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Where Is the Quality in the Health Care Quality Improvement Act of 1986?

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I. INTRODUCTION

In *Patrick v. Burget*,[1] the United States Supreme Court cleared the way for Dr. Timothy Patrick to recover a judgment of nearly two million dollars from several physicians in Oregon who used the intrahospital physician peer review[2] process in violation of fed-

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1. 486 U.S. 94 (1988).

2. Physician peer review, as it is generally understood in the hospital industry, is the intrahospital process under which medical staff members review the clinical competence of a fellow physician. The process is triggered in three instances: (1) consideration of candidates for initial appointment to a hospital's medical staff, (2) consideration of incumbent staff members for reappointment, and (3) consideration of corrective action against an incumbent during the term of his appointment to the staff.

> The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—
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> (A) the physician's association, or lack of association, with a professional society or association,
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> (B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to solicit or retain business,
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> (C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
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> (D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or
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> (E) any other matter that does not relate to the competence or professional conduct of a physician.

42 U.S.C. § 11151(9) (1988).

eral antitrust laws.[3] In doing so, the Court rejected the defendants' argument "that *any* threat of antitrust liability will prevent physicians from participating openly and actively in peer-review proceedings."[4] This decision stunned the hospital industry. One editorial claimed that *Patrick* would chill the independent judgment of physicians and impede their efforts to police themselves.[5] A more dramatic commentator stated that the Supreme Court had dropped "the atom bomb of the antitrust laws" on peer review bodies.[6]

Largely in response to the jury's verdict in *Patrick*, Congress passed the Health Care Quality Improvement Act of 1986 (the "Act").[7] The Act begins with congressional findings that medical malpractice and poor quality medical care are nationwide problems that cannot be solved by the individual states.[8] Congress

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> The term "professional review activity" means an activity of a health care entity with respect to an individual physician—
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> (A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
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> (B) to determine the scope or conditions of such privileges or membership, or
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> (C) to change or modify such privileges or membership.

Id. § 11151(10).

The terms "peer review," "professional review," and "professional review action" are synonymous and are used interchangeably throughout this article.

3. More specifically, the Court reversed the Ninth Circuit's ruling that the reviewing physicians' conduct was immune from antitrust liability under the state action doctrine. *Patrick*, 486 U.S. at 105-06. The Court ruled that the State of Oregon was not sufficiently involved in the peer review process to constitute "active state supervision," one of the two elements of the state action immunity test. *Id.* at 105. Because the case did not satisfy this element, the Court concluded its analysis without considering the other prong of the test: whether " 'the challenged restraint [has been] "clearly articulated and affirmatively expressed as state policy." ' " *Id.* at 100 (quoting California Liquor Dealers Ass'n v. Midcal Aluminum, Inc., 445 U.S. 97, 105 (1980) (quoting Louisiana Power & Light Co., 435 U.S. 389, 410 (1978) (opinion of Brennan, J.))).

4. *Id.* at 105 (emphasis added).

5. Gainer & Miles, *The Impact of* Patrick v. Burget *on Peer Review*, 2 MED. STAFF COUNS. 13 (1988) (citing *Court Ruling Will Undercut Peer Review*, HEALTH WEEK, June 6, 1988, at 24).

6. *Doctors Can Sue in Peer Reviews, Justices Declare*, N.Y. Times, May 17, 1988, at 1; *see also* Gainer and Miles, *supra* note 5, at 13.

7. 42 U.S.C. § 11101-11152 (1988). Congressmen from the states comprising the area governed by the United States Court of Appeals for the Ninth Circuit, which heard the *Patrick* appeal, were instrumental in the passage of the Act. *See* Note, *Physician Staff Privilege Cases: Antitrust Liability and the Health Care Quality Improvement Act*, 29 WM. & MARY L. REV. 609, 625 n.83 (1988).

8. Specifically, Congress found: "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." 42 U.S.C. § 11101(1) (1988). The Office of the Inspector General of the Department of Health and Human Services recently conducted a study of state medical licensing boards.

found that there is an overriding national need for effective peer review.[9] It apparently believed that physician peer review before the passage of the Act was "ineffective" because the threat of liability for damages resulting from a physician's participation in peer review discouraged participation, as evidenced by the outcry over *Patrick*.[10] Thus, the Act creates a "safe harbor" designed to protect peer review participants from liability for damages in certain cases.[11] By removing this threat of liability, Congress hoped that physicians would be more willing to identify incompetent or unprofessional physicians through the peer review process.

This Article analyzes the impact of the Act on the current peer review process and suggests an alternative approach to evaluating the quality of a physician's professional services. The fundamental problem with peer review today is that the process asks physicians to criticize their colleagues. This problem is especially acute when the reviewers work closely or compete with the physician under review. Under these circumstances, it is not surprising that physicians are reluctant to engage in effective peer review.

See OFFICE OF THE INSPECTOR GEN., U.S. DEP'T OF HEALTH & HUMAN SERVS., MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW (1986). This study demonstrated that since the establishment of the Medicare program, states have been unable to identify and eliminate incompetent physicians. *See* Kusserow, Handley & Yessian, *An Overview of State Medical Discipline*, 257 J. A.M.A. 820 (1987). The study concluded that although physician incompetence is a major problem, only a small number of state disciplinary proceedings address it. *Id.* at 822-23.

9. "There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(5) (1988).

10. "The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." *Id.* § 11101(4).

11. The Act provides:

> If a professional review action . . . of a professional review body meets all the standards specified in Section 11112(a) of this title, except as provided in subsection (b) of this section:
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> (A) the professional review body,
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> (B) any person acting as a member or staff to the body,
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> (C) any person under a contract or other formal agreement with the body, and
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> (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, *et seq.* and the Civil Rights Acts, 42 U.S.C. 1981, *et seq.* Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under Section 15c of title 15, where such an action is otherwise authorized.

Id. § 11111(a)(1).

The Act, if amended, can help to overcome some physician reluctance in two respects. First, the Act should be revised to create an incentive for hospitals and their physicians to rely on outside medical experts to perform the substantive clinical review of physicians under scrutiny. Second, Congress should bolster the protection of the Act by immunizing hospitals and their reviewers against *all* claims, except those instances in which outside review was used as a pretext to keep a physician off the hospital's medical staff.

This Article first describes the health industry dynamics that led to the passage of the Act and discusses the Act's provisions and inadequacies. Next, it describes the legal infrastructure of peer review and identifies the major obstacles to this process. Finally, the Article offers some suggestions for improving the Act.

II. The History and Impact of the Health Care Quality Improvement Act of 1986

Congress passed the Act to calm the fear that federal antitrust exposure for peer review participants would deter their participation in the process. This concern became more profound in light of the damages awarded in *Patrick*. A review of the *Patrick* litigation and the specific provisions of the Act shows that Congress was not interested in protecting the type of "peer review" found in *Patrick*. Instead, the Act was designed to teach hospitals and reviewers how to conduct peer review to avoid exposure under various laws. Nevertheless, the protections of the Act are illusory and its current provisions should not quell the fears generated by *Patrick*.

A. Patrick v. Burget — *The Impetus for the Act*

Patrick v. Burget[12] is perhaps the most famous medical staff dispute to date. In *Patrick*, the members of a private, group medical practice, the Astoria Clinic, consistently refused to deal professionally with Dr. Patrick, a general and vascular surgeon, after he rejected a partnership in the clinic and began an independent competing practice.[13] Even when the clinic had no general surgeon on its staff, the clinic's physicians refused to make referrals to Dr. Patrick.[14] The clinic's physicians also were reluctant to assist Dr. Patrick with his own patients, and repeatedly criticized him for failing to obtain outside consultations and adequate backup

12. 486 U.S. 94 (1986).
13. *Id.* at 96.
14. *Id.*

coverage.[15]

Subsequently, a clinic surgeon asked the executive committee of the medical staff of Columbia Memorial Hospital, the only hospital in town, to review Dr. Patrick's competence.[16] A majority of the hospital's medical staff were employees or partners of the clinic.[17] In the peer review proceedings, physicians from the clinic reviewed Dr. Patrick's cases, which they discussed more often and criticized more thoroughly than those of other surgeons.[18] The executive committee of the medical staff voted to recommend terminating Dr. Patrick's privileges because it found that his patient care services fell below the hospital's standards.[19]

The hospital provided Dr. Patrick with a hearing before a five-member committee chaired by a partner of the clinic, who two years earlier had complained about Dr. Patrick to the hospital's executive committee.[20] Nine cases out of the 2000 to 2500 surgeries performed by Dr. Patrick ultimately comprised the evidence against him, and experts later disagreed as to the quality of Dr. Patrick's performance in these cases.[21]

At the peer review hearing, the committee members were inattentive during Dr. Patrick's presentation of his position.[22] They also refused to answer questions from Dr. Patrick's attorney regarding their personal knowledge of the evidence and their personal biases against Dr. Patrick.[23] Before the completion of these proceedings, Dr. Patrick resigned from the staff and filed a federal antitrust lawsuit against the hospital and the partners of the clinic.[24]

Dr. Patrick prevailed in a jury trial and was awarded a judgment of nearly two million dollars against the clinic.[25] On appeal, the Ninth Circuit reversed and held that the peer review process, even

15. *Id.*
16. *Id.* at 97.
17. *Id.* at 96.
18. Patrick v. Burget, 800 F.2d 1498, 1503-04 (9th Cir.), *rev'd*, 486 U.S. 94 (1986).
19. *Patrick*, 486 U.S. at 97.
20. *Id.* The complaint was based upon Dr. Patrick's delegation of care to an experienced associate, who allegedly left the patient unattended. The executive committee referred the complaint to the Oregon Board of Medical Examiners, which issued a letter of reprimand. This letter was withdrawn when Dr. Patrick sought judicial review of the Board's action. *Id.* at 96-97.
21. *Patrick*, 800 F.2d at 1504.
22. *Id.*
23. *Id.*
24. *Patrick*, 486 U.S. at 97.
25. *Id.* at 98. The jury awarded Patrick $650,000 in damages for his two Sherman Act claims, and the district court trebled the damages as required by law. *Id.*

if tainted, is immune under the state action doctrine from antitrust scrutiny.[26] The Supreme Court disagreed, however, and reinstated the district court's award of damages.[27]

Patrick is the archetypal example of the misuse and abuse of the peer review process. This abuse may not be typical or pervasive; however, when physicians exert their power in purely anticompetitive ways under the guise of peer review, antitrust liability may be warranted.

Although the verdict in *Patrick* inspired the passage of the Act, this statute would not have immunized any of the defendants found liable in the *Patrick* case. Thus, the Act was not designed to protect the tainted peer review process employed in *Patrick*. Instead, the Act's purpose was to establish some parameters for conducting peer review without the threat of liability for damages.

B. Peer Review and Litigation Avoidance

The potential for litigation poses a primary disincentive for physician participation in peer review. Physicians are reluctant to participate in peer review because they wish to avoid involvement in retaliatory lawsuits brought by disgruntled physicians who sue the hospital and all other responsible parties for denial of their hospital membership or privileges.[28] A peer review action adverse to a physician generally gives rise to at least five causes of action: (1) defamation, (2) tortious interference with advantageous business relationships, (3) intentional infliction of mental distress, (4) breach of contract, and (5) violation of federal and state antitrust laws.[29]

This litigation can be quite costly even when parties settle out of court. For example, in *Weiss v. York Hospital*,[30] the court found the medical staff of the hospital liable for antitrust violations to Dr. Weiss and other osteopaths. Four of the peer reviewers also were

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26. *Patrick*, 800 F.2d at 1509.

27. *Patrick*, 486 U.S. at 105-06. Specifically, the Court recognized that the Act did not apply retroactively to the circumstances in *Patrick*. *Id.* at 105 n.8. Prior to the effective date of the Act, only state action could immunize peer review activities from antitrust liability. At the time of the *Patrick* case, Oregon did not provide such immunity. *Id.* at 105-06.

28. Curran, *Legal Immunity for Medical Peer-Review Programs: New Policies Explored*, 320 NEW ENG. J. MED. 233 (1989).

29. Chayet & Reardon, *Trouble in the Medical Staff: A Practical Guide to Hospital Initiated Quality Assurance*, 7 AM. J. L. & MED. 301, 312-14 (1981).

30. 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).

held liable for interfering with Dr. Weiss's business relations.[31] Shortly before the trial for damages, the defendants agreed to pay more than four million dollars to settle the case.[32] Similarly, Dennis L. Brooks, an ophthalmologist, sued the San Diego Academy of Ophthalmology, after the Academy criticized him for delegating follow-up care for cataract patients to other ophthalmologists.[33] This criticism caused hospitals to curtail Dr. Brooks's privileges.[34] Dr. Brooks brought an antitrust suit against the Academy and three of its officers.[35] During the litigation, the parties deposed more than 120 people, legal fees exceeded one million dollars, and the Academy went bankrupt.[36] The three individual defendants paid Dr. Brooks $400,000 to settle the case, and several members of the Academy each paid approximately $30,000, resulting in a total settlement amount between two and three million dollars.[37]

1. State Law Immunity

Although most states have enacted statutory protection for peer review participants,[38] these statutes generally have failed to allay physicians' fear of potential litigation. The immunity provided by these statutes ranges from qualified immunity in defamation actions to absolute immunity in all civil litigation.[39] This protection, however, generally depends upon the peer review action being taken in good faith[40] or reasonably.[41] Thus, a complaint alleging

31. Holoweiko, *How to Stop a Wayward Doctor Without Getting Burned*, MED. ECON., Nov. 20, 1989, at 184, 187.

32. *Id.*

33. *Id.* at 191.

