

The Health Care Quality Improvement Act (HCQIA) passed by Congress in 1986, for example, encourages peer review and professional discipline by giving immunity from a lawsuit for damages to physician and dentist peer reviewers and by requiring that disciplinary actions against physicians and dentists be reported to the National Practitioner Data Bank. Physicians and dentists involved in peer review are protected from liability for anticompetitive behavior if their review is conducted “1) in the reasonable belief that the action was in the furtherance of quality health care; 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 adequate notice and hearing procedures].”(3)

Recent appellate court decisions in Pennsylvania and other jurisdictions raise the question whether the immunity afforded hospitals and reviewers under the federal Health Care Quality Improvement Act (HCQIA) have allowed the peer review system to be improperly utilized, or even abused in some cases.

HCQIA was enacted by Congress in 1986 to provide immunity against civil litigation damages for physicians and hospitals engaging in professional peer review, and to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of prior damaging or incompetent medical performance. Immunity under HCQIA can be established if the peer review process meets four general standards:

- It had an objective, reasonable belief that its action furthered quality health care.
- It made an objective, reasonable effort to obtain the facts.
- Under the *totality of the circumstances*, the physician being reviewed received adequate notice and hearing (i.e., due process) procedures.
- The organization had a reasonable belief that its actions were warranted.

Superficial review of this four-part test suggests physicians should receive due process throughout the entire peer review, and serious quality of care issues must exist before a physician’s privileges can be suspended, reduced or revoked. Case law and experience demonstrate the contrary.

Bias and Conflicts of Interest Immaterial

In *Manzetti v. Mercy Hospital of Pittsburgh*, the Pennsylvania Supreme Court held on July 18, 2001 that the hospital and reviewers were entitled to immunity under HCQIA. The Supreme Court disregarded all evidence relating to the reviewed physician’s competitors’ involvement in the case and attacks against him. The Court stated that any self-interest, bias or conflicts of interests by the reviewers were *immaterial*. According to

the Court, the only time HCQIA precludes an economic competitor from involvement in the internal peer review process is at the hearing panel phase of the case; however, HCQIA does not preclude economic competitors from perpetrating due process violations and inculcating bias throughout the early phases of the review process. Under most hospital bylaws, by the time the physician gets to the fair hearing panel, the burden has shifted against the physician with the requirement that the physician prove by clear and convincing evidence that all prior decisions were arbitrary and capricious or factually baseless. Practical experience demonstrates this is a virtually impossible burden to sustain and standard to satisfy.

The Supreme Court also held that the "reasonable effort" prong of the four-part HCQIA immunity test is satisfied if the review activities are "sensible," but they do not have to be "flawless." Thus, the Supreme Court has countenanced due process violations and errors in the peer review process.

Sloppy, Negligent and Wrong Peer Review Warrants Immunity

In *Donnell v. HCA Health Services of Kansas, Inc.*, the Kansas Court of Appeals held on July 6, 2001 that physician peer reviewers are immune from liability under HCQIA even if their investigations are *sloppy, negligent, and wrong*. Physicians must prove bad faith and malice to have a peer review decision overturned.

This decision, like *Manzetti* above, allows a hospital to make serious mistakes about the quality of a physician's health care. It also permits termination of the physician's staff privileges, and the detrimental effect of a Data Bank entry, all with immunity from liability and practical impunity.

One Mistake and Done: Free Ride for Abuse

In *Meyer v. Sunrise Hospital*, the Nevada Supreme Court held on May 15, 2001 that a hospital's decision to terminate a physician based upon a *single incident*, regardless of the high quality of care the physician provided throughout the remainder of his career, was sufficient to protect the hospital under HCQIA's immunity provisions.

One Justice on the Supreme Court recognized the unfairness of the statute, but was compelled to uphold the decision. The Justice noted that HCQIA can sometimes be used, "not to improve the quality of medical care, but to leave a doctor who was unfairly treated without any viable remedy." That Justice also stated: "basically as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, *whether legitimate or not*, they are immune from liability, which *leaves the hospitals free to abuse the process for their own purposes*."

