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The Health Care Quality Improvement Act of 1986

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The peer review process is the method by which physicians review the quality of care delivered by their physician colleagues. This process has been sanctioned by the various states that provide by statute for the confidentiality of the information generated during the peer review process. Congress also recognized the value of and necessity for effective peer review, as well as a mechanism to encourage physicians to participate.

Despite the efforts of Congress to provide immunity to physicians participating in the peer review process, physician discipline and privilege termination actions still result, with some frequency, in litigation. Disciplined physicians may bring a variety of claims (e.g., antitrust, breach of contract, tortious interference with business relationships, defamation, civil rights violations, etc.) against hospitals and the peer review participants, who are primarily physicians. It was in response to the perceived chilling effect on peer review participation because of the threat of litigation that Congress passed the Health Care Quality Improvement Act ("HCQIA") in 1986.[1] In passing the HCQIA, Congress made the following findings regarding the necessity for and purpose of the HCQIA:

- The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become national problems that warrant greater efforts than those that can be undertaken by any individual state.
- There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.
- The nationwide problem can be remedied through effective, professional peer review.
- 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.
- There is an overriding national need to provide incentive and protection for physicians engaging in effective, professional peer review.

There is a second part of the HCQIA that is perhaps of even greater interest to emergency physicians: the reporting requirement. This section provides that adverse professional review actions by hospitals and payments made in settlement of malpractice

claims, whether through insurance, self-insurance, or otherwise, must be reported to the National Practitioner Data Bank.[3] The operation of the National Practitioner Data Bank, including details as to what peer review actions must be reported and how, will be covered in a subsequent issue of *ED Legal Letter*.

Immunity

The first substantive section of the HCQIA provides immunity for peer review participants, a sign of the importance Congress placed on the provision of immunity. It is through this provision of immunity that Congress sought to combat the reluctance of physicians to police their profession effectively and to encourage physician participation in the peer review process. This section is, in the eyes of physicians, perhaps the most important section of the HCQIA, whether they participate as peer reviewers and want the immunity protection or are the subject of a peer review action and seek to obtain damages from the participants. If a professional review action (as defined in the HCQIA), taken by a professional review body, meets all the procedural safeguards listed in section 11112(a) of the HCQIA **(discussed below in the Standards for Professional Review Actions section, pg. 41)**, limited immunity is provided to the participants in the peer review process.[4]

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The participants in the peer review process are immune from damages under any law of the United States or of any state with respect to the peer review action. This immunity applies to: 1) the professional review body; 2) any person acting as a member of or staff to the body; 3) any person under a contract or other formal agreement with the body; and 4) any person who participates with or assists the body with respect to the action.[5] This seemingly broad grant of immunity, however, refers only limited immunity, and there are important exceptions. Because the immunity is not absolute, expensive, and sometimes protracted, litigation may result, which can lead to significant legal expense.

The immunity under the HCQIA is from damages, not from suit. That is, peer review participants who meet the required procedural safeguards of the HCQIA are immune from a money judgment (i.e., they cannot be made to pay if the plaintiff physician wins his or her lawsuit). There is, it is now clear, no immunity from being sued. While Congress intended courts to "address the immunity issue well before trial"[6] and, thereby dispose of many, if not most, cases by summary disposition at an earlier stage, this is not always the case. Depending on the judge hearing the case, these lawsuits may be allowed to proceed well into discovery, even to trial. Second, there is no immunity to damages for claims brought under any law, federal or state, relating to civil rights.[7] Therefore, if the plaintiff physician can state a prima facie case for discrimination protected by a federal or state civil rights statute, not only may the suit proceed, but the peer review participants may be liable for money damages should the plaintiff prevail. Finally, in order for the peer review participants to be immune, the affected physician must have been provided all the procedural safeguards listed in the HCQIA, at least substantially.

Case #1. In *Manion v Evans*,[8] the Court of Appeals for the Sixth Circuit addressed the issue of whether the immunity provided for in the HCQIA included a "right not to stand trial." A previous Supreme Court case, in a different context, had suggested that "qualified immunity" was "immunity from suit rather than a mere defense to liability."[9] Dr. Manion's privileges in pathology had been suspended by the hospital based upon allegations of incompetency. After exhausting his right to a hearing and appeal under the medical staff bylaws, Dr. Manion brought suit in federal district court, raising an antitrust claim and various state law causes of action. Further factual details are not relevant to the primary issue in the case (i.e., whether the immunity of the HCQIA allowed the defendants to avoid standing trial).