34. *Id.*

35. *Id.*

36. *Id.*

37. *Id.*

38. *See, e.g.*, ARK. STAT. ANN. § 20-9-502 (1987); COLO. REV. STAT. § 12-36.5-105 (1990); CONN. GEN. STAT. ANN. § 38-19a(b)-(c) (West 1987); ILL. REV. STAT. ch. 111 1/2, para. 151.2 (1989); IND. CODE ANN. § 16-10-1-6.5 (West Supp. 1990); LA. REV. STAT. ANN. § 37:1287 (West 1988); MD. HEALTH OCC. CODE ANN. § 14-601(f) (Supp. 1990); OHIO REV. CODE ANN. § 2305.25 (Anderson Supp. 1989); OKLA. STAT. ANN. tit. 76, §§ 25-28 (West Supp. 1990); PA. STAT. ANN. tit. 63, § 425.3 (Purdon Supp. 1990); R.I. GEN. LAWS § 5-37-1.5 (1987); S.D. CODIFIED LAWS ANN. § 36-4-25 (1986); TENN. CODE ANN. § 63-6-219 (1990); UTAH CODE ANN. § 26-25-1 (Supp. 1990); VT. STAT. ANN. tit. 26, § 1442 (1989); VA. CODE ANN. § 8.01-581.16 (Supp. 1990); WASH. REV. CODE ANN. § 4.24.240 (1988); W. VA. CODE § 30-3C-2 (1986); WIS. STAT. ANN. § 146.37 (West 1989).

39. *See, e.g.*, ARK. STAT. ANN. § 20-9-502 (1987); COLO. REV. STAT. § 12-36.5-105 (1990); CONN. GEN. STAT. ANN. § 38-19a(b)-(c) (West 1987); ILL. REV. STAT. ch. 111 1/2, para. 151.2 (1989); IND. CODE ANN. § 16-10-1-6.5 (West Supp. 1990).

40. *See, e.g.*, WASH. REV. CODE ANN. § 4.24.240(2) (1988).

41. *See, e.g.*, LA. REV. STAT. ANN. § 37:1287 (West 1988).

bad faith or unreasonable or malicious use of peer review will require physicians named as defendants to remain in the lawsuit until the issues regarding the application of immunity are resolved in their favor. Even if the peer reviewers ultimately succeed, the costs of defending such lawsuits may be prohibitive.[42]

Congress was aware that most review actions already were protected by state law immunity and confidentiality provisions.[43] It apparently believed that these protections adequately served the interests of peer review and quality assurance at the state level, but that a small number of federal antitrust actions had overridden these protections.[44] For reasons not contained in the Act or its legislative history, Congress believed that peer review in the United States had deteriorated because of the threat of potential federal antitrust liability for the participants.[45] Congress failed to explore whether, or why, peer review was ineffective at the state level despite the presence of state statutory protections for peer review participants.

2. Immunity Under the Act

Congress recognized that litigation avoidance is a strong force in the hospital industry, particularly in the context of discipline for incompetent physicians.[46] Prior to the passage of the Act, hospitals often accepted a physician's "voluntary" resignations in return for the hospital's silence about the reasons for the resignation.[47] Hospitals made these agreements to avoid costly, lengthy, and unpredictable litigation.[48] The threat of litigation also strongly affected the physicians who conducted peer review.[49]

The Act sets out a four-part immunity test for determining whether a particular peer review action is protected.[50] The peer

42. Even if these costs are covered by the hospital's commercial or self-insurance policy, the negative economic impact is not eliminated. Insurance premiums tend to increase as claims increase. Moreover, the coverage limits of a policy may be unclear at the outset of a peer review action because of the uncertain nature of potential litigation.

43. H.R. REP. No. 99-903, 99th Cong., 2d Sess. 2, *reprinted in* 1986 U.S. CODE CONG. & ADMIN. NEWS 6384, 6391 [hereinafter HOUSE REPORT].

44. *Id.*

45. *Id.*

46. *Id.* at 6385.

47. *Id.*

48. *Id.*

49. *Id.*

50. The federal antitrust immunity of the Act went into effect on November 14, 1986. The Act's immunity for actions under state law went into effect on October 14, 1989, in states that did not otherwise opt in or out of the protection of the Act. 42 U.S.C. § 11111(c) (1988).

review action must be conducted:

(1) in the reasonable belief that the action was taken 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 have been afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of (3) above.[51]

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51. *Id.* § 11112(a). The statute provides:

(a) In general

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

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating—

(A) (i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B) (i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating:

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

The plaintiff-physician has the burden of proving by a preponderance of the evidence that any of these standards has not been satisfied.[52]

The Act also provides adequate notice and fair hearing procedures to satisfy the third part of the Act's immunity test. The adequate notice element is satisfied if the physician is given notice:

> (1) that a peer review action has been proposed against the physician,
> (2) of the reasons for the proposed action,
> (3) that the physician has the right to request a hearing on the proposed action within a specified time limit,
> (4) of a summary of the physician's hearing rights as described in the Act,
> (5) of the time, place, and date of the hearing within thirty days, if a hearing is requested, and
> (6) of a list of witnesses expected to testify at the hearing on behalf of the peer review body.[53]

A hearing is deemed fair under the Act if:

> (i) before an arbitrator mutually acceptable to the physician and the health care entity,
> (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
> (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
>
> (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
>
> (C) in the hearing the physician involved has the right—
> (i) to representation by an attorney or other person of the physician's choice,
> (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
> (iii) to call, examine, and cross-examine witnesses,
> (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
> (v) to submit a written statement at the close of the hearing; and
>
> (D) upon completion of the hearing, the physician involved has the right—
> (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
> (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.
>
> 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.

Id. § 11112(a)-(b).

52. *Id.* § 11112(a).

53. *Id.* § 11112(b)(1)-(2).

> (1) it is held before an arbitrator acceptable to both parties, or a hearing officer, or panel of individuals not in economic competition with the physician; and
> (2) the physician is afforded the right to: (i) be represented by an attorney; (ii) have the hearing recorded; (iii) call, examine, and cross-examine witnesses; (iv) present relevant evidence; (v) submit a written statement; (vi) receive the written recommendation and analysis of the arbitrator, officer, or panel; and (vii) receive from the hospital a written notice of the decision and its basis.[54]

If a peer review procedure meets the four-part immunity test of the Act, the hospital and its peer review participants will not be liable for damages as a result of the peer review process, unless the claim involves certain federal civil rights violations.[55] The Federal and state governments are not precluded from bringing actions challenging the review process.[56] Compliance with the Act does not immunize the hospital or its peer review participants from lawsuits seeking declaratory or injunctive relief.[57]

The Act's protection is limited to peer review decisions based upon the physician's clinical competence or quality of care.[58] A decision to reject an applicant for appointment or reappointment based upon nonclinical factors, such as the applicant's failure to maintain certain minimum levels of malpractice insurance or the inability of the hospital to accommodate the applicant's expertise (e.g., when patient volume for certain services is too low to justify the addition of physicians providing these services or when the hospital decides to discontinue a service such as its open-heart program because of low volume), is not protected.[59]

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54. *Id.* § 11112(b)(3).
55. *Id.* § 11111(a)(1).
56. *Id.*
57. *Id.* The clear terms of the Act show that it provides immunity only against actions for damages. *Id.*
58. *Id.* § 11112.
59. Hospitals often deny physicians access to their facilities for reasons not related directly to the physicians' clinical abilities. *See, e.g.*, Pollock v. Methodist Hosp., 392 F. Supp. 393 (E.D. La. 1975) (lack of malpractice insurance coverage); Yeargin v. Hamilton Memorial Hosp., 229 Ga. 870, 195 S.E.2d 8 (1972) (failure to provide emergency room coverage); Szczerbaniuk v. Memorial Hosp., 180 Ill. App. 3d 706, 536 N.E.2d 138 (1989) (sexual harassment); Knapp v. Palos Community Hosp., 125 Ill. App. 3d 244, 465 N.E.2d 554 (1984) (overutilization of hospital facilities); Koelling v. Board of Trustees of Mary Frances Skiff Memorial Hosp., 259 Iowa 1185, 146 N.W.2d 284 (1967) (medical records violations); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589 (1971), *cert. denied*, 404 U.S. 995 (1971) (inability to work with others); Guerrero v. Burlington County Memorial Hosp., 70 N.J. 344, 360 A.2d 334 (1976) (overcrowded facility). Because these decisions do not relate directly to the clinical abilities of the physician denied access to the hospital, input from the medical staff is unnecessary. The board and administration should be able to make these managerial decisions without

Instead, the Act protects only peer review actions that find a physician clinically incompetent or dangerous if the actions are reported to the federal government for the purpose of putting all hospitals in the United States on notice of the action.[60] The physician whom the report will stigmatize has every incentive to file a lawsuit against the hospital and the peer review participants for injunctive relief to clear his or her name. The Act does nothing to protect hospitals or peer review participants from such lawsuits.

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triggering the peer review process. See Anne Arundel Gen. Hosp., Inc. v. O'Brien, 49 Md. App. 362, 432 A.2d 483 (1981), wherein the court stated, "The requirement that the Hospital hold a hearing on what is essentially a management decision vested in the several governing boards of the private hospital was not contemplated by the charter and bylaws of the Hospital." *Id.* at 373, 432 A.2d at 489; *see also* Engelstad v. Virginia Mun. Hosp., 718 F.2d 262 (8th Cir. 1983) (hospital may terminate a department head, due to conflicting ideas about how the department should operate, without triggering the peer review process). Although these decisions are not protected by the Act, a hospital's unilateral decision to deny appointment or reappointment or to remove a physician for nonclinical reasons generally does not need special protection from the antitrust laws. Absent involvement from competing physicians, the likelihood of expensive antitrust litigation over these matters is reduced. Moreover, absolutely immunizing the nonclinical decisions of hospitals will do nothing to promote effective peer review. *See Szczerbaniuk*, 180 Ill. App. 3d at 710-11, 536 N.E.2d at 141 (actions of hospital administrators involving removal of a physician outside of the peer review process were not protected by the state peer review immunity statute). Therefore, the Act should not be expanded to immunize these actions from all lawsuits that a disgruntled physician might bring.

60. Specifically, the Act provides:

> (a) Reporting by health care entities
>
> (1) On physicians
>
> Each health care entity which—
>
> (A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;
>
> (B) accepts the surrender of clinical privileges of a physician—
>
> (i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or
>
> (ii) in return for not conducting such an investigation or proceeding; or
>
> (C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,
>
> shall report to the Board of Medical Examiners, in accordance with section 11134(a) of this title, the information described in paragraph (3). . . . .
>
> (b) Reporting by Board of Medical Examiners
>
> Each Board of Medical Examiners shall report, in accordance with Section 11134 of this title, the information reported to it under subsection (a) of this section and known instances of a health care entity's failure to report information under subsection (a)(1) of this section.

42 U.S.C. § 11133(a)(1), (b) (1988).

3. The Illusory Protection of the Act

Because the Act protects only certain types of *reasonable* conduct, federal antitrust actions for damages may proceed at least to the discovery stage of litigation if the disgruntled physician alleges that the peer review action was taken: (1) in the *unreasonable* belief that it furthered quality health care, (2) after an *unreasonable* effort to obtain the facts of the matter, (3) with *inadequate* notice and hearing procedures that were *unfair* to the physician, and (4) in the *unreasonable* belief that the action was warranted by the facts known following *unreasonable* efforts to obtain the facts. Indeed, alleging and proving any one of these facts by a preponderance of the evidence may defeat the immunity of the Act.[61] A complaint challenging peer review action that fails to allege at least one, if not all four, of these facts is virtually inconceivable.

Consequently, a court could reject a well-drafted complaint for damages, at the earliest, after the filing of a motion for summary judgment based upon the Act's immunity. This motion would be successful only after all parties in the case had an opportunity to conduct expensive and time-consuming discovery. Discovery could include document requests, interrogatories, and depositions of hospital personnel and peer review participants. The issues regarding the four-part immunity test of the Act also would have to be briefed fully and argued.