No Constitutional Infractions

In *Freilich v. Board of Directors of Upper Chesapeake Health, Inc.*, a federal court in Maryland held on May 14, 2001 that the HCQIA immunity provisions do not violate due process or equal protection under the U.S. Constitution.

Review Must Be 100% Wrong?

In *Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999), it was proven that the hospital's outside expert report had several incorrect conclusions. The Court of Appeals, however, ignored these mistakes because it found the report to be "otherwise thorough." The Court implied that the expert report must be entirely mistaken, and that the mistakes must be obvious. Because they were not, the hospital's decision was not unreasonable, and the first and fourth prongs of the HCQIA immunity test were satisfied.

Bias and Mistakes Early and Often Mean Nothing

In *Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa. Cmwlth. 1998), Commonwealth Court found that there is a presumption of validity of the hospital's disciplinary procedures. An outside consultant was retained. The Hearing Officer was an attorney, who was determined not to be in economic competition with the physician, but was a neutral party. Even though some of the physician's direct economic competitors were involved in the decision, and there was evidence of a history of hostility toward him, none of those individuals participated in drafting the outside report. The Court then looked to the *totality of the process* leading to the professional review action. Under that broad test, even though some parts of the process were critically flawed and biased, the Court said, in totality, the physician got all the process he was due.

These cases are the latest in a series of decisions nationwide leaving physicians who are subjected to peer review without any legal remedies, and without any right to secure a fair hearing and a fair outcome.

The Dreaded Data Bank

An "adverse action" following peer review results in the hospital reporting (through the Medical Board) the physician to the National Practitioner Data Bank, commonly referred to as the "Data Bank." Many reports conclude physicians' care was "incompetent," "unprofessional" or other professionally disastrous terms. Economic experts have opined that such a negative statement in the Data Bank directly results in substantial economic loss to a physician. The Pennsylvania Supreme Court in *Hayes v. Mercy Health Corp.*, 559 Pa. 21, 739 A.2d 114 (1999) stated that a physician's Data Bank entry may, if left unchallenged, have a deleterious effect on the physician's medical career.

Money and Vengeance

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often than not in the author's experience, peer review is initiated against a physician for one of three reasons: (1) by economic competitors for financial reasons; (2) in retaliation against the physician for not "playing ball" in one manner or another (economic or otherwise); or (3) in retaliation for the physician raising concerns about other physicians' care and seeking to have those providers' outcomes reviewed. The state "whistleblower" law does not protect these physicians. The Pennsylvania Peer Review Protection Act, which allows physicians to litigate tort and contract breach claims in state court against hospitals whose peer review is effectuated by malice or bad faith, has been "trumped" (although not technically preempted) by the federal HCQIA immunity standards.

Shifting Sands

Hospital bylaws impose difficult legal standards and burdens on physicians. Typically, after a physician is the subject of an adverse recommendation or an adverse action by a medical executive committee, the physician is given a fair hearing. Traditional notions of fairness might lead one to believe that the hospital would have the burden of proof by at least a preponderance of the evidence to demonstrate the physician's quality of care was below some recognized and measurable standard warranting a quality of care concern. After all, hospitals have a legitimate concern about corporate liability and "negligent credentialing" following the Supreme Court's *Nason Hospital* decision in 1991.

Absolutely every set of hospital bylaws the author has reviewed do not contemplate a truly fair system for the physician being reviewed. Instead of the hospital accepting the burden of proof with a reasonable standard based upon measurable guidelines for quality infractions, the bylaws shift the burden of proof to the physician and create a nearly impossible standard to overcome. The physician typically has the burden to prove that the hospital's decision was arbitrary and capricious. Some bylaws even state that the physician must prove that there was no material basis for the action or there was a complete absence of facts in the record to support the action. An utterly biased, sloppy, negligent and mistake-riddled report by an outside reviewer still cannot be overcome by this enormous burden if there is just a shred of truth in the report.