The court first looked to the plain language of the HCQIA, noting that the statute does not provide for "immunity from suit;" rather, it provides that "if a professional review action meets the Act's standards, the peer review participants 'shall not be liable in damages.'"[10] Next, the court examined the legislative history of the

HCQIA, which was contained in the House Committee Report. In this report, the House Committee stated that, "as redrafted, the bill [HCQIA] now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill."[11] A previous version of the HCQIA had contained a more complete grant of immunity. There were, however, other portions of the House Committee Report that rendered the report, in its entirety, somewhat ambiguous on this issue.

With the legislative history unclear, the court held that the statutory language made it clear only that immunity from damages was intended. Nothing in the statute made it sufficiently clear that the statute was intended to provide immunity from suit (i.e., freedom from standing trial). The result, then, is that if the procedural protections of the HCQIA are provided to the physician, he or she may sue the hospital and the physicians participating in the peer review process. If the plaintiff physician prevails, however, he or she may only obtain injunctive relief (e.g., restoration of privileges), not money damages. The defendant physicians will be protected from paying damages, but not from the potentially significant costs of defending the suit. Remember also, the qualified immunity of the HCQIA does not extend to suits brought "under any law of the United States or any state relating to the civil rights of any person or persons . . . "[12] Because of this exception, many of the reported cases involve an allegation of a civil rights violation.

Commentary. *In addition to the immunity provided to peer review bodies and the individuals participating therein, near complete immunity is provided to individuals who provide information to professional review bodies.[13] In contrast to the limited immunity described above that protects the actual participants in the peer review process, individuals providing information to a peer review body receive complete immunity, so long as they do not knowingly provide false information to the peer review body. This immunity is not just from damages, it also includes immunity from being sued.*

There is a final exception from the immunity provisions of the HCQIA.[14] If the Department of Health and Human Services (HHS) has reason to believe that a health care entity has failed to report information as required under the HCQIA, the secretary is required to provide the entity notice of the noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing. If the secretary of HHS then determines that the health care entity has failed substantially to report as required, the secretary will publish the name of the entity in the Federal Register. In addition, the entity will lose its immunity for a three-year period, beginning 30 days after publication of the entity's name.

Case #2. This case illustrates the standard that courts generally apply in determining whether the peer review committee and its participants acted reasonably.[15] The court in this case noted that, under the provisions of the HCQIA, a physician challenging a peer review process "must prove, by a preponderance of the evidence, that the [peer] review process was unreasonable." The burden of proof as to this issue is on the plaintiff.

The physician, a surgeon, had recently been granted provisional staff membership and privileges at the hospital in accordance with the relevant medical staff bylaws. Soon thereafter, he performed an abdominal aortic aneurysm (AAA) repair and, during the course of the surgery, the patient allegedly suffered a number of visceral injuries and died on the operating table. Over the next two years there were a number of other significant incidents, including a number of unexpected patient deaths. As a result of these incidents, the hospital extended the physician's provisional status rather than promoting him to an attending staff position. Later, the physician's quality of care in the treatment of AAAs was both reviewed internally and by an outside reviewer. Both of these reviews were very critical of the physician's practice.

The physician's AAA repair privileges were suspended by the hospital after completion of the outside reviews. Soon thereafter, all of the physician's privileges were suspended. He exercised his right under the medical staff bylaws to a hearing at which he was represented by an attorney. The hearing committee recommended that the adverse actions be upheld, and the physician appealed the adverse recommendation of the hearing committee, again as provided in the medical staff bylaws. The appeal panel recommended that the physician's AAA privileges remain suspended but that his other privileges be restored. Finally, the hospital's governing board ultimately decided that the physician should be allowed to perform AAAs under the supervision of a more experienced surgeon and agreed that his other privileges should be restored.

