

**The fox guarding the henhouse: how the Health Care Quality Improvement Act of 1986 and state peer review protection statutes have helped protect bad faith peer review in the medical community. 18 J. Contemp. Health L. and Pol'y 239-71 (2001).**

**By Yann H.H. van Geertruyden\***

**Introduction**

It is hard to imagine that anyone today would consider being seen by a physician who failed to wash his or her hands prior to performing an examination. Confronted with a thirty percent mortality rate of mothers delivering babies in a hospital compared with a relatively low mortality rate for women who gave birth in their home, Dr. Ignaz Semmelweis, a nineteenth century Hungarian obstetrician, is credited with making one of the most significant discoveries in medicine. 1 Dr. Semmelweis found that medical students who failed to wash their hands prior to examination had infected expectant mothers. 2 Today he is regarded as the pioneer of antiseptic treatment. 3 [\*240] Due to personality conflicts with his supervisors and peers, however, the Viennese medical society rejected his findings, refused to promote him to clinical professor and eventually ostracized him from the medical profession. 4 Having been forced out of practicing medicine, Dr. Semmelweis suffered a nervous breakdown, and subsequently was committed to a mental hospital where he ultimately died. 5 Integrity is the cornerstone of how individuals in a community come to respect and trust a profession. Physicians more so than any other profession, depend on the integrity of its members to maintain an exceptionally high level of care and mutual trust with their patients. Physicians must maintain this level of respect so as not to compromise their patients' faith in the quality of medical treatment they will obtain.

To maintain the integrity of their practice, an elaborate system of evaluation has evolved over time to provide for the review and critique of physicians who may allegedly be perceived as damaging their profession. Centuries ago, a peer review process was established to review and monitor physicians to ensure a high quality of care. Today, as a result of a hospital's responsibility to select and supervise its medical staff, 6 the peer review process has evolved into a more formal process to shield hospitals from the threat of corporate liability. 7 Hospitals delegate the supervision of its physicians to peer review committees, composed mostly of medical staff, which review physicians' credentials and quality of care. 8 These committees review all applications of physicians for admission to the medical staff; they also determine what privileges a doctor may have at the hospital. 9 It is within this peer review process that the opportunity for corrupt and ulterior motives presents itself. [\*241] Laws at both the national 10 and state 11 levels have also been established to foster and protect the peer review process. These well-intentioned laws were passed in the 1970s and 1980s to address

what was seen as a decline in the quality of health care in this country, and seek to ensure that physicians meet a certain standard of care. 12 While hospitals and legislatures have generally been successful in implementing procedures to review physicians and their practice of medicine, concern has arisen in the medical community that the process is fatally flawed in its treatment of the reviewed doctor. Many in the medical community argue that the peer review process often has little to do with the actual pursuit of quality of care; but rather it is used as a tool for economic or political motives - in essence a review performed in bad faith, or with malice. 13 This Comment addresses the evolution and current status of bad faith peer reviews of physicians, focusing on the unanticipated effect certain federal and state laws have had in promoting bad faith peer review. Part I provides an in-depth historical overview of the peer review process in the medical community, focusing in particular on hospital procedures, as well as federal and state laws that attempt to address the peer review process. Part II examines the flaws in the current peer review process that allow for a bad faith peer review to take place. Part III explores the consequences a bad faith peer review can have on a physician's career. Part IV presents a case history of bad faith peer review claims, and probes the difficulties involved in ultimately prevailing on a claim of malice in a peer review. Finally, this Comment concludes by presenting possible solutions to the currently flawed physician peer review system that would remove the opportunity for bad faith peer review. These solutions instead would encourage a fair and judicious process that would return the flawed [\*242] peer review process to its original goal, namely, to guarantee a high quality of health care for all Americans.

#### I. The Current Peer Review Process A. Historical Overview

Some form of a peer review process in the medical community has been present in the United States prior to its declaration of independence from England. 14 Beginning in the mid-eighteenth century, "when American colonies created boards of medical examiners to evaluate and license individuals they found qualified to practice medicine, the States have regulated the practice of medicine." 15 In addition, the medical profession saw the development of professional societies that "developed professional standards that the States adopted to monitor physicians." 16 In order to practice medicine today, physicians not only need a license to practice, but also must meet a number of other requirements, including hospital privileges, to offer complete and quality care to their patients. 17 Hospital (clinical) privileges are defined by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) as the "permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and his experience, competence, ability, and judgment." 18 It is nearly impossible for a physician to practice without hospital privileges. 19 With the advent of technology and support services that only hospitals are able to afford, such as medically staffed operating rooms, patient wards, or diagnostic equipment, it is vital to a physician's practice to acquire these hospital privileges. 20 It is at this stage in a physician's career that the peer review process plays

such a critical role in determining the fate of their ability to practice medicine. Any refusal or curtailment of physicians' hospital privileges has a devastating effect on [\*243] their practice. However, to maintain privileges at a hospital, physicians must be willing to be reviewed by a committee (usually made up of their peers), which determines whether they are qualified to practice medicine at the hospital.  
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#### B. The Peer Review Process in Hospitals

Each hospital or medical facility generally will have in its bylaws an established procedure for conducting a peer review of a physician. 22 The peer review committees conducting the reviews are composed of physicians at the hospital or facility who already have privileges and are members of the medical staff. 23 While the peer review process was originally established to provide for a periodic review of the quality of care provided by a physician, it has now "developed into the primary method of evaluating the [general] quality of physician services at a hospital." 24 The peer review process now provides a hospital with continuous clinical evaluation and monitoring of physicians who are, or would like to practice medicine at its facility. 25 Most hospitals establish a "credentials committee" which is composed of physicians from the hospital who typically practice in the field of the reviewed physicians. 26 For an initial applicant, the credential committee conducts a review of past performance and clinical experience. 27 For staff members who already have privileges at the hospital, "the peer reviewers are also able to review quality assurance data, diagnostic and laboratory utilization reports and other information regarding each staff member's actual practice at the hospital." 28 After a peer review group has evaluated the physician, it forwards its findings to the governing body of the hospital, typically the hospital board. 29 The board then makes the ultimate decision regarding whether [\*244] or not to grant a physician privileges to practice medicine at the hospital. 30 Depending on the state, a hospital board can be made up of medical staff, administrators, physicians or other interested parties. 31 Boards can make a number of decisions based on the findings of the peer review group: "Based on the reports of the clinical departments, the credentials committee and others that may have been involved, the executive committee recommends either a denial, reduction, or revocation of privileges. The board of trustees has the final decision-making authority for medical staff appointments... ." 32 Typically, however, the governing board will defer to the recommendations of the medical staff. 33 Once the governing board has determined whether or not to grant, deny, or curtail a physician's privileges, the reviewed physician has few options to challenge a decision with which he disagrees. The physician is left with little if any appellate options. Since a hospital is considered independent, and responsible for its own decisions, the health care entity (usually the hospital) makes the final decision of whether to grant, deny, restrict or revoke the staff privileges of a physician. 34 The hospital, however, is required to adhere to certain guidelines for its own peer review promulgated by JCAHO, federal and state law. 35

### C. Independent Peer Review Guidelines

The JCAHO, for example, requires that a health care facility provide limited due process protections as well as peer review standards in their bylaws. 36 States have also established due process procedures for peer review actions. The Illinois State Medical Society's Due Process Guidelines, for example, sets out specific procedures that a hospital must follow in a peer review or credentialing decision. 37 Specific instructions [\*245] are given regarding proper notification requirements, a physician's right to a hearing, an unbiased review as well as a right to be represented by counsel. 38 Nevertheless, the problem remains that the sanctioned physician is unable to appeal beyond the governing board of the hospital. 39 There is no independent body in place to review a hospital's decision on peer review matters. 40 As a result, many consider peer review as an overly autonomous and arbitrary process providing a physician no readily available recourse short of filing a lawsuit for a wrongful action. 41

