

HCQIA DOES NOT PROVIDE ADEQUATE DUE PROCESS PROTECTION, IMPROVE HEALTHCARE QUALITY AND IS OUTDATED UNDER “OBAMA CARE”

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I. INTRODUCTION

Dr. Thomas Wieters, was a surgeon practicing at Roper Hospital, South Carolina, for more than ten years.¹ A decorated Vietnam veteran, he had strong convictions about putting patient care and safety first.² When the once reputable and storied hospital changed administrations, he noticed the quality of patient care declining, such as medication errors and poor patient monitoring, sometimes with catastrophic consequences.³ Wieters wrote complaints to the administration and requested incident reports be placed in patient charts. Displeased, the hospital's

¹ Steve Twedt, *The Cost of Courage: When Right Can be Wrong*, PITTSBURGH POST-GAZETTE, Oct. 27, 2003, <http://www.post-gazette.com/stories/news/us/the-cost-of-courage-when-right-can-be-wrong-520672/>

² *Id.*

³ *Id.*

administration labeled him disruptive and ordered a peer review investigation on him.⁴ Wieters was summarily suspended without a hearing, in spite of the department of surgery committee finding that his behavior was explainable and that there were no quality issues in his patient care.⁵ Many colleagues and nurses on staff signed petitions calling for his reinstatement, but to no avail.⁶ His suspension was reported to the National Physician's Data Bank ("NPDB") which has made it impossible for him to work at any major hospital, either locally or in another state.⁷ In his resulting lawsuit, the United States District Court ruled against him, citing that the hospital's immunity under the Health Care Quality Improvement Act of 1986 ("HCQIA") gave it considerable discretion in matters of physician discipline.⁸ The Fourth Circuit later affirmed this ruling.⁹ Wieters was subsequently ordered to pay \$357,000 in attorneys' fees for the hospital.¹⁰ This judgment, along with his inability to establish a substantial practice due to the NPDB listing, has caused him to declare personal bankruptcy and has ruined his career.¹¹ It was of little consolation that his complaints led to an investigation of the hospital by the state inspectors several months after his suspension where issues involving "serious threats to the health and safety of patients" were found.¹²

Dr. Wieters' story is just one example of how peer review under HCQIA has led to the unfair treatment of targeted physicians and has not served as an effective tool in improving the quality of health care.

Peer review is a process where a physician's patient-care and professional behavior in the hospital setting is reviewed

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Wieters v. Roper Hosp., Inc.*, 58 F. App'x 40 (4th Cir. 2003).

⁹ *Id.* at 47.

¹⁰ *Twedt*, *supra* note 1.

¹¹ *Id.*

¹² *Id.*

by a group of his peers.¹³ An adverse decision by the peer review committee can result in limitation or loss of a physician's hospital privileges and listing on the National Physician's Data Bank.¹⁴ These types of actions can severely damage a physician's career and result in loss of livelihood. Congress enacted the HCQIA to provide immunity to peer review committee members and the hospital and, thus, encourage peer review in hopes of improving the quality of health care.¹⁵ However, in the private hospital setting, the lack of mandatory due process procedures and poorly defined standards have led to abuse of the peer review process.¹⁶

The current practice of physician peer review in the private hospital setting under the HCQIA shield of immunity is not effective in regulating physician behavior, assuring quality care, or lowering health care cost. Additionally, as the institution responsible for review, there are further risks to the hospital in terms of compliance and possible challenges under the False Claims Act.¹⁷

Section II of this article will discuss the peer review and its history in American private hospitals, the origin and elements of HCQIA, and recent pertinent case law. Section III will discuss the negative impact HCQIA has on both the peer reviewed and reviewing physicians as well as the host hospital. Section IV will discuss how HCQIA is not meeting

¹³ Katherine Van Tassel, *Hospital Peer Review Standards and Due Process: Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines*, 36 SETON HALL L. REV. 1179, 1190 (2006).

¹⁴ *Id.* at 2000.

¹⁵ See generally Eleanor D Kinney, *Hospital Peer Review of Physicians: Does Statutory Immunity Risk of Unwarranted Professional Injury?* 13 MICH. ST. L.J. OF MED. AND L. 57, 79 (2009).

¹⁶ *Id.* at 60 (citing Steve Twedt, *The Cost of Courage: How the Tables Turn on Doctors*, PITTSBURGH POST GAZETTE, Oct. 26, 2003, available at www.postgazette.com/pg/03299/234499.stm (The article is the first article in a series on different occasions of so-called sham peer review and actions against "disruptive" physicians around the country)).

¹⁷ BNA Insights: Health Law Resource Center, *Quality of Care, Medical Necessity, and the Peer Review Process: A Compliance Risk that Every Hospital Should Understand*, (Sept. 27, 2012), <http://www.bna.com>.

its intended goal of improving patient care and poses risks for all parties involved in the peer review process. Section V will discuss potential legislative, judicial and health system remedies to better reach the end goal of balancing patient protection, quality care, the independent interest of hospitals, and the property and liberty interests of physicians.

II. PEER REVIEW BACKGROUND AND STATUES

Entry into the profession of medicine is regulated through state licensure boards, which are comprised mostly of physicians. In the United States, physicians practicing in hospitals are organized into a medical staff with medical staff bylaws based on state licensure law and private accreditation standards.¹⁸

Credentialing and peer review of physicians by hospitals is the primary method of regulating physicians who practice in hospitals, and it is required by accrediting bodies such as the *Joint Commission*,¹⁹ states as a condition of hospital licensure,²⁰ as well as Medicare and Medicaid programs.²¹

¹⁸ Kinney, *supra* note 15, at 60 (citing Paul Van Grunsven, *The Physician and State Regulations* §3.01, HEALTH CARE LAW DESK REFERENCE 37-38 (Alison Barnes, Steve Fatum, Robert Gatter & Kevin Gibson eds., 2001)).

¹⁴ *Id.* at 60-61 (“The . . . (JCAHO) is the primary accrediting body for allopathic hospitals in the United States. As such, the JCAHO establishes standards for the organization and operation of the hospital medical staff.”) (citing JOINT COMMISSION, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK, STANDARD MS 1.20-5.10 (2007)). (The JCAHO sets standards for medical staff peer review) (see Kathy Matzka, COMPLIANCE GUIDE TO THE JCAHO MEDICAL STAFF STANDARDS (2006)).

²⁰ States also require that hospitals have medical staffs that conduct peer review as a condition of licensure. See Timothy S. Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Health Care and the Public Interest*, 24 B.C. L. REV. 835, 841-49 (1983).

²¹ The Medicare and Medicaid programs require that hospitals have medical staffs and engage in peer review in order to participate in these programs. 42 C.F.R. § 482.22 (2008).

A. History of Quality Oversight in American Hospitals

Patient care was predominantly outpatient based (either in the physician's office or the patient's home) before the early 1900s. Prior to that time, hospitals were perceived to be poorly run, considered mainly as charitable institutions for the poor and insane, and to be avoided if possible due to the periodic bouts of institutional infections.²² However, with the advances in medicine, hospitals and hospital medical staff appointments began to play an increasingly important role in surgical practices and specialization.²³ The number of hospitals grew at a rapid rate, so that by 1930 there were 6719 hospitals. The American College of Surgeons ("ACS") was formed in 1913 to help standardize hospital care. The ACS established the "Minimum Standard" for safety and performance along with the Hospital Standardization Program ("HSP") to monitor and refine this "Minimum Standard". The "Minimum Standard" proposed an organized medical staff to adopt rules and policies for the professional work of the hospital. This led to standardization and minimum requirements for admission to more than 90% of medical staffs by 1935. The Joint Commission on Accreditation of Hospitals ("JCAH") was formed in 1951 by the joint efforts of the ACS, the American Hospital Association, the American Medical Association, the American College of Physicians and the Canadian Medical Association.²⁴ In 1952 the HSP was transferred to the JCAH which later was later renamed the Joint Commission on Accreditation of Healthcare Organizations ("JCAHO", also known as "The Joint Commission" or "TJC"). The Joint Commission is a private, non-profit organization and following its guidelines is optional, however, most hospitals strive to maintain JCAHO compliance and accreditation in order to qualify for state Medicare payments and to meet many state licensure requirements. JCAHO continues to require that all hospitals have an independent, self-governing medical staff that is responsible for and

²² Van Tassel, *supra* note 13, at 1186-89.

