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Ronald G. Spaeth
Evanston Northwestern Healthcare

Kelley C. Pickering
Loyola University Chicago, School of Law

Shannon M. Webb
Loyola University Chicago, School of Law

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Quality Assurance and Hospital Structure: How the Physician-Hospital Relationship Affects Quality Measures

Ronald G. Spaeth¹, Kelley C. Pickering, and Shannon M. Webb²

I. INTRODUCTION

In 1999, a study released by the Institute of Medicine may have changed the way we measure and evaluate quality health care. The report, *To Err is Human*, suggested that the failure of the health care industry to adequately monitor and correct quality problems was resulting in a dramatic toll on patient health and safety.³ The Institute offered several solutions to address the problems with quality, including the implementation of a “cleaner system” of self-review and governance within the health care facility itself.⁴ Upon securing the endorsement of the Federal government, these proposed solutions became the new front-page concerns for physicians, hospitals, and health care providers throughout the country.⁵

Improving patient care became all the rage as health care institutions struggled to establish themselves as “quality” caregivers.⁶ Within the hospital environment, sophisticated measures began to establish internal quality control measures, including: (1) credentialing programs; (2) peer review programs; (3) internal standards; (4) minimum numbers of cases

1. Mr. Spaeth joined Evanston Northwestern Health care in January 2000, when Highland Park Hospital merged with Evanston Northwestern Health care. Prior to the merger, Mr. Spaeth served as the President and Chief Executive Officer of Highland Park Hospital for seventeen years. He received his B.A. from Western Reserve University and his M.B.A. from the University of Chicago. Mr. Spaeth is currently a member of the Board of Commissioners of the Joint Commission on the Accreditation of Health care Organizations.

2. Kelley C. Pickering and Shannon M. Webb are both graduating with J.D. degrees in May 2003 from Loyola University Chicago School of Law. Both are candidates for the Health Law Certificate, and are Article Editors for the *Annals of Health Law*.

3. See generally COMM. ON QUALITY OF HEALTH CARE IN AM., INST. OF MED., *TO ERR IS HUMAN: BUILDING A SAFER HEALTH CARE SYSTEM*, (LINDA T. KOHN ET AL., eds., 2000) (commenting throughout the book about the quality of health care in America).

4. See *id.* at 5-15.

5. See e.g., Agency for Health care Research & Quality, <http://www.ahrq.gov>; see also Nat'l Ctr. for Patient Safety, <http://www.patientsafety.gov/vision.html>.

6. See generally *id.* (providing information to providers).

performed; and (5) hospital wide policies, such as those suggested by The Leapfrog Group,⁷ to supervise the physicians and evaluate their performance. These programs sought to promote a greater quality of health care through peer assessment, and the encouragement of self-policing and whistle-blowing.⁸ The hospital-physician relationship, essentially an employer-employee bond, has in turn changed through the implementation of such procedures in hospitals around the country.

This paper will give a structural illustration of today's more multifaceted hospital environment and explain how the quality-driven processes of peer review, credentialing, and standards work in both the typically smaller community hospital setting, and the generally larger university-affiliated institution. Problems with this system will be described, as well as the ever-present involvement of medical malpractice concerns. The conclusion presents several alternatives that could serve as possible solutions to these quality-driven quandaries.

II. CREDENTIALING AND PEER REVIEW

Today's hospitals are structurally complicated as a result of the struggle for quality. The main administrative body serves as the governing board that is responsible for overseeing the activities of the hospital and is centrally concerned with meeting quality guidelines. Interestingly enough, however, until recently it has generally been comprised chiefly or entirely of non-physicians.⁹ This requires the board to rely on the hospital's staff physicians to evaluate their co-workers' job performances as a necessary step for the hospital to achieve quality care.¹⁰ Two means of such evaluation are through credentialing and peer review, both of which are principally the physicians' responsibilities.¹¹

Credentialing refers to the process of determining whether to make a physician a member of the hospital staff. This is done by means of an investigation, followed by further analysis every two years to decide whether reappointment is appropriate.¹² The credentialing committees refer to past performance and recommendations from peer physicians to

7. See The Leapfrog Group for Patient Safety, at http://www.leapfroggroup.org/consumer_intro2.htm.

8. See generally Jason M. Healy et al., *Confidentiality of Health Care Provider Quality of Care Information*, 40 BRANDEIS L.J. 595 (2002).

