey showing that seventy-five percent of U.S. doctors failed to report errors to their patients, which was not markedly different from a showing of sixty-one percent in New Zealand, “a country that has had no-fault malpractice insurance for more than three decades.”²¹⁵

(*Applegrad II*), 51 A.3d 119, 124 (N.J. Super. Ct. App. Div. 2012) (observing that “the Legislature was manifestly concerned” about the underreporting and analysis of adverse incidents in New Jersey resulting from the “inhibition” of medical staff from “reporting or criticizing unsafe practices within the institution”); *id.* at 127 (observing that “the PSA’s umbrella of confidentiality” was designed, among other reasons, “to foster internal self-critical analysis”).

²¹⁰ Annas, *supra* note 119, at 2065.

²¹¹ Hyman & Silver, *supra* note 206, at 894.

²¹² *Id.* at 919.

²¹³ *Id.* at 920 (quoting Ellison C. Pierce, Jr., *ASA Monitoring Guidelines: Their Origin and Development*, 66 AM. SOC’Y ANESTHESIOLOGISTS NEWSL., Sept. 2002, at 22, 22, available at http://www.asahq.org/Newsletters/2002/9_02/feature7.htm).

²¹⁴ *Id.* at 918.

²¹⁵ See Annas, *supra* note 119, at 2065.

Some scholars also question whether privileges actually enhance the frequency and quality of patient safety procedures. For example, Susan Scheutzow, a health law practitioner and academic, through analyzing the National Practitioner Data Bank, found that peer-review protections, contrary to perceived wisdom, do not promote the public policy of encouraging peer review and thus “risk being little more than special interest laws protecting physicians and hospitals.”²¹⁶ Scheutzow therefore argued for the elimination—or at the very least, reformation—of such laws.²¹⁷

In light of these general claims, one must ask what the PSA has accomplished thus far. From a large-scale public policy perspective, it is too early to tell. Nonetheless, the *Applegrad* litigation has brought to light at least one useful case study—the patient safety apparatus of Valley Hospital.

This much is clear: the Appellate Division recognized that many regulatory and professional standards already existed prior to passage of the PSA, many of which called for peer review and self-evaluation procedures quite similar to those required by the PSA.²¹⁸ On remand, and following days of oral arguments and document inspection, Judge Reddin concluded that he could discern “no tremendous difference” between Valley’s procedures prior to and following the PSA. As the judge noted, this reality does not in itself raise any presumptions of wrongdoing; to the contrary, it might even show that Valley was ahead of the curve in patient safety. Yet perhaps even more remarkably, the judge further found that the PSA “has done nothing” to change pre-PSA regulations and that “all the Patient Safety Act does is encourage more reporting . . . to create an atmosphere of trust.”²¹⁹

One must therefore consider the irony that the PSA may ultimately result in a raw deal for patients—as a result of a codified and absolute self-critical analysis privilege, they may

²¹⁶ Scheutzow, *supra* note 5, at 8–9.

²¹⁷ *Id.* at 8.

²¹⁸ See *Applegrad ex rel. C.A. v. Bentolila (Applegrad I)*, No. L-0908-08, 2011 WL 13700, at *5 (N.J. Super. Ct. App. Div. Jan. 5, 2011); see also *supra* Part IV.

²¹⁹ Sept. 14 Record, *supra* note 167, at 12.

discover less as litigants. At the same time, as hospitals continue to engage in procedures virtually identical to those prior to the PSA, they will get little added safety in return.

Providers, on the other hand, may have much to gain. Initially, Valley asserted that all six of the suppressed materials were privileged under the PSA.²²⁰ Following the Law Division's ruling that "the mere labeling of a hospital document does not necessarily control its legal classification," Valley changed course and instead argued that only *two* documents were "PSA" materials deserving of a full privilege, conceding that the rest could be subject to a *Christy* analysis.²²¹ This author wonders whether other providers have taken note of *Applegrad* and have, as a result, attempted to reconfigure their existing peer review and adverse occurrence procedures in order to be afforded the maximum level of protection. Thus, a hospital would prudently comply with any requisite PSA formalities—however minor and inconsequential they may be to actual patient safety—simply in order to demonstrate that it has complied with the statute. Procedures that could have been introduced for a variety of reasons could overnight become "patient safety" procedures.²²²

If a change like this occurs, it could alter the dynamics of medical malpractice litigation. In such cases, one side—the defendant—will inevitably possess the vast majority of evidence, both inculpatory and exculpatory.²²³ Plaintiffs therefore rely on a

²²⁰ *Applegrad I*, 2011 WL 13700, at *2.