The physician brought suit against the hospital and the heads of the department of surgery and the section of cardiothoracic surgery. The trial court granted summary judgment for the defendants, and the physician appealed to the Court of Appeals for the Third Circuit.

Commentary. *Our interest in this case is in how the appellate court handled the issue of immunity under the HCQIA, and, particularly, whether the reviewers acted reasonably. The court, like other appellate courts that have addressed this issue, adopted an objective standard of reasonableness. Under this standard, the issue is whether it would have been reasonable for "reasonable" reviewers to have concluded as did the panel in this case, given the information available to them at the time they made their decision. The court stated that, under this standard, "the good or bad faith of the reviewers is irrelevant."[16] The good or bad faith of the particular reviewers would have been relevant had the court decided on a subjective stan-*

dard of reasonableness, in which the motives of the reviewers would have been considered as well as potential biases and other subjective factors.

This objective standard of review, which appears to have been what Congress intended, has been adopted by all circuits, with one partial exception. In a 1996 case, the Court of Appeals for the Tenth Circuit seemed to allow a somewhat subjective standard when it held that a reasonable jury could have found the panel's review to have been "unreasonably restrictive and not taken after a reasonable effort to obtain the facts."[17,18] This was based on the plaintiff physician's expert who testified at trial that he disagreed with the determination made by the hearing panel, yet never opined that reasonable reviewers could not have reached the conclusion that the hearing panel had reached. The latter should really be the issue if a truly objective standard is used.

Case #3. No discussion of peer review immunity would be complete without addressing *Patrick v Burget*, the case that continues to terrify many physicians who have been asked to review and, possibly, participate in the discipline of a physician colleague.[19] The jury in *Patrick v Burget* returned a verdict against the defendant physicians, assessing damages of $650,000. Because the court is required by law to treble antitrust damages, the total damages were nearly two million dollars. Before panicking, it is important to look at the facts of the case.

First, the immunity of the HCQIA (which includes antitrust immunity) was not available to the defendants in *Patrick v Burget* because the events in the case occurred well before the passage of the HCQIA, and the act was not retroactive. Second, as in *Brown v Presbyterian Healthcare Services*, mentioned above and discussed below, *Patrick v Burget* can be used as an outline as to how *not* to conduct peer review. In *Patrick v Burget*, the events occurred in a small town in Oregon where there was only one hospital. The majority of the members of the medical staff were employees or partners of the Astoria Clinic, a private group medical practice in town. A small community with one hospital and a dominant private physician group should always prompt caution. The plaintiff, Dr. Patrick, was originally an employee of the Astoria Clinic, but when invited to become a partner, he declined and began an independent practice in competition with the surgeons at the Astoria Clinic.

After Dr. Patrick established his independent practice in general surgery, the physicians of the Astoria Clinic essentially boycotted him and "refused to have professional dealings with him."[20] The clinic doctors referred patients to physicians as far as fifty miles away rather than to Dr. Patrick and often declined to consult on his patients. Dr. Patrick received virtually no referrals from the physicians at the Astoria Clinic, despite the fact that, at times, the clinic had no general surgeon on its staff.

At the request of one of the Astoria Clinic surgeons, a review of Dr. Patrick's practice was initiated by the hospital's medical executive committee. The committee was chaired by another of the Astoria Clinic physician partners. The medical executive committee recommended that Dr. Patrick's privileges be terminated because he allegedly failed to practice up to the standard of care at the hospital. While there appears to have been little, if any evidence to support this decision, there was ample evidence that the peer review process was influenced, if not dominated, by physicians from the Astoria Clinic, Dr. Patrick's former employer. In addition, there was evidence that there had been considerable anti-competitive activity by these same physicians, and the Astoria Clinic in general, against Dr. Patrick, which was not related to quality-of-care issues.