9. Paul L. Scibetta, *Restructuring Hospital-Physician Relations: Patient Care Quality Depends on the Health of Hospital Peer Review*, 51 U. PITT. L. REV. 1025, 1031-32 (1990).

10. *Id.* at 1032.

11. *Id.*

12. *Id.*

determine if the individual is fit to practice in that facility.¹³ Peer review is a similar process, conducted on a continual basis within the hospital and the departmental settings.¹⁴ The goal of the peer review process is to ensure quality care through consistent monitoring of physicians by their peers, who determine incompetence through evidence of a pattern of inadequate care.¹⁵ Many states have protected peer review participants through legislation aimed at encouraging the “free flow of information without threat of reprisal in the form of civil liability.”¹⁶ In 1986, Congress enacted The Health Care Quality Improvement Act (“HCQIA”), aimed at providing incentives to physicians to actively engage in peer reviewing programs.¹⁷ HCQIA works in conjunction with those state statutes to provide qualified immunities to peer reviewers, and it also requires that all findings be reported to a national clearinghouse.¹⁸ Despite these protections, however, physicians and hospitals still face a myriad of difficulties brought on by these procedures.

The hospital’s governing board is ultimately responsible for any harm or risk of injury to patients.¹⁹ However, the assessment of the quality of a physician’s work can often only be properly determined by someone who practices within the same specialty.²⁰ Thus, from the hospital’s perspective, the level of quality provided to patients depends upon how well the processes of credentialing and peer review are carried out by their physicians.²¹ Hospitals must continually strive to eliminate the barriers to these processes and struggle to streamline the methods, encouraging the physicians’ timely reporting efforts and perfecting the means of discovering and addressing quality concerns.

However, there are significant impediments to the processes of peer review and credentialing on participating physicians.²² Major barriers to the smooth and efficient operation of these processes include: the fear of

13. *Id.*

14. *Id.*

15. *Id.*

16. *Browning v. Burt*, 613 N.E.2d 993, 1007 (Ohio 1993); Katherine T. Stukes, *The Medical Peer Review Privilege After Virmani*, 80 N.C. L. REV. 1860, 1862-64 (2002); Steven D. Williger & Maynard A. Buck, *A World of Privilege and Immunity*, 49-JAN. FED. LAW. 32, 32-33 (2002).

17. Stukes, *supra* note 16, at 1868-69.

18. Williger & Buck, *supra* note 16, at 32.

19. Scibetta, *supra* note 9, at 1032.

20. *Id.*

21. Stukes, *supra* note 16, at 1862-64.

22. Teresa L. Salamon, *When Revoking Privilege Leads to Invoking Privilege: Whether There is a Need to Recognize a Clearly Defined Medical Peer Review Privilege in Virmani v. Novant Health, Inc.*, 47 VILL. L. REV. 643, 645 (2002).

subsequent personal lawsuits, the effect on referrals, the lack of compensation for participating physicians, and the social tensions that accompany adverse recommendations.²³ All hospitals, large and small alike, must face these obstacles, because the smooth and efficient operation of credentialing and peer review are critical to assuring quality; yet, the specific structure of the smaller community hospital creates even more tensions in the “employment” relationship between the physicians and the hospital board, and their endless quest for quality improvement.

III. QUALITY CONTROL IN DIFFERENT HOSPITAL STRUCTURES

The majority of hospitals in our country today “employ” voluntary medical staffs. These facilities, typically known as community hospitals, function with no employer-physician employee relationship and in a non-academic setting. It is therefore readily distinguishable from the university-affiliated hospitals. These differences, however, create very diverse environments and quality measures within the institution, as each structure faces unique challenges in their pursuit for quality.