²³ *Id.*

²⁴ *Id.*

accountable to hospital governing board for the quality of medical care provided by medical staff members.²⁵ A physician's ability to treat patients at a hospital is contingent on being a member of the medical staff. A physician's "clinical privileges" at a hospital defines the scope of patient treatment he may provide and this is decided by the medical staff, based on the physician's education, license, experience, training, competence, judgment and health.²⁶

The medical staff is required to have its own bylaws which establish, among other things: (1) a medical staff executive committee and define its functions; (2) "fair-hearing and appellate review mechanisms for medical staff members and other individuals holding clinical privileges"; (3) "mechanisms for corrective action, including indications and procedures for automatic and summary suspension of an individual's medical staff membership or clinical privileges"; (4) "the medical staff's organization, including categories of medical staff membership"; (5) "[a] mechanism designed to provide for effective communication among the medical staff, hospital administration, and governing body"; and (6) "medical staff representation and participation in any hospital deliberation affecting the discharge of medical staff responsibilities."²⁷

B. HCQIA Historical Background

A widely publicized Supreme Court case involving Dr. Timothy Patrick, a surgeon at the only hospital in the small city of Astoria, Oregon, helped set the stage for HCQIA. Dr. Patrick had decided to set up his own practice, rather than join the main group at the hospital. His competitors initiated peer review proceedings against him and he resigned his staff privileges rather than have them

²⁵ *Id.*

²⁶ *Id.*

²⁷ JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORGS., COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS: THE OFFICIAL HANDBOOK P MS.1, at MS-2, PP MS.2.3 to MS.2.3.8, at MS-3 to MS-4. (1999) [hereinafter CAMH].

terminated.²⁸ A legal battle ensued and Dr. Patrick was awarded a \$2.28 million verdict in a federal antitrust suit, which was reversed by the United States Court of Appeals for the Ninth Circuit.²⁹ In 1988, the United States Supreme Court reversed the Ninth Circuit ruling in *Patrick v. Burget*, and reinstated the verdict holding that medical peer-review associated activities in this case did not meet the requirements for a state action exemption from federal antitrust liability.³⁰ This case and the associated events saw an increase in antitrust suits against hospitals and peer review physicians, which lead to medical and hospital associations to lobby Congress for immunity under federal antitrust laws.³¹ During the HCQIA legislative process, peer review immunity from antitrust laws was vigorously opposed by the Federal Trade Commission; House oversight committees for the federal antitrust laws; and the Department of Justice, who wrote that antitrust review would encourage quality health care by preventing cost-effective and innovative doctors from being excluded from the market.³² However, the HCQIA and the NPDB were established when Congress found the need to control

- (1) The increasing occurrence of medical malpractice and improve the quality of medical care . . .
- (2) [and] the ability of incompetent physicians to move from State to State without disclosure [and a need for]
- (3) effective professional peer review.
- (4) [without the] the threat of private money damage liability, including treble damage liability

²⁸ *Patrick v Burget*, 800 F.2d 1498 (9th Cir. 1986).

²⁹ *Id.*

³⁰ 486 U.S. 94, 105-06 (1988), *rev'g* 800 F.2d 1498, (9th Cir. 1986).

³¹ Kinney, *supra* note 15, at 64 (citing John K. Iglehart, *Congress Moves to Bolster Peer Review: The Health Care Quality Improvement Act of 1986*, 316 NEW ENG. J. MED. 960 (1987); *see generally* HEALTH CARE QUALITY IMPROVEMENT ACT OF 1986: A LEGISLATIVE HISTORY OF PUB. LAW NO. 99-660 (Bernard D. Reams ed., 1990)).

³² *Id.*

under Federal antitrust law³³

C. The Statutes Involved

The peer review process is governed by both federal and state statutes.

*1. Health Care Quality Improvement Act (“HCQIA”)*³⁴

For peer review body members, staff, contractors, and informants to obtain qualified statutory immunity from federal antitrust laws as well as other federal and state legal actions³⁵ 42 U.S.C. § 11112(a) states:

For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken--

- (1) in the reasonable belief that the action was in the furtherance of quality healthcare,
- (2) after a reasonable effort to obtain the facts of the matter,
- (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
- (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of

³³ 42 U.S.C. § 11101 (2013).

³⁴ 42 U.S.C. § 11101-11152 (2013).

³⁵ Excepted are actions by State Attorneys General (42 U.S.C. § 11111(a)(1)(D) (2013); 15 U.S.C. § 15c (2013)) and for violation of federal rights laws (42 U.S.C. § 11111(a)(1)(D) (2013)).

this title unless the presumption is rebutted by a preponderance of the evidence.³⁶

Subsection 11112(b) then goes to describe adequate notice and hearing standards but ends the subsection with: “A professional review body’s failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3).”³⁷ Thus, although the Due Process requirements meet the constitutionally mandated standards set in *Goldberg v. Kelly*,³⁸ this last provision, by making the requirements optional, has allowed courts to overlook the procedural elements of the peer review protections in considering immunity and effectively eviscerate the due process protections in § 11112(b).³⁹

2. NPDB

Due to concerns about incompetent physicians moving to other parts of the country and reestablishing practices without disclosure of previous censures of their performance, Congress, through HCQIA, authorized the establishment of the National Practitioner Databank (“NPDB”). NPDB is maintained by the federal government and most malpractice judgments and settlements and disciplinary actions by hospital peer review committees must be reported to it.⁴⁰

If a physician is reported to the NPDB he has the option to appeal to the Secretary of Health and Human Services on the grounds that NPDB report is inaccurate or on technical grounds:⁴¹ However, less than 5% of these appeals are successful.⁴²

³⁶ 42 U.S.C. § 11112 (2013).

³⁷ 42 U.S.C. § 11112(b) (2013).

³⁸ 397 U.S. 254, 255, 262-63 (1970).

³⁹ Kinney, *supra* note 15, at 66.

⁴⁰ 42 U.S.C. § 11101-11115; 42 U.S.C. § 11131-11153 (2013).

⁴¹ 45 C.F.R. § 60.16 (2013).

⁴² Michael J Panella, *The Legal Ramifications Under the Health Care Quality Improvement Act of Physicians Labeled Disruptive For Advocating Patient Quality of Care Issues*, 24 J.L. & COM. 281, 288

3. *Indiana Peer Review Act*

Many states including Indiana have further refined HCQIA protection. The Indiana Peer Review Act provides absolute immunity for civil liability for medical staff peer review committee members.⁴³

Indiana's due process protections for the accused physician allow her

(a) to see any records accumulated by a peer review committee pertaining to the provider's personal practice.

(b) the opportunity to appear before the peer review committee with adequate representation to offer rebuttal information . . . [which]

(c) shall be a part of the record.⁴⁴

Indiana also specifically excludes from membership on the peer review committee a physician who is in direct economic competition with the targeted physician and provides for committee members outside of the medical staff.⁴⁵

D. Description of the Hospital Peer Review Process

The quality of patient care in the United States is monitored through the state medical malpractice system, the state licensure system, and the hospital peer review system.⁴⁶ The state systems are public and provide due process to physician defendants prior to providing a negative report to the NPDB. The hospital peer review, aside from government-run hospitals such as a Veterans Administration ("VA") hospital, is private and there is no

(2005) (citing Steve Twedt, *A Negative Data Bank Listing Isn't Easy to Erase*, PITTSBURGH POST-GAZETTE, Oct. 27, 2003, <http://www.post-gazette.com/pg/03300/234532.stm>).

⁴³ IND. CODE § 16-21-2-8 (2013).

⁴⁴ IND. CODE 34-30-15-4 (2013)

⁴⁵ IND. CODE 34-30-15-5 (2013)

⁴⁶ Kinney, *supra* note 15, at 79.

obligation to provide physicians with due process protections during the hearing process.⁴⁷ The hospital medical staff, through either an appointed or elected committee is obligated to ensure the quality of care and treatment provided by practitioners it has approved and privileged through the credentialing process.⁴⁸ A number of events could trigger a peer review process and potentially result in the imposition of formal sanctions. These events include accusations of substandard clinical competence, physical or mental impairment, disruptive behavior, and loss of license or malpractice insurance, or violations of the medical staff bylaws.⁴⁹ In these instances, a peer review process which generally involves investigations and hearings based on the institution's bylaws would be started on the accused physician. If the allegations are substantiated, the physician can be penalized in a variety of ways, including termination of the physician's hospital staff privileges. Any adverse actions that affect the privileges of a physician more than 30 days must be reported to the state licensure board, which ultimately must report the action to the NPDB.⁵⁰ Hospitals are required to query the NPDB data bank prior to granting medical staff privileges to a physician.⁵¹ Once a physician has had a decredentialing listing by the NPDB, it is generally felt that he would have significant difficulties in obtaining further staff privileges at any hospital. The inability to obtain hospital privileges can seriously curtail a physician's ability to practice medicine, even with a valid state medical license.⁵²

⁴⁷ Katherine Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2052-2053 (2012).

⁴⁸ CAMH, *supra* note 27, at P MS.1, at MS-2 (2005). (The credentialing process involved gathering, verifying, and evaluating the physician's training, competence and record, either on initial application for staff privileges or on renewal. Clinical privileges, which define a physician's scope of practice, are assigned based on the evaluation.).

⁴⁹ Van Tassel, *supra* note 13, at 1191.

⁵⁰ *Id.*

⁵¹ *Id.*

⁵² Van Tassel, *supra* note 47, at 2053-54.

Bolstering the list that could trigger peer review and possible adverse action was the “Sentinel Events Alert,” issued by JCAHO in July 2008, which expanded the list that could trigger peer review and possible adverse action. The “Alert” highlighted the impact of disruptive behavior on patient safety and set new standards for institutions to create a code of conduct that defines acceptable and unacceptable behaviors and a formal process for managing unacceptable behavior.⁵³

If the peer review committee follows the HCQIA standards for “adequate notice” and “fair” process, the censured physician is unable to sue for damages but can still sue for injunctive and other types of equitable relief.⁵⁴ However, these legal challenges generally fail due to the vague standards and judicial deference of courts in favor of hospital administrations.⁵⁵

E. Illustrative Cases under HCQIA

Several cases illustrate the potential for abuse and the frustrations experienced by the targeted physicians under HCQIA.