Commentary. *There is absolutely no reason for peer review participants to end up in the same situation as the defendants in* Patrick v Burget *and, therefore, no reason for others to be terrified by the verdict and judgment in the case. First, there seemed to be a significant likelihood that the actions of the peer reviewers in* Patrick v Burget *actually were based on anti-competitive animus, not quality-of-care issues. Peer review should always be based on professional competence and conduct and never on economic issues. Second, always use an objective outside reviewer if there is even an appearance that the medical staff members performing the peer review might be biased for any reason. It is never a bad idea to use an objective outside reviewer; it is often a bad idea not to. If the peer review process maintains the procedural safeguards of the HCQIA, the medical staff bylaws are followed, and physicians with possible bias are kept out of the process, there is no reason to fear the Patrick result.*

It is important to point out that it is not always possible, or even desirable, to eliminate all economic competitors from the peer review process. There are, in fact, cases where physicians have complained that the reviewers were not in the physician's specialty.[21] Particularly at the initial review stage, peer review essentially requires that physicians in the same specialty perform the review. These physicians, if they are in the same community, will likely be in direct economic competition with the physician who is subject to the review. There are numerous reported cases of direct economic competitors participating in the peer review process and the courts finding the procedure to be fair. However, if direct economic competitors participate in the review of the physician, and an adverse recommendation is made, it is always a good idea to have a corroborating review by an objective, outside reviewer or reviewers. While economic competitors may, of necessity, participate in the initial review of a physician, they should never participate in any subsequent hearing or appeal of an adverse recommendation.

Standards for Professional Review Actions

In order for a peer review entity and its participants to receive the immunity protections of the HCQIA described above, the professional review action must conform to specific standards.[22] These standards require that the 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 adequate notice and hearing procedures.[23]

The procedures that must be followed such that the requirement of adequate notice and hearing procedures will have been satisfied are specified in the HCQIA.[24] First, the affected physician must be provided notice of the proposed action. Such notice must include: 1) that a professional review action has been proposed to be taken against the physician; 2) the reasons for the proposed action; 3) that the physician has the right to request a hearing on the proposed action; 4) any time limit (not less than 30 days) within which to request such a hearing; and 5) a summary of the rights in the hearing.[25] Second, if a hearing is requested on a timely basis, the physician involved must be given notice stating: 1) the place, time, and date of the hearing, which shall not be less than 30 days after the date of the notice; and 2) a list of the witnesses, if any, that are expected to testify at the hearing on behalf of the professional review body.[26]

Finally, certain basic requirements as to the conduct of the hearing are specified. If a hearing is requested on a timely basis, the hearing should be held: 1) before an arbitrator mutually acceptable to the physician and the health care entity; 2) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved; or 3) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved.[27] The right to a hearing may be forfeited if the physician fails, without good cause, to appear. At the hearing, the physician must be provided the right: 1) to representation by an attorney or other person of the physician's choice; 2) 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; 3) to call, examine, and cross-examine witnesses; 4) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law; and 5) to submit a written statement at the close of the hearing.[28] Upon completion of the hearing, the physician involved must have the right: 1) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations; and 2) to receive a written decision of the health care entity, including a statement of the basis for the decision.[29]

Failure to meet the required conditions for the notice and hearing does not, itself, prevent a peer review body from receiving the benefit of the immunity of the HCQIA. The HCQIA provides that there shall be a presumption that a professional review action meets the required standards and, therefore, the participants are granted immunity. This presumption may be overcome by a preponderance of the evidence, the burden of proof being on the plaintiff.

It is also important to note that all of these detailed notice and hearing requirements do not necessarily have to be met to receive the immunity of the HCQIA. The act allows for these notice and hearing procedures, "or after such other procedures as are fair to the physician under the circumstances."[30] It is, however, always a good idea to provide at least the procedural steps delineated in the HCQIA, as this will operate as somewhat of a "safe harbor" for the peer review participants. There is no reason to put yourself into the position of having to defend why you deviated from the suggested procedure.

It is extremely important that physicians participating in peer review activities that might lead to an adverse action against a physician be certain that they are operating according to the medical staff bylaws. These medical staff bylaws always should be reviewed by hospital counsel for the purpose of determining whether they conform with the requirements of the HCQIA. Procedural due process that exceeds the requirements of the HCQIA may be provided; however, the procedures should never fall below the standards of the HCQIA. In addition, hospital counsel should be involved early in any peer review process when it is anticipated that the result may be an adverse recommendation regarding a physician. The groundwork for an early motion for summary judgment for the hospital and reviewing physicians, should the physician sue, must be carefully laid during each phase of the peer review process.