Within most American hospitals, physicians are organized by their area of expertise into departments. Each department has a chairperson, a physician member of that department who serves to oversee the department and the other doctors, while keeping the administration abreast of any quality concerns. This individual is responsible for credentialing his or her members and running the department. This is, essentially, the structure of peer review within the hospital. The intention is to ensure that patients are receiving quality care from competent and knowledgeable physicians. Any deviation from the standard of care by one physician should spark whistleblowing by others in his or her department, which would then proceed through the structural hierarchy – from department chair, to hospital administration, and finally to the board. However, the differences between the university and community hospitals can produce very different results when these processes are applied.

A. The University Hospital

University hospitals are typically very prominent both as care facilities and research centers. Often, affiliating your name with a university hospital carries more meaning – and perhaps more business – for a physician. Department chairs are typically recruited from outside the institution by the medical school, rather than elected from the hospital staff by the department members. They are typically highly-regarded people in their fields of

23. Scibetta, *supra* note 9, at 1033-35.

expertise. They are also compensated for their work as chairs, and are heavily marketed by the hospital so the individual receives recognition that may boost personal success. Moreover, in a university hospital, the position generally has no term limit. Therefore, the chairperson is not generally concerned that the position will be refilled after a year with another department member.

Thus, individuals serving as department chairs for a group of physicians in a university hospital are often not equal peers with their department members. They command a higher salary; are generally in a permanent position; are specifically recruited by the administration-university for the title; are recognized and therefore marketed by the hospital and the university; and often split time between their roles as physicians, professors, and researchers. While the processes of credentialing and peer review undeniably will cause tensions between peer workers in any setting, the distinction between the department chair and his or her physician members is clearly delineated by the university hospital administration and structure. The differences between the positions in such a setting are generally considered acceptable, thus creating less friction for the peer review and credentialing procedures. The hospital can thus benefit more freely from operating quality control mechanisms that are conducted more smoothly.

B. The Community Hospital

Community hospitals are structured much more differently than the university institutions. These distinctions create very different quality-seeking environments. Community hospitals pull the department chairs from their existing staff, holding elections among physicians within the departments. This creates a tension nonexistent in the university hospital setting, as physicians must choose a chairperson from among their own ranks to oversee and manage them. This chairperson, who does not necessarily have any more expertise or tenure over his or her department members, is responsible for addressing quality issues, reprimanding doctors for errors, and assuming the responsibility of running the department and actively striving for higher quality work product from its members. This all has to be done under the microscope of the department members and the hospital administration.

Additionally, the community hospital generally does not pay the department chair any additional compensation for his or her efforts, and is not structured to do so, even though the position requires extra work and

long hours, keeping the doctor at work but away from his or her patients.²⁴ The community hospital does not market the individual openly to the community as a department chair, as this would be seen as an unfair act of favoritism, or even as antitrust by the other members of the department. Additionally, the position as chair is not indefinite. New elections are held every one to two years, which means that a newly-elected physician has barely served as chair when considerations for the next chairperson are being made. This regular turnover causes problems, especially if the embittered department member who was reprimanded ends up as the new chair just one year later.

While this structure may function well in the university hospital setting, it seems somehow contrary to achieving quality in the community hospital environment. Where no compensation or community recognition is offered for increased responsibilities, and personal discord and strife are likely to emerge, what is the incentive for chairs to report quality problems and bring more negative attention upon themselves? This also poses a problem for doctors, such as specialists, who rely heavily on their peers' recommendations to patients for income. Once a rift is created between physicians as a result of an adverse peer review recommendation, many doctors find themselves biting the hand that feeds them. This is the case since they are effectively cutting off an often significant income stream that they had previously enjoyed. Ironically, from a patient's perspective, this means that the very methods employed by hospitals and physicians to improve health care quality might deprive a patient of an appropriate referral, merely because of personal tensions or a soured relationship between two physicians.

