The Health Care Quality Improvement Act of 1986 and Physician Peer Reviews: Success or Failure?

By: Bryan G. Hall

The Master Said to Narendra:
"Have you become an experienced physician?"
Quoting a Sanskrit verse he said, "He who has killed only
a hundred patients is a novice in medicine;
but he becomes an expert after killing a thousand."
- Ramakrishna

Abstract

In the early 1980's, in response to numerous newspaper articles reporting cases of physician ineptitude, the medical community increased its efforts to limit the practice of incompetent physicians through the implementation of professional peer review and credentialing procedures for a physician's obtaining of hospital privileges and membership. However, as the decade progressed, the success of the peer review process became hindered by an increase in lawsuits filed by the disciplined physician against the individual review committee and hospital.

In response to this increase in litigation, the Health Care Quality Improvement Act (HCQIA) of 1986 was passed by Congress with the expectation that it would help protect hospitals and individual's participating on medical peer review committees from potential liability in the form of money damages after the revocation of a physician's hospital privileges. The Act has established standards for the hospital peer review committees, provides immunity for those involved in peer review, and has created the National Practitioner Data Bank, a system for reporting physicians whose competency has been questioned or when the physician has been sanctioned.

The effect of HCQIA on many of those that have been on the receiving end of a bad faith peer review committee has been unjust and unfair. Critics argue that the HCQIA helps foster an environment in the

medical community that, instead of promoting the goal of quality health care in America, allows the peer review process to be perverted for political and economic motives. This report will analyze the current peer review process and the importance of hospital privileges, the standards and immunity provided by the Health Care Quality Improvement Act, as well as a critique of the Act regarding its protection of bad faith or malicious peer review committee. This report will also offer some suggested remedies in order to ensure a more equitable and just peer review system and thus help realize the primary goal of the Act, the implementation of the best quality health care system possible.

Introduction

The doctor "under the microscope." Such is the position felt by many physicians who are scrutinized by hospital peer review committees. It is argued by some that due to state law and the passage of the Health Care Quality Improvement Act of 1986, medical peer review committees have become prone to misuse by those with a vendetta or dislike for the reviewed physician, and thus the primary purpose of the Act – to attempt to guarantee the best quality health care system possible - has become tainted and perverted. As children, we are told that "sticks and stones may break your bones, but words will never hurt you." However, this sentiment is untrue in the professional world, where negative words, justified or not, that are reflected in a medical peer review can potentially have a horrible effect on a physician's reputation and adversely affect his or her professional and economic opportunities.

A hypothetical case has been advanced: Dr Amelia Adams, fresh from medical school and a successful residency, began her profession as a cardiologist with an established health maintenance organization (HMO). [1] While working hard as the third member of the team of cardiologists,

Dr. Adams began to realize that the training of the other doctors was out of date, by much as twenty years.[2] As a way to help her colleagues, without embarrassing any of the older physicians by pointing out their outdated methods, Dr. Adams began an informal training program on the new trends and techniques in cardiology.[3]

However, the senior cardiologist felt the new techniques were too expensive, and they were summarily rejected.[4] Disappointed and discouraged at the decision, Dr. Adams became very blunt in expressing her disappointment, and as a result of her outspoken attitude, Dr. Adams began to be viewed as a threat by the senior medical staff.[5] Indeed, other cardiologists began to refuse to do rounds on her patients, and began to spread false rumors as to her competency – and ultimately, the senior physician publicly ridiculed her for an isolated incident concerning a procedure that Dr. Adams had completed that had led to nonfatal complications for the patient.[6]

Later, Dr. Adams was confronted by the senior staff and was asked to resign her position in the department; she refused to voluntarily resign, and was subsequently threatened with an ad hoc peer review investigation - the word that was used to describe the action to take place was "screw-tinized."[7] The only option given to her was a "transfer" to a lower paid position in the internal medicine department, and Dr. Adams, unwilling to accept this offer, tried to relocate and seek employment as a cardiologist at other institutions.[8] However, her attempts failed. She was advised that until the problems she had at the HMO were dealt with, she would not be able to move.[9] Upon reapplying

for her cardiology privileges at the HMO, the incident concerning the nonfatal complications was brought up, and the doctor's report to the executive committee described her work as "below the acceptable standards."[10] Unfortunately, the senior staff's bad behavior in this case is not limited to the world of the hypothetical.