²²¹ This salient fact was not lost on the Appellate Division the second time around. *See Applegrad ex rel. C.A. v. Bentolila (Applegrad II)*, 51 A.3d 119, 143 (N.J. Super. Ct. App. Div. 2012) ("The Hospital exhibited its confusion about the PSA in this very litigation by first asserting other privileges and not invoking the PSA; then arguing, after the trial court's initial in camera review, that all of the withheld documents were protected by the PSA; and ultimately arguing on remand that only DV2 and DV5 are covered by the PSA.").

²²² Alternatively, the Appellate Division's "exclusivity test" could result in an unintended irony: hospitals which (laudably) enacted comprehensive patient safety procedures *prior* to enactment of the PSA will now be punished for their foresight because their initially voluntary practices, now mandated by the PSA, are not "exclusively" a PSA product and are thus not entitled to the statutory privilege.

²²³ *See, e.g., Christy v. Salem*, 841 A.2d 937, 940 (N.J. Super. Ct.

liberal discovery system to ensure the disclosure of every possibly relevant document and the deposition of every possible witness. As the *Christy* court made clear, a plaintiff has good cause to discover nearly all hospital documentation concerning an adverse event, even if the facts are available from alternate sources, because of the possibility of uncovering “subtle differences in both testimony and documented facts, which support an argument bearing on credibility.”²²⁴ Therefore, a plaintiff’s incentives could change if certain hospital documents become increasingly less available. Under an “absolute” PSA regime, an incident at a hospital that prompts many peer review and patient safety sessions will not necessarily imply that there will be an opportunity for broad discovery of these documents.²²⁵ As a result, plaintiffs’ attorneys may be more reluctant to take on cases where negligence (or, for that matter, outright fraud or cover-up) must be argued circumstantially: for example, through showing inconsistencies in deposition testimony and patient safety documents.

There is, of course, a counterargument. While the plaintiffs’ bar may feel that the patient safety movement is simply tort reform in disguise,²²⁶ a regime emphasizing the importance of

App. Div. 2004) (observing that critical evidence regarding claims of medical malpractice “would logically be expected to be in the possession of an adversary”).

²²⁴ *Id.* at 941–42.

²²⁵ One plaintiff’s attorney, in commenting on *Applegrad*, opined that: [T]rying to get discovery from some hospitals is like trying to find the proverbial needle in a haystack. Except you are first told that: (a) there is no haystack; (b) if there ever was a haystack, it did not have any needles; and finally (c) if there was a haystack with a needle, any discussion of it is privileged. If you persist, you are then advised that (d) all haystacks and needles were designed, manufactured, distributed, maintained and utilized by persons who were independent contractors and, furthermore, (e) the hospital is entitled to a limitation of liability.

Abbot S. Brown, *Hospital Malpractice: Finding the Needle in the Haystack*, N.J.L.J., May 30, 2011, at 1.

²²⁶ See generally Peter P. Budetti, *Tort Reform and the Patient Safety Movement: Seeking Common Ground*, 293 JAMA 2660, 2618 (2005) (drawing parallels between the results of tort reform and the patient safety movement).

patient safety may in fact be more willing to entertain novel claims of relief for plaintiffs. The health law and bioethics scholar George Annas, in *The Patient's Right to Safety—Improving the Quality of Care Through Litigation Against Hospitals*,²²⁷ argues that:

[J]udicial recognition of an explicit “right to safety” for hospital patients, with a correlative duty of hospitals to implement patient-safety measures, can become the primary motivator for the development of systems to improve patient safety. Hospitals that do not take specific actions to improve safety should be viewed as negligent and be subject to malpractice lawsuits when a violation of the right to safety results in injury.²²⁸

Annas suggests that physicians, patients, and the plaintiffs’ bar join forces to propose initiatives to “pressure hospitals to change their operating systems” to ensure patient safety.²²⁹ Annas’s argument is important because it reaffirms an obvious principle of tort law that the PSA minimized: a robust tort system that constantly patrols for incidents of fault, a system that (to use the disapproving language of the PSA) cultivates a “punitive culture” focusing on “assigning blame,”²³⁰ can actually *promote*, not hinder, the development and implementation of innovative safety procedures. Plaintiffs’ lawyers may therefore experiment with new patient-safety-oriented claims for relief in cases where more traditional negligence theories may be difficult to prove.