IV. LIABILITY ISSUES AND THEORIES

Among the barriers posing threats to the efficiency of credentialing and peer review are concerns about personal litigation stemming from these processes.²⁵ While state statutes and HCQIA specifications limit some of the liability,²⁶ physicians are still concerned with both defending their credibility, should it be called into question by fellow physicians, and with insulating themselves from lawsuits, should their assessment of another doctor backfire. This proves to be another challenge to the hospital: how to encourage physicians to continue blowing the whistle on inadequate care,

24. George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 727-29 (2001).

25. Scibetta, *supra* note 9, at 1033-34.

26. *Id.*; Willinger & Buck, *supra* note 16, at 32-33 (discussing protections afforded under HCQIA).

despite the potential threat of personal liability, while at the same time providing physicians a forum to be heard, should they need to defend their own actions against their peers.

A. *The Antitrust Theory*

Several legal theories have risen out of this precarious relationship, and physicians discharged from hospitals as a result of peer review effort have brought suits against both the institution and the doctors involved.²⁷ Some of these suits have been brought under an antitrust theory, where disciplined physicians have sued both the reviewing doctor and the hospital, claiming the peer review was done with the intent to reduce the number of competing physicians in the reviewer's practice group.²⁸ By reporting to the hospital board that a peer was failing to provide quality care, the reviewing physician effectively eliminated any other doctors with whom they were competing for patients and privileges.²⁹

Assuming they can show that their recommendations to the hospital were made in good faith, generally, suits under an antitrust theory have failed because of the implementation of state statutes providing immunity to reviewing physicians.³⁰ However, even with this protective legislation in place, many physicians still find the thought of defending their recommendations in a court a severe deterrent to notifying the hospital board of a peer's inadequate performance.³¹ Thus, hospital measures to improve quality care are chilled to the extent the physicians are reluctant to become involved, due to the risk of being entangled in a lawsuit.

B. *The Due Process Theory*

Discharged physicians have been much more successful bringing suits under a due process theory of law.³² This claim can be used by a doctor who has been terminated from a hospital staff, or who has been refused appointment.³³ Essentially, physicians argue that they were denied fair procedure in the decision-making process of the hospital board.³⁴ While

27. See Scibetta, *supra* note 9, at 1039.

28. *Id.* at 1034.

29. See, e.g., Patrick v. Burget, 486 U.S. 94, 105 (1988) (holding that the state action doctrine did not protect peer review activities from application of the federal antitrust laws where a surgeon brought an action against physicians, alleging violations of the Sherman Act and interference with prospective employment).

30. Scibetta, *supra* note 9, at 1034.

31. *Id.*

32. *Id.* at 1035.

33. *Id.*

34. *Id.*

this is a constitutionally-grounded argument, thus applicable to public hospitals by the Fifth and Fourteenth Amendments, it has also been applied to private institutions under common law and contract theory.³⁵ The courts have decided that hospitals may not make an arbitrary exclusion, but must provide the individual with a hearing and appeal process, much like a mini-trial being held within the hospital.³⁶ As a result of a number of successful due process claims, hospitals often are compelled to institute a slew of procedural safeguards for their physicians, quite often unnecessarily.³⁷ This results, however, in more barriers to the efficiency of the peer review process. Money and resources the hospital spends on establishing these safeguards and conducting hearings are therefore not available to fund and improve the credentialing and peer review processes.³⁸ Additionally, the focus on preparing for an in-house hearing and establishing a case against a physician solid enough to deter litigation discourages doctors from participating actively in peer review. This perhaps silences many of the recommendations that would be crucial to quality improvement in the hospital.³⁹

V. CONSEQUENCES

Due to the differences in hospital structure between the community and university hospitals, the same measures used to obtain a higher quality of care may often result in very opposite outcomes. The effect of credentialing and peer review in the community hospital may actually be detrimental to the ultimate goal of quality improvement. Moreover, smaller hospitals may find themselves better served by exploring new ways to amend the peer review and credentialing processes to ensure patients receive quality health care. Because of the measures hospitals must take to encourage physician involvement in the reviewing procedures, and to protect those physicians' rights should they receive an adverse recommendation, much of the effort is actually being focused away from ensuring quality. Thus, this strongly suggests that smaller community hospitals may require different peer review processes that are designed to be more compatible with their unique structure and physician hospital relationships.

35. *Id.* at 1036.