### D. Federal Legislation and Controlling Law of Peer Review

Hospitals became greatly concerned in 1986 following the Supreme Court's landmark decision in *Patrick v. Burget*, 42 which involved a physician who was found to be a victim of a malicious peer review. 43 The Supreme Court upheld the suit of a physician who alleged antitrust violations in the termination of his privileges. 44 In response to this decision, the federal government addressed the issue of encouraging peer review through statutory protections by Congress' enactment of the Health Care Quality Improvement Act of 1986 (HCQIA). 45 Additionally, each state and the District of Columbia has passed its own peer review statutes that encourage thorough and quality control of physicians practicing in its jurisdiction. 46 The primary function of these statutes is to provide the hospital, the peer review board and the accusing physician immunity from a libel suit brought by the accused physician. 47 The HCQIA addresses two issues in its attempt to improve the quality of care in medicine. First, the act establishes federal protections, already [\*246] found at the state level, that grant immunity to peer review committees. 48 Second, it establishes the National Practitioner Data Bank 49 to monitor the credentialing of physicians by hospitals and states. 50

#### 1. Federal protections of immunity to peer review committees

The HCQIA, like comparable state statutes, provides immunity from liability for peer review participants. 51 Congress intended to establish protections for health care professionals who engage in the good faith evaluation of their peers by limiting the participant's liability. 52 Congress believed that the overriding "threat of private money damage liability under federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective peer review," 53 thus the establishment of federal immunity protection for peer reviewers. The Act establishes four standards that peer review actions must meet in order to be eligible for the protections under the Act. 54 The HCQIA requires a peer review to be taken:

(1) in the reasonable belief that the action was in furtherance of quality of 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. 55

The Act establishes a presumption that the peer review action meets the above criteria, "unless the presumption is rebutted by a preponderance of the evidence." 56 Since the peer review committee need only show the subjective requirement that a "reasonable belief that the [\*247] action was warranted", the accused physician has a heavy burden to overcome. 57

## 2 The National Practitioner Data Bank

Another goal of the HCQIA was to establish a "clearinghouse of information", which would permit hospitals and other health care entities access to physicians' records who have had adverse actions taken against them by other hospitals and health care organizations. 58 Congress titled this new information repository the National Practitioner Data Bank (NPDB). 59 Information reportable to the NPDB includes: medical malpractice payments 60; any sanctions by a Board of Medical Examiners 61; and any review actions taken by health care entities such as hospitals, Health Maintenance Organizations, and professional societies. 62 The goal of the NPDB is to prevent physicians who have had their privileges revoked by a hospital from simply going to another hospital to gain privileges and continue their practice of medicine. 63 Because of the unique and sensitive nature of the information in the NPDB, the intent of the legislation was to keep the information strictly confidential. Data would be made available only for use by hospitals and select health care entities so that they may be alerted to physicians who had adverse actions taken against them, that resulted in a loss of their licenses or privileges. 64

The information contained in the Data Bank, however, has become easily obtainable by numerous health care entities with an interest in the information. 65 Those eligible to request information from the NPDB must be one of the following: a Board of Medical Examiners or other State licensing board; a hospital; a health care entity that provides health care services through a formal peer review process; a professional society that [\*248] engages in professional review activity through a formal peer review process; or a plaintiff's attorney in certain cases. 66 Peer review actions have always enjoyed confidentiality under the law. 67 However, "public reports [as with the NPDB] negate that confidentiality, making assessments available to attorneys, to managed care organizations interested in credentialing physicians, and to members of the media interested in publicizing certain events." 68 These public reports add misguided speculation, which confuses the circumstances regarding a reported physician.

In late 1999, yet another data bank was established by Congress under the Health Insurance Portability Act of 1996, 69 directing the Secretary of Health and Human Services (HHS) to create the Health Care Integrity and Protection Data Bank (HIPDB) "to combat fraud and abuse in health insurance and health care delivery." 70 "The new data bank ... requires that state and federal law enforcement organizations, licensing and certifying boards, and private health plans report a range of adverse actions taken against licensed health care practitioners, providers and suppliers." 71 "The reportable offenses include licensing actions, exclusions from the Medicare and Medicaid programs and criminal convictions and civil judgments." 72 While the American Medical Association (AMA) originally supported the concept of a national data bank for physicians, it withdrew its support after the data bank was expanded so far as to include medical malpractice information. 73 AMA president Dr. Thomas R. Reardon argues, "malpractice information has a relation to competency. Even the very best physicians are subject to lawsuits, and most malpractice insurers allow for the settlement of a lawsuit even without the [\*249] approval of the physician." 74 Inaccurate or incomplete information can be devastating to a physician's career if it becomes public.

The introduction of a second data bank to monitor physicians has raised concern among physicians that the information will be used incorrectly, or in bad faith, against them when their privileges would come up for review at a hospital. 75 While some protections still exist regarding who may query the information in the data banks, recent efforts in Congress are focused on expanding accessibility to information in the data banks to the general public. In the 106<sup>th</sup> Congress, Representative Thomas Bliley (R-VA) introduced legislation that would allow for complete public access to any of the reported information on the NPDB. 76 The Patient Protection Act of 2000 includes a provision that would allow the general public access to the raw data found in the data bank on hundreds of thousands of physicians without including an explanation of what the data contains. 77 Consumers would be given access to data that is meant for experts, creating the possibility for uninformed decisions by lay individuals who have no expertise in the field. A misinformed public compounds the problem of false or inaccurate reporting as they will most likely reconsider being examined by a reviewed doctor. This only exacerbates the harm to a physician who is a recipient of bad faith peer review and has limited options to correct his record.

#### E. State Laws and Peer Review Immunities

Immunity protections are not solely provided for peer reviewers at the federal level. Each individual state as well as the District of Columbia offers its own immunity protections for peer reviewers. Not only do states offer immunity protections from libel suits, as is found at the federal level, but immunities are also granted to the actual proceedings and records of the peer review committees. 78 The state laws offer broad protections for [\*250] documents produced by peer review committees and other similarly situated health care entities, such as health care providers and professional medical societies. 79 A

typical example of a statute protecting peer review proceedings and documents is Alabama Code section 6-5-333(d):

"All information, interviews, reports, statements or memoranda furnished to any committee, as defined in this section, and any findings, conclusions or recommendations resulting from the proceedings of such committee are privileged. The records and proceedings of any such committee are confidential and may only be used by the committee and its members in the exercise of the committee's proper functions and will not be public records, available for court subpoena or for discovery proceedings. 80 "

Protection statutes like the Alabama section, force physicians to confront the immense challenge of overcoming a bad faith peer review, a significant flaw in the peer review process. Physicians who are accused of wrongdoing are solely at the mercy of the accusing physician(s) and the peer review committee hearing their case. At this stage in the process, however, few appellate options are available. Because the records of the peer review proceeding are confidential and non-discoverable, should an accused physician choose to contest the decision of a peer review committee in a civil trial, the plaintiff must overcome a heavy burden to prove bad faith. A total of seventeen states 81 have sought to address this [\*251] problem by qualifying confidentiality and non-discoverability statutes. These states make an exception in their "non-discoverability" statutes by permitting "a physician to obtain access to peer review materials when challenging the curtailment, suspension, termination or denial of staff privilege." 82 In those states, contesting a revocation or curtailment of staff privileges by the accused physician places a much heavier burden on the peer review committee to perform a fair and honest review of a physician's medical records.

In addition, state and federal laws 83 include immunity protection for health care entities participating in the peer review process. 84 "These statutes provide varying degrees of immunity, ranging from absolute immunity in all civil suits to qualified immunity in some civil suits." 85 Each state includes in its immunity statute a provision that addresses the need for good faith in the review process. A typical state statute reads as follows:

There is no liability on the part of and no action for damages will arise against the individuals or organizations outlined in 65-4909(a) supra, for good faith investigation or communication of information regarding the quality of care of a patient... if such association or committee or such individual member thereof acted in good faith and without malice. (Kansas) 86

This statute illustrates the immense challenge physicians face in overcoming a bad faith peer review. As discussed later in this Comment, the burden to show malice or bad faith depends to a large degree on the information produced in the peer review proceeding. 87 It is difficult to determine whether a fair and non-partial review of the physicians records actually took place, because the confidentiality and non-discoverability statutes as presently found in most states make it nearly impossible for an attorney to gather the evidence necessary to challenge the good faith question.