A case that illustrates the above scenario is *Austin v. McNamara*,[62] the first and only reported decision under the Act. In *Austin*, a neurosurgeon alleged violations of the Sherman Antitrust Act[63] and brought state business tort claims against five physician peer reviewers and a hospital. The court initially did not dismiss the complaint, and the parties engaged in discovery that included depositions of the individual physician-defendants.[64] Although the court held that the Act immunized the hospital and its peer reviewers from damages, the case proceeded to summary judgment.[65] The court granted defendants' motions after the parties filed voluminous moving papers, declarations, and exhibits. The plaintiff's failure to address, much less rebut, the defendants' evidentiary showing made the defense's task much easier. The complaining neurosurgeon failed to mention the Act in his response despite the

61. *Id.* § 11112(a).
62. 731 F. Supp. 934 (C.D. Cal. 1990).
63. 15 U.S.C. §§ 1-7 (1988).
64. *Austin*, 731 F. Supp. at 935.
65. *Id.* at 944.

defendants' reliance on it in their moving papers.[66] The plaintiff's failure to establish a factual issue regarding the Act's four-part immunity test gave the court little choice but to rule in favor of the hospital and its peer reviewers.

Although the Act prevented the case from going to trial, the parties had to undergo discovery and engage in a burdensome briefing process. The peer review action, which lasted over four years,[67] practically went uncontested because the plaintiff ignored the Act in his response to the defendants' motions. Thus, even when the circumstances heavily favor the peer reviewers, as they did in *Austin*, the process can be lengthy, disruptive, and costly.

Had the neurosurgeon in *Austin* raised a factual issue regarding the Act, such as the unreasonableness of the peer review participants' beliefs and actions that led to the peer review action, he would have defeated the summary judgment motion and forced the case to trial. Although this point was not tested in *Austin*, the unresolved factual issues created by the Act's immunity test could force most cases to trial. The Act fails, therefore, to shorten significantly the litigation process or reduce its costs.

Further, the Act makes the reasonableness of the beliefs and actions of the peer review participants one of the central issues in the proceedings.[68] Under the Act, the court or the jury must decide whether the defendants reasonably believed that they were acting: (1) in furtherance of quality health care, (2) after a reasonable investigation of the matter, (3) after providing the physician with adequate notice and a fair hearing, and (4) in the reasonable belief that the rejection was warranted under the facts.[69] If the defendants acted fairly and reasonably in taking the peer review action, they are not liable under the federal antitrust laws in the first place. Thus, the Act provides the hospitals and peer review participants little, if any, additional protection from antitrust laws, because the fundamental inquiry in every antitrust case is whether the challenged actions were reasonable.[70] The Act fails to narrow this inquiry.

Congress also intended courts to rule on the Act's immunity even though a case involved other issues.[71] Congress believed that

66. *Id.* at 942.
67. *Id.* at 936.
68. *See id.* at 939-42.
69. *Id.*
70. *See, e.g.*, Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).
71. HOUSE REPORT, *supra* note 43, at 6394.

the court could find a defendant immune from damages under the Act, yet allow the plaintiff to demonstrate that the peer review action was otherwise improper.[72] Thus, the case could proceed to address whether injunctive, declaratory, or other relief would be appropriate.[73]

Assuming that a viable claim for injunctive relief remained following a favorable immunity ruling for the defendants, the plaintiff could argue that, by virtue of the Act's immunity, he has no adequate remedy at law and he is being harmed irreparably.[74] Thus, a favorable immunity ruling for the defendants would assist the plaintiff in making his claim for injunctive relief and perhaps assist in ultimately allowing the plaintiff to be placed or to remain on the hospital's staff.[75]

Consequently, the Act raises false hopes of avoiding litigation. It will not stop the filing of lawsuits and will do very little, if anything, to terminate these lawsuits at an early stage in the litigation process. Once physicians realize the true limitations and applications of the Act, they may well conclude that it provides no meaningful protection for participation in effective peer review. The energy hospitals and physicians might expend in complying with the Act, only to realize the meager protection it offers, might create disillusionment with the Act and with the peer review process itself.

4. The Reporting Provisions of the Act

Under the Act, any peer review action that adversely affects the clinical privileges of a physician for more than thirty days, or any surrender of clinical privileges by a physician who is under investigation by the hospital for incompetence or unprofessional conduct, or in exchange for not conducting such an investigation, is reporta-

72. *Id.*

73. *Id.*

74. It is difficult to conceive of a lawsuit in which injunctive relief would be appropriate if the defendants acted with the reasonable belief of furthering quality health care, after a reasonable effort to obtain the relevant facts, following adequate notice and fair hearing procedures, and with the reasonable belief that the action was warranted. If peer review participants prevail on the immunity issues, the entire lawsuit should be dismissed at the summary judgment phase.

75. *See generally In re* Feit & Drexler, Inc., 760 F.2d 406 (2d Cir. 1985) (party may not obtain injunctive relief if the claimed loss can be adequately remedied by an award of damages); Roland Mach. Co. v. Dresser Indus., Inc., 749 F.2d 380 (7th Cir. 1984) (a court may issue a preliminary injunction if the moving party can establish that: (1) he has a chance of prevailing on the merits; (2) he will suffer irreparable harm without injunctive relief; (3) the balance of hardships to the parties tips in his favor; and (4) the injunctive relief would serve the public interest).

ble to the federal government for inclusion in the National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners.[76] The report must contain the name of the physician, a description of the reasons for the peer review action or surrender of privileges, and any other information deemed relevant by the Secretary of Health and Human Services.[77] The Act then requires other hospitals to obtain this information every time a physician applies for staff membership or clinical privileges and once every two years for incumbent staff members.[78] Additionally, hospitals have the option to request this information at other times.[79]

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76. 42 U.S.C. § 11133 (1988). On October 17, 1989, the Department of Health and Human Services published its final regulations setting forth the criteria for reporting to and requesting information from the National Practitioner Data Bank as mandated by the Act. *See* Final Regulations for National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 54 Fed. Reg. 42,722 (1989) (to be codified at 45 C.F.R. pt. 60); Corrections to Final Regulations on National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 54 Fed. Reg. 43,890 (1989). These regulations became effective on September 1, 1990, when the data bank became operational. Announcement of Opening Date of National Practitioner Data Bank, 55 Fed. Reg. 31,239 (1990). For a general discussion of the nature of this data bank, see *infra* notes 77-86 and accompanying text.

77. Specifically, the Act provides:

> The information to be reported under this subsection is—
>
> (A) the name of the physician or practitioner involved,
>
> (B) a description of the acts or omissions or other reasons for the action or, if known, for the surrender, and
>
> (C) such other information respecting the circumstances of the action or surrender as the Secretary deems appropriate.

42 U.S.C. § 11133(a)(3) (1988).

78. The Act provides:

> (a) In general
>
> It is the duty of each hospital to request from the Secretary (or the agency designated under Section 11134(b) of this title), on and after the date information is first required to be reported under Section 11134(a) of this title) [sic]—
>
> (1) at the time a physician or licensed health care practitioner applies to be on the medical staff (courtesy or otherwise) of, or for clinical privileges at, the hospital, information reported under this subchapter concerning the physician or practitioner, and
>
> (2) once every 2 years information reported under this subchapter concerning any physician or such practitioner who is on the medical staff (courtesy or otherwise) of, or has been granted clinical privileges at, the hospital.
>
> A hospital may request such information at other times.
>
> (b) Failure to obtain information
>
> With respect to a medical malpractice action, a hospital which does not request information respecting a physician or practitioner as required under subsection (a) of this section is presumed to have knowledge of any information reported under this subchapter to the Secretary with respect to the physician or practitioner.

Id. § 11135(a)-(b).

79. *Id.* § 11135(a).

This national data bank on physicians will also contain information about allegations of the physician's medical malpractice. Under the Act, medical malpractice payments, no matter how small, are reportable to the federal government.[80] The information to be reported includes:

(1) the name of the physician involved,
(2) the amount of the payment,
(3) the name of the hospital with which the physician is affiliated,
(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and
(5) any other information deemed necessary by the Secretary of Health and Human Services.[81]

Although Congress understood that the relationship between poor quality of care and a malpractice settlement may be tenuous, it believed that hospitals authorized to obtain this data would use it responsibly to evaluate a physician's qualifications.[82]

Thus, the Act focuses on identifying incompetent or unprofessional physicians and preventing these physicians from continuing to injure patients.[83] Congress realized that state licensing boards, hospitals, and medical societies often failed to weed out incompetent or unprofessional physicians and, even if they did so, the phy-

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80. Specifically the Act provides:

(a) In general

Each entity (including an insurance company) which makes payment under a policy of insurance, self-insurance, or otherwise in settlement (or partial settlement) of, or in satisfaction of a judgment in, a medical malpractice action or claim shall report, in accordance with Section 11134 of this title, information respecting the payment and circumstances thereof.

(b) Information to be reported

The information to be reported under subsection (a) of this section includes—

(1) the name of any physician or licensed health care practitioner for whose benefit the payment is made,
(2) the amount of the payment,
(3) the name (if known) of any hospital with which the physician or practitioner is affiliated or associated,
(4) a description of the acts or omissions and injuries or illnesses upon which the action or claim was based, and
(5) such other information as the Secretary determines is required for appropriate interpretation of information reported under this section.

(c) Sanctions for failure to report

Any entity that fails to report information on a payment required to be reported under this section shall be subject to a civil money penalty of not more than $10,000 for each such payment involved. . . .

Id. § 11131(a)-(c).

81. *Id.* § 11131(b) (1988).

82. House Report, *supra* note 43, at 6396.

83. *Id.* at 6384.

sicians were free to move from state to state without disclosing their past practices.[84] As discussed above, the reporting requirements of the Act will generate negative information about physicians in two contexts: medical malpractice and hospital-medical staff relations. The data bank required by the Act, which may be tapped by every hospital in the United States interested in a particular physician, could stigmatize physicians tremendously.

In addition, by requiring hospitals to report a physician's staff resignation in lieu of disciplinary action, the Act eliminates the only avenue hospitals had to resolve a medical staff dispute without creating a substantial risk of litigation. Health industry witnesses informed Congress that this national reporting system would result in an enormous increase in litigation.[85] Physicians, subject to peer review action and faced with the certainty that they will be unable to hide their past performance from other hospitals nationwide, will feel compelled to challenge the action as if their careers were in jeopardy.[86]

This discussion, however, is not a criticism of the reporting requirements. On the contrary, a national data bank that contains accurate and reliable information about a physician's performance will be useful in promoting quality health care. Congress, however, seemed to ignore the tremendous potential for litigation involved with such a system. Instead of dismantling the data bank, Congress should improve the protections of the Act for reviewing and reporting incompetent physicians.

III. The Legal Infrastructure of Peer Review

Peer review owes its existence and structure to a number of historical, economic, and legal factors. Peer review places physicians in the important role of gatekeepers who control a physician's access to valuable hospital resources that may be essential to a particular physician's ability to practice medicine; for example, hospital privileges are essential for the practice of cardiac surgery. Physicians exercise this control by reviewing the applications of candidates for medical staff appointment and reappointment, and the clinical data of physicians subject to corrective action due to possible incompetence. Through a complicated structure of medical staff committees and hearings, the physician peer reviewers recommend the appropriate action that the hospital's board of directors

84. *Id.* at 6385.
85. *Id.*
86. *Id.*

should take regarding the physician under review. In general, hospital boards are reluctant to reject these recommendations because they defer to the reviewing physicians' expertise in evaluating the clinical performance and competence of other physicians. Additionally, they fear the adverse economic ramifications that may follow from an action that goes against the wishes of the hospital's medical staff. Decisions that alienate a medical staff may cause a hospital's staff physicians to admit their patients to other hospitals. Thus, the existence, structure and influence of physician peer review is founded in large part upon the economic power staff physicians have over hospitals. This power has manifested itself in the way hospital care is reimbursed and organized.

A. The Economic Power of Physicians

The economic power of physicians is founded upon state medical practice acts, which allow only physicians to practice medicine.[87] This prohibition against the unlicensed practice of medicine prevents hospitals from employing physicians or otherwise controlling their professional judgment in patient care.[88] Accordingly, only physicians can order medical tests, prescribe drugs, recommend surgery, or admit a patient to a hospital.[89] Hospital boards and administrators are prohibited by law from admitting patients or providing other hospital services without the intervention and consent of a licensed physician.[90] This control over patient admissions gives staff physicians substantial power over the financial destiny of a hospital and, as a result, its board and management.

Because of their unique position to control the use of hospital services, physicians historically have viewed hospitals as nothing more than "doctors' workshops" or auxiliaries to their private office practices.[91] In 1917, a surveyor for the American College of

87. *See, e.g.*, ILL. REV. STAT. ch. 111, para. 4400-3 (1989) ("[n]o person shall practice medicine . . . without a valid, existing license to do so"); *see also* People v. United Medical Servs., 362 Ill. 442, 200 N.E. 157 (1936) (only individuals can practice medicine); Note, *The Corporate Practice of Medicine Doctrine: An Anachronism in the Modern Health Care Industry*, 40 VAND. L. REV. 445, 464-67 (1987).

88. For a thorough critique of this doctrine, see Hall, *Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment*, 137 U. PA. L. REV. 431 (1988).