36. *Id.*

37. *Id.*

38. *Id.*

39. *Id.*

VI. DISCOVERABILITY OF PEER REVIEW DOCUMENTS IN THE MEDICAL MALPRACTICE SETTING

An additional hurdle in the process of achieving quality health care through peer review is the physicians' fear that peer review documents may be used against them in a negligence action brought by a third party.⁴⁰ Indeed, despite current immunity and confidentiality legislation, it is not uncommon for a large portion of the peer review documents to be considered discoverable in a medical malpractice action.⁴¹ Taken together with the lack of a federal cap on damages in medical malpractice cases,⁴² the situation clearly leads to a "chilling effect" in the peer review process.⁴³

To begin with, many of the peer review documents, created by mandate in many cases, are discoverable in negligence actions brought by patients.⁴⁴ While it is true that many states have peer review privilege, immunity, and confidentiality statutes that address this problem,⁴⁵ they do not go far enough in easing the physicians' fears of litigation.⁴⁶ Specifically, many of these statutes only protect those documents that are originally created in a peer review committee.⁴⁷ This leaves items such as patient charts, records, billing information, and general medical error and safety information discoverable.⁴⁸ Moreover, these peer review statutes vary greatly from one state to another, which leads to inconsistent protections.⁴⁹

The federal government's response to the physicians' concerns, regarding the discoverability of peer review documents, has been to enact privacy legislation.⁵⁰ Specifically, HCQIA was enacted in 1986 in an effort

40. See Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 YALE J. ON REG. 383, 396-97 (2001).

41. See Healy et al., *supra* note 8, at 597.

42. See *Wright v. Cent. DuPage Hosp. Ass'n*, 347 N.E.2d 736, 743 (Ill. 1976).

43. Christina A. Graham, *Hide and Seek: Discovery in the Context of the State and Federal Peer Review Privileges*, 30 CUMB. L. REV. 111, 113 (2000).

44. Healy et al., *supra* note 8, at 617-18; Susan O. Scheutzow & Sylvia Lynn Gillis, *Confidentiality and Privilege of Peer Review Information: More Imagined than Real*, 7 J.L. & HEALTH 169, 182-92 (1993).

45. Scheutzow & Gillis, *supra* note 44, at 170-71; Joseph T. Butz & Dennis C. Waldon, *Protecting Physician Whistleblowers Under Illinois and Federal Law*, 85 ILL. B.J. 328, 330-31 (1997).

46. Scheutzow & Gillis, *supra* note 44, at 170-71.

47. Newton, *supra* note 24, at 731.

48. See Chiang, *supra* note 40, at 396-405; Bryan A. Liang, *The Adverse Event of Unaddressed Medical Error: Identifying and Filling the Holes in the Health-Care and Legal Systems*, 29 J. L. MED. & ETHICS 346, 351-52 (2001).

49. Scheutzow & Gillis, *supra* note 44, at 193-94.

50. Healy et al., *supra* note 8, at 631-32; see generally Susan L. Horner, *The Health Care Quality Improvement Act of 1986: Its History, Provisions, Applications and Implications*, 16 AM. J.L. & MED. 455 (1990).

to provide qualified immunity to individuals involved in peer review committees.⁵¹ However, the quality control materials created by these same committees are not provided for under the HCQIA.⁵² In 1996, the government again enacted privacy legislation, the Health Insurance Portability and Accountability Act ("HIPAA"), which was partially aimed at easing physicians' fear of peer review.⁵³ HIPAA established new safeguards for protecting individually identifiable medical information that is "transmitted or maintained electronically or in any other form or medium."⁵⁴ However, the structure of HIPAA does not necessarily provide a true privilege or protection for medical care providers; it merely sets forth confidentiality requirements.⁵⁵ Furthermore, HIPAA mandates that "patients have the right to inspect, copy, and amend their health-care information; authorize or refuse to authorize its use; and receive a formal accounting of how their information is used."⁵⁶ Clearly, both pieces of federal legislation have failed to address all of the confidentiality, privilege, and immunity concerns that face physicians involved in peer review or quality control activities.