Finally, how will the PSA affect judges? If the statute’s absolute privilege is upheld, judges will be deprived of the opportunity to engage in the fact-sensitive and context-oriented balancing that previously existed under the common law. Instead, and as occurred in *Applegrad*, a court’s “exquisite weighing process” will give way to the more rigid, yet still complex, task of determining whether the defendant hospital has in “good faith” “substantially complied” with the Act; or,

²²⁷ Annas, *supra* note 119.

²²⁸ *Id.* at 2063.

²²⁹ *Id.* at 2066.

²³⁰ See N.J. STAT. ANN. § 26.2H-12.24(e) (West 2007 & Supp. 2012).

according to the Appellate Division's test, whether the alleged privileged material was created "exclusively" for PSA functions.²³¹ Decades of self-critical analysis jurisprudence and case law will now be of little use to judges confronted with assertions of a PSA privilege.

On the other hand, perhaps not much will change after all. Judges, now tasked with determining the contours of the statute, may develop their own "exquisite weighing process" in evaluating whether to apply the privilege. First, as the litigation in *Applegrad* made clear, merely *distinguishing* between PSA documents and related patient-safety/peer-review materials was itself a controversial and fact-sensitive inquiry.²³² Second, the Appellate Division imposed several requirements on providers, such as the "exclusivity" test, or the requirement that "competent" personnel of "various disciplines" administer the reviews.²³³ A court will find it difficult to determine whether a hospital complied with these requirements, and if the facts of *Applegrad* are any indicator, it will require days of testimony (and cross-examination) of hospital staff.²³⁴ How can hospitals be sure that *their* patient safety documents will be deemed absolutely privileged in the future, and if they cannot be sure, will that reality, in and of itself, frustrate the PSA's primary goal of encouraging frank discussions and full disclosure? As one commentator predicts, "Due to the highly fact specific analysis undertaken by the Court in [*Applegrad*] and apparently to be applied by the courts considering the application of this privilege, uncertainty will remain as to the ultimate outcome in any given scenario."²³⁵ Yet, as this Note has described,

²³¹ See *Applegrad ex rel. C.A. v. Bentolila (Applegrad II)*, 51 A.3d 119, 139 (N.J. Super. Ct. App. Div. 2012) ("[W]hether the item had an independent genesis [aside from the PSA] . . . at times . . . may be obvious. At other times, it might not, and would require closer scrutiny of how each particular fact or opinion was created.").

²³² See *id.* at 128.

²³³ *Id.* at 141–42.

²³⁴ *Id.* at 129 ("On remand, the trial court heard testimony over seven days from persons at the Hospital who were involved in the development of the allegedly privileged records.").

²³⁵ Sharlene Hunt, *Court Addresses Confidentiality Under the Patient*

“uncertainty” has always been the predominant dynamic of self-critical analysis. Perhaps the ambiguous patient safety dynamics that existed under the common law will continue under this new PSA regime, simply under a new name. The Appellate Division made the unassailable point that a hospital’s “mere labeling” of a document as “privileged” counts for very little.²³⁶ So too, the Appellate Division’s recognition of the PSA privilege as being “absolute” will be of little significance to providers and plaintiffs in light of the significant caveats the court imposed.