89. Christoffel, *Hiring on the Cheap: Health Care Costs, the Eclipse of Physicians and Change in Licensing Laws*, 4 ST. LOUIS U. PUB. L.F. 57 (1984).

90. For an excellent discussion and analysis of how physicians and hospital administrators should interact with respect to patient admissions and treatment to achieve certain cost containment objectives, see Hall, *supra* note 88.

91. P. STARR, THE SOCIAL TRANSFORMATION OF AMERICAN MEDICINE 178 (1982).

Surgeons reported that physicians viewed the hospital's role as merely providing space with proper heat, light, and food for the patient.[92] The courts also have supported the view that a hospital is not much more than a specialized hotel serving the physician's patients.[93]

Today, physicians still view hospitals as their "workshops" and admit and treat patients in hospitals essentially without interference from the board or the administration.[94] Certain preadmission utilization review requirements imposed by third-party payors, as well as hospital bed and service capacity,[95] impose the only practical obstacles to patient admissions. Although the physician participates as a medical staff member within the limits of the hospital and medical staff bylaws, these internal controls do not authorize the hospital administration to supervise how the physician treats patients.[96] The medical staff, generally divided into clinical departments based upon the specialties of its member physicians (e.g., pediatrics, cardiology, surgery), usually plays a more direct role in supervising its own members.[97] These departments often have the responsibility to monitor and evaluate the professional care provided by their members. In general, however, physicians bill and collect for their services as "individual entrepreneurs," not collectively as members of the hospital's staff or of any particular department.[98]

The hospital administration's role is to manage an institution that makes various resources available for the physician's use.[99] The administration generally provides nonphysician patient care services (e.g., nursing and operating rooms) and institutional support services (e.g., accounting and data processing).[100] The hospital receives its revenues only from patient care services it provides to patients admitted to the hospital by individual physicians.[101] Thus, the hospital and its physicians have a symbiotic economic

92. Goldberg, *The Duty of Hospital Medical Staffs to Regulate the Quality of Patient Care: A Legal Perspective*, 14 PAC. L.J. 55, 66 (1982).

93. Smith v. Duke Univ. Hosp., 219 N.C. 628, 634, 14 S.E.2d 643, 647 (1941) (hospitals provide only room and board), *overruled on other grounds*, Rabon v. Rowan Memorial Hosp. Ass'n, 269 N.C. 1, 152 S.E.2d 485 (1967).

94. Harris, *Regulation and Internal Control in Hospitals*, 55 BULL. N.Y. ACAD. OF MED. 88, 90 (1979).

95. *Id.* at 93.

96. *Id.* at 94.

97. *Id.* at 90.

98. *Id.* at 92.

99. *Id.* at 92.

100. *Id.*

101. *Id.* at 93.

relationship under which each party's activities contribute to the economic well-being of the other party. In light of this relationship, coupled with the administration's inability to identify physician incompetence, the impetus to curtail a physician's use of hospital facilities generally does not come from the hospital.[102]

Instead, limitations on a physician's use of a hospital come from other physicians. By organizing themselves into formal medical staffs, physicians concentrate their individual authority to affect the financial stability of the hospital and create a separate entity that has substantial control over the hospital's operations. Medical staff authority not only controls hospital operations, but also has a profound effect on the structure and process of peer review.

B. The Role of Hospital Accreditation

Hospital accreditation organizations, controlled by physicians, have been perhaps the most influential force shaping the peer review process. In 1919, as part of an effort to establish minimum standards for hospital care, the American College of Surgeons adopted a requirement that any hospital seeking its approval must organize its affiliated physicians into a medical staff.[103] This staff was required to adopt rules governing the professional practices of the physicians in the hospital "and to review and analyze regularly their clinical experiences."[104] The standards of the American College of Surgeons eventually became the accreditation standards of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).[105] The JCAHO is a private accreditation organization that is governed by a board composed of commissioners from the American College of Physicians, the American College of Surgeons, the American Dental Association, the American Medical Association and the American Hospital Association.[106] Obviously, the JCAHO is heavily influenced by physicians. Under the JCAHO's standards, the hospital's medical staff plays a major role in ensuring that each staff member is qualified through the peer

102. Hospitals are concerned, however, with possible liability for negligent selection or review of staff members. For a discussion of corporate negligence, see *infra* notes 129-41 and accompanying text.

103. Goldberg, *supra* note 92, at 67-68.

104. *Id.* (quoting L. DAVIS, FELLOWSHIP OF SURGEONS 205, 204 n.65 (1960)); *see also* Goldberg, *The Duty of Hospitals and Hospital Medical Staffs to Regulate the Quality of Patient Care*, 129 W.J. MED. 443, 445-46 (1978).

105. Goldberg, *supra* note 92, at 68.

106. Jost, *The Joint Commission on Accreditation of Hospitals: Private Regulation of Healthcare and the Public Interest*, 24 B.C.L. REV. 835, 840-60 (1983).

review system.[107] In addition, the staff must provide regular mechanisms to monitor medical staff practices and functions.[108]

The JCAHO acts as a quality control agency for hospitals and, although JCAHO accreditation is voluntary,[109] it is valuable to hospitals in several significant respects. First, the federal government relies heavily upon JCAHO accreditation to certify hospitals for participation in the Medicare program.[110] If a hospital is accredited by the JCAHO, it generally will be deemed to comply with Medicare's conditions of participation for hospitals.[111] Without satisfying these conditions, a hospital cannot receive reimbursement from the Medicare program.[112] Other private third-party payors, such as Blue Cross, also require JCAHO accreditation as a payment prerequisite.[113]

Thirty-nine states have elevated certain JCAHO standards to the level of law by incorporating them into their hospital licensing statutes.[114] As a result, eighty percent of all acute-care hospitals in the United States are accredited by the JCAHO, and therefore have complied with the JCAHO's standards for physician quality control.[115]

The 1989 JCAHO Hospital Accreditation Manual contains specific standards for the governing body, administration, and medical staff.[116] A detailed review of these provisions is beyond the scope of this Article. The standards concerning quality assurance and

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107. *See generally* JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG., ACCREDITATION MANUAL FOR HOSPS., 1990 MED. STAFF STANDARDS (1990). The Joint Commission on Accreditation of Hospitals recently changed its name to the Joint Commission on Accreditation of Health Care Organizations.

108. *See, e.g., id.* at M.S.3.7, M.S.6, and M.S.6.1.

109. *See id.* at xv.

110. Medicare and Medicaid Guide (CCH) ¶ 12,660 (hospitals accredited by the JCAHO are deemed to meet all of the Medicare conditions of participation for hospitals); Jost, *supra* note 106, at 853.

111. Medicare and Medicaid Guide (CCH) ¶ 12,660.

112. *Id.*

113. Jost, *supra* note 106, at 912.

114. *Id.*; *see, e.g.*, FLA. STAT. ANN. § 395.0115(3)(G) (1990) (the procedures for medical staff disciplinary actions must comply with the standards of the JCAHO). Today most state hospital licensure laws and regulations require hospitals to have semi-autonomous medical staffs with separate bylaws. *See* Hall, *supra* note 88 at 528-29 (citing AM. HOSP. A., HOSP. STATISTICS (1985) (fifty-state survey of law controlling the organized medical staff)).

115. Jost, *supra* note 106, at 911. Moreover, the overwhelming majority of institutions surveyed by the JCAHO are accredited. *Id.* Recently, the JCAHO denied full or provisional accreditation to only one percent of the institutions surveyed. *Id.*

116. JOINT COMM'N ON ACCREDITATION OF HEALTHCARE ORG., ACCREDITATION MANUAL FOR HOSPS., 1989 MED. STAFF STANDARDS (1989) [hereinafter, JCAHO ACCREDITATION MANUAL, 1989].

peer review, however, help to explain why hospitals operate as they do regarding these matters.

A JCAHO-accredited hospital must have a "single organized medical staff that has overall responsibility for the quality of the professional services provided by individuals with clinical privileges as well as the responsibility of accounting therefor to the governing body."[117] State hospital licensure statutes and regulations also have mandated the existence of a separate medical staff with a number of quality control roles in the institution.[118]

The medical staff of a JCAHO-accredited hospital must develop and adopt its own "bylaws, rules and regulations to establish a framework for self-governance . . . and accountability to the board of directors."[119] The medical staff bylaws must be adopted by the staff and approved by the board.[120] Moreover, neither the staff nor the board may amend these bylaws unilaterally.[121] The bylaws normally include: the election of medical staff officers; the establishment of various staff committees, clinical departments, and medical staff categories (i.e., active, associate, or courtesy); and the establishment of standards and procedures for physician appoint-

117. *Id.* at MS.1.

118. *See* Roberts, Coale & Redman, *A History of the Joint Commission on Accreditation of Hospitals*, 258 J. A.M.A. 936, 939 (1987); *see also, e.g.*, ARIZ. REV. STAT. ANN. § 36-401(28) (1990) (an "organized medical staff" is a formal organization of physicians with the authority and responsibility to maintain proper standards of care in the hospital); FLA. STAT. ANN. § 395.011(3)(a) (1990) (the governing body of each hospital shall set standards and procedures to be applied by the hospital and its medical staff in considering and acting upon applications for staff membership or professional clinical privileges); IND. CODE § 16-10-1-6.5(a)(z) (1990) (the governing body of the hospital, with the advice and recommendations of the medical staff, is responsible for the appointment of the members of the medical staff and the granting of clinical privileges); MISS. CODE ANN. § 73-25-93 (1989) (a hospital may deny or limit the privileges of an applicant or staff member if the governing body, after consultation with the medical staff, considers the physician to be unqualified because of unprofessional conduct, incompetency, or disciplinary action taken by his peers); MO. REV. STAT. § 205.195(2) (1990) (the organized medical staff shall initiate and adopt bylaws and policies governing the professional activities in the hospital); NEB. REV. STAT. § 71-2046 (1986) (each hospital must cause a medical staff committee to be formed and operated for the purpose of reviewing the medical care provided in the hospital); OHIO REV. CODE ANN. § 3701.351(A) (Anderson 1988) (the hospital's board must set standards and procedures to be applied by the hospital and its medical staff in acting upon applicants for staff membership or clinical privileges); ORE. REV. STAT. § 441.055(3)(d) (1990) (the hospital must ensure that its physicians are organized into a medical staff so as to effectively review the professional practices of the hospital); S.C. CODE ANN. § 44-7-310 (Law. Co-op. 1986) (each hospital must have a single organized medical staff that has the overall responsibility for the quality of medical care provided).

119. JCAHO ACCREDITATION MANUAL, 1989, *supra* note 116, at MS.2.

120. *Id.* at MS.2.1 and GB.1.18.1.

121. *Id.* at MS.2.1.

ment, reappointment, and corrective action.[122] Under JCAHO standards, physicians who are not appointed or reappointed, or who are subject to corrective action, are entitled to a fair hearing and appellate review by the hospital's medical staff.[123] State hospital licensing laws also can require a hospital to provide a review process for physicians.[124] The common law in certain states similarly affords physicians due process rights.[125] The final decision regarding the appointment, reappointment, or disciplining of a physician, however, rests with the board, as governing body of the hospital, after it has received recommendations from the medical staff.[126]

C. The Effect of the Corporate Negligence Doctrine

The board's ultimate authority in matters of appointment, reappointment, or disciplining of a physician should not be taken lightly. In recent cases, the judicial view of hospitals as functioning merely as "physicians' workshops" has given way to viewing

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122. Chayet & Reardon, *supra* note 29, at 304.

123. JCAHO ACCREDITATION MANUAL, 1989, *supra* note 116, at MS.2.4.2.

124. *See, e.g.*, ILL. ADMIN. CODE tit. 77, § 250.310 (1985). The statute provides:

> The medical staff shall be organized in accordance with written bylaws, rules and regulations, approved by the Governing Board. The bylaws, rules and regulations shall specifically provide but not be limited to the following provisions:
>
> (1) written procedures relating to the acceptance and processing of initial applications for medical staff membership, granting and denying of medical staff reappointment, and medical staff membership or clinical privileges disciplinary matters.
>
> (A) The procedures for initial applicants at any particular hospital may differ from those for current medical staff members. However, the procedures at any particular hospital shall be applied equally to each practitioner eligible for medical staff membership under Section 250.150 (Medical Staff) of this Part. . . .
>
> (B) The procedure shall grant to current medical staff members at least: written notice of an adverse decision by the Governing Board; an explanation and reasons for an adverse decision; the right to examine and/or present copies of relevant information, if any, related to an adverse decision; an opportunity to appeal an adverse decision; and written notice of the decision resulting from the appeal. The procedures for providing written notice shall include time frames for giving such notice.

Id.