Generally, courts are reluctant to broadly read the provisions of the state or federal peer review statutes.⁵⁷ Therefore, the statutory language must unambiguously grant the sought immunity or privilege in order for the court to find the statute applicable.⁵⁸ One reason behind this narrow interpretation of legislation is the desire to balance the plaintiff's right to discovery with the need for unfettered quality control and peer review processes in the medical community.⁵⁹ Specifically, many scholars perceive the peer review privilege as harmful to patients' malpractice claims, because they do not have access to key peer review documents.⁶⁰ On the other hand, many also view the peer review privilege as a way to "level the judicial playing field" in medical malpractice cases.⁶¹ Indeed, without this privilege plaintiffs would be able to use any and all quality control and peer review documents, *created by physicians*, against a physician in a medical malpractice action.⁶²

51. Horner, *supra* note 50, at 455; Newton, *supra* note 24, at 732.

52. Liang, *supra* note 48, at 352.

53. Healy et al., *supra* note 8, at 632-33.

54. *Id.*

55. *Id.* at 635.

56. 45 C.F.R. §§ 164.524, 164.526, 164.528 (2000)); Liang, *supra* note 48, at 353.

57. Scheutzow & Gillis, *supra* note 44, at 176-77.

58. *Id.*

59. See Graham, *supra* note 43, at 113; Liang, *supra* note 48, at 353; Newton, *supra* note 24, at 736-37.

60. Graham, *supra* note 43, at 114-15.

61. Newton, *supra* note 24, at 737.

62. *Id.* at 736.

These differing perspectives have almost always found the plaintiff's right to discovery as the appropriate balance.⁶³ This right to discovery, however, has led to a resurgence of medical malpractice actions and all the negative consequences that attach, including increased malpractice insurance premiums, higher health care costs, and decreased quality and access to care.⁶⁴ Specifically, medical malpractice insurance premiums are skyrocketing for many physicians, especially those practicing in obstetrics, neurosurgery, and emergency medicine.⁶⁵ "Doctors alone spent \$6.3 billion last year to obtain coverage."⁶⁶ Indeed, "[e]ven where mistakes are not made, the imperfections of our legal system sometimes permit patients with bad outcomes to sustain legal actions, and even to recover damage awards."⁶⁷ Therefore, physicians whom may have never even faced a medical malpractice claim once in their careers are now forced to pay much higher costs for malpractice insurance.⁶⁸

This increase in insurance costs for physicians has led some physicians to leave the health care field, and many more have chosen to move to states where the malpractice damage awards are capped by state statutes.⁶⁹ The negative consequences of such physician decisions are already being seen in states where there are physician shortages. Some physicians have even stopped performing medical procedures, such as delivering babies, because of their high-risk nature.⁷⁰ Clearly, access to care, quality or not, is being threatened by the repercussions of the current medical malpractice process.⁷¹

Moreover, the total financial impact of the medical malpractice system in many states merely begins with a discussion about physicians' rising insurance premiums.⁷² Other costs tied to malpractice liability that physicians face are: (1) defensive medical costs; (2) liability-related administrative costs, such as corporate compliance activities; and (3) medical device and pharmaceutical liability costs that are passed on due to

63. See Liang, *supra* note 48, at 353.

64. See U.S. DEP'T OF HEALTH & HUM. SERVS., CONFRONTING THE NEW HEALTH CARE CRISIS: IMPROVING HEALTH CARE QUALITY AND LOWERING COSTS BY FIXING OUR MEDICAL LIABILITY SYSTEM 1-2 (July 25, 2002), <http://aspe.hhs.gov/daltcp/reports/litrefm.htm> [hereinafter CONFRONTING THE NEW HEALTH CARE CRISIS].

65. *Lawyers vs. Patients*, WALL ST. J., October 1, 2002, at A20.

66. CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 6.

67. Charles M. Key, *Maintaining Professional Liability Insurance Coverage: Basics for the Careful Shopper*, 12 HEALTH LAWYER 23, 23-24 (1999).

68. CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 1.

69. *Id.* at 2.