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## II. Bad Faith Peer Review

### A. Flaws in the Peer Review Process

The current process of peer review as a tool for assessing the quality of health care is the subject of much debate. 88 In 1992, a survey was conducted of "all published studies from 1966 to 1990 that evaluated the effectiveness of peer review". 89 The survey came to the conclusion that: "Overall, physician agreement regarding quality of care is only slightly better than the level expected by chance. This finding casts considerable doubt on the standard of practice of peer assessment." 90 Although it is inaccurate to assume that all peer review committees are predisposed to targeting a certain type of physician, it is nonetheless accurate to suggest that the peer review process, as currently structured, offers peer review participants the ability to practice arbitrary peer review with little fear of repercussion. 91 The victims of bad faith peer reviews share many of the same traits that usually make them an easy target for those seeking to disqualify them from practicing in a hospital. 92

Solo practitioners lacking political support are frequently victims of arbitrary peer review actions. Physicians in large groups, who have politically connected mentors and colleagues, can often deflect disciplinary actions. A solo physician doesn't have the same resources. Similarly, doctors who are new on staff and haven't developed strong relationships are on the hot seat. So are physicians who do procedures that are new or different. 93

Bad faith peer review can involve both the presence of ulterior motives in the accusations of wrongdoing by peers as well as a failure to invoke the peer review process to avoid reporting incidents. This results in arbitrary underreporting. The review process, often seen as a highly political, can be easily manipulated to achieve economic or power-driven gains. 94 [\*253] Flaws in the current peer review process have focused on three main areas. The primary concern is the strong immunity protections afforded to both accusatory physicians and hospital committees participating in the review process. 95 A second concern with the peer review process is the lack of consistent and substantive due process procedures available to an accused physician. A third concern with the peer review process is the opportunity for underreporting or false reporting. 96 The lack of sanctions for non-reporting has led some to argue that hospitals should avoid taking action against physicians through peer review actions. 97 In an effort to remedy these concerns and reassert the integrity seemingly lost in the current process, many in the medical community are calling for the revision, expansion or elimination of the process altogether. 98 A serious and thorough review of the current peer review process is critical, on both the state and federal levels to safeguard a quality and respected health care system in the future. 99

#### 1. Non-discoverability of peer review hearings

Immunity poses special problems for accused physicians who find themselves at the receiving end of a bad faith peer review action. Due to the strong language found in a majority of state statutes that prevents discovery of proceedings involved in a peer review, 100 physicians are required to overcome an immense burden in showing a court that there was in fact malice or bad faith involved in the peer review process. Accusatory physicians who are involved in the peer

review process are easily able to manipulate the process to achieve ulterior motives, such as eliminating the economic competition in a particular practice field. 101 The exemptions provided for in both the HCQIA and state statutes allow for a broad immunity on materials produced at a peer review hearing, as well as immunity for physicians and peer review committees from libel suits brought by the accused physician. 102 In addition, a number of recent court [\*254] decisions both at the state and federal level have questioned and subsequently failed to find immunity privileges in peer review challenges. 103

## 2. Lack of Due Process

An accused physician, who finds himself or herself the recipient of a negative peer review recommendation, is regrettably left with few due process options to appeal a final decision by a governing board. In a majority of states, the JCAHO, and to a large extent the HCQIA, has established guidelines that a hospital must follow in order to grant a physician the opportunity to have a hearing on the accusations raised against them. 104 These procedures might include "[a] written statement of the charges, timely notice of the hearing, [a] fair hearing, the right to produce evidence, the right to counsel..., [and a]n appeal process." 105 Once the governing board makes its final determination, however, the accused physician is left with no option to appeal the decision of the board, save attempting to take the hospital, and the accusing physicians, through a lengthy and costly trial. 106 These guidelines, however, offer limited appellate procedures for the accused physician. On account of the severe consequences of losing or having one's license restricted, adequate appellate procedures would provide the accused physician a neutral forum in which to have his review conducted.

## 3. Underreporting of peer review actions

Underreporting of peer review actions by hospitals and health care entities has also recently become a problem. In 1995, the Office of Inspector General (OIG) published a report 107 that "raised concern that there may be underreporting by hospitals of physicians with performance problems." 108 Under HCQIA, hospitals are required to report to the NPDB any actions against a physician to include: medical malpractice [\*255] payments 109, licensure actions taken by the Board of Medical Examiners 110, and adverse actions on clinical privileges. 111 The NPDB requires the reporting of two types of actions, those that adversely affect clinical privileges for a period of more than thirty days, and in those cases where there is a surrendering or restriction of privileges while the physician is under investigation. 112

Despite the strict reporting requirements and the possible imposition of fines for non-reporting, the 1995 OIG report found that over a three-year period, nearly three-quarters of all hospitals had failed to report a single action to the NPDB. 113 Most hospitals have developed strategies to avoid reporting to the NPDB. Hospitals can either impose a suspension that is less than the thirty day reporting requirement imposed by the Act or utilize "alternative disciplinary mechanisms that don't require data bank reporting, such as written reprimands and different types of counseling or warning systems." 114 A leading reason why hospitals may decide to pursue actions to avoid reporting is to protect a physician from possible scrutiny, but also "public reports negate ... confidentiality, making

assessments available to attorneys, to managed care organizations interested in credentialing physicians, and to members of the media interested in publicizing certain events." 115 Publicity is something both physicians and hospitals want to avoid, so hospitals utilize alternative ways of reporting claims. 116

### III. Consequences of Bad Faith Peer Review

The consequences that accused physicians must face when confronted with a bad faith peer review decision can be devastating. Areas that will be impacted by an adverse action on behalf of a peer review committee [\*256] include: reporting to the NPDB, loss or suspension of privileges, notification to insurance/HMO/Medicare and damaged reputation in the medical community all resulting in an overall inferior quality of care.

#### A. Loss of Hospital Privileges

As discussed previously, in the modern medical profession, hospital privileges are critical for a physician to practice medicine. 117 A physician must have access to hospital resources in order to provide quality care and effective medicine to his patients. Hospitals offer operating facilities, rehabilitation services, expensive life support equipment and critical nursing staff without which most doctors would be unable to practice competent and responsible medicine. 118 Once a physician peer review occurs, a recommendation is made to the governing board of the hospital as to what type action, if any, should be taken. 119 Essentially, any action taken that refuses, terminates, suspends or restricts a physician's privileges at the hospital is an impediment to a physician's ability to practice. In addition, when an adverse board decision occurs, a physician will also receive a devastating blow to his or her reputation both in the medical and patient communities. 120 The damage to a physician's reputation will have a longstanding effect on the physician's marketability, regardless of whether the disciplinary action is overturned. Other physicians may hesitate to refer patients, and patients themselves may feel uncomfortable with a physician who has a questionable record. 121 Once all appeal procedures are exhausted at the hospital level, the only alternatives left for a physician are to pursue a costly legal remedy through a claim under antitrust law or to file a libel suit alleging bad faith peer review under HCQIA or similar state statute. 122 Faced with the legal burden of proving bad faith, combined with the confidentiality and immunity protections provided at both the state and federal level, the chances of an unemployed, or negatively [\*257] affected physician pursuing a court battle are slim. 123

#### B. National Practitioner Data Bank Report

Not only must a physician who is a victim of a bad faith peer review overcome the exclusion or suspension from practicing medicine at the accusing hospital, but he or she must also confront the hospital's duty to report the adverse action to the NPDB. 124 Under the NPDB, reporting of credentialing actions, malpractice payments and licensure actions is mandatory. 125 Once the action is reported to the NPDB, the consequences reach far beyond the community in which the adverse action was taken.