Practical Effect

As the case law outlined above illustrates, the physician's economic competitors and antagonists can initiate the peer review process, retain outside consultants and virtually direct the outcome of the report that will form the basis of the hospital's adverse action. After the antagonist's bias, conflict of interest, self-interest, direct economic competition and retaliation motives are all effectuated, they are immaterial and not reviewable by the courts, since all of those problems purportedly can be remedied by retaining a three-member independent panel to conduct the hearing.

Most fair hearing panels are truly independent. But, even if the panel calls "balls and strikes" fairly, the burden of proof and standard of review are so high it cannot be overcome practically. There is no legal remedy or recourse to the physician under the "totality of the circumstances" test. Hospitals have figured out that all they need to do is

establish an independent fair hearing panel, give minimal due process at that final phase of the case, and their immunity will be intact.

JCAHO Doesn't Care

The JCAHO accreditation manual for hospitals contains medical staff standards. One standard requires "mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges." When discussing the broad HCQIA immunity and typical hospital bylaws burden shifting and standard setting procedures that are anything but fair and balanced, JCAHO staff take the position that they "don't care about detail" even if, as applied, the physician has no chance to overcome the standards.

Courts Don't Care

Although courts have no hesitancy involving themselves in the intricacies of physician practice in the context of medical malpractice liability, courts take a contrary view when physicians seek redress as a result of faulty peer review and retaliation. In *Lyons v. St. Vincent Health Center*, Commonwealth Court stated: "It is not up to the courts to second-guess hospitals in their decisions as to the best way to deliver services; it is up to the institution itself."

Early Intervention Strategy

A physician subjected to peer review may have little chance of surviving unless early and aggressive measures are taken. Understanding the case law and limitation on judicial remedies, it is prudent for the physician and counsel to quickly retain the best conceivable expert in the subject area to address the outside reviewer report. In many cases, it becomes very clear that the outside reviewer's report significantly overstates quality of care infractions, is based on no published peer reviewed medical journal articles or positions, and is academically pedantic without taking into consideration reasonable and acceptable standards of care.

Successful resolution using this strategy can be achieved with minimal disruption to the physician, including perhaps CME and monitoring, without causing a damaging Data Bank entry.

Statewide Independent Peer Review

The process described in this article has led many physicians, and some organizations, to propose a statewide peer review requirement that would utilize independent, non-biased peer review organizations that make judgments based upon clearly acceptable standards, taking into consideration reasonable differences of opinion. Like a physician being judged for a licensure infraction, the burden of proof would remain on the entity seeking to impose discipline (the hospital) with at least a preponderance of the evidence standard,

if not a clear and convincing standard. Only this level of independence would balance the playing field and return quality of care to the forefront of peer review.

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In the medical profession, peer review is a "process by which physicians and hospitals evaluate and discipline staff doctors[.]" *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1321 (11th Cir.1994), *cert. denied*, 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995). The "HCQIA grants limited immunity, in suits brought by disciplined physicians, from liability for money damages to those who participate in professional peer review activities." *Id.* The HCQIA thus provides that, if the peer review action "meets certain due process and fairness requirements, then those participating in such a review process shall not be liable under any state or federal law for damages for the results." *Id.* at 1321-22.

In fact, because the peer review process is a legal process much more than a scientific or medical process, attorneys should be involved at the outset. The statute passed by Congress, known as the Health Care Quality Improvement Act (HCQIA), was designed to encourage good faith peer review by providing immunity for physicians who conduct peer review and set out standards and protections for physicians whose work is reviewed in the area of due process. The statute, however, was enacted before the National Practitioner's Data Bank became operational. Because disciplinary actions are reportable events, the process and its outcome has become even more important to physicians.

The basic start for the peer review process for physicians is their Code of Professional Responsibility. The Code, section 9.10, provides that medical societies, hospital credentialing, utilization and peer review committees established to scrutinize physicians' professional conduct must balance a physician's right to exercise medical judgment independently with the obligation to do so wisely and temperately. Committees that perform peer review work, whether for a hospital or medical society, are called upon to act ethically and to observe the principles of due process of law.