One only has to look at the recent case involving Dr. Kenneth Clark to realize that, unfortunately, bad faith peer reviews are not limited to hypothetical situations. While working as a psychiatrist with staff privileges at the Truckee Meadows Hospital, Dr. Clark had concerns that the hospital was not following appropriate procedures on a wide variety of care.[11] His concerns included the providing deficient child psychiatric care, the hospital's policy of premature patient discharge once the patient's insurance lapsed, as well as the hospital's use of his superb credentials to improperly qualify an affiliate hospital for accreditation, even though Dr. Clark did not work there.[12]

In order to correct these deficiencies, and to bring government attention to the problems, Dr. Clark wrote a series of letters to the federal insurance provider CHAMPUS, JCAHO, and the Nevada State Board of Medical Examiners.[13] In response to Dr. Clark's actions of going outside of the hospital's administration, a peer review meeting was held which determined that Dr. Clark's actions were disruptive, and would "eventually have an adverse impact on the quality of health care at the hospital" and subsequently terminated his physician privileges at Truckee Meadows Hospital.[14]

Dr. Clark took his case to court, and faced the uphill battle of

proving that the termination of his hospital privileges was excluded from the protection of HCQIA.[15] Finally, however, the Supreme Court of Nevada held that the hospital's actions were not entitled to HCQIA immunity because the terminating of Dr. Clark's hospital privileges was due to his activities as a whistleblower, and that the termination was not "in the reasonable belief that the action was in furtherance of quality health care."[16] Indeed, the court went on to state that it was the physician in this case who attempted to improve the quality of health care at the hospital by reporting improper conduct.[17]

Unlike many other physicians in his position, Dr. Clark was able to rebut the presumption that the peer review was fair – it was a rare victory for doctors who are maligned and have their reputations slandered due to bad faith or malicious peer reviews. But what about the countless cases similar to the hypothetical Dr. Adams, and others who are not able to overcome that presumption due to a system that is skewed toward granting immunity to peer review committees at the sake of professional healers reputations and livelihoods?

Statement of the Issue

While the passage of the Health Care Quality Improvement Act of 1986 was passed with the intention of promoting the best quality health care system, it has subsequently had some unintended negative affects. Specifically, the peer review immunity and the limits on discoverability provided by the Act contribute to allowing peer review members to engage in arbitrary, bad faith, or malicious peer review hearings without fear of successful reprisal by the unjustly disciplined physician. In

addition, the Act's implementation of the National Practitioner Data Base has created the opportunity for unjust negative publicity and damage to the reputations of those physician's that are on the wrong end of a bad faith or malicious peer review.

Analysis

I. Physician Peer Review and Hospital Privileges

In the 1980's, the health care profession increased its efforts to limit the practices of incompetent physicians through the promotion of credentialing and professional peer review.[18] To sustain the honor of a physician's practice, an intricate system of peer evaluation has evolved, and this system provides for the review and critique of physicians who may be perceived as damaging to the profession of physicians.[19] Generally, state licensure and accreditation standards require hospitals, as well as a few other health care entities, to examine and evaluate the competency and quality of care provided by physicians who have, or are requesting, hospital privileges.[20] The Joint Commission on Accreditation of Health Care Organizations (JCAHO) has defined hospital privileges as the "permission to provide medical or other patient care services in the granting institution, within well-defined limits, based on the individual's professional license and his experience, competence, ability, and judgment."[21]

There are essentially two situations in which hospitals have determined the clinical competency of physicians; either when a physician first applies for medical staff membership and privileges, or when each physician who is already a member of a medical staff is required to

periodically apply for reappointment for membership and privileges.[22] The established procedures for conducting a peer review is generally found in the hospital's bylaws, and provides that the hospital is required to engage in continuous clinical evaluation and monitoring of its physicians, as well as those applying for privileges.[23]