The NPDB has become a primary tool for determining privilege and credentialing of physicians. 126 Under the HCQIA, hospitals have an affirmative duty to query

the NPDB when a physician applies for medical staff privileges or requests clinical privileges. 127 Joseph A. Berry, National Medical Director of United HealthCare Corporation, states that the NPDB is "the primary source of information about sanctions and malpractice information" regarding a physician's practice history. 128 Thus, great care must be taken in managing the information reported on the NPDB.

Once a report has been submitted to the NPDB, whether legitimate or not, any hospital at which the reprimanded physician attempts to obtain privileges will be notified of the adverse action. Due to the reporting requirements of the NPDB, the reviewed physician is essentially "blacklisted" 129 in both the community where he or she practices, as well as other communities in which the physician may wish to practice. 130 In addition, other health care entities, such as HMOs, insurance companies and government agencies (e.g. Veteran's Administration and the Health Care Financing Administration) all have access to the data in the NPDB.

[\*258] A process exists to appeal a report made to the NPDB. 131 "The regulations establish a procedure whereby a physician can dispute the accuracy of the information in the Data Bank concerning himself." 132 The physician must contact the Secretary of Health and Human Services (HHS), who is in charge of maintaining the database, and inform the Secretary of the disagreement. 133 The Secretary will then review the information and determine whether the information is correct or whether a rescission is necessary. 134 Again, this is not an appellate procedure of the actual peer review action; it is simply an appeal of the reported information.

Although a process exists for doctors who have had adverse actions reported against them to dispute the NPDB report, "the damage it does may be too difficult to overcome." 135 By the time a doctor even receives a hearing on the matter, "in the case of a summary suspension, the damage may already be done." 136 The mere perception that a doctor may have had an adverse action taken against her is enough to prevent the doctor from gaining privileges at another hospital. 137 To compound the problem, physicians who have undergone the peer review process, regardless of being found innocent of the allegations made against them, may still be victims of disparate treatment. 138 Although the NPDB was originally intended to monitor problem physicians, many in the medical community are concerned that it has accomplished the complete opposite, leading to the unintended consequence of destroying the careers of many qualified physicians. 139

#### IV. Case History in Bad Faith Peer Review

##### A. Immunity of Peer Review Actions

In large part due to the immunity and confidentiality protections [\*259] afforded peer reviewers and the proceedings, it is extremely unlikely that a suit alleging bad faith will result in a trial proceeding. 140 Prior to 1986 and the passage of the HCQIA, physicians had a number of bases available to challenge arbitrary peer review, such as defamation and breach of contract. 141 The seminal case in the law concerning medical peer review is *Patrick v. Burget*. 142 In *Patrick*, a physician was subjected to peer review involving malice after he elected not to

join a town's only medical practice. The Supreme Court upheld a jury's decision to award the physician 2.2 million dollars in damages for the exercise of bad faith peer review. In addition, the Court's decision addressed the notion that hospitals were immune from antitrust suits.

As a result of the lower court's decision in *Patrick* to award damages, and before the Supreme Court's final decision on the matter, Congress passed the HCQIA that federalized the peer review immunity statutes that were already found in some states. The Court in *Patrick*, notes that by enacting HCQIA, "Congress clearly noted and responded to the concern that the possibility of antitrust liability will discourage effective peer review." 143 The Court went on to recognize that "the Act essentially immunizes peer-review action from liability if the action was taken "in the reasonable belief that [it] was in furtherance of quality health care." 144 Since the passage of the HCQIA, physicians may only sue if they can demonstrate that the hospital did not provide the physician adequate due process during the peer review process, or if the physician can show bad faith was involved. 145 Since hospitals have the ability to keep peer review proceedings strictly confidential, challenging a peer review on the basis of bad faith is very difficult. 146 Since *Patrick* and the passage of the HCQIA, few courts have been willing to allow a physician to overcome the immunity and confidentiality protections afforded peer review proceedings. 147 Disciplined physicians must overcome the difficult burden of proving bad faith to challenge a peer review decision. 148 [\*260]

Some rare cases, however, have been upheld where a showing of blatant and extreme bad faith existed. In *Brown v. Presbyterian HealthCare Services*, 149 a jury found that there had in fact been an element of bad faith involved in the peer review of the disciplined physician and awarded damages accordingly. The district court judge presiding over the case, however, set aside the award concluding that the plaintiff had failed to present adequate proof of actual damages. 150 The Tenth Circuit Court of Appeals affirmed the jury's decision that the defendants were not immune under the HCQIA from antitrust and defamation claims and granted the compensatory damages to the plaintiff. 151 The court found that the facts showed a direct link between the accusing physician who initiated the peer review action and the ultimate influence on the peer review committee and governing board. 152 The Court placed particular attention on the fact that the accusing physician herself was on the governing board which made the ultimate decision to revoke the plaintiff's privileges. 153

The proof needed to show a link between malice and the peer review action is not always as blatant. In *Zamanian v. Christian Health Ministry* a physician's license was suspended following a peer review action. 154 In 1998, the doctor's case overcame claims of immunity brought by the defendant under Louisiana law and was finally allowed to go to trial. The Louisiana Fourth Circuit Court of Appeals reversed the district court's summary judgment after finding that "members of the peer review committee "may have acted with malice or a lack of good faith' during the peer review process." 155 The judges had found that there "was evidence that Mercy Hospital had financial reasons to want to discipline Dr. Zamanian because he kept patients in the hospital for more days than Medicare

authorized, resulting in the hospital's losing money." 156 Finally, [\*261] two years after going to trial, in September 2000, a jury awarded Dr. Zamanian six million in damages finding the peer review process had been conducted in bad faith. 157 Just two weeks later, however, a civil district judge reversed the jury decision and set aside the award by the jury finding that the peer review process, which Mercy conducted, was "subject to immunity under state and federal laws." 158 The case is currently on appeal. Again, this case highlights the immense burden placed on the disciplined physician to show that there is malice or bad faith involved in the peer review process. Even if a doctor can make a showing that bad faith is involved, he must still be willing and able to expend the cost of pursuing a lengthy legal battle. 159 Few cases persevere this far into the process. 160 In fact, this was the first case of its kind to reach a jury trial in Louisiana. 161

#### B. The Hurdle of Non-Discoverability Peer Review Statutes

Overcoming the immunity protections provided at both the state and federal level is not the only challenge facing a disciplined physician. Often, overcoming the burden of proving bad faith depends on revealing information disclosed during the actual peer review proceedings. As discussed previously, some states have made an exception to their non-discoverable peer review statutes, allowing discovery when a physician is challenging the adverse decision of a peer review committee. 162 A recent state Supreme Court decision in Pennsylvania may provide precedent that a state need not have legislated such an exception for one to be found. *Hayes v. Mercy Health Corp.* 163 involved a physician who had been suspended by the defendant for his involvement in a malpractice claim. 164 After a hearing on the suspension, a peer review committee determined [\*262] that "the facts do not support suspension". 165 Later, however, the hospital's Medical Board altered the peer review committee's findings to state, "the facts do not support continued suspension", implying the suspension had been warranted at some point, resulting in a permanent mark on the physicians record in the NPDB. 166 It came to the attention of the plaintiff that there was bad faith involved when the Medical Board made their finding and the plaintiff sought a copy of an audio tape made of the Board's meeting to determine if in fact bad faith had played a role in the decision. 167 The hospital refused and the physician sued to acquire a copy of the tape.

In its decision, the court focused on the intent of the Pennsylvania statute which sought to keep peer review proceedings confidential. 168 The statute states that peer review proceedings are to remain confidential "in any civil action ... arising out of the matters which are the subject of evaluation and review by such committee." 169 The court interpreted the language of the statute to mean that it was intended "to prevent the disclosure of peer review information to outside parties seeking to hold professional health care providers liable for negligence, while at the same time ensuring ... confidentiality did not operate to shield from discovery those rare instances in which the peer review process was misused." 170 The court held that the plaintiff should receive a copy of the tape with the restriction that it be only used to determine if the proceedings had been misused.