Dr. Poliner was an independent interventional cardiologist who had been in practice for 20 years with a clean record. He was in competition with the major cardiology group at Presbyterian Hospital. On May 14, 1998, after a preliminary peer review, he was presented with the option of signing a temporary abeyance of his privileges or face summary suspension due to one missed diagnosis from a cardiac catheterization case and some other minor patient care issues raised by his competitor

⁵³ Joint Commission on the Accreditation of Healthcare Organizations, *Sentinel Event Alert: Behaviors that Undermine a Culture of Safety*, (July 9, 2008), available at http://www.jointcommission.org/assets/1/18/SEA_40.PDF

⁵⁴ Van Tassel, *supra* note 13, at 1197. (Many state statutes provide broader immunity for the hospital and peer review participants, but unlike HCQIA, in most cases, state immunity will not provide protection from federal antitrust actions. See *Islami v. Covenant Med. Ctr.*, 822 F. Supp. 1361, 1379-80 (N.D. Iowa 1992)).

⁵⁵ *Id.* at 1204-10.

cardiologists. He was not given the option of seeking legal counsel or defending his care prior to signing. His privileges were ultimately restored several months later. He subsequently sued the peer reviewers and the hospital and in 2004 a Texas jury awarded him \$33 million in damages.⁵⁶ This judgment was later reversed by the 5th Circuit Court of Appeals, based on HCQIA's articulated "reasonable belief" standard and that Congress's grant of "limited immunity from suits for money damages to participants in professional peer review actions"⁵⁷, and there is a "presumption that a professional review [action] meets the standards for immunity, unless the presumption is rebutted by a preponderance of the evidence"⁵⁸ and that the evaluation of evil intent or anticompetitive motives is an objective one, therefore "subjective [anticompetitive] motivations [do not] overcome HCQIA immunity".⁵⁹

Dr. Ulrich had been on the staff of Laguna Honda Hospital for nearly 10 years. When the hospital began to lay off physicians for budgetary reasons, he openly criticized this action,⁶⁰ but immediately found himself the target of a peer review action.⁶¹ He resigned his staff membership, rather than face peer review. When he found that that resigning in the face of a pending peer review action was reportable to the NPDB, he tried to rescind his resignation; the hospital refused and reported him to the NPDB anyway.⁶² He subsequently sued the hospital and peer review members based on violating of his First Amendment rights of free speech and Fourteenth Amendment right to due process.⁶³ A jury later awarded him \$4.3 million.⁶⁴

⁵⁶ Poliner v. Tex. Health Sys. 537 F.3d 368 (5th Cir. 2008)

⁵⁷ *Id.* at 376.

⁵⁸ *Id.* at 377.

⁵⁹ *Id.* at 380.

⁶⁰ Ulrich v. City and County of S.F. 308 F.3d 968, 986 (9th Cir. 2002)

⁶¹ *Id.*

⁶² *Id.*

⁶³ *Id.*

⁶⁴ Ulrich v. City and County of S.F., No. C-99-05003-TEH, 2004 WL 1635542, *1 (N.D. Cal. July 12, 2004).

Dr. Kenneth Clark was a physiatrist at a Reno hospital. When the hospital discovered that he had written letters of complaint about certain hospital policies and substandard care to Champus and to JCAHO, it instituted peer review proceedings on him and terminated his privileges based on disruptive conduct.⁶⁵ In the legal action by Dr. Clark against the hospital that ensued, the district court granted the hospital summary judgment on the basis of HCQIA immunity,⁶⁶ a decision which the Nevada Supreme court later reversed holding that the hospital was not immune because the revocation of Dr. Clark's staff privileges was not made with the reasonable belief that it was in furtherance of quality healthcare⁶⁷ and that whistle blowing is conduct protected as a matter of public policy.⁶⁸

Dr. Poliner's case illustrates the difficulty of piercing the shield of immunity afforded by HCQIA and its potential abuse by those in a position of power in the private hospital setting. The cases of Drs Ulrich and Clark were unusual in that the censured physicians were successful, but nevertheless illustrate the potential difficulties that a physician speaking out against hospital policies can encounter. The potential for abuse makes the peer review a tool for bullying and potentially defeats the goal of better patient safety and improved health care. Physicians who perceive the process as unfair may refrain from complaint about the quality of care issues or disclosing a colleague's insufficiencies.

⁶⁵ Clark v. Columbia/HCA Info. Servs, Inc., 25 P.3d 215, 219 (Nev. 2001).

⁶⁶ *Id.*

⁶⁷ *Id.* at 220.

⁶⁸ *Id.*

III. HCQIA DOES NOT ADEQUATELY PROTECT THE CONSTITUTIONAL PROPERTY AND LIBERTY RIGHTS OF PHYSICIANS UNDERGOING PEER REVIEW

A. Medical Licenses and Medical Staff Privileges are Protected Liberty and Property Interests for Physicians

The Fourteenth Amendment protects an individual's protected liberty and property interests from state deprivation without procedural due process.⁶⁹ A two step inquiry is used to evaluate a due process claim: 1) whether the state has interfered with a protected liberty or property interest and 2) whether the procedures "attendant upon that deprivation were constitutionally sufficient."⁷⁰

A protected liberty or property interest is one that is "recognized and protected by state law"; therefore a physician's medical license, which is issued by the state, is a protected property interest.⁷¹ Whether the procedures used to deprive those interests were constitutionally sufficient is measured by the three-part test of *Mathews v Eldridge*:

First, the private interest that will be affected by the official action; second, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and finally, the Government's interest, including the function involved and the fiscal and administrative burdens that the

⁶⁹ *Chudacoff v. Univ. Med. Ctr of S. Nev.*, 609 F. Supp. 2d 1163, 1172 (D. Nev. 2009) (citing *Bd. of Regents of State Colls. v. Roth*, 408 U.S. 564, 569 (1972)).

⁷⁰ *Id.* (citing *Humphries v. Cnty of L. A.*, 554 F.3d 1170, 1184–85 (9th Cir. 2009) (quoting *Ky. Dep't of Corr. v. Thompson*, 490 U.S. 454, 460 (1989)).

⁷¹ *Id.* (finding that a state-issued driver's license may not be withdrawn without affording due process (citing *Paul v. Davis*, 424 U.S. 693, 710-11 (1976))).

additional or substitute procedural requirement would entail.⁷²

Professor Van Tassel has advanced the Constitutionality Argument that the private hospital peer review process that leads to the listing of physicians on the NPDB fails to protect the property and liberty rights of targeted physicians.⁷³ Besides a property interest in her medical license and many states also acknowledge that medical staff privileges standing alone are a property right because loss of staff privileges greatly limits a physician's ability to practice medicine and use her state granted medical license.⁷⁴ This is illustrated most clearly in the case of a surgeon who has her privileges terminated at the only hospital in town.⁷⁵ The termination constitutes a negative peer review, which would have to be reported to the NPDB. Listing on the NPDB could have a career ending effect on the doctor (Dr. Ullrich's case is an example).⁷⁶ A negative peer review could also trigger an investigation by the State Licensing Board and cascade of other events.⁷⁷ Physicians also have a liberty interest in their reputation.⁷⁸ When the federally run NPDB sends negative peer reports to a hospital or other health care entity, the state action threshold has been crossed and this give rise to constitutional rights.⁷⁹ Due process as measured by the three part test of *Matthew v Eldridge* is not available as part of the peer review process.⁸⁰ Thus listing on the NPDB unconstitutionally impacts the property and liberty rights of

⁷² *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

⁷³ Van Tassel, *supra* note 47, at 2033, 2063.

⁷⁴ *Id.* at 2057-58.

⁷⁵ *Id.*

⁷⁶ *Id.* at 2059-60; *see also supra* note 60 and accompanying text.

⁷⁷ Van Tassel, *supra* note 47, at 2061-62.

⁷⁸ *Id.* at 2063f. Three Supreme Court cases that support this argument are *Wisconsin v. Constantineau*, 400 U.S. 433 (1971); *Goss v. Lopez*, 419 U.S. 565 (1975); and *Paul v. Davis*, 424 U.S. 693 (1976).

⁷⁹ Van Tassel, *supra* note 47, at 2033, 2062.

⁸⁰ *Id.* at 2033.

targeted physicians because of the lack of due process protection in the peer review process.⁸¹

B. The "Presumption of Immunity" and the "Reasonable Belief" Standard under HCQIA Creates an Almost Insurmountable Barrier for Defense of Targeted Physician's Due Process Rights

In examining the judicial review of adverse peer actions, it appears that although the courts have attempted to strike a balance between the interests of the physician, the hospital, and the public, court decisions have decidedly been in favor of the interests of the public and the hospital by providing a high level of deference to hospital's decisions.

"Human lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff. The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance."⁸²

Courts have generally deferred the factual evaluation of medical competence to the hospital peer review process, and have been more willing to review adverse peer outcomes to ensure that the hospital treated the physician with fundamental fairness and provided appropriate procedural due process. For governmental institutions, this protection has its basis in the Constitution, and for private hospitals the due process review is based on contract as stipulated by the medical staff bylaws, fiduciary duty, common law fairness, or statute.⁸³ However, an analysis of physician

⁸¹ *Id.* at 2033, 2062.

⁸² Van Tassel, *supra* note 13, at 1201 (quoting *Sosa v. Bd. of Managers of the Val Verde Mem'l Hosp.*, 437 F.2d 173, 177 (5th Cir. 1971)).

