

## **Peer Review Immunity: History, Operation and Recent Decisions - Has HCQIA Accomplished its Goals?**

[Michael A. Cassidy](#)

Tucker Arensberg, P.C.

In November of 1986, in the throes what now appears to be a perpetual malpractice crisis and following an anti-trust decision holding a group of physicians liable for treble antitrust damages on the basis of a conspiracy to restrain trade, the U.S. Congress enacted the Health Care Quality Improvement Act (HCQIA) and established the National Practitioners Data Bank (NPDB), making the following findings of fact in the process:

1. The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.
2. There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.
3. This nationwide problem can be remedied through effective professional peer review.
4. The threat of private money damage liability under Federal law, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
5. There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

"The intent of Title IV of Public Law 99-660 is to improve the quality of health care by encouraging state licensing boards, hospitals, and other health care entities and professional societies to identify and discipline those who engage in unprofessional behavior, and to restrict the ability of incompetent physicians, dentists and other health care practitioners to move from state to state without disclosure or discovery of previous medical malpractice payment and adverse action history. Adverse actions can involve licensure, clinical privileges and professional society membership.

The Division of Quality Assurance (DQA) of the Bureau of Health Professions (BHP) of the Health Resources and Services Administration (HRSA) of the Department of Health and Human Services (DHHS) is statutorily responsible for managing the NPDB program. The actual operation of the program is a contract service. Unisys Corporation operated the Data Bank from its inception on September 1, 1990 through June 1995; SRA International, Inc. replaced Unisys at that time and has operated NDPD since then.

### **Coordination with HIPDB.**

The Health Care Integrity and Protection Data Bank (HIPDB) is another reporting program operated by DHHS. It was established by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) in order to detect and combat fraud and abuse in the health care industry. To alleviate the reporting burdens

for entities which must report to both programs, DHHS has established the Integrated Querying and Reporting Service (IQRS) to simplify the reporting obligations.

The focus of this article will be on the reporting an immunity provisions relating to adverse professional review actions only, not the malpractice reports required by the NPDB or the fraud and abuse reports required by the HIPDB. Since becoming operational in 1990, there have only been 715 adverse action reports through December 31, 2000. Many commentators speculate this is representative of a significant under reporting problem, and that peer review activities are being "managed" to avoid reporting obligations.

### **Adverse Professional Review Actions**

The concept of an adverse professional review action or an adverse peer review action is actually a combination of two definitions in the HCQIA, i.e. "adversely affecting" and "professional review actions".

Professional review action is defined as a recommendation or action [and recommendation is included to encompass those medical staff procedures in which medical staff committees only make recommendations to be considered or rejected by the hospital's governing board] made as part of a professional review activity, which is based upon the competence or professional conduct of the physician and which adversely affects the clinical privileges or medical staff membership of the physician. "Adversely affecting" is defined to include "reducing, restricting, suspending, revoking, denying or failing to renew clinical privileges or membership".

Not all adverse actions must be reported to the Data Bank 45 C.F.R. §60.9 defines reportable adverse actions. Each health care entity (defined in 42 USC §11151(4) as a state licensed hospital, any entity providing health care services with a formal peer review process, or any professional society of health care practitioners with a formal peer review process) must report to the Board of Medical Examiners in the state in which the health care entity is located the following actions:

- (1) Any professional review action that adversely affects the clinical privileges of a physician or dentist for a period of longer than 30 days;
- (2) Acceptance of the surrender of clinical privileges or any restriction of such privileges by a physician or dentist.
  - (a) while the physician or dentist is under investigation by the health care entity relating to possible incompetence or improper professional conduct, or
  - (b) in return for not conducting such an investigation or proceeding, or
- (3) In the case of a health care entity which is a professional society, when it takes a professional review action concerning a physician or dentist.