70. *Id.* at 1-3.

71. *Id.*

72. Healy et al., *supra* note 8, at 620.

increasing manufacturer's insurance.⁷³ All of these increased financial pressures on physicians are then passed on to all Americans "through higher premiums for health insurance . . . higher out-of-pocket payments when they obtain care, and higher taxes."⁷⁴

One possibility in alleviating this crisis situation that has erupted is to enact state and federal legislation that caps at least some aspect of medical malpractice damages available to the plaintiff-patient.⁷⁵ Several states, such as California, have already enacted legislation that limits the amount of non-economic damages available in a medical malpractice case.⁷⁶ The states that have malpractice award caps also have significantly lower malpractice insurance premiums, as the two are inextricably linked.⁷⁷ However, many states do not have malpractice award caps in effect and due to the unpredictable nature of malpractice claims and awards, physicians in those states are forced to pay the higher insurance premiums.⁷⁸

In response, on the federal front, there is legislation pending in the Senate that would cap non-economic damages at \$250,000.⁷⁹ This bill would also set punitive damages at the greater of \$250,000, or twice the economic damages.⁸⁰ Consequently, this legislation has the potential to reduce medical malpractice premiums by twenty-five to thirty percent.⁸¹ This reduction in cost to the physician would lead to lower health care costs not only for the American people individually, but also for the government as a whole.⁸²

In the end, despite the potential for discovery of peer review documents by third parties, by limiting the physicians' liability in medical malpractice actions physicians may be more willing to participate in meaningful peer review and quality control processes. However, until the medical malpractice awards are capped consistently across the country through federal legislation, quality, cost, and access issues will prevail in many states. Therefore, medical malpractice reform is a necessary measure that should be taken in an effort to achieve higher quality medical care for all.

73. *Id.*

74. CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 6.

75. *Id.* at 12-14.

76. *See, e.g.,* Fein v. Permanente Med. Group, 695 P.2d 665 (Cal. 1985); CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 10-11.

77. CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 12-15; *Lawyers vs. Patients*, *supra* note 65.

78. CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 1, 12-14.

79. *Lawyers vs. Patients*, *supra* note 65.

80. *Id.*

81. *Id.*

82. *Id.*

VII. CONCLUSION AND POSSIBLE SOLUTIONS

The struggle for greater quality health care has become so complex that it creates its own disincentives, especially within the community hospital environment. It may be possible, however, to reconfigure the peer review and quality control processes to better fit the unique structure of a community hospital. Specifically, an outside independent reviewing agency could be created with specific input from the local medical community and assigned to individual hospitals as a type of “risk management” team. This team would be composed of physicians; however, the obstacles that would normally face a Department Chair or a peer review committee would be alleviated because this physician team would only be responsible for peer review.

Of course, this proposed solution does not address the issue of how the documents used by this “stand-alone” quality review committee would be protected from discovery in litigation. It is clear that individual state statutes cannot provide the necessary protection for these documents, given the current discoverability of many peer review documents.⁸³ A federal statute that sets forth a bright-line rule regarding quality control privileges, immunities, and confidentiality must be enacted.

Moreover, in order to promote effective quality control processes in health care, there must be a federally enacted cap on all medical malpractice non-economic damages. The current legislation that is pending in the Senate would be a vast departure from the state to state inconsistencies that currently prevail in this area.⁸⁴ Such legislation is absolutely necessary. It is *essential* that federal legislation be enacted that addresses the health care crisis that has been created by the continually skyrocketing medical malpractice awards.⁸⁵

In the end, quality health care is everyone’s goal; therefore, we should be committed to ensuring that the quality control and peer review processes are effective for the hospital structure on which they are imposed. It is only by addressing, and eventually overcoming, the obstacles to effective peer review procedures that quality health care can be achieved in America.

83. See Butz & Waldon, *supra* note 45, at 330-31; Scheutzow & Gillis, *supra* note 44, at 170-71.

84. See *Lawyers vs. Patients*, *supra* note 65.

85. See CONFRONTING THE NEW HEALTH CARE CRISIS, *supra* note 64, at 1-3.