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Hayes v. Mercy is important for a number of reasons. The Hayes court acknowledges that there should be exceptions made to the confidentiality provision in states where it is not expressly worded in statute. The court recognized that the issues at stake were the fairness and integrity of the peer review proceedings and whether the plaintiff-physician was the victim of bad faith. 172 One attorney in the case concluded that, "peer- [\*263] review organizations have been used to weed out competitors rather than investigate health care concerns. This decision prevents peer-review organizations from being misused." 173 Hayes also highlights the difficulty facing a physician who attempts to clear his name. The cost to overcome a confidentiality statute and to show bad faith is something that most physicians are simply unable to afford. Unfortunately, Pennsylvania has been the only state to make such a finding. 174 Most recently, in June 2000, the Appeals Court of [\*264] Massachusetts considered in Grande v. Lahey Clinic, 175 whether the reviewed physician could depose an expert used in a peer review action in a subsequent defamation suit. 176 The plaintiff, Dr. Grande, who was cleared in the peer review action, sought to depose the expert to determine if she was aware of any bad faith being involved in the peer review action. 177 The appeals court held that the non-discoverable peer review protection applied to the expert's testimony. 178 Thus, the plaintiff was prevented from discovering potentially damaging testimony that would support his defamation suit.

## V. Possible Solutions to a Flawed Peer Review Process

### A. Current Remedies Available

As discussed earlier, options for a disciplined physician are currently somewhat limited. The HCQIA, 179 JCAHO, 180 as well as the statutes of most states, 181 set out guidelines for hospitals to follow when conducting a peer review. These guidelines are incorporated into the bylaws of a hospital and must be followed in order for a court to conclude that a doctor was given "due process." 182 Such bylaws, however, are often drafted in favor of protecting the hospital, and can be very difficult for a physician to discern. 183 These bylaws can impose limited administrative [\*265] procedures and even restrict a physician's ability to utilize an attorney in the proceedings. 184 The primary problem remains, however, that the appeals process ends with a decision by the governing body of the hospital. 185 Once the governing body makes its decision, it is very difficult to obtain any additional review of the adverse action. Most courts are unwilling to hear a suit on the merits brought by the disciplined physician challenging the decision of a peer review board. 186 A disciplined physician has no other recourse against a bad faith peer review decision other than to file a suit for libel.

Immediately following an adverse decision made by the peer review committee and approved by the board, the finding is forwarded to the National Practitioner Data Bank. At this point, the disciplined physician acquires some appellate options, but only with regard to the report posted on the NPDB. 187 The physician has the ability to petition the Secretary of HHS to review the report, and if the Secretary determines there is no basis for the report, the record will be

cleared. 188 This procedure is limited to having the adverse report expunged from the physician's record. Further, it does nothing to affect the hospital board's decision, not to mention clear the physician's name in the community.

Should a physician find that bad faith or malice was involved in the proceedings, she can take the matter to court under a defamation or antitrust claim. 189 To overcome the immunity and confidentiality protections afforded to peer review proceedings under state and federal laws, a showing of bad faith must be made. 190 Antitrust is one theory of [\*266] law under which courts may be more willing to hear cases involving bad faith. 191 Even though courts are more reluctant to find antitrust violations in the area of health care, 192 the Supreme Court has held in several key decisions that an antitrust claim against a health care provider, like a hospital, is subject to federal jurisdiction 193 and that health care providers may not necessarily use traditional defenses against those suits. 194

With the passage of the HCQIA, however, alleging an antitrust violation has proven to be much more difficult because the Act requires merely that a peer review action be taken "in the reasonable belief that the action was in the furtherance of quality health care." 195 The broad standards afforded to health care entities in the HCQIA afford hospitals a great number of options to protect themselves from an antitrust allegation, including having the "bylaws expressly provide that the committee's recommendations to the Hospital Board in no way preclude the Board from exercising its own judgment; or a hospital could rely on pro-competitive justifications." 196 These techniques allow hospitals to avoid litigation by claiming they are doing everything they can to remain objective.

## B. Possible Solutions

This Comment is by no means intended to suggest that the medical profession is free of substandard physicians. Nor is it meant to suggest that appropriate evaluations of physicians should be eliminated. On the contrary, it is intended to highlight a problem in the medical community that is not often discussed. The peer review process as it exists today, is flawed. The following are suggested changes to both the peer review system, as well as the medical evaluation system in general, which seek to achieve the goals of fairness in the evaluation process and achieve a higher quality of care. 197 When compromises are made in the evaluation [\*267] process, the end result is that the integrity of the medical community - and especially the quality of care that patients receive - suffers.

### 1. Expansion of the current peer review appeals process

Much of the problem that plagues the current peer review system stems from the lack of any meaningful appellate procedure available to the accused physician. Once the governing board has made a determination, the disciplined physician has no alternative but to accept the decision. 198 Creating a method of allowing a sanctioned physician to appeal a decision to an independent review board outside of the hospital would alleviate much of the ambiguity tainting the current system. 199 An independent analysis of all the facts offered by independent

reviewers would likely neutralize much of the pressure facing both peer reviewers in addition to those being peer reviewed. Physicians who perform the initial peer review of their colleague's work would surely welcome an independent analysis to ensure consistent application of generally accepted medical standards. If, however, they are confident of their review, these reviewing physicians could assert at a libel trial that an independent review board agreed with their findings. 200.

A similar alternative would be to allow a state agency oversight over the activities of hospitals within their jurisdiction. 201 State medical boards are already responsible for the licensing of physicians within the state 202, although the boards are not responsible for oversight of granting staff privileges in a hospital. As the importance of acquiring such privileges in a hospital has become so critical to practicing medicine within the state, it follows that states should play a role in overseeing which physicians are afforded privileges. As a result of the "decrease in the amount of reimbursement and more hospitals closing, there is more competition to be placed in the hospital staff. Peer review organizations have been used [\*268] to weed out competitors rather than investigate health-care concerns." 203 State oversight would consist merely of a review panel of doctors from around the state who would review the peer review committee's findings. It could even relieve the hospital of any supervisory activity by simply allowing all peer review actions to be controlled by the state.

If the state is not willing to accept the responsibility of overseeing the peer review process, the state should then provide physicians the ability to immediately appeal the hospital board's decision to the state courts. As was discussed in Patrick, the United States Supreme Court acknowledged the unwillingness of the state court system to review hospital privilege matters. 204 Physicians should have some recourse available for a quick and fair review of their discipline.

## 2. Immunity provisions, and expansion of state exceptions to non-discoverability provisions

Currently, seventeen states have adopted exceptions to their non-discoverability peer review provisions. 205 These statutes permit physicians to obtain access to peer review materials when challenging the curtailment, suspension, termination or denial of staff privileges. 206 The HCQIA presently does not carry any such protection for disciplined physicians. Thus, the burden to obtain evidence showing that malice was present at a peer review proceeding makes it difficult for the disciplined physician to bring a case alleging bad faith to trial. 207 While it is important to keep the peer review proceeding confidential in civil trials involving malpractice claims, physicians should have the right to inspect and offer evidence of bad faith discovered at the peer review proceedings.

Likewise, the immunity provisions found under state and federal laws afforded to physicians who participate in the peer review process must be relaxed. It is vital to remove the immunity veil that physicians are able to hide behind, which allows

them to manipulate the peer review process in order to achieve politically or economically motivated goals. 208 By taking away the immunity shields, physicians will be forced to rely more on [\*269] sound medical principles and less on personally driven agendas.