### **Immunity**

One key aspect of HCQIA is the immunity granted for participation in and reporting of peer review actions or adverse professional review activities. One of the cases that garnered significant professional attention at the time and which has been cited as a precipitant factor in the passage of HCQIA was Patrick v. Burget, 486 S. 94 (1988). Dr. Burget sued the Astoria Clinic and several physician-partners in a surgery practice from which he had resigned, alleging that the hospital and physicians conspired to restrain him from practicing, and used the peer review process merely as a means to terminate his clinical privileges and prevent him from establishing a competing surgery practice. The appellate court reversed a decision entering \$2 million judgment in Dr Burget's favor on the grounds that the peer review proceedings were mandated by the state hospital licensing laws and therefore sheltered from anti-trust liability pursuant to the state action doctrine. The Supreme Court reversed the 9<sup>th</sup> Circuit, holding that the peer review proceedings were not sufficiently state regulated to qualify under the state action exemption. The fears that hospital and physicians participating in peer review proceeding, could be liable for multi-million dollar damages under federal anti-trust laws contributed greatly to the demand for peer review immunity.

HCQIA deals with the potential civil liability for peer review activities by providing immunity for both the participation in and the reporting of adverse professional review actions.

Peer Review Activity: 42 U.S.C. § 11111 states that a professional review body, any person acting as a member of that body, any person providing services to the body, and any person who participates with or assists the peer review body in the conduct of a professional review action that meets the standards specified in HCQIA for such actions "shall not be liable in damages under any law of the United States or of any State with respect to the action". Reporting: 42 U.S.C. §11137(c) provides that no person shall be held liable in any civil action with respect to any report filed pursuant to HCQIA provided such report was made "without knowledge of the falsity of the information contained in the report."

### **Standards for Professional Review Actions**

42 U.S.C. §11112(a) establishes four basic due process requirements in order to qualify for the peer review immunity authorized by HCQIA, and creates a significant barrier for plaintiff physicians by further providing that "a professional review action shall be presumed to have met the preceding standards... unless the presumption is rebutted by a preponderance of the evidence". The significance of this presumption will be discussed following a review of the four standards, which require that professional review actions be taken:

- (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 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 the facts and after meeting the requirements of paragraph (3).

### **Reasonable Belief/Furthermore of Quality Healthcare**

There are two "reasonable belief" requirements, and whenever the same terms are used for different elements of some requirement or condition there is usually some confusion. Although there are a number of cases that recite compliance with this standard, it is sometimes applied as a somewhat amorphous or intangible requirement that the participants must merely have intended to act in the furtherance of improving healthcare quality. In that sense, it would be very difficult to prove this standard had not been satisfied in any particular matter.

However, there is one case in which a court seizes upon the absence of this condition to withhold immunity from the participants. In Clark v. Columbia/HCA, 25 P.3<sup>rd</sup> 215 (Nev. Sup. Ct. 2001), the Nevada Supreme Court reversed a trial court summary judgment award on behalf of the peer review defendants. Dr. Clark, a psychiatrist, had sued a Columbia/HCA hospital (Truckee Meadows Hospital) and a number of physicians who participated in a peer review proceeding, which culminated in the revocation of his medical staff membership, alleging defamation, restraint of trade, tortious interference and breach of contract. The Defendants moved for and obtained summary judgment on the basis of HCQIA peer review immunity. The Nevada appellate court reversed and remanded, finding that Dr. Clark had demonstrated by a preponderance of the evidence that the action was not based upon a reasonable belief of furthering quality healthcare.

In reviewing the facts, the Nevada Supreme Court concluded that the activities for which Dr. Clark was being reviewed consisted of "whistleblowing conduct", e.g. letters to outside doctors and regulatory agencies, complaints about the hospital care and scheduling, etc. The Court concluded, "To punish a physician for reporting potentially dangerous practices to appropriate authorities to improve the quality of patient care cannot logically be construed to be an action that one could reasonably believe is in furtherance of quality health care".

## **Reasonable Investigation**

There are two questions raised by the reasonable investigation requirement, i.e. what constitutes a reasonable investigation and when may any action be taken during the investigation, i.e. must the investigation be complete before any action is taken?

In Singh v. Blue Cross and Blue Shield of Mass. Inc., 2001 U.S. Dist. LEXIS 16355, the District Court clearly states the prevailing opinion regarding the necessary quality of the required investigation, stating: "the HCQIA entitled Singh to a reasonable investigation, not a perfect one."