D. Potential for Future Patient Safety: Rule 407

This Note concludes by offering an alternative model for analyzing self-critical patient safety documents. The fact/opinion distinction which governed the majority of critical analysis jurisprudence but was discarded under the PSA represents a doctrinal and practical compromise for litigants: the discoverer will be entitled to crucial pieces of evidence, while his adversary can still maintain a degree of confidence that he will not be penalized for his investigation. This distinction also recognizes a more basic reality of trial practice: sometimes opinions can be more damaging than facts.²³⁷ This Note therefore suggests that the rationale for the self-critical analysis privilege may be better served through a different evidentiary paradigm, one recognized in virtually every state, as well as under the Federal Rules of Evidence: the Subsequent Remedial Measures doctrine.²³⁸

Safety Act, N.J. HEALTHCARE BLOG (Aug. 14, 2012), <http://www.njhealthcareblog.com/2012/08/court-addresses-confidentiality-under-the-patient-safety-act/>.

²³⁶ *Applegrad II*, 51 A.3d at 141 (“What matters for judicial review is the actual functions and activities involved, rather than the nomenclature adopted by the health care facility.”).

²³⁷ Flanagan, *supra* note 40, at 576 (“[T]he use of the conclusions of such reviews in litigation renders the peer reviewers involuntary experts for one of the parties.”); *see also* Bredice v. Doctors Hosp., Inc., 50 F.R.D. 249, 250 (D.D.C. 1970) (“[C]onstructive professional criticism cannot occur in an atmosphere of apprehension that one doctor’s suggestion will be used as a denunciation of a colleague’s conduct in a malpractice suit.”).

²³⁸ FED. R. EVID. 407 (“Subsequent Remedial Measures”) provides:

When measures are taken that would have made an earlier injury or

The New Jersey version of this rule provides that “[e]vidence of remedial measures taken after an event is not admissible to prove that the event was caused by negligence or culpable conduct.”²³⁹ The rationale for this rule “rests on a social policy of encouraging people to take, or at least not discouraging them from taking, steps in furtherance of added safety.”²⁴⁰ Courts and commentators have recognized the parallels between the self-critical analysis privilege and the subsequent remedial measures doctrine.²⁴¹ For example, one court recognized that both rules protect parties from the

Hobson’s choice of aggressively investigating accidents . . . , ascertaining the causes and results, and correcting the violations or dangerous conditions, but thereby creating a self-incriminating record that may be evidence of liability, or deliberately avoiding making a record on the subject (and possibly leaving the public exposed to danger) in order to lessen the risk of civil liability.²⁴²

harm less likely to occur, evidence of the subsequent measures is not admissible to prove: negligence; culpable conduct; a defect in a product or its design; or a need for a warning or instruction. But the court may admit this evidence for another purpose, such as impeachment or—if disputed—proving ownership, control, or the feasibility of precautionary measures.

²³⁹ N.J. R. EVID. 407.

²⁴⁰ FED. R. EVID. 407 advisory committee’s note. As Baron Bramwell described it over a century ago, this rule rejects the idea that “because the world gets wiser as it gets older, therefore it was foolish before.” *Hart v. Lancashire & Yorkshire Ry.*, 21 L. Times Rep. (n.s.) 261, 263 (Eng. 1869).

²⁴¹ See, e.g., *Making Sense of Rules of Privilege*, *supra* note 46, at 1351–55 (advocating that federal courts evaluate self-critical analysis claims utilizing the “activity-privilege” inquiry of Rule 407 rather than the broader “relational” privilege rules under Rule 501); see also *Reid v. Lockheed Martin Aeronautics Co.*, 199 F.R.D. 379, 384 n.2 (N.D. Ga. 2001); *Capallupo v. FMC Corp.*, 46 Fair Empl. Prac. Cas. (BNA) 1193 (D. Minn. 1988) (noting that a defendant’s claim of self-critical analysis “is perhaps most closely related to the philosophy of Rule 407 of the Federal Rules of Evidence”).

²⁴² *Reichhold Chems., Inc. v. Textron, Inc.*, 157 F.R.D. 522, 524 (N.D. Fla. 1994).