### 3. Continuous Improvement as a health care solution 209

The peer review process has been criticized not only for its lack of attention to the possible infusion of bad faith into the proceedings, but also for its inability to improve the quality of health care provided in the United States. The peer review process is often viewed in the profession as aggressive and adversarial. 210 Most physicians are put on the defensive to protect themselves against inquiries that may lead to a complete revocation of their licenses to practice medicine. An alternative approach to the peer review process that has been advocated by many in the medical profession views quality of care not from an adversarial, aggressive standpoint, but rather from a theory of continuous improvement. 211 In states, like "Massachusetts, for example, a physician merely talking with a hospital administrator about the physicians involvement in a mishap may commit a hospital administrator by law to report that physician to the Board of Registration in Medicine." 212 Instead of seeking the highest quality of care for their patients, the existing peer review process conditions physicians to be cognizant of potential sanctions and adversarial actions, requiring a physician to be constantly on the defensive.

A competing approach has been advocated, that focuses on "the Theory of Continuous Improvement, 213 which is the continuous search for opportunities for all processes to get better." 214 By working with colleagues towards self-development and improvement, rather than against them, quality of medical care will be the ultimate beneficiary. We must allow physicians to "free themselves from the fear, accusation, defensiveness and na<um i>vete of an empty search for improvement through inspection and discipline." 215 By staying on the defensive, health care will never improve. 216 [\*270] Critics of the NPDB argue that the national data bank is a good example of why physicians and hospitals may not seek improvement in the quality of care. 217 The NPDB imposes strict reporting requirements with consequences that encourage hospitals not to report actions taken. 218 Rather than attract public exposure to potential problems at the hospital, health care entities will often seek out alternative corrective measures to avoid reporting. 219 The alternatives used by health care entities should be the goal of the NPDB; further education and training should be the rule, rather than permitting a simple submission of a name to a data bank that would effectively end the career of a physician. 220

### Conclusion

The quality and integrity of health care in the United States is critical to the sustainment of prosperity. People expect competent and highly skilled medical professionals when they utilize the health care system. Existing quality control

measures imposed by state and federal laws seek to provide a continuous monitoring system that utilizes peers in the medical profession to evaluate their colleagues. Today's system relies heavily on immunity and confidentiality protections to shield a peer reviewer from liability for his participation.

The current immunity and confidentiality protections have the effect of providing a safe-harbor for physicians who have ulterior motives, whether economic or political. These physicians abuse the peer review system and the safe-harbor provisions to eliminate the competition in their community. In addition, the state and federal laws place an undue burden on the disciplined physicians to show the presence of malice or bad faith in the peer review process.

At a minimum, the safe-harbor provisions that protect accusing physicians from liability for claims made in bad faith, combined with the incredible burden accused physicians must overcome to show bad faith, must be removed. Further, an effort should be made to expand a reviewed physician's appellate options at the state level to ensure an unbiased and truly independent review of his work. Should the arbitrary peer review process continue without any changes to the protections [\*271] currently afforded to peer review committees - or the review process itself - many outstanding physicians who become the target of an adverse peer review and are unable to afford costly litigation to clear their name, will simply be eliminated as they will have no alternative but to quit the medical profession.

FOOTNOTES:

n1. [www.semmelweissociety.org](http://www.semmelweissociety.org) (citing "Simmelweis, Ignaz Phillip," Microsoft (R) Encarta. Copyright 1993 Microsoft Corporations. Copyright 1993 Funk & Wagnall's Corporation), available at <http://www.semmelweissociety.org> (last visited Mar. 12, 2001)

n2. Id.

n3. [www.semmelweissociety.org](http://www.semmelweissociety.org) (citing Sendfelder, Leopold, Ignaz Phillip Semmelweis(1996)), at <http://newadvent.org/cathen/13712a.htm>) available at <http://www.semmelweissociety.org> (last visited Mar. 12, 2001).

n4. [www.semmelweissociety.org](http://www.semmelweissociety.org) (citing Biography, Ignaz Phillip Semmelweis (1999)), available at <http://artemis.austinc.edu/acad/cml/tcates/1997-98/ci11d/semmelweis/biography.html> (last visited Feb. 4, 2000).

n5. Id.

n6. Susan L. Horner, The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications, 16 Am. J. L. and Med. 455, 458 (1990).

n7. See *Darling v. Charleston Memorial Community Hospital*, 211 N.E.2d 253 (Ill. App. Ct. 1965).

n8. See Horner, *supra* note 6, at 461.

n9. Barbara Harty-Golder, M.D., Peer Review and Sour Grapes: Follow These Steps to Protect Yourself from a Disgruntled Colleague, *Physician's Prac. Dig.*, July 1998, available at <http://www.helix.com/resc/ppd/july98/peerrvw.htm>.

n10. See Health Care Quality Improvement Act of 1986, 42 U.S.C. 11101-11152 (1994).

n11. Every state, including the District of Columbia, has passed its own version of a Peer Review Immunity Law to address peer review of physicians licensed in their state. See Lee J. Stillwell, Am. Med. Ass'n, A Compendium of State Peer Review Immunity Laws, (1994).

n12. See Ron A. Virmani, M.D., Medical Errors, Peer-Review & The National Practitioner Data-Bank, *LSUMC Bytes* (2001), at <http://www.lsumcbytes.com/bios/errors.html>.

n13. See, e.g., Josephine M. Hammack, The Antitrust Laws and the Medical Peer Review Process, 9 J. Contemp. Health L. & Pol'y 419, 421 (1993).

n14. Jonathan P. Tomes, *Medical Staff Privileges and Peer Review* 10 (1994)

n15. Id

n16. Id.

n17. Id. at 13.  
n18. Id.  
n19. Id.  
n20. Id.  
n21. See Virmani, supra note 12.  
n22. See Tomes, supra note 14, at 10  
n23. Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit - Is it time for a Change?, 25 Am. J.L. & Med. 7, 12 (1999).  
n24. Id. at 12-13.  
n25. Id. at 12. See also Tomes, supra note 14, at 9.  
n26. See Tomes, supra note 14, at 23.  
n27. See Scheutzow, supra note 23, at 13.  
n28. Id. at 14.  
n29. Id. at 12.  
n30. See Tomes, supra note 14, at 22.  
n31. See id.  
n32. Id. at 23-24.  
n33. See id. at 24.  
n34. See id. at 48. See also Laura-Mae Baldwin, M.D. et al., Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports, 282 JAMA 349, 354 (1999) (stating that the "governing board of the facility has the final authority with respect to the award, denial, reduction, or revocation of medical staff privileges.")  
n35. See id.  
n36. See id. at 42.  
n37. See id. at 42.  
n38. See id. at 42-44.  
n39. See Illinois State Med. Soc'y, Due Process Guidelines for Physicians (1988); see Tomes, supra note 14, at 46.  
n40. See David W. Townsend, Hospital Peer Review is a Kangaroo Court, 3 Med. Econ. 133 (2000), available at <http://me.pdr.net/me...rnals/m/data/2000/0207/thcqia.html>.  
n41. See Charles Silver, M.D., Letter to the Editor: Peer Review, 23 Surgical Rounds 432 (2000).  
n42. 486 U.S. 94 (1986).  
n43. Horner, supra note 6, at 461.  
n44. See id.  
n45. 42 U.S.C. 11101(4)(1994). See Susan O. Scheutzow, supra note 23 at 9.  
n46. See Stillwell, supra note 11.  
n47. See Tomes, supra note 14.  
n48. See Troyen A. Brennan, M.D., Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report, 282 JAMA 381 (1999).  
n49. See 45 C.F.R. 60.1-14 (2000).  
n50. See 45 C.F.R. 60.1-4 (2000).  
n51. See Scheutzow, supra note 14 at 7, 9.  
n52. See Tomes, supra note 14, at 64; see also 42 U.S.C. 11101(4)-(5), 11111(a) (1994).  
n53. 42 U.S.C. 11101(4) (1994).  
n54. See id. 11112(a)(1)-(4); see also 11111(a) (listing immunity protections).  
n55. Id. 11112(a)(1)-(4) (emphasis added).  
n56. Id. 11112(a).  
n57. Tanya Albert, LA Verdict Against Peer Review is Reversed, Am. Med. News, Oct. 9, 2000, available at <http://www.ama-assn.org/sci-pubs/amnews/pick 00/rsb1009.htm>.  
n58. See 45 C.F.R. 60.2 (2001).  
n59. Id. 60.1-14.  
n60. 45 U.S.C. 11131 (1994).  
n61. Id. 11132 (1994).  
n62. 45 U.S.C. 11133 (1994).  
n63. See Scheutzow, supra note 23 at 7, 10.  
n64. See 42 U.S.C. 11137(b)(1) (1994).  
n65. See Bernard M. Jaffe, M.D., And Then There Were Two, 23 Surgical Rounds 9 (2000).  
n66. See U.S. Dept. of Health and Human Services, National Practitioner Data Bank: Fact Sheet Querying (2000); see also 45 C.F.R. 60.11(a) (2000).  
n67. See id.  
n68. Brennan, supra note 48 at 381.  
n69. Health Insurance Portability and Accountability Act of 1996, Pub.L. No. 104-191, 221(a), 110 Stat.