125. *See, e.g.*, Kelly v. St. Vincent Hosp., 102 N.M. 201, 692 P.2d 1350 (1984); Miller v. National Medical Hosp. of Monterey Park, Inc., 124 Cal. App. 3d 81, 177 Cal. Rptr. 119 (1981); Holmes v. Hoemako Hosp., 117 Ariz. 403, 573 P.2d 477 (1977); Silver v. Castle Memorial Hosp., 53 Haw. 475, 497 P.2d 564, *cert. denied*, 409 U.S. 1048 (1972); Bricker v. Sceva Speare Memorial Hosp., 111 N.H. 276, 281 A.2d 589, *cert. denied*, 404 U.S. 995 (1971); Woodard v. Porter Hosp., Inc., 125 Vt. 419, 217 A.2d 37 (1966); Greisman v. Newcomb Hosp., 40 N.J. 389, 192 A.2d 817 (1963).

126. JCAHO ACCREDITATION MANUAL, 1989, *supra* note 116, at MS.5.8 and MS.1.2.3.1.8.

hospitals as responsible for granting staff membership and privileges only to competent physicians.[127] The current view is that a hospital owes a duty to its patients to exercise reasonable care in selecting its medical staff members and in granting clinical privileges.[128] This duty arises out of the doctrine of corporate negligence first enunciated by the Illinois Supreme Court in *Darling v. Charleston Community Memorial Hospital*.[129] In *Darling*, the court found that a hospital may be negligent for failure to review a patient's treatment at the hospital and failure to require appropriate consultations with medical staff members.[130] The court held that hospitals have a duty to provide a sufficient number of trained nurses for bedside care of all patients at all times. These nurses, the court stated, must be capable of recognizing progressive and dangerous conditions of patients requiring additional medical attention. Additionally, the court imposed upon the hospital a duty to ensure that its medical staff sought consultation with other staff members in complicated cases. These duties were predicated on language found in state hospital rules and regulations, JCAHO accreditation standards, and the bylaws, rules, and regulations of the hospital.[131] *Darling* established that a hospital has an independent responsibility to patients to supervise the medical treatment provided by its staff members.[132] It has been described as the "most

127. *See* Pedroza v. Bryant, 101 Wash. 2d 226, 677 P.2d 166 (1984); Elam v. College Park Hosp., 132 Cal. App. 3d 332, 183 Cal. Rptr. 156 (1982); Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 301 N.E.2d 156 (1981); Corleto v. Shore Memorial Hosp., 138 N.J. Super. 302, 350 A.2d 534 (1975).

128. *See* cases cited *supra* note 127.

129. 33 Ill. 2d 326, 211 N.E.2d 253, *cert. denied*, 383 U.S. 946 (1965).

130. *Id.*

131. *Id.* Since *Darling* was decided, at least 18 states have adopted the corporate negligence doctrine. *See* Insinga v.La Bella, 543 So. 2d 209 (Fla. 1989) (the Florida Supreme Court adopted the doctrine and stated that at least 17 other states had done so); *see also* Thompson v. Nason Hosp., 370 Pa. Super. 115, 535 A.2d 1177 (1988); Greenwood v. Wierdsma, 741 P.2d 1079 (Wyo. 1987); Hannola v. Lakewood, 68 Ohio App. 2d 61, 426 N.E.2d 1187 (1980).

132. The court in *Darling* stated:

> The conception that the hospital does not undertake to treat the patient, does not undertake to act through its doctors and nurses, but undertakes instead simply to procure them to act upon their own responsibility, no longer reflects the fact. Present-day hospitals, as their manner of operation plainly demonstrates, do far more than furnish facilities for treatment. They regularly employ on a salary basis a large staff of physicians, nurses and internes [sic], as well as administrative and manual workers, and they charge patients for medical care and treatment, collecting for such services, if necessary, by legal action. Certainly, the person who avails himself of "hospital facilities" expects that the hospitals will attempt to cure him, not that its nurses or other employees will act on their own responsibility.

influential hospital law opinion of the last 50 years."[133]

The doctrine of corporate negligence is based upon the perception of the modern hospital as a multifaceted health care facility responsible for the quality of medical care and treatment rendered.[134] Hospitals have evolved into complex corporate institutions assuming "the role of a comprehensive health center ultimately responsible for arranging and coordinating total health care."[135] Hospital patients receive care from a number of individuals of varying capacities and are not merely treated by a physician acting in isolation.[136] As the Supreme Court of Wisconsin stated:

> The concept that a hospital does not undertake to treat patients, does not undertake to act through its doctors and nurses, but only procures them to act solely upon their own responsibility, no longer reflects the fact. The complex manner of operation of the modern-day medical institution clearly demonstrates that they furnish far more than mere facilities for treatment. They appoint physicians and surgeons to their medical staffs, as well as regularly employing on a salary basis resident physicians and surgeons, nurses, administrative and manual workers and they charge patients for medical diagnosis, care, treatment and therapy, receiving payment for such services through privately financed medical insurance policies and government financed programs known as Medicare and Medicaid. Certainly, the person who avails himself of our modern "hospital facilities" (frequently a medical teaching institution) expects that the hospital staff will do all it reasonably can to cure him and does not anticipate that its nurses, doctors and other employees will be acting solely on their own responsibility.[137]

Additionally, the Nevada Supreme Court stated that "[t]he hospital's role is no longer limited to the furnishing of physical facilities and equipment where a physician treats his private patients and practices medicine in his own individualized manner."[138] In short,

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Darling, 33 Ill. 2d at 332, 211 N.E.2d at 257 (quoting Bing v. Thunig, 2 N.Y.2d 656, 661, 143 N.E.2d 3, 8, 163 N.Y.S.2d 3, 11 (1957); *see also* Pedroza v. Bryant, 101 Wash. 2d 226, 229, 677 P.2d 166, 168 (1984).

133. Hall, *supra* note 88, at 459.

134. *Bryant*, 101 Wash. 2d at 231, 677 P.2d at 169.

135. Southwick, *The Hospital as an Institution—Expanding Responsibilities Change Its Relationship with the Staff Physician*, 9 CAL. W.L. REV. 429 (1973).

136. *Bryant*, 101 Wash. 2d at 231, 677 P.2d at 169.

137. Johnson v. Misericordia Community Hosp., 99 Wis. 2d 708, 724, 301 N.W.2d 156, 164 (1981).

138. Moore v. Board of Trustees, 88 Nev. 207, 212, 495 P.2d 605, 608, *cert. denied*, 409 U.S. 879 (1972).

in the eyes of the law, the era of hospitals functioning merely as "physicians' workshops" is over.

Instead, under current law, hospitals have a direct and independent responsibility to their patients, over and above the duties of the physicians within the hospital. Hospitals now are required to take reasonable steps to ensure that their medical staffs are qualified for the privileges granted to them by the hospital, and to evaluate the care provided by them through the prudent selection, review, and continuing evaluation of the physicians granted staff privileges.[139] To satisfy this duty, the hospital's governing body must rely on its medical staff, and in particular on the credentials committee, to investigate and evaluate the qualifications of medical staff applicants.[140] However, this delegation to the staff "does not relieve the governing body of its duty to appoint only qualified physicians and surgeons to [the] staff and periodically to monitor and review their competency."[141]

The doctrine of hospital corporate negligence, particularly in the context of physician credentialing and supervision, has altered significantly the relationship among hospitals, medical staffs, and individual physicians. Although at one time hospitals had little incentive to limit the practices of physicians within their institutions, because to do so would reduce hospital revenue, today the failure to monitor and correct physician deficiencies can be quite costly. Ironically, while hospitals are now charged with the responsibility of monitoring the quality of care provided by their staff physicians within the hospitals, the responsibility for monitoring individual physicians rests almost entirely with the medical staff.

D. The Anticompetitive Nature of Peer Review

As a result of certain state hospital licensing statutes, laws regarding reimbursement for services involving hospitalization, judicial decisions regarding medical staff disputes and negligent credentialing or supervision of physicians, and JCAHO accreditation standards, nearly every hospital in the United States now requires an extensive medical staff credentialing and review process.

139. *Johnson*, 99 Wis. 2d at 725, 301 N.W.2d at 165; Elam v. College Park Hosp., 132 Cal. App. 3d 332, 340, 183 Cal. Rptr. 156, 164 (1982); *see also* Blanton v. Moses H. Cone Memorial Hosp., Inc., 319 N.C. 372, 354 S.E.2d 455 (1987) ("hospital owes a duty of care to its patients to ascertain that a doctor is qualified to perform an operation before granting him the privilege to do so"); Janulis & Hornstein, *Damned if You Do, Damned if You Don't: Hospital's Liability for Physician's Malpractice*, 64 NEB. L. REV. 689 (1985).

140. *Johnson*, 99 Wis. 2d at 744, 301 N.W.2d at 174.

141. *Id.*

A physician's seeking appointment or reappointment, or potentially becoming subject to corrective action, generally triggers a process that involves input from: (1) the appropriate clinical department, (2) the medical staff credentials committee, (3) the medical staff executive committee, (4) the ad hoc hearing committee, and (5) an appellate review committee of the board of directors. This process can be long, difficult, and expensive. Moreover, if it is not executed properly and convincingly, it may lead to costly litigation.[142]

The potential for abuse of this process is striking. Physicians can place pressure on a hospital "in the name of quality of care that in reality is motivated by a desire to enhance prestige, increase convenience, further professional rivalries, or protect or enhance their economic positions."[143]For example, there is currently an oversupply of certain specialists, which creates a buyer's market for hospitals[144] and may foster hostility from incumbent staff members in those specialties. The adverse economic effect of increased competition resulting from an oversupply of physicians has created an atmosphere conducive to misusing the peer review process to destroy competition.[145]

Peer review is inherently anticompetitive.[146] The process described above, as mandated by state law and the JCAHO, requires physicians to exercise their authority to limit or exclude business opportunities for other practitioners in their field when these competitors fail to meet certain standards. The members of the medical staff engaged in the peer review process are independent practitioners competing with other practitioners for patients.[147] The peer review process allows competitors to have substantial influence, if not actual control, over a competitor's access to the marketplace. As a result, it is difficult to accept that physicians, who are fighting to maintain their practices and incomes, will review their competitors objectively.[148] It is equally unrealistic to expect the unfavorably reviewed physician to accept that anticompetitive

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

143. INST. OF MED., NAT'L. ACAD. OF SCI., FOR-PROFIT ENTERPRISE IN HEALTH CARE 173 (1986).

144. Nord, *The Big Change*, BRIEF, Winter 1985, at 7.

145. *See, e.g.*, Patrick v. Burget, 486 U.S. 94 (1988).

146. Curran, *supra* note 28, at 233-35.

147. *See, e.g.*, Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).

148. Chenen, *Peer Review-It's Time for a Change*, 4 MED. STAFF COUNSELOR 75 (1990).

motives did not affect the review.[149]

E. The Current Environment

Two major developments have eroded the effectiveness of the physician-controlled peer review structure within hospitals. First, the doctrine of hospital corporate negligence has given hospital boards and administrators great incentive to participate actively in deciding who will be allowed to use their facilities and to what extent they will be allowed to do so.[150] The second major development is the actual or perceived oversupply of physicians in certain communities, which has given physicians an incentive to place their personal financial considerations above the hospital's concerns for quality of care.[151] This second development has led to antitrust lawsuits brought by disgruntled physicians against hospitals and their reviewers. These suits have caused physicians either not to participate in peer review, or to do so without rendering decisions that adversely affect the physician under review. This situation creates a dilemma for physicians. On the one hand, some physicians may wish to use peer review as a means to control or eliminate competition. On the other hand, many physicians are unwilling to participate in peer review if their participation will likely result in litigation. In short, the intrahospital peer review structure is incompatible with the new legal and economic environment affecting hospitals.

Although a board of directors has ultimate responsibility for the peer review decisions of its staff physicians, boards historically have deferred to recommendations of medical staffs because of the board's perception of the staff's superior medical judgment. This situation, however, now creates a dilemma for the board. On the one hand, it must reasonably exercise its responsibility to control the quality of care provided by the individual members of the medical staff.[152] On the other hand, the board cannot trust the judgment of the physician peer reviewers to be based completely or even substantially upon quality of care concerns.[153] The difficulty of identifying good or bad quality of care among physicians further complicates the board's task. Therefore, the board must identify

149. *Id.*
150. *See supra* notes 129-41 and accompanying text.
151. *See supra* notes 143-49 and accompanying text.
152. *See supra* notes 129-41 and accompanying text.
153. *See supra* notes 143-49 and accompanying text.

quality in health care without always having the unbiased expertise to do so.

IV. The Obstacles to Effective Peer Review

Three factors hamper the effectiveness of intrahospital peer review as a quality control mechanism: (1) the historical use of peer review as a form of political power among physicians within the medical profession, (2) physicians' natural disincentive to criticize their immediate colleagues, and (3) the difficulty of identifying or measuring inadequate performance of physicians. Neither the Act nor its legislative history address these obstacles to peer review. As a result, the Act, in all likelihood, will fail to accomplish its objective of encouraging "effective professional peer review."[154]

A. The History of Peer Review

In the early years of peer review, medical staff "appointment decisions depended largely on non-technical considerations, such as personality and social background."[155] For example, one hospital executive explained that in earlier days of hospital administration, competitive examinations for interns were discontinued because the people who scored highest on these tests were Jewish.[156] The physician's need for hospital staff membership and privileges made the physician dependent on the "inner fraternity" of the profession.[157] A physician's career depended upon his relationship with his professional colleagues.[158] Access to important positions in hospitals came through "sponsorship" by established physicians,

> who could advance or exclude aspirants at various stages of their careers by influencing professional school admissions, dispensing hospital appointments, referring patients, and designating proteges and successors. Because the hospital was essential to successful practice, its various grades could be used as delicately calibrated rewards to signal the progress of a career.[159]

Thus, physicians have long used their power to grant or withdraw hospital privileges as a means to regulate professional and personal

154. 42 U.S.C. § 11101 (1988).