⁸³ *Id.* at 1202 (citing Craig W. Dallon, *Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions*, 73 TEMP. L. REV. 597, 678 (2000)).

law suits challenging peer review decisions, 2003-2007 showed decisions were predominately in favor of the hospital and committee.⁸⁴ Reviewing courts have almost exclusively upheld the presumption of immunity for the hospital and peer review committee members based on the following⁸⁵: 1) A reasonable belief that decision was in furtherance of quality care. 2) The burden of proof by plaintiff (targeted physician) is preponderance of the evidence.⁸⁶ 3) HCQIA does not require that decision has to be correct, and only a reasonable effort to obtain the facts. 4) Courts were generally reluctant to enforce strict due process standards. 5) Bad faith is irrelevant to HCQIA claims (especially if “breaches of quality were demonstrated”). 6) Many mistakes and irregularities by the peer review committees were accepted by the courts.⁸⁷

In fact, judicial review is not permitted for the merits of privilege decisions in most states; however, the courts may assess whether the hospital has followed hospital bylaw procedural requirements in its decisions concerning privileges. But courts will become involved for claims based on gender or race discrimination, penalizing a physician for whistle blowing, or other tortuous acts. Therefore, except for certain exceptions of improper application of review standards, whistle blowing activity, and constitutional

⁸⁴ Kinney, *supra* note 15, at 74-75.

⁸⁵ *Id.* at 69f.

⁸⁶ *Id.* at 69 (“[I]n only 2 cases have federal courts reversed an order of summary judgment based on immunity because the physician demonstrated by a preponderance of the evidence that the board failed to give appropriate fair notice and procedures in accordance with § 11112(a)(3).” (quoting *Clarke v. Columbia/HCA Info. Serv., Inc.*, 25 P.3d 215, 223 (Nev. 2001))).

⁸⁷ *Id.* at 71 (citing *Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1153-54 (Nev. 2001). The *Meyer v. Sunrise Hospital* ruling upheld the HCQIA immunity for a hospital that terminated a physician with record of high quality care due to a single incident, although a death. A concurring justice stated that HCQIA can be used “not to improve the quality of medical care, but to leave a doctor who was unfairly treated without any viable remedy. . . . Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes.” See *supra* Poliner case as an example of the difficulty of piercing the shield of immunity provided by HCQIA.

violations depending on the jurisdiction, courts have been reluctant to find a hospital liable for privilege decisions. Given the broad presumption of immunity for a hospital's peer review, federal courts have found mostly in favor of hospitals and peer review members.⁸⁸

Legal scholars, the physician community as well as the media have expressed concerns about the antitrust immunity afforded peer review under HCQIA as well as associated abuses.⁸⁹

Only in the most flagrant improper application of review standards has HCQIA immunity been successfully challenged as illustrated by two cases. In *Brown v. Presbyterian Healthcare Serv.*, 101 F.3d 1324 (10th Cir. 1996), the court held that review of only two patient charts prior to revoking obstetrical privileges in a peer review action did not meet the reasonable effort to obtain the facts of the matter standard, thus the hospital and review board members were not entitled to HCQIA immunity.⁹⁰ In *Islami v. Covenant Med. Ctr.*, the court held that the hospital peer review board breached its contract by not following procedures listed in bylaws, and thus not meeting the fair notice and hearing procedure standard under the HCQIA where a surgeon had privileges immediately suspended.⁹¹

⁸⁸ Panella, *supra* note 42, at 287-88; *see also* Clark Columbia /HCA Info. Servs., 25 P.3d 215, 222 (Nev. 2001) (adverse peer review for disruptive behavior involving only whistle blowing conduct is not shielded under HCQIA immunity).

⁸⁹ Kinney, *supra* note 15, at 77; *see also* Gerald Weiss, *Is Peer Review Worth Saving?* 82 MED. ECON. 46 (2005); Tanya Albert & Damon Adams, *Peer Review under Fire: Real Problems or Trumped-Up Accusations?* AMNEWS (Oct. 10, 2005), *available at* <http://www.ama-assn.org/amednews/2005/10/10/prsa1010.htm>.)

⁹⁰ Panella, *supra* note 42, at 289 (citing *Brown v. Presbyterian Healthcare Serv.*, 101 F.3d 1324 (10th Cir. 1996)).

⁹¹ *Id.* at 289-90 (citing *Islami v. Covenant Med. Ctr.*, 822 F. Supp. 1361, 1365 (N.D. Iowa 1992) (In *Islami*, the surgeon asserted his right under the bylaws to exclude competitors from the reviewing committee and right to provide additional evidence and testimony, but the court denied summary judgment for the hospital and remanded the case for a jury trial)).

One might argue that most physician adverse peer reviews are warranted, and only the very publicized or successfully litigated appear as abusive or malicious. Undoubtedly, incompetent and badly behaved physicians are a threat to patient safety and the smooth operation of a hospital, and that the legal immunity is needed to protect the peer reviewers. However, the process of regulation of physician conduct should operate in a fair manner with respect to physicians and also protecting the public. A system that does not cause unnecessary injury to any of the parties involved can only prove beneficial in the long run.

Courts have also ruled differently on Constitutional challenges to HCQIA. The Court in *Ulrich v. City and County of San Francisco* stipulated that a 14th Amendment claim of liberty interest of future employment was potentially affected when the hospital filed a NPDB report, due to the physician resigning while under peer review investigation, and remanded for lower court to determine if NPDB listing was stigmatizing and thus could affect future employment.⁹²

A different approach taken by 4th Circuit in *Freilich v. Upper Chesapeake Health, Inc.* where it denied a physician's constitutional challenges to HCQIA immunity in an adverse peer review decision and held there was no due process or equal protection violation by using rational basis review (HCQIA did not burden any fundamental right or draw distinctions based on suspect criteria). The Court found that HCQIA was rationally related to a legitimate government purpose of quality improvement of the nation's health care system and upheld the reasonable standard that governs the grant of peer review immunity stating that it was not unconstitutionally vague. Furthermore, the court held the HCQIA did not violate the Tenth Amendment as Congress had authority under the Commerce Clause to enact statues concerning physician peer review.⁹³

⁹² *Id.* at 292 (citing *Ulrich v. City of San Francisco*, 308 F.3d 968, 986 (9th Cir. 2002)).

⁹³ *Id.* at 297 (citing *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 210 (4th Cir. 2002)).

The argument can be put forth that in the private institution setting, contract principles apply and fair procedure, not strict due process is necessary.⁹⁴ However (applying the three prong test of *Mathews v Eldridge*), the affected physician's liberty interest is great and without adequate due process, the risk of error and injury is great, and although the Government has an interest in improving health care quality, it should also have an interest in protecting the liberty interests of all of its citizens. Since mandating the additional safeguard of due process in peer review is a minimal burden, as it is already mandated in government hospitals, it should also be mandated in the private hospital setting.

*C. Vague Standards for Judging Physician Competence
Further Compounds the Problem*

In spite of varying degrees of enforcement, most courts are in accord with the procedural due process protections that should be offered to a physician (right to representation, right to have a record made of proceedings, right to examine witnesses and present evidence). However, there is disagreement on the HCQIA requirement of "fairness of standards" in peer review. Some courts feel that specific criteria can be objectively applied; others feel that objective criteria are not possible.⁹⁵

Standards for judging physician competence have been hard to define, by both hospitals and courts. Vague standards not only violate an essential element of due process but have negative implications for all stake holders in the peer review process by: 1) not giving fair notice of expected competency or conduct to the targeted physician, 2) increasing the risk of arbitrary decisions by the peer review committee, thus also increasing the chance of their loss of immunity, 3) and making meaningful judicial review difficult.⁹⁶ Many courts have opined that due to the rapid

⁹⁴ Kinney, *supra* note 15, at 70 (citing *Goodstein v. Cedars-Sinai Med. Ctr.*, 66 Cal. App. 4th 1257 (1998)).

⁹⁵ Van Tassel, *supra* note 13, at 1203-04.

⁹⁶ *Id.* at 1205-06.

advances in medical care, it would be hard to provide objective criteria for judging physician competence, and that these challenges to vagueness have survived in the context of malpractice and medical licensure proceedings.⁹⁷ The difficulty with defining competency standards may be the reason courts have focused on enforcing the mechanical portion of due process protections in the peer review setting. But vague standards in the peer review setting have greater potential for causing harm than in a malpractice action. In the later, the decisions makers are judges, juries, and administrative officials without prior dealings with the targeted physician, whereas in the former, the peer review committee is highly likely to be composed of in-house persons with prior and probably future personal and economic dealings with the targeted physician and who may be influenced by the local hospital politics.⁹⁸

1. Arbitrary Standards and Their Capricious Application.

One extreme example of the use of arbitrary standards and their capricious application is illustrated in *Wyatt* where the California Court of Appeals held that a hospital board's requirement that physicians or surgeons admitted to the medical staff are to be those with the "best possible care and professional skill" as judged by the board, set standards which left too much to the whim and caprice of the board to exclude applicants.⁹⁹ Courts, however, have failed to state how to create clearly articulated standards.¹⁰⁰

2. Are Clear Standards Feasible?

The court in Jackson articulated what many courts feel is a very difficult task of setting standards for measuring physician competence:

⁹⁷ *Id.* at 1184-85.

⁹⁸ *Id.*

⁹⁹ *Wyatt v. Tahoe Forest Hosp. Dist.*, 345 P.2d 93, 97 (Cal. Ct. App. 1959).

¹⁰⁰ Van Tassel, *supra* note 13, at 1209-10.

In the area of personal fitness for medical staff privileges precise standards are difficult if not impossible to articulate.... The governing board of a hospital must therefore be given great latitude in prescribing the necessary qualifications for potential applicants . . . detailed description of prohibited conduct is concededly impossible, perhaps even undesirable, in view of rapidly shifting standards of medical excellence and the fact that a human life may be and quite often is involved in the ultimate decision of the board.¹⁰¹

Standards currently used in evaluating physician competence in peer review fall into one of the following three types: (1) those that rely on the absolute discretion of the decision-makers; (2) those that rely on customary care of the local or a wider community; and (3) those that rely on general negligence standards.¹⁰² Each of these standards is problematic and fails to balance the interest of the stakeholders.