Case #4. Failure to consult with counsel during the peer review process can have disastrous consequences in subsequent litigation. The Brown case, mentioned above in the context of HCQIA immunity, illustrates the potential consequences of proceeding without the advice of experienced counsel. In *Brown v Presbyterian Healthcare Services*, the physician's obstetrical privileges were revoked, allegedly at the instigation of a competitor on the medical staff and with the assistance of the hospital's administrator. The purported grounds for the revocation was a failure to abide by a previously imposed consultation requirement in high-risk obstetric cases. This consultation requirement had been imposed after a review of just three cases. A later cursory review of only two cases at a medical staff hearing resulted

in a determination that the physician had failed to comply with the consultation requirement. The hearing committee then recommended that the physician's obstetric privileges be revoked, a recommendation that was later adopted by the hospital board.

In the subsequent litigation, the physician retained an expert who, after reviewing all her obstetric cases for the six months prior to revocation of her privileges, opined that the consultation requirement had been unwarranted and the sample relied upon by the hearing committee in recommending revocation of privileges (two cases) was too small to support the committee's conclusion. The Court of Appeals for the Tenth Circuit upheld the trial court's ruling that whether the defendants had acted reasonably was a question of fact for the jury. Other circuits had held that this was a question of law (i.e., for the judge, not the jury). In *Brown v Presbyterian Healthcare Services*, the jury ultimately awarded the plaintiff physician $500,000, which the judge was obliged to triple under the Sherman Act to $1.5 million.

Commentary. *The* Brown v Presbyterian Healthcare Services *case provides an excellent illustration of exactly how not to conduct peer review proceedings. Courts generally are quite deferential to hospital peer review bodies. There are, however, limits. In* Brown v Presbyterian Healthcare Services*, the court noted that "the jury heard evidence at trial that tended to show Dr. Williams, a competitor of Dr. Brown, and Teresa McCallum, a nurse who had made anti-semitic remarks about Dr. Brown in Dr. Williams' presence, were responsible for identifying all five of Dr. Brown's charts that were reviewed during the two peer review proceedings. Dr. Williams authored the criticisms that Ms. Miller sent to the outside reviewing physicians, and she testified against Dr. Brown at the revocation peer review proceeding. Ms. Miller asked Dr. Williams to prepare the summary of criticisms that were attached to the cases sent to the outside reviewing physicians even though Dr. Brown had complained to Ms. Miller about a personality conflict between Dr. Williams and Dr. Brown. Furthermore, Ms. Miller instituted the formal peer review proceedings against Dr. Brown by sending a complaint to the Medical Staff Executive Committee, she presented the 'hospital's position' at the formal review proceeding, and she served on the Board of Trustees.*

"Thus, the record is replete with evidence tending to show Ms. Miller and Dr. Williams were the catalysts behind, or played a crucial role in, every step of the proceedings against Dr. Brown. Viewing the entire evidence in the light most favorable to Dr. Brown, we believe a reasonable jury could have concluded that Dr. Williams and Dr. Brown (sic) [the court meant Dr. Williams and Ms. Miller] controlled, coerced, or unduly influenced the decision making process."[31]

It should be obvious that peer review should be based on an adequate sample of charts and that those charts should be selected in a random fashion by a disinterested person. While it may well be reasonable to initiate a peer review proceeding based on a small number of cases or, in certain circumstances, even a single case, it is seldom reasonable to conduct an entire peer review proceeding on only a handful of cases. This is not, however, to say that it is never appropriate to summarily suspend a physician's privileges based on a single case. In certain situations, as discussed below, this may be appropriate.

Summary Suspension

The normal procedure outlined in the HCQIA for peer review proceedings is that an affected physician be provided adequate notice and a right to a hearing prior to any peer review action becoming final. This is important because only final actions are required to be reported to the National Practitioner Data Bank and, generally, an action will not be final until the entity's governing body (e.g., the hospital board) adopts the adverse recommendation. The HCQIA does provide for an exception to the prospective notice and hearing requirement in situations where a failure to take immediate action (i.e., a summary suspension) may result in an imminent danger to the health of an individual.[32] In such cases, a physician may be summarily suspended provided he or she is given notice and an opportunity for a hearing, in this case, after the action was taken.