155. P. Starr, *supra* note 91, at 167.

156. *Id.* at 168 (citing Cleveland Hosp. Council, Cleveland Hosp. and Health Survey 858, 863 (1920)); Hall, *The Stages of a Medical Career*, 53 Am. J. Soc. 331 (1948).

157. P. Starr, *supra* note 91, at 168.

158. *Id.*

159. *Id.*

behavior.[160]

In the 1950s and 1960s, local medical hierarchies of private practitioners ran the American hospital system.[161] As in earlier years, informal networks of physicians, often using ethnic or religious grounds, effectively excluded outsiders, built up "dominant positions for elite physicians," granted and maintained professional status, controlled physician behavior, and minimized medical competition and conflict.[162] Collective physician professional standard-setting during this period was weak.[163] Intrahospital physician appraisal of quality and outcomes of hospital care was marked by mild criticism, data production without analysis, and lack of meetings.[164] Even with the help of computer systems that could produce reams of data during the late 1950s and 1960s, there was little critical review of physician performance in hospitals.[165] The medical staff's overriding ethos was to maximize individual physician autonomy, avoid standardizing procedures, and provide little peer criticism of physicians.[166]

The systematic exclusion of outsiders from hospital medical staffs has manifested itself most recently in a number of federal antitrust and civil rights cases. For example, in 1973, when the Medicare program began reimbursing for chiropractor services, the American Medical Association (AMA) became concerned that hospitals would admit chiropractors to their medical staffs. Accordingly, it published an article that offered advice to hospital trustees across the United States, and advised that hospitals might

160. *Id.* As to the effect of this power on quality, Paul Starr wrote:

> It is unclear whether the use of this power in the early twentieth century did raise the quality of private practice in America. But there can be no doubt it was used to exclude doctors unacceptable to the organized profession. By the twenties, membership in the local medical society had become an informal prerequisite for membership on the staff of most local hospitals. In 1934 the AMA tried to institutionalize its control over hospital appointments by requiring all hospitals accredited for internship training to appoint no one to their staff except members of the local medical society. Black doctors, who were excluded from the local societies, could be kept out of hospital positions on those grounds. So could anyone else who threatened to rock the boat. The private practitioners, who had first seen hospitals as a threat to their position, had succeeded in converting them into an instrument of professional power.

Id. at 168-69.

161. R. STEVENS, IN SICKNESS AND IN WEALTH 242 (1989).

162. *Id.*

163. *Id.* at 246.

164. *Id.*

165. *Id.*

166. *Id.*

lose their accreditation if they dealt with chiropractors.[167]

In 1976, chiropractors sued the AMA, among others, for violating federal antitrust laws.[168] The court found that the AMA and its members participated in a conspiracy against chiropractors in violation of these laws.[169] In reaching this conclusion, the court relied heavily on evidence that the AMA considered chiropractic an unscientific cult and that it was unethical for a physician to associate professionally with chiropractors.[170] According to the court, the AMA instituted this boycott to prevent: (1) physicians from referring patients to chiropractors and accepting referrals of patients from chiropractors, and (2) chiropractors from obtaining access to hospital diagnostic services and membership on hospital medical staffs.[171]

Osteopaths also have been excluded from hospitals. In *Weiss v. York Hospital*,[172] the Third Circuit Court of Appeals held that the exclusion of osteopaths from a hospital's medical staff constituted a per se illegal boycott by the staff physicians in violation of the Sherman Act.[173] Although osteopaths have had less success in other cases, these lawsuits suggest that access to hospital facilities is a major source of conflict between physicians and other health care providers.[174]

Podiatrists have met similar resistance in their efforts to obtain hospital privileges.[175] Nurse-anesthetists and nurse-midwives also

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167. Simonaitis, *The Right and Duty of Hospitals to Exclude Chiropractors*, 226 J. A.M.A. 829 (1973).

168. Wilk v. American Medical Ass'n, 671 F. Supp. 1465, 1474 (N.D. Ill. 1987).

169. *Id.*

170. *Id.*

171. *Id.*

172. 745 F.2d 786 (3d Cir. 1984), *cert. denied*, 470 U.S. 1060 (1985).

173. *Id.* at 280 (a per se discrimination rule, as opposed to a rule of reason, applied because exclusion of osteopaths from medical staff was not based on a legitimate explanation, such as being less qualified as a group than M.D.s).

174. *See, e.g.*, Hull v. Board of Comm'rs of Halifax Hosp. Medical Center, 453 So. 2d 519 (Fla. Dist. Ct. App. 1984) (state nondiscrimination statute was not violated by criteria that excluded osteopaths because the criteria applied equally to osteopaths and medical doctors); *but see* Fritz v. Huntington Hosp., 39 N.Y.2d 339, 348 N.E.2d 547, 384 N.Y.S.2d 92 (1976) (hospital's rejection of an osteopath's staff application for failing to complete an M.D. training program was reviewable under a New York statute); *cf.* Stern v. Tarrant County Hosp. Dist., 755 F.2d 430 (5th Cir.), *vacated*, 778 F.2d 1052 (5th Cir. 1985) (en banc), *cert. denied*, 476 U.S. 1108 (1986) (a medical postdoctoral-training requirement did not violate an osteopath's constitutional right to equal protection); Don v. Okmulgee Memorial Hosp., 443 F.2d 234 (10th Cir. 1971) (denial of staff privileges did not violate an osteopath's due process rights).

175. *See* Health Care Management Corp., 107 F.T.C. 285 (1986) (Federal Trade Commission consent order prohibited Alabama hospital and its medical staff from imposing restrictions that effectively excluded podiatrists from the hospital); Hatch v. North

have challenged the exclusionary practices of hospitals and physicians.[176] A handful of cases brought by outsiders, such as foreign medical graduates, under Title VII of the Civil Rights Act[177] and other civil rights laws further suggests that the hospital-medical staff environment described by Paul Starr and Rosemary Stevens is still with us today.[178]

B. Peer Review and Peer Pressure

Perhaps the most significant disincentive for physicians to participate in peer review is their fear of the professional and personal consequences arising out of such participation. Physicians are reluctant to engage in peer review for a number of reasons, including: loss of referrals, respect, and friends; possible retaliation; and vulnerability to litigation.[179] In light of the historical roots of peer

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Colo. Medical Center, 1986-2 Trade Cases (CCH) ¶ 67,268 (D. Colo. 1986); Cooper v. Forsyth County Hosp. Auth., Inc., 604 F. Supp. 685 (M.D.N.C., 1985), *aff'd*, 789 F.2d 278 (4th Cir.), *cert. denied*, 479 U.S. 972 (1986) (various hospital staff committees successfully opposed medical staff bylaw amendments that would have allowed podiatrists onto the medical staff); Kaczanowski v. Medical Center Hosp., 612 F. Supp. 688 (D.C. Vt. 1985) (podiatrist alleged a conspiracy among 17 hospitals); Feldman v. Jackson Memorial Hosp., 571 F. Supp. 1000 (S.D. Fla. 1983), *aff'd*, 752 F.2d 647 (11th Cir.), *cert. denied*, 472 U.S. 1029 (1985) (same); *but see* Dooley v. Barberton Citizens Hosp., 11 Ohio St. 3d 216, 465 N.E.2d 58 (1984) (medical staff bylaws discriminated against podiatrists as a group.); Cameron v. New Hanover Memorial Hosp., Inc., 58 N.C. App. 414, 293 S.E.2d 901 (1982); Settler v. Hopedale Medical Found., 80 Ill. App. 3d 1074, 400 N.E.2d 577 (3d. Dist. 1980); Charter Medical Corp. v. Miller, 605 S.W.2d 943 (Tex. Civ. App. 1980) (alleged denial of civil rights).

176. *See* Nurse Midwifery Ass'n v. Hibbett, 689 F. Supp. 799 (M.D. Tenn. 1988), *aff'd in part, rev'd in part*, Nos. 88-5842, 89-5491 (6th Cir. Nov. 7, 1990) (LEXIS, Genfed library, Courts file) (a physician-controlled insurance company denied medical malpractice insurance to a physician who served as a backup physician to certified nurse-midwives); Medical Staff of Memorial Medical Center, 5 Trade Reg. Rep. (CCH) ¶ 22,508 (Jan. 28, 1988) (Federal Trade Commission consent order prohibited medical staff from denying hospital privilege to nurse-midwives without a reasonable basis); Oltz v. St. Peter's Community Hosp., 861 F.2d 1440 (9th Cir. 1988) (anesthesiologists and hospital conspired to exclude a nurse-anesthetist in violation of the Sherman Act); Wicker v. Union County Gen. Hosp., 673 F. Supp. 177 (N.D. Miss. 1987) (denial of staff privileges to a nurse-anesthetist).

177. 42 U.S.C. § 2000e-2000e-17 (1988).

178. *See* Diggs v. Harris Hosp., 847 F.2d 270 (5th Cir.), *cert. denied*, 488 U.S. 956 (1988) (alleged discrimination on the basis of race and sex); Mitchell v. Frank R. Howard Memorial Hosp., 853 F.2d 762 (9th Cir. 1988) (alleged discrimination against a Mormon physician); Pardazi v. Cullman Medical Center, 838 F.2d 1155 (11th Cir. 1988) (alleged discrimination against an Iran-educated medical practitioner); Mousovi v. Beebe Hosp., 674 F. Supp. 145 (D.C. Del. 1987), *aff'd*, 853 F.2d 919 (3d Cir. 1988) (alleged discrimination against an Iranian physician); Vuciecevic v. MacNeal Memorial Hosp., 572 F. Supp. 1424 (N.D. Ill. 1983) (alleged discrimination against a Serbian-Yugoslavian physician).

179. Humana Hosp. Desert Valley v. Superior Court, 154 Ariz. 396, 400, 742 P.2d 1382, 1386 (Ct. App. 1987).

review and the importance physicians still attach to their relationships with physician-colleagues, legislation may not succeed in protecting a physician from the professional damage he might cause by participation in peer review. The mere potential for retaliation from colleagues, loss of friendship, or loss of referrals may discourage most physicians from engaging in peer review in all but the most egregious cases.

Ironically, although physicians have been given the power to control access to hospital facilities by virtue of their special expertise, they may have little incentive for exercising this power to promote quality of care.

C. The Difficulty of Identifying Quality Health Care

The most fundamental assumption about the efficacy of peer review is that quality of medical care can be measured or evaluated to support decisions about who may become or remain a part of a hospital's medical staff.[180] An accepted methodology for evaluation of quality health care, however, has yet to be developed.[181] As one commentator has stated, "[t]he art and science of quality assurance and peer review [in health care] are still in their infancy."[182] It was not until December 10, 1988, that the JCAHO officially adopted a definition of quality patient care.[183] According to this definition, quality patient care is measured by the "degree to which patient-care services increase the probability of desired patient outcomes and reduce the probability of undesired outcomes, given the current state of knowledge."[184]

Avedis Donabedian, a leading expert in the field of health care

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180. Bartels & O'Donnell, *Quality Criteria for Medical Staff Admission: A Beginning*, 34 HOSP. AND HEALTH SERVS. ADMIN. 269, 272 (1989).

181. *Id.* at 273.

182. Thompson, *Exploding 12 Myths About Quality Assurance and Peer Review*, 2 MED. STAFF COUNS. 39, 39 (1988).

183. *JCAHO Adopts Definition of Quality Patient Care*, MOD. HEALTHCARE, Dec. 16, 1988, at 10.