The first standard is derived from hospital bylaws with wording such as "the right to remove any member of the medical staff . . . [that] the good of the hospital or the patients may demand"¹⁰³ or where the level of competence is defined as "best possible care."¹⁰⁴ This leaves complete discretion to the peer review decision-makers, provides minimal due process protection for the targeted physician,

¹⁰¹ *Id.* at 1212 (citing *Jackson v. Fulton -DeKalb Hosp. Auth.*, 423 F. Supp. 1000 (N.D. Ga. 1976); the author notes that the language that it is "impossible to articulate" standards of medical competence was taken from a case where the court was discussing character qualifications and standing in relation to fitness for medical staff privileges).

¹⁰² *Id.* at 1214.

¹⁰³ *Id.* at 1215 (citing *N. Broward Hosp. Dist. v. Mizell*, 148 So. 2d 1, 2-5 (Fla. 1962)).

¹⁰⁴ *Id.* (citing *Wyatt*, 345 P.2d at 95).

and makes judicial review of the peer review decision very difficult.¹⁰⁵

The second standard relies on what is considered to be customary care.¹⁰⁶ However, there may be disagreement in the local or larger national medical community on what is the proper standard of care, and even when agreed upon, that standard may be detrimental to the quality of patient care.¹⁰⁷ Additionally, costly discovery of colleagues' patient records may be required to decide what is customary in a particular hospital.¹⁰⁸

The third standard which relies on general negligence standards with bylaws language such as requiring patient care in a "non-negligent manner", may provide slightly more clarity due to influence from malpractice case law but still has inherent problems of vagueness depending whether the "community" or "national rule" standard is used.¹⁰⁹

Under any of these standards, there are additional due process concerns when unavoidably the peer review decision-makers have personal and economic dealings with the targeted physician, which has the potential to introduce bias into the process.¹¹⁰ This is distinctly different from malpractice litigation where the judge or jury has no prior dealings with the defendant.¹¹¹ This difficulty of judging physician competence due to vague standards makes strict interpretation of due process rights even more important in preventing abuse under HCQIA.

D. The Punishment Does Not Fit the Crime

In the cases of disputed adverse peer review that have been presented in this note, most involve an accusation of one or more instances of substandard patient care against a backdrop of criticizing hospital policies (Drs. Ulrich and

¹⁰⁵ *Id.* at 1215-16.

¹⁰⁶ *See* discussion *infra* Part IV.B.

¹⁰⁷ Van Tassel, *supra* note 13, at 1227.

¹⁰⁸ *Id.* at 1217-29.

¹⁰⁹ *Id.* at 1229-31.

¹¹⁰ *Id.* at 1230.

¹¹¹ *Id.* at 1229-31.

Clark) or economic competition (Drs. Poliner and Partrick).¹¹² In no instance has there been an accusation of malice, purposeful patient harm, or necessarily malpractice. However in each case, the hospital and peer review committee were able to deprive the targeted physician of a right and harm his career, as well as remove from the public another choice of a generally capable health care worker. It does not seem the punishment of suspension of hospital privileges fits the crime of having a patient or a few patient complications. This is especially so, in light of the fact that medicine is an art, not a science, and many complications are unavoidable, and every physician has or eventually will have complications from performing treatments.¹¹³ The sanctioning of a physician should be on a graduated scale. Depending on the magnitude of the problem, there should be available other, less retaliatory methods of correction, such as education, rehabilitation, monitoring and lesser levels of restriction.¹¹⁴ A reviewing court should look for evidence of these other corrective attempts in evaluating the reasonableness of an adverse action. One should perhaps take an example from how attorneys are sanctioned within their own profession. Disbarment is usually a measure of last resort and a competent lawyer who is negligent and makes a mistake, is generally not subject to professional discipline as well as malpractice liability.¹¹⁵

The NPDB is the first time the federal government has engaged in blacklisting since the McCarthy era.¹¹⁶ Unlike other forms of blacklisting such as sexual predators, where the risk of harm is much greater, physicians who are serving the community receive far fewer procedural safeguards than those other targeted groups. Professor Van Tassel stated that:

¹¹² Kinney, *supra* note 15, at 58-9, 63.

¹¹³ Personal communication, Frank Stinchfield, MD, Professor of Orthopedic Surgery, Columbia Presbyterian Medical Center, New York, NY, , circa 1983.

¹¹⁴ Gunthrie M, *Guidelines for disciplinary action from peer review*. PHYSICIAN EXECUTIVE 35(4): 78-9, 2009.

¹¹⁵ Hal R. Kuebeman, *Ethics, Lawyer Misconduct, and Sanctions: The Disciplinary Committee Perspective*, C641 ALI-ABA 121, 124 (1991).

¹¹⁶ Van Tassel, *supra* note 47, at 2037.

In contrast to blacklisting sexual predators, when physician are blacklisted by the federal government, they have not been provided with a procedurally safeguarded opportunity to contest the accuracy of the facts included in the reports that are filed with, and then disseminated by, the NPDB . . . alleged sexual predators are provided with the additional safeguard of having the highest burden of proof placed on the government to prove the allegations against them. Hospitals in peer review only have to establish the allegations against physicians by a preponderance of the evidence.¹¹⁷

Additionally, if we compare other types of black lists such as suspected gang members, suspected terrorists, and No-Fly Lists; those persons have procedurally safeguarded opportunity to contest the accuracy of alleged membership. In contrast, physicians who are blacklisted, in the vast majority of cases do not have access to the judicial system.¹¹⁸

In *Hamdi v Rumsfeld*, the Supreme Court held that a suspected terrorist's "risk of erroneous deprivation" of his liberty interest was unacceptably high under the government's rule of limiting his due process (the government was concerned about the risk of disclosing of military secrets).¹¹⁹ It is hard to harmonize a rule that guarantees due process for suspected terrorists with one that is denying this protection to physicians who are serving the community.¹²⁰

¹¹⁷ *Id.* at 2040 (citing *Conn. Dep't of Pub Safety v Doe* 538 U.S. 1(2003)).

¹¹⁸ *Id.* at 2041.

¹¹⁹ *Hamdi v. Rumsfeld*, 542 U.S. 507, 507-08, 530 (2004).

¹²⁰ Van Tassel, *supra* note 47, at 2094.

IV. HCQIA DOES NOT EFFECTIVELY IMPROVE HEALTH CARE QUALITY AND IS OUTDATED IN TODAY'S HEALTH CARE ENVIRONMENT

The lack of well-defined physician competence standards, and the immunity granted under HCQIA with subsequent reporting of adverse credentialing actions to the NPDB system perpetuate custom-based practices (rather than promoting evidence-based practices). These two elements undermine efforts to improve quality and costs of health care, and are being used to silence physician whistleblowers, which directly also undermine efforts to control the quality and cost of care.¹²¹

A. Whistle Blowers are at Risk of Sanctioning under HCQIA

Physicians, because of their training and authority, have a moral responsibility to be strong patient advocates and to voice concerns over inadequate or riskier care, given the patient's relative lack of knowledge especially in today's cost conscious health care environment where the emphasis is on doing more for less. Even with this mandate, physicians both historically¹²² and presently under the HCQIA, can jeopardize their careers in speaking out for patients. The HCQIA may actually be hindering the improvement of quality medical care by providing disincentives for physicians to speak out about poor medical care in the hospital setting.¹²³ Hospital peer review could be used to silence a practitioner's disagreement with hospital practices, especially when the criticized activity could affect the hospital's profits, and therefore work against lowering the cost of health care.¹²⁴

¹²¹ *Id.* at 2032.

¹²² Panella, *supra* note 42, at 281-82. In the mid 1800's Viennese physician Dr. Semmelweis, was ostracized by the medical community after suggesting that doctors' hand washing could reduce fatal infections arising in new mothers.

¹²³ *Id.*

¹²⁴ *Id.* at 297.

If a physician is labeled disruptive, a hospital can initiate a peer review proceeding to determine whether the physician's conduct is compromising the quality of the patient care. If the peer review committee finds his behavior to be disruptive, the hospital can institute a variety of corrective measures, including revocation of his hospital privileges. The hospital is protected in this action by a presumption of immunity under the HCQIA. If the targeted physician decided to challenge this presumption in court, he is faced with the high evidentiary hurdle imposed by HCQIA of showing by a preponderance of the evidence that: 1) the hospital peer review was not based on a reasonable belief that the review was in furtherance of quality health care; 2) reasonable efforts were not used in obtaining the facts surrounding the case; 3) the physician was not afforded adequate notice and hearing procedures; and 4) a reasonable belief did not exist that the review was actually warranted.¹²⁵ The targeted physician faces two additional problems in avoiding sanctions. First, the hospital has significant power in selecting the hearing officers due to the language of the HCQIA which states: hearings can be conducted before an arbitrator mutually acceptable to the physician and hospital, or a hearing officer or panel of individuals, who are appointed by the hospital, provided there is no economic conflict with the physician.¹²⁶ Thus, the hearing officer(s) could be hostile to the physician in non-economic matters. Second, the issue of what constitutes "disruptive" behavior is not well delineated and can be left to subjective interpretation under the lens of the hospital's politics and finances. For instance, a major economic producer's behavior could be allowed much greater latitude than that of a physician whose economic impact is small.¹²⁷

The danger of criticizing the hospital and being labeled disruptive is illustrated by the cases of Drs. Ulrich, Clark and Wieters who each were sanctioned for complaining

¹²⁵ 42 U.S.C. § 11112 (a) (2012).