In the case of a summary suspension, it is advisable that the medical staff bylaws provide for an expedited review of the suspension by the medical executive committee or other appropriate body. This will, in retrospect, make the summary action more defensible if it was taken by a single person (e.g., the chief of staff or the hospital administrator).

Recovery of Attorneys Fees

The HCQIA allows defendants to recover their reasonable attorney fees from the plaintiff physician under certain circumstances. However, physicians participating in peer review should always make sure that the hospital will not only indemnify them for any possible damages, but will also pay their attorney's fees. The standard for recovering attorney's fees is high and difficult to meet. In order to recover attorney's fees, the defendants must show that the plaintiff's claim was "frivolous, unreasonable, without foundation, or in bad faith."[33] Because of this high standard, the recovery of attorney's fees is unlikely. Therefore, it is prudent that peer review physicians obtain an agreement in writing that the hospital will cover all attorney's fees.

Case #5. *Johnson v Nyack Hospital* provides an example of how difficult it is for defendants to prevail on a motion for attorney's fees.[34] In this case, the physician was

a member of the section of thoracic and vascular surgery and had privileges to perform vascular and thoracic surgery. The newly appointed head of the section of thoracic and vascular surgery, together with the director of the department of surgery and the hospital administrator, decided to conduct a quality review of all cases performed by section members. There was, at this point, no focus of attention on Dr. Johnson. After performing this review, the section head concluded that Dr. Johnson's care "fell below minimally acceptable standards" and "recommended . . . the revocation of Johnson's medical staff privileges to perform thoracic and vascular surgery."[35] Prior to taking further action, the hospital arranged for an independent, outside review by two experts in thoracic and vascular surgery. These two experts, "in separate and independent reports, also found that Johnson provided substandard care."[36] The hospital's credentials committee then recommended the revocation of Johnson's privileges, and, subsequent to that, the medical executive committee adopted this recommendation on a vote of 22-1. After all these procedural steps were completed, the revocation of Dr. Johnson's privileges became effective.

Dr. Johnson requested a hearing pursuant to the medical staff bylaws, and, after a hearing at which Dr. Johnson was represented by counsel, the hearing officer concluded that Dr. Johnson's "privileges to practice vascular surgery and thoracic surgery should be revoked."[37] Upon appeal to the hospital's joint conference committee, Dr. Johnson claimed possible bias on the part of the hearing officer. In response to this complaint, the hospital offered Dr. Johnson another hearing before a different hearing officer. Dr. Johnson eventually refused and filed a lawsuit against the hospital and various physicians who participated in the peer review process.

Commentary. *The purpose of this long recitation of the facts in this case is to demonstrate the care with which the hospital followed its medical staff bylaws and the extensive procedural due process provided to Dr. Johnson, all of which met, if not exceeded, the requirements of the HCQIA. At each stage in this process, including independent, outside reviews by two experts, the result was unequivocally that Dr. Johnson's privileges should be revoked. Despite what seems to have been a completely fair process, with more than adequate provision of procedural fairness to Dr. Johnson, and no equivocation at any step along the way, the court refused to grant the defendants' motion for attorney's fees. The court found that the defendants had failed to sustain their burden for the award of attorney's fees (i.e., that the complaint was "frivolous or entirely without foundation").*[38] *Bottom line: Do not count on an award of attorney's fees no matter how fairly you have treated the disciplined physician; get an agreement in writing from the hospital to indemnify any judgment and to cover all attorney's fees.*

Peer Review Do's and Don'ts

Do's

1. Always work closely with hospital counsel in conducting peer review proceedings and especially when preparing critical reports or recommending adverse action.
2. Make sure that the hospital considers you to be its agent in participating in the peer review process and that you are covered by the hospital's insurance policy or that you are otherwise indemnified against loss and legal expenses should litigation result.
3. If you are ever the subject of a focused, in-depth review, or other potentially significant peer review of your practice, consult with experienced counsel immediately.
4. Consider the use of an outside reviewer when conducting peer review of a physician so as to avoid the involvement of direct economic competitors of the physician in the review process.
5. Review the procedures to be utilized during peer review, especially at the hearing or appeal stage, with counsel before proceeding. A handbook of procedure prepared by knowledgeable counsel can be extremely helpful.
6. Consult with hospital counsel prior to submitting a final written report, no matter the stage of peer review. Defending the fairness and appropriateness of the peer review process is much more difficult if there has been inconsistency or ambiguity in the reports generated.
7. Make sure any peer review involves a fair sample of medical records that have been objectively selected.
8. Avoid summary suspension unless the failure to take such an action may result in an imminent danger to the health of any individual.
9. Always consult with hospital counsel before any summary suspension.