184. *Id.* The JCAHO has recently selected 17 hospitals to test new clinical indicators that will monitor care provided to trauma, cardiovascular, and oncology patients. *JCAHO Selects 17 Test Sites for New Clinical Indicators*, MOD. HEALTHCARE, Oct. 27, 1989, at 9. Over the past two years 17 other hospitals have been using JCAHO-developed indicators to monitor the quality of obstetrical and anesthesia care. *Id.* These indicators are designed to describe measurable care processes, clinical events, complications, and outcomes. Michael R. Callahan, Barrows and Other Medical Staff Legal Issues (September 22, 1989) (unpublished presentation to the Illinois Association of Hospital Attorneys at its Seventh Annual Health Law Symposium). Examples of indicators include death, hospital acquired infection, severe adverse drug reaction, and return to the operating room from the recovery room. *Id.* These quality of care indicators may eventually be used to evaluate hospital physicians. *Id.*

quality assessment, has identified three elements for assessing quality in health care: structure, outcome, and process.[185] An assessment of structure involves the evaluation of the relatively stable characteristics of the hospital environment, such as the condition of the physical plant and the extent and quality of its equipment and support services.[186] Quality structure is measured by the sufficiency of resources and systems of the hospital.[187] For example, a rural community hospital typically will not have the medical support staff and technology found in tertiary care institutions, such as major teaching hospitals. Structure affects quality by increasing or decreasing the probability of favorable results, but it is only an indicator of general tendencies for the institution.[188]

Perhaps the most graphic indicator of quality in health care, or lack thereof, is outcome. Outcome analysis measures the change in a patient's health that results from the physician's intervention.[189] Donabedian asserts that "outcomes tend to be inherently valid in the sense that there is usually no need to argue whether they are, in themselves, good or bad. For example, there is general agreement that life is preferable to death, functional integrity preferable to disability, and comfort preferable to pain."[190] The major problem with outcome analysis is that little is known about the efficacy of certain treatments or practices on a patient's condition.[191] Studies have shown tremendous variations in the rate at which surgical procedures are performed in various localities despite similar demographic and health profiles.[192] Physicians have not reached a consensus on when certain procedures should be performed. Only a small number of medical procedures have been subject to rigorous controlled clinical trials.[193] It is even more difficult to determine whether a generally effective treatment accomplishes positive results when applied to a particular patient.[194] In other words, it is

185. A. DONABEDIAN, 1 THE DEFINITION OF QUALITY AND APPROACHES TO ITS ASSESSMENT 79-84 (1980).

186. *Id.* at 81.

187. *Id.* at 82.

188. *Id.*

189. *Id.* at 82-83.

190. *Id.* at 102.

191. Horwitz, *Measuring Quality of Care*, 2 MED. STAFF COUNS. 31, 32-33 (1988).

192. Hall, *supra* note 88, at 480.

193. *Id.* at 481 (citing OFFICE OF TECHNOLOGY ASSESSMENT, ASSESSING THE EFFICACY AND SAFETY OF MEDICAL TECHNOLOGIES 7 (1978)) ("It has been estimated that only 10 to 20 percent of all procedures currently used in medical practice have been shown to be efficacious by controlled trial").

194. *Id.*

difficult to attribute a positive outcome to a particular course of treatment.

Nevertheless, bad results are typically the prime reason for a hospital's decision to take a closer look at the practices, or process, of the responsible physician. The focal point of peer review, thus, is the process a physician follows in treating a patient, and this process usually is not questioned unless and until it yields bad results for patients.[195]

In the evaluation of physicians, the simplest complete unit of care is the physician's management of a discrete episode of illness in a given patient.[196] This management has both technical and interpersonal dimensions.[197] Quality technical care consists of the application of medical science and technology to the patient's illness in a way that maximizes health benefits without increasing health risks.[198] Interpersonal care involves the social and psychological interaction between the physician and patient, and its quality depends upon the conformity of the physician's acts with commonly accepted, socially defined values and norms that govern the interrelationship between the parties.[199] Identifying norms of care in light of scientific uncertainty, however, is a difficult, if not impossible, undertaking.

Of the two aspects of medical care management, peer review is concerned primarily with the technical aspects of care. Technical care consists of identifying the patient's problem, identifying goals, selecting treatment, and providing treatment.[200] In order to judge a physician's performance in any particular case, the norms of care for the condition in question must be identified.[201] For peer review to be effective, a group of practitioners must be able to "predict

195. Similarly, as part of the Medicare program, federal peer review organizations (PROs) perform a retrospective review of medical records to determine, in part, whether physician services are of a quality which "meet[ ] professionally recognized standards of health care." 42 U.S.C. § 1320c-3(a)(1)(B) (1988). The PROs are authorized to recommend sanctions to the Secretary of Health and Human Services for physicians who either failed in a substantial number of cases to satisfy the appropriate performance standard or grossly and flagrantly violated it. *Id.* § 1320c-5(b)(1). Physicians who are sanctioned by PROs may not meet certain *minimum* standards for the privilege of practicing at a particular hospital. However, these sanctions do not help hospitals to identify physicians who might be less obviously unqualified to practice medicine at their institutions or who fail to meet some higher standard of care.

196. A. DONABEDIAN, *supra* note 185, at 4-6.

197. *Id.*

198. *Id.*

199. *Id.*

200. Donabedian, *Quality, Cost and Clinical Decisions*, 468 ANNALS 196, 200 (1983).

201. *Id.*

what the outcomes *should* be for patients of a certain age and general health status with a particular diagnosis, *if* optimal achievable care is provided."[202] These predictions then serve as benchmarks or norms against which the results of actual care are measured.[203] Unless the delivery of patient care is based upon pure guesswork, these standards must exist. Only in this way can peer reviewers make systematic and clear determinations whether poor results were clinically unavoidable or whether the care contributed to these results.[204]

Much of peer review, however, is not conducted on the basis of statistically significant and otherwise appropriate norms. Rather, peer review often involves a small number of practitioners reviewing a small number of a particular physician's patient charts. Under these circumstances, patterns of care seldom are determined.[205] This approach "seriously limits the usefulness of review findings, because the disclosure of an isolated occurrence of anything but the grossest error cannot be the basis for any meaningful action."[206] Isolated poor outcomes may not identify incompetent practitioners.

These limited chart reviews also suffer from too much subjectivity.[207] As one group of commentators explained, this approach is not based on an objectively identified standard of care; rather, each reviewer relies on his or her implicit and subjective clinical judgments in reviewing the patient's chart.[208] Thus, the review is only as good as the reviewer.

A chart-by-chart peer review process also makes corrective action difficult to implement because the deficiencies are not identified according to objective measures.[209] Patterns of deficiencies based on proper norms must be evident in order to select appropriate corrective action.[210] Only under these circumstances will participants approach peer review as a scientific activity and not succumb to the social, psychological, professional, and economic

202. C. JACOBS, T. CHRISTOFFEL & N. DIXON, MEASURING THE QUALITY OF PATIENT CARE: THE RATIONALE FOR OUTCOME AUDIT 2 (1976) [hereinafter JACOBS, CHRISTOFFEL & DIXON].

203. *Id.*

204. *Id.*

205. *Id.* at 27.

206. *Id.*

207. *Id.*

208. *Id.*

209. *Id.*

210. *Id.*

pressures typically directed at peer reviewers.[211] Chart-by-chart review moves the focus of peer review from the care provided to the competence of the reviewer. As long as peer review is not based upon objective clinical standards determined through statistically significant sample sizes, the actions it yields are subject to question. Physicians, who understand this fundamental problem with peer review, are extremely reluctant to participate in it. The lack of objectivity in peer review may be the single greatest cause of the litigation the Act was designed to reduce or eliminate.

This lack of objectivity seems to stem from the art-versus-science dichotomy of medical care.[212] Understanding this dichotomy lies at the heart of evaluating the quality of patient care. The uncertainty created by this dichotomy affects the clinical judgment of physicians. As a result, evaluating a physician's clinical judgment or actions becomes extremely difficult.

Physicians have relied on this uncertainty to establish domains of control and influence free from outside review.[213] Scientific consensus on clinical practice would greatly improve the ability of lay persons, such as hospital administrators and board members, to evaluate physicians. For this reason, the medical profession has been reluctant to work toward developing this consensus.[214] The profession relies on clinical uncertainty to defeat even internal oversight by peers.[215] In general, the peer review process should help identify and develop practice norms. Once a physician has become the subject of peer review, the hospital's physician review committee will collect all of the relevant clinical data the hospital has at its disposal. This data usually consists of patient medical

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211. *Id.*

212. The process of diagnosing and treating patients requires physicians to rely on their scientific understanding of the human body and their ability to obtain enough data from the patient to select a proper treatment. Data collection and evaluation and treatment selection go beyond this scientific understanding. They require physicians to engage in the art of using their judgment and experience to choose a course of treatment based upon the known facts. This treatment selection process constitutes the art of practicing medicine.

213. Hall, *supra* note 88, at 477.

214. *Id.* Hall states:

> The profession's motives in suppressing the full play of scientific certainty are demonstrated by the AMA's active role in demolishing the National Center for Health Care Technology, an agency whose work was considered critical to achieving greater standardization in medicine. The AMA argued that "the center should not make general statements about appropriate medical care" because this was "trying to dictate the practice of medicine."

Id. (citation omitted).

215. *Id.* at 478.

records, but may also include incident reports from hospital personnel and support staff who have witnessed the physician's practices at the hospital. Once the physician reviewers identify a potential quality of care problem, the physician in question has the burden to justify any deviations from these norms on the basis of special circumstances presented in a particular case.[216] The review, however, is of doubtful value without objective norms of care.

The goal of peer review is to eliminate or reduce iatrogenesis, or injuries to patients caused by physicians. In writing about iatrogenesis, Ivan Illich, an outspoken critic of the medical profession, characterized it as a problem of epidemic proportions:

> The pain, dysfunction, disability, and anguish resulting from technical medical intervention now rival the morbidity due to traffic and industrial accidents and even war-related activities, and make the impact of medicine one of the most rapidly spreading epidemics of our time.[217]

Few studies have attempted to gauge the magnitude of the problem of iatrogenesis. One study reviewed 815 consecutive admissions to a medical ward of a university hospital with the following results: thirty-six percent of the patients studied developed major iatrogenic or minor iatrogenic illnesses; nine percent developed other major iatrogenic complications that threatened life or limb of the patients; and two percent died as a result of iatrogenesis.[218] The study concluded that the risk incurred by patients during hospitalization has not diminished over the last twenty years, and the risk of serious complications may have increased.[219]

The medical profession consistently has resisted efforts to develop performance data for patient care.[220] In the 1860s, Florence Nightingale attempted to develop a uniform system for collecting and presenting hospital statistics broken down according to age, sex, and disease.[221] This system was not widely accepted.[222] A similar effort in 1908 by E. W. Groves, a British surgeon, seeking to document operation results, had a limited effect.[223] Shortly thereafter, Dr. Ernest Amory Codmen, crusaded for the adoption

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216. JACOBS, CHRISTOFFEL & DIXON, *supra* note 202, at 41-45.

217. I. ILLICH, MEDICAL NEMESIS: THE EXPROPRIATION OF HEALTH 26-27 (1976).

218. Steel, Gertman, Crescini & Anderson, *Iatrogenic Illness on a General Medical Service at a University Hospital*, 304 NEW ENG. J. MED. 638 (1981).

219. *Id.* at 641.

220. JACOBS, CHRISTOFFEL & DIXON, *supra* note 202, at 23-25.

221. *Id.* at 23.

222. *Id.*

223. *Id.*

of a system to collect and tabulate surgical outcome data.[224] This effort was met with great resistance from the medical community and, after World War I, Codmen's idea was defeated.[225] With few isolated exceptions, support for an outcome-oriented physician performance evaluation methodology was nearly nonexistent until the 1950s and 1960s.[226] In 1976, the JCAHO advocated the use of patient outcome audits as a means of measuring and improving the quality of patient care.[227] Again, the industry generally has not used this methodology, and the JCAHO is now in the process of developing a patient outcome assessment program for accrediting hospitals. As in the past, physicians have managed to escape the scrutiny of reviewers in search of objectively verifiable standards of care based upon statistical analyses of patient care outcomes. Without these standards, however, peer review will continue to lack statistical or clinical validity.

The governing body of a hospital has the ultimate responsibility to monitor all three aspects of quality health care in the hospital. It is directly responsible for the structural aspects of the institution. Through management, it ensures that the facility is structurally sound, adequately equipped, and appropriately staffed to serve its health care mission. Under the current peer review system, however, it has delegated supervision over process and outcome to the medical staff. The legislative history of the Act, and the medical literature addressing iatrogenesis, fail to provide compelling empirical proof that physician peer review improves the quality of patient care. Based upon the apparent resistance of the medical profession to the development of legitimate practice norms, peer review, as we know it, may have done little, if anything, to improve the quality of care provided in hospitals. Arguably, peer review merely has maintained the status quo in hospital care for over the last twenty years. Yet, it remains the hallmark of every hospital's quality assurance program.

Further studies of iatrogenesis and ways to reduce it are needed. While the reasons for physician-caused injury to patients may be difficult to ascertain or evaluate due to the uncertainties involved in medical care, these reasons must be explored. If the quality of medical care cannot be monitored or identified because it is more art than science, the entire concept of peer review should be re-

224. *Id.*
225. *Id.* at 23-24.
226. *Id.* at 24.
227. *See generally* JACOBS, CHRISTOFFEL & DIXON, *supra* note 202.

evaluated with the goal of reducing its significant role in hospital quality assurance. More input from physicians, and perhaps non-physicians, on the relationship between peer review and quality of care is critical. Public confidence in hospital care and the future of a quality assurance system for hospitals hang in the balance.