¹²⁶ 42 U.S.C. § 11112(b)(3) (2012) (emphasis added).

¹²⁷ Panella, *supra* note 42, at 286-87.

about quality of care issues at their respective hospitals.¹²⁸ This potential for being labeled as disruptive and being a target of an adverse peer review action and being blacklisted has a significant chilling effect on physicians speaking out about potential problems with patient care. Additionally, if peer review is perceived as unfair then it could make physicians reluctant to speak out or bring their peers into the peer review process thus also compromising quality of care.¹²⁹ As we become more aware of mistakes being made in patient care, rising health care costs, and a projected looming physician shortage, it becomes increasingly important that the peer review process be perceived as fair and that physicians be protected in expressing their views.

B. Customary Care Is Perpetuated Under HCQIA

Professor Van Tassel has put forth the argument that peer review as currently practiced relies heavily on customary care, which is based on physician preference, geography, and not on objective, scientific evidence.¹³⁰ Therefore, according to the argument, customary care does not improve the quality or cost of health care:

“Customary care” is that care which would customarily be given by other physicians under the same or similar circumstances. This practice of providing customary care is also referred to by many as “eminence-based medicine” and it is the normative practice in the United States. Unfortunately, a steadily growing number of studies demonstrate that many customary treatment choices have a negative impact on quality of care. Another

¹²⁸ See discussion of cases *supra* Parts I, II.E.

¹²⁹ Panella, *supra* note 42, at 281-82.

¹³⁰ Katherine Van Tassel, *Harmonizing the Affordable Cared Act with the Three Main National Systems for Healthcare Quality Improvement: The Tort, Licensure and Hospital Peer Review Systems*, 78 BROOK. L. REV. (forthcoming 2013) (manuscript at 4-5), available at <http://ssrn.com/abstract=2150825>.

large group of studies indicate that there is a wide variation in customs across the country and that the choice of customary treatment is more linked to geography than to quality.¹³¹

One example is related to the evidence that use of aspirin within the first twenty-four hours after a heart attack increases the rate of survival. But of the hospitals studied in 2004, only a fraction of eligible patients received this simple aspirin treatment.¹³² Studies also show that patients in Idaho Falls are twenty times more likely to have lumbar fusions than ones living in Bangor, Maine and the rate of spinal surgery in Bradenton, Florida is almost double that in Tampa, Florida.¹³³ These studies show that customary care is based on the medical culture of a particular area and may well be unrelated to a quality choice for the patient.

Customary care is also expensive and not cost effective. For example, McAllen, Texas has been brought to light nationally as one of the most expensive medical communities and an example of the disconnect between cost and quality. Medicare spends twice the national average on Medicare enrollees in McAllen as compared to neighboring El Paso, a similar community; yet McAllen's hospitals performed worse than El Paso's on multiple Medicare quality metrics.¹³⁴

¹³¹ *Id.*

¹³² *Id.* at 6.

¹³³ Ctr. for the Evaluative Clinical Sci., *Dartmouth Atlas of Health Care: Studies of Surgical Variation Spine Surgery*, DARTMOUTH ATLAS.ORG, http://www.dartmouthatlas.org/downloads/reports/Spine_Surgery_2006.pdf (last visited Jan 3, 2014).

¹³⁴ Atul Gawande, *The Cost Conundrum*, THE NEW YORKER, June 1, 2009, available at http://www.newyorker.com/reporting/2009/06/01/090601fa_fact_gawande?currentPage=all. "Between 2001 and 2005, critically ill Medicare patients received almost fifty percent more specialist visits in McAllen than in El Paso. . . They received one-fifth to two-thirds more gall bladder operations, knee replacements, breast biopsies, and bladder scopes. They received two to three times as many pacemakers, implantable defibrillators, cardiac-bypass operations, carotid endarterectomies, and coronary-artery stents. And Medicare paid for five times as many home-nurse visits."

The HCQIA and the advantages that it grants to the hospitals and peer reviewers have the effect of making physicians reluctant to deviate from the customary care standard in their community, and that customary care is not always the best care for the patient.

C. Present Standards Under HCQIA Create Risks for Hospitals and Peer Review Committees

On the hospital side, it must navigate the narrow waters of providing quality care by weeding out incompetent physicians who may cause potential medical malpractice liability for the hospital, but in doing so it may expose itself to antitrust liability when denying or limiting a physician's privileges. The peer review process is JCAHO mandated and a standard method of health care quality control. Mandatory due process protocols, consistent and clearly enunciated standards, as well as a root analysis and rehabilitative approach to medical errors and physician behavior, so that all parties feel fairly treated, would go a long way to avoiding costly litigation. Notwithstanding the fact that few antitrust cases brought by physicians adversely affected by peer review decisions have been favorable to the plaintiff physician¹³⁵, a hospital is still

¹³⁵ Barbara K. Miller, Note, *Defending the System: Application of the Intraenterprise Immunity Doctrine in Physician Peer Review Antitrust Cases*, 75 TEX. L. REV. 409, 411-12 (1996) (citing BCB Anesthesia Care, 36 F.3d at 667 (staffing and privileges litigation decisions "almost always come to the same conclusion: the staffing decision at a single hospital was not a violation of section 1 of the Sherman Act"); Charity Scott, *Medical Peer Review, Antitrust, and the Effect of Statutory Reform*, 50 MD. L. REV. 316, 333 (1991) (whether there is really a "need for peer review immunity considering how few physicians succeed on their antitrust allegations"); Joe Sims & Kathryn M. Fenton, *Antitrust Defenses to Peer Review and Medical Staff Privileges Claims*, in DEVELOPMENTS IN ANTITRUST HEALTH CARE LAW 15, 15 (Phillip A. Proger et al. eds., 1990) ("the low success rate for antitrust challenges to medical peer review and staffing decisions [can be] due to the various defenses available to defendants"); Tim A. Thomas, Annotation, *Denial by Hospital of Staff Privileges or Referrals to Physician or Other Health Care Practitioner as Violation of Sherman Act* (15 USCS 1 et seq.), 89 A.L.R. FED. 419, 426 (1988). *Contra* Bolt v.

exposed to the expense and time of litigation.¹³⁶ The willingness of targeted physicians to file antitrust law suites is at least partially explained by the economic consequences of hospital privilege denial, as a physician without hospital privileges is severely limited in her ability to care for patients.¹³⁷ One commonly asserted antitrust allegation in the peer review context is a Section 1 violations under the Sherman Act, that is either that the members of the peer review committee conspired among themselves, and/or that the members of the peer review committee conspired with the hospital to limit the physician's access to the hospital's facilities.¹³⁸ The three common defenses that a hospital can put forth when it faces a Section 1 conspiracy allegation are the state action doctrine, the HCQIA, and the intraenterprise immunity doctrine.¹³⁹

In *Summit Health v Pinhas* the Supreme Court held that actions taken for anticompetitive purposes were not protected under the HCQIA and that the hospital's peer review process affected interstate commerce.¹⁴⁰ Additionally, where a hospital's actions were allegedly taken for the sole purpose of excluding a doctor from performing his ophthalmologic services within a geographic area, HCQIA immunity did not apply, and federal jurisdiction under the Sherman Act was applicable.¹⁴¹

The state action defense doctrine, which was first recognized by the United States Supreme Court in *Parker v Brown*, has effectively become unavailable to private hospitals after the United States Supreme Court's decision in *Patrick v. Burget*¹⁴² because most private hospitals are

Halifax Hosp. Med. Ctr., 891 F.2d 810, 828 (11th Cir. 1990) ("reversing the directed verdict awarded to a hospital on charges of antitrust violations regarding the hospital's peer review activities").

¹³⁶ Miller, *supra* note 135, at 412.

¹³⁷ *Id.* at 417 (citing John J. Miles, 2 HEALTH CARE & ANTITRUST LAW: PRINCIPLES AND PRACTICE §10:1 (1995)).

¹³⁸ *Id.* at 412.

¹³⁹ *Id.* at 417.

¹⁴⁰ *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 333 (1991).

¹⁴¹ *Id.*

¹⁴² *Patrick v. Burget*, 486 U.S. 94 (1988).

unable to fulfill the two-prong test that was first stated in *Dealers Ass'n v. Midcal Aluminum, Inc.*: that "the challenged restraint must be "one clearly articulated and affirmatively expressed as state policy" and "the policy must be "actively supervised' by the State itself."¹⁴³

The Intraenterprise Immunity Doctrine has been used as a third area of defense in a Section 1 Sherman Act claim if the defendant hospital can claim that it and the peer review committee acted as a single entity. However the circuit courts are split on the use of this defense.¹⁴⁴ Additionally this defense would fail if a personal stake exception exists such as when a peer review member or hospital agent acts for personal gain.¹⁴⁵ Therefore following a strict policy of using impartial peer reviewers is mandatory to avoid liability.

There have been several cases of multimillion dollar settlements made by hospitals to resolve False Claims Act liability for unnecessary procedures, where the hospitals were alleged to have been aware of conduct engaged in by its medical staff, but nevertheless, took no action to address the quality of care or medical necessity concerns because the physician was a high producer or the hospital wanted to maintain their profitability.¹⁴⁶ Since peer review

¹⁴³ *Dealers Ass'n v. Midcal Aluminum, Inc.*, 445 U.S. 97, 105 (1980).