Don'ts

1. Don't be ambiguous when writing peer review reports. Ambiguity simply plays into the hands of the physician's attorney should a lawsuit result.
2. Don't fail to accept your responsibility to participate in peer review.
3. Never talk to the attorney for the physician being reviewed without having hospital counsel present.
4. Don't deviate from the medical staff bylaws without first consulting with hospital counsel.
5. Don't allow direct economic competitors of the physician being reviewed to inappropriately influence peer review proceedings.
6. Don't allow direct economic competitors to participate at the hearing or appeal stage of a peer review proceeding.

Conclusion

Physicians have a responsibility to the public, their profession, and, most importantly, to themselves to participate in effective peer review. There are, to be sure, risks of lawsuit to those who "step up to the plate" and accept the responsibility to police our profession. However, if we fail to do so, we can only expect that someone else will do it for us, whether it will be the hospital, managed care organizations, or government agencies. The risks of peer review participation are low if proper procedures are used (in particular, strict adherence to the procedural provisions delineated in the medical staff bylaws). Hospital counsel should review the medical staff bylaws to ensure that the procedures provided therein are adequate. Finally, it is crucial to involve hospital counsel early in peer review matters. A little time spent with counsel at the early stages can help to avoid what can become extremely expensive and protracted litigation later.

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11. H.R. Rep. No. 903, 99th Cong., 2d Sess. (1986).
12. 42 U.S.C. § 11111(a)(1).
13. 42 U.S.C. § 11111(a)(2).
14. 42 U.S.C. § 11111(b).
15. *Brader v Allegheny General Hospital*, 1999 U.S. App. LEXIS 2203, (3rd Cir. 1999).
16. Id. at *10.
17. *Brown v Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996).
18. Id. at 1334.
19. 486 U.S. 94 (1988).
20. Id. at 96.
21. See, e.g., *Imperial v Suburban Hospital Association*, 37 F.3d 1026 (4th Cir. 1994).
22. 42 U.S.C. § 11112.
23. 42 U.S.C. § 11112(a).
24. 42 U.S.C. § 11112(b).
25. 42 U.S.C. § 11112(b)(1).
26. 42 U.S.C. § 11112(b)(2).
27. 42 U.S.C. § 11112(b)(3)(A).
28. 42 U.S.C. § 11112(b)(3)(C).
29. 42 U.S.C. § 11112(b)(3)(D).
30. 42 U.S.C. § 11112(a)(3).
31. *Brown*, 101 F.3d at 1335.
32. 42 U.S.C. § 11112(c)(2).
33. 42 U.S.C. § 11113.
34. 773 F.Supp. 625 (S.D.N.Y. 1991).
35. Id. at 627.
36. Id.
37. Id at 629.
38. Id. at 631.

CME Questions:

30. The Health Care Quality Improvement Act provides:
    a. limited immunity to peer review participants.
    b. a requirement that adverse peer review actions be reported to the National Practitioner Data Bank.
    c. possible recover of attorney's fees by defendants.
    d. All of the above

31. Health Care Quality Improvement Act immunity:
    a. applies to all physicians on the medical staff.
    b. applies to physician participants in the peer review process provided certain procedural requirements are met.
    c. is total immunity.
    d. None of the above

32. When conducting peer review:
    a. direct economic competitors should never participate.
    b. outside reviewers may be utilized.
    c. summary suspension is never allowed.
    d. All of the above

33. Hospital counsel should be involved in:
    a. review of medical staff bylaws to ensure compliance with the Health Care Quality Improvement Act.
    b. at an early stage in peer review proceedings.
    c. in writing peer review reports.
    d. All of the above

In Future Issues:

Operation of the National Practitioner Data Bank