The standard appears to be a classic facts and circumstances situation. "The mere fact that some other hospitals dealing with other physicians performing different types of procedures may have conducted investigations that were larger than the one conducted here does not rebut the presumption that Appellees expended a reasonable effort investigating this matter."

The courts have also been fairly uniform about holding that the peer review process is just that, a process, and that interim disciplinary steps may be taken during the investigatory process.

"We reject this interpretation of Mathews. [Mathews v. Lancaster General Hospital, 87 F.3<sup>rd</sup> 624 (3<sup>rd</sup> Cir. 1996)] Mathews in 710 fashion stands for the proposition that a professional review action may not be taken prior to the completion of an investigation or a hearing . . . The Mathews court concluded that the professional review event it was examining was merely a "professional review activity" and thus it need not comply with the four prongs of § 11112(a) because no action had yet been taken. The court did not, however, state that a professional review action may never be taken prior to the completion of an investigation or holding of a hearing."

## **Adequate Due Process**

42 U.S.C. § 11112(b) defines specific standards for the peer review process, i.e. the notice to the physician, the conduct and timing of any hearing, appeal rights, etc. The thrust of the requirement is that the physician must have a reasonable opportunity to defend himself against the peer review charges. However, despite the specificity of the standards, the standards are not absolute requirements; they are only recommendations. The statute itself specifically states, "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) of this section".

A hospital is not required to satisfy all characteristics and requirements set out in Health Care Quality Improvement Act (HCQIA) for conducting hearings and providing notice in order to meet the due process requirements. Rather, HCQIA's listing of characteristics describes a safe harbor for obtaining immunity. Smith v. Ricks, 31 F.3d 1478 (9<sup>th</sup> Cir. 1994), cert. den. 115 S. Ct. 1400.

In Islami v. Covenant Medical Center, Inc., 822 F. Supp. 1361 (Dist. Ct. N.D. Iowa 1992), the Court held that the hospital had provided neither the due process rights provided by the bylaws nor the safe harbor standards enunciated by HCQIA, and therefore denied summary judgment and immunity to the defendants. Nevertheless, the court concluded that whether the hospital provided due process to Dr. Islami, and was therefore enlisted to immunity, was a jury question.

"Here there is a genuine issue of material fact regarding whether the procedures were fair to Dr. Islami under the circumstances. There are voluminous arguments from both parties giving their accounts of how the procedures were fair or unfair . . . This court believes that this is the most appropriate method for resolving the immunity question. The court will allow the jury to answer the question of whether the procedures which the defendants afforded Dr. Islami were fair given the entire factual circumstances in this case."

## **Reasonable Belief Action Warranted**

This second reasonable belief standard is the most difficult for plaintiff physicians to overcome, particularly when coupled with the presumption mentioned above. Numerous cases have held this fourth

requirement creates an objective test, i.e. would the facts known after the investigation reasonably support a conclusion that the action taken was warranted. Mathews v. Lancaster General Hospital, supra., Austin v. McNamara, 979 F.2d 728 (9<sup>th</sup> Cir. 1992).

Because of the presumption, several courts have used this objective standard to conclude that the malice or bad faith of the participants is irrelevant if the facts would nevertheless support the conclusion. "In a HCQIA action, plaintiffs are not permitted to introduce evidence of bad faith of the participants in the peer review process. The "reasonableness" requirements of § 11112(a) create an objective standard, rather than a subjective good faith standard."

### **Conclusion**

After a little more than 10 years of operation, the conclusions about the effectiveness of Data Bank operations in relation to its stated goals relating to peer review immunity, and prevention participation, are mixed. From the immunity and participation perspective, HCQIA has clearly accomplished its goals of protecting participation in the peer review process. Court decisions have established clear guidelines from the immunity provisions of HCQIA. However, from a detection perspective, the relative paucity of reported adverse actions has prompted inquiries as to whether the healthcare profession is adequately policing itself.

[>Back](#)

**FastFind:**

[A Century of Service](#) | [Visitor Area](#) | [Contact Webmaster](#)

Copyright © 2000 Tucker Arensberg, P.C.