¹⁴⁴ *Miller*, *supra* note 135, at 423-24 (citing *Copperweld Corp. v. Independence Tube Corp.*, 467 U.S. 752, 770-72 (1984): two conditions if met, make the intraenterprise conspiracy immunity is available –1) the parent and its alleged conspirators have a unity of economic interest, and 2) the parent exerts control over the decisions of its officers, employees, and agents) (the Third, Fourth, Sixth and Seventh Circuits have held that a hospital is not capable of conspiring with its medical staff, while the Eleventh Circuit held to the contrary).

¹⁴⁵ *Id.* at 434 (referencing *Islami v. Covenant Med. Ctr., Inc.*, 822 F. Supp. 1361, 1382 (N.D. Iowa 1992) where summary judgment was denied on antitrust claims against a hospital and peer review physicians, noting that the personal stake exception exists when evidence indicates that the reviewing physicians "were acting for their own personal benefit.").

¹⁴⁶ BNA Insights: Health Law Resource Center, *supra* note 17 (citing Press Release, Dep't of Justice. *Lafayette General Medical Center to Pay \$1.9 Million to Settle Fraud Allegations in Connection with Medically Unnecessary Cardiology Procedures*, (Jan. 11, 2008), available at <http://www.justice.gov/usao/law/news/wdl20080111.pdf>, and

frequently operates in its own silo, there is a tremendous risk that information that would trigger compliance concerns will remain sealed within the peer review apparatus and will never be addressed.¹⁴⁷ To avoid these problems, it is advantageous for the hospital to conduct peer review in a manner that will withstand governmental scrutiny. A systematic “random sampling of records” and possible use of outside clinical reviewers would help ensure a non-biased peer review process. It has been recommended that the hospital compliance department should consider regular evaluation of the peer review process.¹⁴⁸

D. Modern Health Care Systems and “Obama Care” Have Made HCQIA Outdated

The evolution of health care is quickly making the HCQIA an anachronism. In 1986 Congress enacted the HCQIA under the presumption that adverse outcomes are mainly due to individual carelessness and that by identifying these individuals through the peer review process, and restricting their practice, adverse events would be reduced.¹⁴⁹ But modern thinking is that, although individuals do make mistakes, adverse outcomes are largely the product of system-level flaws and simply punishing individuals would not correct the larger problem.¹⁵⁰ Additionally today, surgeons, anesthesiologists, and other invasive specialists increasingly practice in outpatient centers, and primary care physicians no longer treat hospitalized patients, thus making hospital peer review and the associated NPDB reporting inaccurate in identifying incompetent physicians.¹⁵¹

Kurt Eichenwald, *Tenet Healthcare Paying \$54 Million In Fraud Settlement*, N. Y. TIMES Aug. 7, 2003, available at <http://www.nytimes.com/2003/08/07/business/tenet-healthcare-paying-54-million-in-fraud-settlement.html?pagewanted=print&src=pm>.)

¹⁴⁷ *Id.*

¹⁴⁸ *Id.*

¹⁴⁹ Haavi Morreim, *Moral Hazard: The Pros and Cons of Avoiding Data Bank Reports*, 4 DREXEL L. REV. 265, 288-91 (2011).

¹⁵⁰ *Id.* at 289.

¹⁵¹ *Id.* at 288-91.

With the passage of the Patient Protection and Affordable Care Act (PPACA) also known as Obama Care or the ACA, and the anticipated creation of Accountable Care Organizations (ACOs) (with attendant protection from antitrust laws) there will be a greater concentration of physicians in large groups and conglomerates.¹⁵² This leaves the smaller physician practices vulnerable to bullying thru censorship. On the flip side, these large conglomerates, which are closed systems, will eventually encompass a major percentage of available physicians. Both these situations create an environment for peer review abuse, thus making stronger due process protection during peer review essential, both to protect the reviewed physician and to preserve patient choice. Alternatively, these conglomerates would likely have their own internal policing systems (with a registry of physician quality issues), which make HCQIA unnecessary.

Additionally, the standards used under HCQIA are based on customary care which has evolved from a fee-for-service system of health care reimbursement (which encourages more utilization, rather than less).¹⁵³ The movement towards ACOs and a quality and outcome based reimbursement system would likely make HCQIA, without some modification an anachronism.

The Centers for Medicare and Medicaid Services (CMS) has adopted several initiatives that provide strong financial incentives for quality of care including non payment for “never events,” higher payments based on quality measures and patient outcomes under the Premier Quality Initiative for hospitals and the Physician Quality Reporting System (PQRS) for physicians.¹⁵⁴ The ACA has created several initiatives for the development of best practices for hospitals and physicians.¹⁵⁵ The ACA has also essentially turned private insurers into regulatory agencies of sorts by

¹⁵² J. D. Harrison, *Health-care Law Driving Doctors Away from Small Practices, Toward Hospital Employment*, WASH. POST, July 19, 2012, available at <http://www.aaos.org/govern/public/pressreleases/WashPostarticle.asp>.

¹⁵³ Van Tassel, *supra* note 13, at 1234.

¹⁵⁴ Van Tassel, *supra* note 130, at 11-12.

¹⁵⁵ *Id.* at 14-15.

requiring them, under the Health Benefit Exchanges that have been created, to evaluate providers through the same quality benchmarks that the CMS uses under PQRS.¹⁵⁶ The quality improvement provisions under the ACA and CMS together create a powerful health care quality regulatory mechanism that in today's health care environment makes the HCQIA shield of immunity an instrument that does more harm than good.

V. PROPOSED SOLUTIONS

Some legal writers feel that the HCQIA provides only a narrowly defined immunity as it only shields monetary damage, but not injunctions, and the HCQIA's good faith requirement only protects those situations where the facts could not support an antitrust claim anyways.¹⁵⁷ Given that opinion on limited protection and the expressed negative aspects of the HCQIA, several scholars have advocated for its repeal. However, repeal may be difficult given that the HCQIA is still strongly supported by organized medicine.¹⁵⁸ Several other less dramatic and more easily achievable methods of reform are outlined.

A. Improve Due Process Under HCQIA to Comport with Constitutional Standards

The last sentence of 42 U.S.C. § 11112(b)(3), "A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3)"¹⁵⁹ should be repealed or amended. By removing the HCQIA's optional requirement for due process, courts would be required to

¹⁵⁶ *Id.* at 15-16.

¹⁵⁷ Miller, *supra* note 135, at 420-21 (citing BARRY R. FURROW ET AL., HEALTH LAW 420-21 (1995)(recognizing that Congress "enacted extremely narrow immunity legislation for peer reviewers" when it passed the HCQIA)).

¹⁵⁸ Kinney, *supra* note 15, at 78, 80 (noting that the American Medical Association has continued to defend immunity under the HCQIA).

¹⁵⁹ 42 U.S.C. § 11112(b) (2013).

review peer review actions under the *Mathews v Eldridge* three-prong test.¹⁶⁰

Analysis of peer review due process under the 3-part balancing test of *Mathews* would go as follows:¹⁶¹

1) The private interest affected by the official action is great as a physician's medical career hangs on the decisions made.

2) The risk of erroneous deprivation through the procedures used is also significant as reliance on standards of customary care or the discretion of hospital administrators to judge physicians' competency creates a high risk of error, which also makes the NPDB data inaccurate and misleading. The evidentiary rules or practices applicable in a formal courtroom setting are not followed, thus allowing for hearsay to factor into the decisions. There is also significant state-to-state disparity in the level of judicial review given to adverse peer review decisions, making the potential for adverse review and unsuccessful judicial appeal more related to geography rather than quality of patient care provided.¹⁶²

The "Reasonable Belief" standard required to qualify for HCQIA immunity is presently open to very loose interpretation by the courts, and it should be addressed by Congress through amendment of the HCQIA or by DHHS through regulation. For example, the standard should be to consider all evidence in the record as a whole—like the United States Supreme Court

¹⁶⁰ *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976).

¹⁶¹ Kinney, *supra* note 15, at 82-83; *see also* Van Tassel, *supra* note 47, at 2067-92.

¹⁶² Van Tassel, *supra* note 47, at 2087.

ruling in *NLRB v. Universal Camera Corp.*¹⁶³ There should also be effective sanctions against abuse through monitoring by the government (by the NPDB), independent Quality Improvement Organizations, or privately by JCAHO; as the courts have proven to be ineffective in sanctioning abuse.¹⁶⁴

3) The government has an interest in improving quality of care, lowering health costs, and protecting patients from bad doctors. The administrative burdens of additional safeguards are reasonable. The lack of complete due process protection during peer review and the potential for NPDB listing prevent those goals from being met. The NPDB has not been documented to be clearly effective, is inaccurate, and can be both over inclusive and under inclusive.¹⁶⁵ The threat of a NPDB listing and the bullying effects of peer review can prevent physicians from being effective patient advocates in this era as hospitals place increasing importance on profit margins. Providing physicians with due process would further these goals and be in the public's interest.

Congress could amend the HCQIA to limit participation in federal health programs to hospitals that follow due process guidelines. These changes should not entail additional cost to the government and should be smooth to implement as government run hospitals like the VA are already required to provide due process to physicians in peer review.¹⁶⁶ Subscribing to these standards would allow

¹⁶³ Kinney, *supra* note 15, at 83; *see also* *NLRB v. Universal Camera Corp.*, 340 U.S. 474 (1951).

¹⁶⁴ Kinney, *supra* note 15, at 83.

¹⁶⁵ Morreim, *supra* note 149, at 278-88.

¹⁶⁶ Van Tassel, *supra* note 47, at 2094.

reviewing courts a baseline to judge the validity of adverse peer review actions.

