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Swinging pendulum of peer review immunity

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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 1996 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

The author has represented orthopedic surgeons, cardiologists, OB/GYNs, thoracic surgeons, anesthesiologists, ophthalmologists, family physicians, internists and other specialists in hospital peer review cases and medical staff privileges litigation. More 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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