When HCQIA was initially passed in 1986, Congress drafted the legislation to protect physicians who conduct peer review from allegations of antitrust law violations. Congress did not, however, give physicians who conduct peer review full immunity and unfettered procedures. A physician who is determined to have taken an adverse action against another physician in violation of his or her rights protected by the Civil Rights Act of 1964 is not immune to liability for damages. The courts have ruled that the immunity afforded physicians who conduct peer review is for damages and not for injunctive relief. Further, the immunity would not prevent the government from determining that the hospital medical staff failed to provide appropriate peer review under HCQIA and, for example, through a survey and certification by the Joint Commission on the Accreditation of Healthcare Organizations (JCAHO), determine a deficiency of meeting the requirements in a particular peer review activity or hospital medical staff bylaws.

In order to invoke HCQIA's provisions for conditional immunity, the professional review action must have been undertaken (1) in the reasonable belief that if furthered the quality of health care; (2) after a reasonable effort to obtain the facts of the matter has been made; (3) after procedural due process protections; and (4) in the reasonable belief that after having conducted a reasonable investigation and satisfying the due process concerns, the facts warranted taking such action against the physician.

Many hospitals, medical staffs and medical societies do not follow HCQIA's explicit requirements regarding procedural due process. Even though HCQIA provides that a professional review body's failure to meet the conditions of any provision of the procedural requirements does not negate the immunity protection, many courts are beginning to review more closely whether the failure to meet the specific requirements provide a physician with sufficient due process protection.

HCQIA requires that adequate notice be given. Specifically, the notice must provide the proposed action to be taken, the reasons for the proposed action, that the physician has a right to request a hearing on the proposed action, the time limit (but not less than 30 days) in which the hearing has to be requested, and a summary of the physician's rights during the conduct of the hearing.

If the hearing is requested by the physician on a timely basis, the physician must be given notice of the hearing which includes the place, time and date of the hearing (which cannot be less than 30 days after the date of this notice), and a list of witnesses expected to testify on behalf of the peer review body.

The hearing is required to be held before an arbitrator mutually acceptable to the physician and the health care entity, a hearing officer who is appointed by the entity and does not have direct economic competition with the physician involved, or before a panel of individuals who are appointed by the entity and who are not in direct economic competition with the physician. The physician's rights are as follows:

1. To be represented by an attorney or other person of his or her choice.
2. To have a record made of the proceedings, copies of which may be obtained by the physician.
3. To call, examine and cross-examine witnesses.
4. To present evidence determined to be relevant by the hearing officer.
5. To submit a written statement at the close of the hearing.

Upon completion of the hearing, the physician has the right to receive the written recommendation of the arbitrator, officer or panel, including the basis for the recommendations, and to receive a written decision of the health care entity or medical society, including a statement of the basis for the decision.

In this day of economic credentialing where reports of adverse peer review action will be reported to medical licensure boards, managed care organizations and the National Practitioner Data Bank, it is important for physicians to pay attention to the HCQIA requirements and call their legal counsel before taking any steps, including attempts to discuss a settlement with the hospital or medical staff.

For more information about when physicians should obtain legal representation, contact McBrayer, McGinnis, Leslie & Kirkland at (859) 231-8780

In a September 28, 2001, decision issued by Justice Joseph J. Maltese, the New York Supreme Court in Richmond County awarded over \$235,000 in costs and attorneys' fees to the defending parties in a peer review lawsuit. **The award was based on a provision in the Health Care Quality Improvement Act (HCQIA) that states an award of fees and costs shall be made to prevailing parties if the court finds the suit was filed against them for frivolous reasons, without foundation, or in bad faith.**

In this case, a physician whose clinical privileges to perform certain surgical procedures at a hospital were suspended filed lawsuits against the hospital, its administrators, members of its medical staff, members of its board of trustees, and the outside expert retained to review the physician's medical charts. The physician alleged, among other things, that statements made in the medical peer review proceedings were defamatory. The suits sought over \$30 million in damages against the hospital and the other parties. The physician commenced one of the suits while the board of trustees was reviewing his suspension.