Even in the oft-cited *Dowling* case, the court recognized that “the difference between pre-accident safety reviews and post-accident investigations is an important one.”²⁴³

To be clear, Rule 407 governs questions of admissibility—it is *not* a privilege—and therefore evidence of subsequent remedial measures is still discoverable.²⁴⁴ Consequently, the preparer or creator of documents attesting to subsequent remedies should not have any reasonable expectation that the documents will remain confidential. Still, allowing for the discovery, but not the admissibility, of patient safety and peer review documents is worth consideration, particularly in New Jersey. First, the state’s Patient Bill of Rights empowers patients with a “right to know” about the treatment they received.²⁴⁵ But on an even more basic level—and as the *Christy* court put it—“the search for truth is paramount in the litigation process.”²⁴⁶ A patient safety protection structured around Rule 407, rather than an absolute privilege, could strike the right balance between an injured patient’s right to *information* and the hospital’s confidence that its own safety procedures will not expose them to *liability*.

The PSA deviated from this “right to know” principle. While it mandated facilities to inform patients of any adverse events, it simultaneously shielded important documents concerning these events. Proponents would argue that this rule is vital: in certain circumstances, overall improvements in patient safety rely upon the knowledge that certain materials will remain inaccessible to an individual patient. The argument is sensible,

²⁴³ *Dowling v. Am. Haw. Cruises*, 971 F.2d 423, 427 (9th Cir. 1992).

²⁴⁴ See 23 CHARLES A. WRIGHT & KENNETH W. GRAHAM, JR., FEDERAL PRACTICE AND PROCEDURE § 5291 (2012) (“Rule 407 is a rule of admissibility, not a privilege; hence, subsequent remedial measures are discoverable.”); see also Donald P. Vandegrift, Jr., *The Privilege of Self-Critical Analysis: A Survey of the Law*, 60 ALB. L. REV. 171, 189 (“Rule 407 is not a privilege rule.”).

²⁴⁵ See N.J. STAT. ANN. § 26:2H-12.8(c) (West 2007). The interplay between this statute and the PSA, in this author’s opinion, is ripe for litigation and worth further judicial exploration.

²⁴⁶ *Christy v. Salem*, 841 A.2d 937, 942 (N.J. Super. Ct. App. Div. 2004).

but, in this author's opinion, contrary to goals of patient safety. If patients have a right to know every detail of their treatment, shouldn't they also have a right to know what occurred *following* their treatment?

Consider the case of Esther and Gedalia Applegrad, who, aside from their "search for truth" as litigants simply seek answers as a mother and father as to why their child's delivery could have gone so horribly wrong.²⁴⁷ Did the hospital evaluate the incident, and if so, how rigorously? Did it determine how the incident occurred? Was a particular medical staff member to blame for the incident, and if so, was the person sanctioned? Was he or she involved in prior adverse incidents? Did the staff member apologize or concede fault? And most importantly, what procedures has the facility instituted or considered instituting to ensure that similar errors do not occur in the future? Clearly, such evidence should be inadmissible at trial. Still, an injured patient deserves to have these questions answered—at least as a way to provide a measure of emotional closure and mental clarity. Rule 407, which would deem patient safety documents discoverable, yet inadmissible, seems to strike a fair and reasonable balance.

To conclude, it is worth returning to one of the Harvard Note's final thoughts:

A court applying the privilege of self-critical analysis should also remember that syllogistic application embodies the policy choice of the institution that decided to adopt the privilege. In adopting the privilege, a determination was made that the public interest weighed in favor of confidentiality. Whether this decision was made by a higher court, the same court at an earlier time, or a legislature, *judges should give due weight to*

²⁴⁷ See Mary Pat Gallagher, *Patient Safety Act Privilege Held Permeable in Malpractice Suit*, N.J.L.J., Aug. 13, 2012, at 4 ("The Applegrads' lawyer, Cynthia Walters . . . says there was almost no contemporaneous record of what happened during the crucial 20-minute delay in resuscitating the baby or what happened with the intubation.").

*the binding effect of a prior determination that the privilege furthers the public interest.*²⁴⁸

The New Jersey Legislature, in passing the PSA, made clear its binding public policy determination that materials of self-critical analysis remain confidential. Courts will do their best to elucidate this mandate. Whether the PSA's "syllogistic application" of the privilege will actually promote the principal goal of the Act—to improve overall patient safety—remains to be seen.

²⁴⁸ *The Privilege of Self-Critical Analysis*, *supra* note 44, at 1099 (emphasis added).