1996.  
n70. U.S. Dept. of Health and Human Services, Healthcare Integrity and Protection Data Bank: Fact Sheet on Entity Eligibility (2000).  
n71. Susan J. Landers, New Data Bank Focuses on Fraud, *Am. Med. News*, Nov. 22-29, 1999, at 5.  
n72. *Id.*  
n73. *Id.* at 6.  
n74. *Id.*  
n75. See Silver, *supra* note 41, at 432.  
n76. Patient Protection Act of 2000, H.R. 5122, 106[su'th'] Cong., (2000).  
n77. See Landers, *supra* note 71, at 5.  
n78. See Tomes, *supra* note 14, at 66. See also, e.g., Del. Code Ann. tit. 24, 1768 (2000) Members of hospital ... medical society committees ... whose function is the review of ... medical care and physicians work ... shall not be subject to, and shall be immune from, claim, suit, liability, damages, or any other resource, civil or criminal, arising from any act or proceeding. The records and proceedings of ... members of hospital medical society committees, or of a professional standards review organization ... whose function is the review of ... physicians' work ... shall be confidential and shall be used by such committees or organizations, and shall not be available for court subpoena or subject to discovery. (Emphasis added).  
n79. See Tomes, *supra* note 14, at 66.  
n80. Stillwell, *supra* note 11, see also Ala. Code 6-5-333(d) (2001).  
n81. *Id.* at vi. [including: Alaska (Alaska Stat. 18.23.030 (Michie 2000)), Arizona (Ariz. Rev. Stat. 32-1451 (2000)), California (Cal. Bus. & Prof. Code 809.2 (2001)), Colorado (Colo. Rev. Stat. 12-36.5-104(10)(b)(I-IV) (2001)), Connecticut (Conn. Gen. Stat. 19a-17b(b) (2001)), Hawaii (Haw. Rev. Stat. 663-1.7 (2000)), Illinois (225 Ill. Comp. Stat. 6015 (2001)), Kansas (Kan. Stat. Ann. 65-4915(4)(c) (2001)), Kentucky (Ky. Rev. Stat. Ann. 311.377 (Michie 2001)), Louisiana (La. Rev. Stat. Ann. 13:3715.3 (West 2001)), Mississippi (Miss. Code. Ann. 41-63-9 (2001)), Missouri (Mo. Rev. Stat. 537.035 (2000)), New Hampshire (N.H. Rev. Stat. Ann. 317-A:17 (2000)), Oregon (Or. Rev. Stat. 441.055 (1999)), Rhode Island (R.I. Code 5 37.3 7 (2001)), South Dakota (S.D. Codified Laws 36-4-26.1 (Michie2001)), and Washington (Wash. Rev. Code 70.41.200 (2001))].  
n82. Stillwell, *supra* note 11, at vi.  
n83. 42 U.S.C. 11101-11151 (1994).  
n84. See Tomes, *supra* note 14, at 66.  
n85. *Id.*  
n86. Kan. Stat. Ann. 65-4915(b) (1994).  
n87. See *infra* pp. 261-264.  
n88. See Scheutzow, *supra* note 23, at 7,12.  
n89. *Id.* at 16.  
n90. *Id.*  
n91. See Townend, *supra* note 40, at 133.  
n92. See Virmani, *supra* note 12.  
n93. Townend, *supra* note 40, at 133.  
n94. Silver, *supra* note 41, at 432.  
n95. Tomes, *supra* note 41, at 64.  
n96. See Scheutzow, *supra* note 23, at 7, 9.  
n97. *Id.* at 54.  
n98. Brennan, *supra* note 48, at 381.  
n99. *Id.* at 382.  
n100. Stillwell, *supra* note 11.  
n101. See Silver, *supra* note 41, at 432.  
n102. See 42 U.S.C. 11101(4)-(5). See also Mich. Stat. Ann. 14.57(21) (1994), Va. Code Ann. 8.01-581.13, 581.17 (1994).  
n103. Brennan, *supra* note 48, at 382.  
n104. Tomes, *supra* note 14, at 41-48.  
n105. *Id.* at 42.  
n106. See *id.* at 22-23. See also Silver, *supra* note 41, at 432.  
n107. Office of Inspector General, U.S. Dept of Health Human Services, Pub. No. OE-01-94-00050, Hospital Reporting to the National Practioner Data Bank (1995).  
n108. Baldwin et al., *supra* note 34, at 350.  
n109. 42 U.S.C. 11131(a) (1994).  
n110. *Id.* 11132 (a)(1).  
n111. *Id.* 11133 (a)(1).  
n112. *Id.* 11133(a)(1)(A)-(B).  
n113. See Baldwin, et al., *supra* note 34.

n114. Phyllis Maguire, *New Data Bank Casts Wider Net: How the Fraud Busters Threaten to Turn up the Heat on Physicians*, ACP-ASIM Observer, Jan. 1999, available at <http://www.acponline.org/journals/news/jan99/databank.htm>.

n115. See 42 U.S.C. 11101(4)-(5). See also Mich. Stat. Ann. 14.57(21) (1994), Va. Code Ann. 8.01-581.13, 581.17 (1994).

n116. Id.

n117. See supra Part I.A.

n118. See John E. Graf, Comment, *Patrick v. Burget: Has the Death Knell Sounded for State Action Immunity in Peer Review Antitrust Suits?*, 51 U. Pitt. L. Rev. 463, 463 (1989).

n119. See Scheutzow, supra note 23, at 13.

n120. See Tomes, supra note 14, at 58.

n121. See id.

n122. See Hammack, supra note 13, at 421.

n123. See Silver, supra note 41, at 432.

n124. 42 U.S.C. 11131-11133 (1994). See also Baldwin et al., supra note 113.

n125. 45 C.F.R. 60.5 (2000).

n126. See Maguire, supra note 114.

n127. 42 U.S.C. 11135(a)(1) (1994). A hospital is also required to query the NPDB every two years concerning a physician who is on their medical staff or has clinical privileges at the hospital. 42 U.S.C. 11135(a)(2) (1994).

n128. See Maguire, supra note 114.

n129. See Virmani, supra note 12.

n130. See id.

n131. 45 C.F.R. 60.14 (2000).

n132. Tomes, supra note 14, at 10.

n133. 45 C.F.R. 60.14(b) (2000). See also infra note 136.

n134. 45 C.F.R. 60.14(c) (2000).

n135. Townsend, supra note 40, at 133.

n136. Id.

n137. See id. at 1-2.

n138. 42 U.S.C. 11134(b) (1994). See also, 45 C.F.R. 60.1 (2000).

n139. See Silver, supra note 41, at 432.

n140. Albert, supra note 57.

n141. See Townend, supra note 40.

n142. *Patrick v. Burget*, 800 F.2d 1498 (9[su'th'] Cir. 1986), rev'd 486 U.S. 94 (1988).

n143. *Patrick*, 486 U.S. at 106.

n144. *Patrick*, 486 U.S. at 105.

n145. See Townend, supra note 40.

n146. Id.

n147. See Albert, supra note 57.