Barring congressional legislative action, a higher level of judicial oversight of due process procedures is needed to serve as a check on hospital peer review. For instance, the Supreme Court of Alaska in *Kiester* held that in order to establish adequate notice, the hospital must identify both “the objective criteria that the physician has violated and the manner in which the physician violated the criteria.”¹⁶⁷ A more stringent and similar judicial interpretation of the HCQIA language, such as “the reasonable belief”¹⁶⁸ standard, would strengthen the due process protection under peer review.

There is motivation for those involved in the peer review process to follow the HCQIA standards for “adequate notice” and “fair” process, which if they were adhered to then they would prevent the targeted physician from suing for damages. Nevertheless, the targeted physician can still sue for injunctive and other types of equitable relief based on constitutional, common law, or medical staff by-law guarantees of fair process.¹⁶⁹ However, these legal challenges generally fail due to the vague standards (which fail to provide adequate notice to physicians and allow for their arbitrary application) that make the procedural safeguards (which themselves are often loosely followed) minimally protective for the challenging physician.¹⁷⁰ The challenging physician is confronted with the HCQIA

¹⁶⁷ Van Tassel, *supra* note 13, at 1208 (citing *Kiester v. Humana Hosp. Alaska, Inc.*, 843 P.2d 1219, 1225 (Alaska 1992)) (“Both the criteria used to judge competency and the violations should be identified with sufficient clarity to allow the physician to prepare a full and fair defense against the claims of the hospital.”); *see also* *Garrow v. Elizabeth Gen. Hosp. & Dispensary*, 401 A.2d 533 (N.J. 1979) (citing 148 *Christenson v Mount Carmel Health*, 678 N.E.2d 255, 262-63 (Ohio Ct. App. 1996)).

¹⁶⁸ 42 U.S.C. §11112 (2013).

¹⁶⁹ Van Tassel, *supra* note 13, at 1197 n.96 (“Many state statutes provide a much broader immunity for both the individual participants in the peer review process and the hospital. Unlike HCQIA, in most cases, the state immunity provisions will not provide immunity from federal antitrust liability.”)

¹⁷⁰ *Id.* at 1204-10.

provision that professional review actions are presumed to have met the statutory standards unless the “presumption is rebutted by a preponderance of the evidence.”¹⁷¹ Nevertheless, although few and far in between, there have been successful challenges to HCQIA immunity. These challenges have been brought under various theories including antitrust,¹⁷² violation of constitutional rights,¹⁷³ and public policy protected conduct.¹⁷⁴ In all of these, the plaintiff was able to show malice on the part of the hospital or peer review committee.

When reviewing a challenge to an adverse peer review proceeding, courts should look for certain situations that have been identified as indicative of malice in the peer review process and that require heightened review by hospital decision-makers, attorneys and judges, such as:

[W]hen the peer review process results in the denial of privileges to an apparently competent physician where (1) complaints are initiated outside of the normal hospital quality assurance channels; (2) actions are taken without affording the doctor due process; (3) due process—notice and opportunity to be heard—is a sham; (4) incompetence is alleged notwithstanding the fact that the doctor's treatment represents an alternative, but recognized, medical school of thought; or (5) the hospital did not consider reeducation, required consultations, monitoring, or

¹⁷¹ Kinney, *supra* note 15, at 66 (citing 42 U.S.C. § 11112(a) (2008)); *Joshi v. St. Luke's Episcopal-Presbyterian Hosp.*, 142 S.W.3d 862, 866 (Mo. Ct. App. 2004).

¹⁷² *Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 333 (1991); *see also Islami v. Covenant Med. Ctr.*, 822 F. Supp. 1361, 1379-80 (N.D. Iowa 1992).

¹⁷³ *Ulrich v. City and County of San Francisco*, 308 F.3d 968 (9th Cir. 2002) (violation of First Amendment right of free speech and Fourteenth Amendment right of due process).

¹⁷⁴ *Clark v. Columbia/HCA Info. Servs., Inc.*, 25 P.3d 215 (Nev.2001) (explaining that the revocation of staff privileges was not made with reasonable belief that it was in furtherance of quality health care, and whistle-blowing is conduct protected as a matter of public policy).

privilege restrictions as alternatives to a total revocation of privileges.¹⁷⁵

Any of these should signal possible abuse of the peer review process and warrant more detailed investigation of the facts.

B. Use a Better-Defined Standard for Judging Physician Competence

Professor Van Tassel has proposed the use of a combination of evidence-based medicine (clinical practice guidelines or CPGs) and tort doctrine as a standard to measure physician competence in peer review.¹⁷⁶

Clinical Practice Guidelines, many of which have been developed by private physician organizations such as the American College of Physicians and the American Academy of Pediatrics, are “systematically developed statements to assist practitioner and patient decisions about appropriate health care for specific clinical circumstances.”¹⁷⁷ Local or centralized CPG committees should be formed to review, adopt, or modify the CPGs that have been put forth by the national practice organization, and once adopted, physicians should be expected to comply with them or document the reasons for deviating.¹⁷⁸

One advantage of using better defined patient care clinical guidelines is that deviation from care is more readily detectable, allowing earlier and probably less severe remedial measures for the involved caregiver. There would also be minimal need for discovery of other physicians' care in review situations, and this may also help guide courts in

¹⁷⁵ Pauline Martin Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 LOY. L.A. L. REV. 357, 395-96 (1993) (footnote omitted).

¹⁷⁶ Van Tassel, *supra* note 13, at 1232.

¹⁷⁷ *Id.* at 1242 (citing INST. OF MED., CLINICAL PRACTICE GUIDELINES: DIRECTIONS FOR A NEW PROGRAM 8 (Marilyn J. Field & Kathleen N. Lohr eds., 1990)); see also THE NATIONAL GUIDELINE CLEARINGHOUSE, <http://www.guideline.gov> (lasted visited Jan. 2, 2014) (providing access to current clinical guidelines).

¹⁷⁸ Van Tassel, *supra* note 13, at 1246-48.

malpractice cases.¹⁷⁹ Since CPGs evolve and presently do not cover all medical situations, Van Tassel proposed using the Tort “Reasonable Care “ standard as a back up.¹⁸⁰

C. Rely on a Systems Approach to Address Medical Errors and Improve Health Care

The modern thinking in regards to most hospital medical errors is that system flaws rather than an individual cause them.¹⁸¹ The 1999 IOM landmark study started a national health care movement to improve patient safety, based on an evidence-based systems approach of reducing medical errors, recognizing that “safety is primarily a systems problem.”¹⁸²

A root analysis approach to discover the system defect, rather than finger pointing and blame of specific caregivers, would encourage a culture of openness and possibly lead to more success in improving health care quality and controlling cost. If a physician is discovered to have incompetencies, a more rehabilitative approach, with alternatives such as reeducation, required consultations, monitoring, or privilege restrictions, would be a less retaliatory and more productive method of correcting the problem while still preserving medical manpower. Physicians would also be more willing to report on their colleagues’ insufficiencies if they know that the review process will be fair and that rehabilitation rather than retaliation will be the end result. Reviewing courts should look for these features in any contested peer review action.

¹⁷⁹ *Id.* at 1249.

¹⁸⁰ *Id.* at 1251.

¹⁸¹ Morreim, *supra* note 149, at 289.

¹⁸² Brian M. Peters & Robin Locke Nagele, *Promoting Quality Care & Patient Safety: The Case for Abandoning the Joint Commission's "Self-Governing" Medical Staff Paradigm*, 14 MICH. ST. U. J. MED. & L. 313, 344-45 (2010) (citing Lucian L. Leape et al., *What Practices Will Most Improve Safety?: Evidence-Based Medicine Meets Patient Safety*, 288 J. AM MED. ASS'N 501, 504 (2002); COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *CROSSING THE QUALITY CHASM: A NEW HEALTH SYSTEM FOR THE 21ST CENTURY* (National Academy Press 2001), available at http://www.nap.edu/catalog.php?record_id=10027.

D. Use an Independent Board for Peer Review

In 2001 the Maryland General Assembly appointed a study, which was conducted by the University of Baltimore. The study found that there was a high potential for whistle blowing doctors who alienated hospital officials to be labeled disruptive and then suffer HCQIA immunity protected adverse peer review actions. The study recommended the formation of a state Physician Administrative Review Board that would investigate potential HCQIA immunity abuse by hospitals and review boards.¹⁸³ Such an independent board would be free of the inherent biases of a hospital based peer review committee and is an option that should be considered.

V. CONCLUSION

The HCQIA, as presently applied in the private hospital setting, does not appear to serve its intended purpose of improving quality of care and protecting the public. Furthermore, because of the lack of enforcement of due process and poorly defined standards in the peer review process, there is a high potential for violating the property and liberty rights of the targeted physicians. The risk of injury makes the the HCQIA outdated or unnecessary in the modern health care environment. Better defined standards of care, ensuring that due process procedures are followed through either repeal or amendment of HCQIA or via stricter judicial interpretation of peer review actions, would help preserve constitutional rights of our physician caretakers and help improve quality of care. Other methods of improving health care quality, including a systems approach to medical errors, and a more rehabilitative approach to physician behavior and competence are also suggested.

¹⁸³ Panella, *supra* note 42, at 296-97(citing Steve Twedt, *The Cost of Courage: Doctor Says Whistleblowers Need More Protection*, PITTSBURGH POST-GAZETTE, Oct. 29, 2003, available at <http://www.post-gazette.com/pg/03302/235115.stm>).