After the New York Public Health Council ruled that the hospital's actions complied with Public Health Law § 2801-b (which requires that hospital credentialing determinations be related to patient care, competency, or institutional objectives) and that the physician had been provided due process, the hospital and the other parties asked the judge to dismiss all claims before trial. That request asserted immunity from liability under HCQIA and New York Public Health Law § 2805-j. HCQIA provides participants in the medical peer review process with immunity from liability if certain due process and other criteria are met. Congress enacted HCQIA to discourage retaliatory litigation and encourage meaningful medical peer review. The request for dismissal was granted, and it was affirmed on appeal by the Appellate Division of the Supreme Court of the State of New York, Second Department. Thereafter, the defending parties requested an award of costs and attorneys' fees.

Noting the congressional finding underlying HCQIA that the threat of financial liability unreasonably discourages physicians from participating in effective peer review, the court ruled that the suits in this case were retaliatory, frivolous, and in bad faith. In the underlying order dismissing the case before trial, the court relied in part on a prior finding that "retaliatory lawsuits of this nature are precisely what HCQIA and the state immunity statutes were intended to discourage in order to encourage frank, open, and meaningful medical peer review." The court also

found that it was in bad faith for the physician to commence a lawsuit while the matter was still under consideration by the hospital's board of trustees since such an action would have a chilling effect on the process.

Statement on the Physician Expert Witness

[by the American College of Surgeons]

One of the most important and controversial figures in malpractice litigation is the physician expert witness. With the increasing number of malpractice suits in the country--and the growing size of awards for damages--the number of available "expert witnesses" has greatly increased in the past few years. In response to the need to define the recommended qualifications for the physician expert witness and the guidelines for his or her behavior, the Professional Liability Committee of the American College of Surgeons has issued the following statement. The statement is an adaptation of guidelines developed by the Council of Medical Specialty Societies and several other medical groups.

I. Recommended Qualifications for the Physician Expert Witness

- A.** The physician expert witness must have a current, valid, and unrestricted license to practice medicine in the state in which he or she practices.
- B.** The physician expert witness should be a diplomate of or have status with a specialty board recognized by the American Board of Medical Specialties, as well as be qualified by experience or demonstrated competence in the subject of the case.
- C.** The specialty of the physician expert witness should be appropriate to the subject matter in the case.
- D.** The physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should be actively involved in the clinical practice of the specialty or the subject matter of the case during the time the testimony or opinion is provided.
- E.** The physician expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case.
- F.** The physician expert should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times the physician expert has testified for the plaintiff or defendant.

II. Recommended Guidelines for Behavior of the Physician Expert Witness

Physicians have an obligation to testify in court as expert witnesses when appropriate. Physician expert witnesses are expected to be impartial and should not adopt a position as an advocate or partisan in the legal proceedings.

A. The physician expert witness should review the medical information in the case and testify to its content fairly, honestly, and in a balanced manner. In addition, the physician expert witness may be called upon to draw an inference or an opinion based on the facts of the case. In doing so, the physician expert witness should apply the same standards of fairness and honesty.

B. The physician expert should be prepared to distinguish between actual negligence (substandard medical care that results in harm) and an unfortunate medical outcome (recognized complications occurring as a result of medical uncertainty).

C. The physician expert witness should review the standards of practice prevailing at the time of the alleged occurrence.

D. The physician expert witness should be prepared to state the basis of his or her testimony or opinion, and whether it is based on personal experience, specific clinical references, evidence-based guidelines, or a generally accepted opinion in the specialty field. The physician expert witness should be prepared to discuss important alternate methods and views.

E. Compensation of the physician expert witness should be reasonable and commensurate with the time and effort given to preparing for deposition and court appearance. It is unethical for a physician expert witness to link compensation to the outcome of a case.

F. The physician expert witness is ethically and legally obligated to tell the truth. Transcripts of depositions and courtroom testimony are public records, and subject to independent peer reviews. The physician expert witness should be aware that failure to provide truthful testimony exposes the physician expert to criminal prosecution for perjury, civil suits for negligence, and revocation or suspension of his or her professional license.

Statements

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