n148. See *Mathews v. Lancaster General Hospital*, 87 F.3d 624 (Tenn. 1996) (reaffirming the immense burden placed on a physician to show that bad faith was involved in a peer review and maintaining that there is a strong presumption that the peer review is performed in good faith).

n149. *Brown v. Presbyterian Health Care Services*, 101 F.3d 1324 (1996).

n150. Id.

n151. Id. at 1334.

n152. Id. at 1333-35.

n153. Id. at 1335.

n154. *Zamanian*, 715 So.2d 57 (La. App.4th Cir. 1998).

n155. See Albert, supra note 57.

n156. Id.

n157. Id.

n158. Id. at 14.

n159. See Virmani, supra note 12.

n160. Albert, supra note 57.

n161. See id.

n162. See Stillwell, supra note 11, at viii.

n163. *Hayes*, 559 Pa. 21, 739 A.2d 114 (1999).

n164. Id. See also Renee H. Martin, *New Peer Review Confidentiality Issues*, *Physician's News*, Dec. 1999, available at <http://www.physiciansnews.com/law/1299.html>.

n165. Id.

n166. Id.

n167. See *id.*

n168. See *id.* See also Peer Review Protection Act, 63 Pa. Cons. Stat. 425.1-4 (1996).

n169. *Id.* See also 63 Pa. Cons. Stat. 425.4 (1996).

n170. Martin, *supra* note 164; see also Hayes, 559 Pa. 21 (1999).

n171. *Id.*

n172. See Danielle Rodier, Justices: Doctor Can Use Tape of Peer Review to Clear Name; Allegations of Misuse Outweigh Concerns of Confidentiality, *Legal Intelligencer*, Oct. 6, 1999, at <http://lawnewsnetwork.com/stories/A7061-1999Oct5.html>.

n173. *Id.*

n174. It is important to note that the federal courts do not necessarily follow the decisions of state courts. Two recent landmark federal court decisions have refused to recognize state privilege protections to peer review material. These cases signal an important trend in the treatment of peer review material that will hopefully lead state courts to follow their findings. In *Virmani v. Novant Health Inc.*, 259 F.3d 284 (7<sup>th</sup> Cir. 2001), the Seventh Circuit Court of Appeals refused to allow a hospital to assert a North Carolina peer review statute to protect material disclosed during a peer review hearing involving one of its physicians. The plaintiff, Dr. Ashutosh Virmani, had filed suit against the hospital for unlawfully terminating his medical staff privileges, alleging discrimination based on race and national origin. Dr. Virmani sought to compel the records of the peer review to support his claim. The hospital refused to disclose the material, claiming the records were privileged from discovery under the North Carolina peer review protection statute. The Seventh Circuit, noting that it is thus far the only Circuit Court to squarely address the issue, rejected the hospital's assertion, holding that "the interest in obtaining probative evidence in an action for discrimination outweighs the interest that would be furthered by recognition of a privilege for medical peer review materials. Therefore, [the court] refuses to recognize such a privilege." *Virmani*, 259 F.3d 284, 293 (7<sup>th</sup> Cir. 2001). Following the Seventh Circuit's decision in *Virmani*, the U.S. District Court for the Northern District of Indiana, upheld the *Virmani* decision in a similar case involving an alleged claim of disability discrimination. In *Mattice v. Memorial Hospital of South Bend*, 2001 U.S. Dist. LEXIS 15076 (Sept. 21, 2001), the plaintiff, Dr. Thomas Mattice, had sought to compel disclosure of documents relating to a medical peer review of Dr. Mattice. The Hospital sought to prevent discovery of the documents, asserting the documents were privileged under an Indiana peer review statute. The District Court, citing the decision in *Virmani*, determined that when "the state-law medical peer review privilege [is weighed] against the interests advanced by the federal anti-discrimination laws, the privilege does not preclude discovery of peer review materials." *Mattice*, 2001 U.S. Dist. LEXIS 15076, 8 (Sept. 21, 2001). The District Court agreed with the Seventh Circuit that in the case of a federal discrimination claim, "peer review documents are not privileged and are subject to discovery." *Mattice*, 2001 U.S. Dist. LEXIS 15076, 12 (Sept. 21, 2001). Of course, these cases involve claims that arise in federal court. Unfortunately, as mentioned in the Comment, state courts have been reluctant to come to the same conclusion as their federal counterparts.

n175. *Grande*, 49 Mass. App. Ct. 77, 725 N.E.2d. 1083 (2000).

n176. Legal Report: Court Bolsters Peer Review, *RMF*, June 2000, at <http://www.rm.harvard.edu/publications/resource/legal-reports/jun2000/>.

n177. See *id.*

n178. *Id.*

n179. 42 U.S.C. 11112(a)-(b) (1994).

n180. See Joint Commission on Accreditation of Health Care Organizations, *Accreditation Manual for Hospitals* (1990). See also *Tomes*, *supra* note 14, at 42.

n181. See *Tomes*, *supra* note 14, at 42.

n182. *Id.* at 42-45.

n183. See *Townsend*, *supra* note 40, at 133.

n184. See *id.*

n185. See *Tomes*, *supra* note 14, at 22.

n186. Moreover, the Oregon courts have indicated that even if they were to provide judicial review of hospital peer-review proceedings, the review would be of a very limited nature. The Oregon Supreme Court, in its most recent decision addressing this matter, stated that a court "should [not] decide the merits of plaintiff's dismissal" and that "it would be unwise for a court to do more than to make sure that some sort of reasonable procedure was afforded and that there was evidence from which it could be found that plaintiff's conduct posed a threat to patient care." *Patrick v. Burget*, 486 U.S. 94, 104-05 (1988)(citation omitted).

n187. 45 C.F.R. 60.14(a) (2000).

n188. 45 C.F.R. 60.14(c)(2)(ii) (2000).

n189. See *Horner*, *supra* note 6, at 461.

n190. 42 U.S.C 11102(a), 11137(b)(1) (1994). See *Tomes*, *supra* note 14, at 64.

n191. See *Tomes*, *supra* note 14, at 51. See also *Hammack*, *supra* note 13, at 429.

n192. See *Tomes*, *supra* note 14, at 51.

n193. See *Summit Health Ltd. v. Pinhas*, 111 S. Ct. 1842, 1850 (1991). See also *Hammack*, *supra* note 13,

at 421.

n194. Patrick, 486 U.S. at 105.

n195. 42 U.S.C. 11112(a)(1) (1994).

n196. Hammack, supra note 13, at 449.

n197. See id. at 450.

n198. See Tomes, supra note 14, at 22.

n199. See Virmani, supra note 12.

n200. A caution put forward by physicians against removing the confidentiality protections is the risk of a libel suit. In light of the accepted tort concept that the medical profession is no longer limited to local customs, physicians would be able to assert that an independent review board agreed with their findings, releasing themselves from the liability of slander.

n201. See Townsend, supra note 40, at 133.

n202. See Tomes, supra note 14, at 11.

n203. Rodier, supra note 172.

n204. Patrick, 486 U.S. at 105.

n205. See Stillwell, supra note 11, at viii. See also, supra note 81.

n206. See id.

n207. See Townsend, supra note 40.

n208. See Silver, supra note 41, at 432.

n209. Donald M. Berwick, M.D., Continuous Improvement As An Ideal In Health Care, 320 New Eng. J. Med. 53 (1989).

n210. See id. at 53; see Jaffe, supra note 65.

n211. See Berwick, supra note 209, at 53.

n212. Id. at 53.

n213. Id. at 54.

n214. Id.

n215. Id. at 56.

n216. See id.

n217. See Brennan, supra note 48, at 381.

n218. 45 C.F.R. 60.5-.9 (2000).

n219. Baldwin, supra note 34, at 354.

\* J.D. Candidate 2002, The Catholic University, Columbus School of Law; B.A. 1996, Kalamazoo College. The author wishes to thank his wife, Brooke, and family for their contributions and support in the preparation of this article. The author is most of all grateful to his devoted father whose sacrifices and guidance have helped him to understand a problem in the medical profession which is known by many, but spoken of by few.