V. IMPROVING THE ACT

The Act can be amended to overcome two of the three obstacles to effective peer review discussed in the previous section. Congress can amend the Act to diminish the political misuse of the process and the individual physician's reluctance to criticize a staff colleague. Allowing outside physicians to supply the clinical critique of the physicians being reviewed can overcome these two obstacles. However, legislating health care quality, the third obstacle impeding effective peer review, is beyond the reach of Congress. The best that can be hoped for from health industry legislation is that it will put in place or promote a *process* that will yield desired *substantive* results. It cannot mandate these results in a way that would help hospitals identify incompetent or inadequate physicians. Legislators, and society in general, must rely upon medical experts to stay current with changing modes of medical care to provide in the review process the substantive analysis of a physician's past and probable future performance. No statute can provide this type of substantive information.

The question then becomes how hospitals can best obtain the substantive clinical expertise they need to evaluate their physicians and staff applicants in light of the political and personal dynamics that play upon physicians engaged in peer review. An amended Act could improve the peer review process in three ways: (1) by creating an incentive to use outside reviewers, (2) by broadening the scope of the immunity, and (3) by increasing the exposure for payment of attorney fees and costs.

A. Encourage Outside Review

First, the Act should create an incentive for hospitals to conduct peer review through the use of third-party reviewers from outside the hospital. The political dynamics of physician relationships make the current system of peer review haphazard and unworkable.[228] Physicians originally used their economic power over hos-

228. One commentator recently stated:

> It [is] . . . impossible for peer review—as it traditionally has been conducted—to continue. Consequently, it is time for a change. Traditional peer review must

pitals to control medical staff appointments, reappointments, and corrective actions, and regularly placed their own political and economic interests over quality-of-care concerns. As long as physicians still choose to allow incompetent or dangerous colleagues to continue practicing medicine because they fear the potential professional and financial ramifications, and the costs of litigation that may follow the initiation of "effective peer review," the current process cannot promote quality. Accordingly, the Act should encourage hospitals to seek the medical expertise essential for proper physician review from nonstaff physician consultants.[229]

Recently enacted legislation in Oregon now permits the State's Board of Medical Examiners (BME) to appoint one or more physicians to conduct peer review upon request for review from (1) the physician being reviewed, (2) the executive committee of the medical staff, and (3) the governing body of the hospital.[230] This statute allows the BME to select a nonstaff expert committee to perform the review at a particular hospital consistent with that hospital's medical staff bylaws.[231] The Oregon Medical Association recommends the members of these committees to the BME.[232]

In *Austin v. McNamara*,[233] the peer review process, which satisfied the immunity requirements of the Act, involved the use of an outside independent review by two neurosurgeons appointed by the California Medical Association. These experts spent a day at the hospital talking to various staff members and reviewing the patient charts of the physician under review. They also spent an hour and a half interviewing the physician.[234] This use of outside experts helped to establish that the hospital's peer review process was fair and objective. Although the Act allows for the use of these experts, it does not insist on their expertise.

The California Society of Anesthesiology (CSA) also offers its services to hospitals seeking outside peer review.[235] The hospital

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> give way to a new system, whereby independent, qualified and objective outside reviewers do the bulk of the work. This will result in more effective, efficient peer review, less litigation, and greater fairness to all physicians involved.

Chenen, *supra* note 148, at 75.

229. *See* Chayet & Reardon, *supra* note 29, at 310.

230. OR. REV. STAT. § 441.055(6) (1990).

231. *Id.* § 441.055(7).

232. *Oregon Responds to Physician's Fears of Peer Review*, HOSPS., Jan. 5, 1990 at 70. This reliance on outside experts has reportedly diffused some physicians' complaints that they did not receive fair peer reviews. *Id.* at 71.

233. 731 F. Supp. 934 (C.D. Cal. 1990).

234. *Id.* at 936.

235. Chenen, *supra* note 148, at 77.

and the physician under review must agree to use the CSA reviewer and to be bound by the reviewer's recommendations.[236] The review consists of the CSA reviewer visiting the hospital and meeting all of the relevant parties.[237] The reviewer, who has considerable discretion over the scope of the review, may examine only a few charts or actually may scrub with the physician in question to observe his clinical performance.[238] The reviewer then prepares a written report with recommendations.[239] The hospital and the physician under review usually split the costs of this review.[240] Even if the review takes several days, the costs are substantially less for each party than the costs of litigation.

These examples of the use of outside reviewers to conduct peer review illustrate its benefits and feasibility. Outside review gives all concerned parties a sense that the process is fair and objective. This point should be especially clear to the physician under review if the critique comes from a practitioner in the physician's own specialty, and the physician has input into the process. Most importantly, outside experts can provide relatively unbiased recommendations to the hospital regarding the physician in question with the aim of correcting the deficiencies. Peer review should not be punitive; it should be a process of identifying and correcting problems.

Accordingly, hospitals should commission outside medical auditors to review physicians in three instances: appointment, reappointment, and corrective action. To assure patient anonymity these auditors should be provided with coded medical records and other quality assurance and utilization data typically maintained by hospitals. The JCAHO requires hospitals to maintain a number of committees to collect and discuss such data on a regular basis.[241]

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236. *Id.*
237. *Id.*
238. *Id.*
239. *Id.*
240. *Id.*
241. Chayet & Reardon, *supra* note 29, at 305. Chayet and Reardon describe the roles of these committees:

> [T]he Tissue Committee provides a monthly surgical case review, including the indication for surgery in all cases where there is a major discrepancy between the preoperative and postoperative diagnoses. The Pharmacy and Therapeutics Committee is responsible for the development and surveillance of polices and practices in those areas, particularly drug utilization in the hospital. The Medical Records Committee is responsible for reviewing records for timely completion, clinical pertinence, and adequacy for use in patient care evaluation. The Blood Utilization Review Committee reviews all transfusions. The Antibiotic Usage Committee reviews the clinical use of antibiotics in the hospital. Finally,

The auditors should be qualified in the specialties of the physician under review and must come from locales outside of the hospital's service area. These physicians may perform these services either as volunteers working to improve their profession, or as paid consultants. In either instance, as persons assisting the peer review process, they should be protected by the Act's immunity provisions.[242]

Members of county or state medical societies, medical school faculties, specialty board certification societies, or noted experts in the relevant field could serve as auditors and should be asked to review systematically the relevant clinical data. Following this chart review, the auditor should have the discretion to visit the hospital, interview appropriate persons, and observe the clinical practices of physicians under review. The overall purpose of these actions is to provide the auditor with sufficient evidence to render an impartial, objective written opinion regarding the merits of the physician's application for appointment or reappointment, or the need for corrective action.[243] This opinion should be presented to the physician under review, hospital management, and board members, and should articulate the quality of care issues in a way that informs a lay audience. Accordingly, hospital boards will not be denied the benefit of essential medical input into the physician evaluation process, and the reviewers will not be subject to the more direct professional pressure physicians feel when reviewing a fellow staff member.[244] To ensure fairness, the physician under review should be allowed to submit a written reply to the auditor's report. The goal of the hospital's board should be to promote the quality of patient care by improving the physician's performance, if possible. Dismissal from the staff or denial of appointment should be viewed as acts of last resort.

A major obstacle to the adoption of outside peer review may be opposition from the hospital's medical staff. It may view outside review as a way of circumventing its historic prerogative of controlling the staff's composition. Hospital physicians probably will object strongly to any effort that may diminish this control. A sys-

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the Quality Assurance and Utilization Review Committee is responsible for evaluating the quality of care provided in the hospital, reviewing utilization, and monitoring professional performances of individual practitioners.

Id. (citations omitted).

242. *See* 42 U.S.C. § 11111(a)(1)(C), (D) (1988).

243. Chayet & Reardon, *supra* note 29, at 310.

244. A finding that a physician is clinically competent, however, may not be dispositive of an action before a board. Hospitals often make appointment, reappointment, and disciplinary decisions that are not limited to this factor. *See supra* note 51 and accompanying text.

tematic elimination of the staff from the peer review process may be unworkable in the political climate of most hospitals. Therefore, the Act should allow its immunity to be used at the hospital's election on a case-by-case basis. For example, hospitals may want the option of using outside reviewers to take advantage of the Act's immunity in cases that are likely to be litigated.[245] The staff, which is usually just as averse to litigation as the hospital, if not more so, should find outside review acceptable under these circumstances. As outside review is used more often, the process may gain wider acceptance and eventually replace the intrahospital peer review model.

B. Strengthen the Immunity

Second, to encourage the adoption of this process by hospitals, Congress should expand the immunity of the Act. The Act should immunize the hospital, its board and management, all informants, and all outside reviewers who participate in this appointment, reappointment, or corrective action process from liability for *all* monetary, injunctive, or declaratory relief. The Act should also provide that this immunity can be defeated only if the aggrieved physician alleges with factual particularity that the hospital's actions were utterly without factual basis. In other words, the hospital and its reviewers should be liable only for damages, with equitable relief available if the outside reviewers were used merely as a pretext or a sham to eliminate a particular physician. The aggrieved physician, however, would have to allege specifically why the peer review action was factually unfounded. Accordingly, the physician should be provided with a copy of the outside consultants' report without disclosing the identity of the consultants, and be given an opportunity to submit a response to the report before the hospital board takes final action on the matter. The physician also should be given a copy of the board's final decision and the reason for it.

C. Expand Exposure for Attorney Fees and Costs

Finally, as a further disincentive to bring suit, the Act should make the losing party liable for all costs of the prevailing party arising out of the action, including reasonable attorneys' fees. The Act currently allows a substantially prevailing party to recover

245. For example, certain medical staff candidates may initiate the application process with threats of litigation if their application is not approved. These physicians would be prime candidates for such review.

these costs only if the claim is frivolous, unreasonable, without foundation, or made in bad faith.[246] This provision appears to add nothing to the provisions of Rule 11 of the Federal Rules of Civil Procedure.[247] The proposed amendment would take good or bad intentions out of the analysis employed in awarding costs and attorneys' fees to the prevailing party. This provision would also cause hospitals to avoid using outside consultants as a mere pretext to discipline a competent physician.

D. Rebuilding the Peer Review Infrastructure

Additionally, the Act should give states a reasonable period of time within which to amend their laws to allow hospitals to bypass the traditional peer review process in favor of using outside consultants. The sanction for failing to do so should be the loss of federal Medicare and Medicaid dollars for hospitals in nonconforming states. The JCAHO also should be required to delete its standards requiring traditional peer review. To encourage this adjustment, the Act should offer the JCAHO the choice of either: (1) allowing the hospital to use and rely upon outside consultants without intrahospital peer review, or (2) having hospitals deemed in compliance with Medicare's conditions of participation if they are licensed by the state, instead of accredited by the JCAHO.

E. Summary

The advantage of these proposed changes is that a system of outside physician review would limit substantially the professional and economic concerns of medical staff members in monitoring quality of care. Hospital physicians would also be relieved of the

246. 42 U.S.C. § 11113 (1988). The Act provides:

> In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

Id.

247. Rule 11 provides that complaints and other pleadings must be "well grounded in fact and . . . warranted by existing law or a good faith argument for the extension, modification, or reversal of existing law, and . . . not interposed for any improper purpose, such as to harass or to cause unnecessary delay or needless increase in the cost of litigation." FED. R. CIV. P. 11.

burden of engaging in peer review at the peril of damaging important professional relationships or incurring substantial litigation expenses. An amended Act would also eliminate the intricate, inefficient, and ultimately ineffective hospital bureaucracy that has developed to implement peer review.

In addition, hospital reliance on attorneys to guide them through the complex maze of adequate notice and fair hearing requirements, which differ from state to state, will be eliminated. Under traditional peer review, attorneys play a substantial role in ensuring that all of the notice and hearing requirements mandated by federal and state law are satisfied to minimize the hospital's legal exposure for improperly employing the peer review process. The resources currently devoted to compliance with laws affecting peer review would be better spent on quality of care data collection and evaluation. The funds hospitals will save on legal fees can be devoted to retention of reliable consultants and improvement of quality assurance data collection and evaluation.

VI. Conclusion

There is no proof that intrahospital physician peer review improves the quality of health care in hospitals. What little is known about evaluating physician performance suggests that this process may be ineffective. The apparent failure of peer review is founded largely upon the economic dynamics of the medical profession.

The Health Care Quality Improvement Act of 1986 fails to address the first and primary concern of physicians—the importance of their relationships with other physicians. If the Act were amended to allow hospital boards and management to retain outside physician reviewers to provide objective analyses of the clinical abilities of the physicians under review, the political influence from the hospital's physicians on these decisions would diminish greatly. Moreover, the protections of the Act should be bolstered to bar all claims for relief or damages, except in cases involving a pretextual reliance on outside review. This proposal would remove the medical staff from the role of professional gatekeeper of the hospital and allow hospital boards and management to focus more upon quality of care than legal issues.

Until the Act overcomes the political barriers to effective peer review and affords some real protection against lawsuits involving peer review decisions, its important objectives will never be realized. Much needs to be learned about how to evaluate the competence of physicians. Improving data collection and engaging

disinterested outside reviewers to grapple with this issue will better educate hospital boards and staff physicians about the quality of their medical care than relying upon intrahospital peer review.