A review will primarily consist of a thorough assessment of the physician's records of surgeries and other performed procedures, in order to search for erroneous diagnoses, unnecessary procedures, and other errors.[24] Once the review is completed, the members of the review committee will forward their recommendations to the hospital's governing board to either grant, reinstate, or deny hospital staff privileges, or to make recommendations on any appropriate disciplinary measures if the physician's clinical performance was viewed as substandard or dangerous to patients.[25]

Many view the medical peer review process as highly beneficial for the hospital, physicians, and the community as well, stating that its intended results are that hospitals hire and retain only competent physicians; physician's benefit by obtaining medical and educational review of their work, and upon obtaining privileges, are given access to operating facilities, medical equipment, and support staff; and that the community benefits by having access to the highest quality of physicians and medical services.[26] A physician's right to access a hospital once the physician has been granted privileges to admit patients and to use the hospital's resources is essential for the success of the physician's practice.[27]

In today's technical and complex world, it is very rare and almost impossible for a physician to have a financially successful practice without hospital privileges.[28] Indeed, with the increasing technology and support services that only hospitals can usually afford (such as patient wards, staffed operating rooms, and medical equipment), it is imperative that physicians obtain hospital privileges; consequently, any denial or restriction of a physician's hospital privileges will have a destructive effect on the physician's practice.[29] Yet, to maintain their privileges, physicians must allow themselves to be reviewed by the hospital's peer review committee, and many in the medical community are now concerned that the peer review process is terribly flawed in its conduct and treatment of the reviewed physician.[30] It is argued that federal law, such as HCQIA, as well as state laws have helped promote a peer review process that has minimal concern for the ultimate goal of quality health care, but instead is used as an instrument for political and economic motives, that is, a "review performed in bad faith, or with malice."[31]

II. The Health Care Quality Improvement Act of 1986

As the 1980's wore on, the efficiency and success of the peer review process became mired down as a result of an increase in litigation initiated by the disciplined physician, in many cases alleging antitrust violations by the reviewing hospital.[32] Physicians denied privileges would likely argue that the denial of privileges violated Sections 1 and 2 of the Sherman Antitrust Act, which proclaims illegal "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade,"[33] and that the formation of a monopoly or attempt to form a

monopoly is also a violation.[34] Essentially, the excluded physician will argue that the subsequent restriction on their practice was "the result of the anti-competitive motives of peer reviewers who perform the same services at the hospital or health care entity."[35] The physician denied hospital privileges and claiming a violation of Section 1 of the Sherman Act must prove: an effect on interstate commerce, a conspiracy or combination, and restraint of trade;[36]and if the argument is successful, and it is proven that there was a violation of antitrust law, the individual physicians participating on the peer review committee can be subjected to treble damages.[37]

The defense of these lawsuits was, of course, costly and time consuming; in addition, hospital physicians on the peer review committees began to fear retaliatory lawsuits from those physician's who were denied privileges, which began to limit the effectiveness of the process of "seeking out and dealing with incompetent physicians."[38] Thus, on November 14, 1986, Congress enacted the Health Care Quality Improvement Act of 1986, in order to, among other things, protect those individuals engaged in professional review.[39] Section 11101 of the Act, titled "Findings," establishes the main reasons for the Act's passage:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state.

(2) There is a national need to restrict the ability of incompetent physicians to move from state to state without disclosure or discovery of the physician's previous damaging or incompetent performance.

(3) This nationwide problem can be remedied through

effective professional peer review.

(4) The threat of private money damage liability under federal laws, including treble damage liability under federal antitrust law, unreasonably discourages physicians from participating in effective professional review.

(5) There is an overriding need to provide incentive and protection for physicians engaging in effective professional peer review.[40]

It was the jury verdict of $2.2 million in damages to the reviewed physician in *Patrick v. Burget* that provided the main impetus for the passage of the Health Care Quality Improvement Act.[41] Briefly, in 1972, Dr. Timothy Patrick was a vascular surgeon practicing in the small Oregon community of Astoria, and became a member of the medical staff of the town's only hospital, Columbia Memorial (CMH), and an employee of the Astoria Clinic.[42] In 1973, the partners of the clinic invited Dr. Patrick to become a partner in the clinic; the offer was declined and Dr. Patrick instead started his own competing clinic.[43] In retaliation, the physicians at the Astoria Clinic consistently refused to have professional relations with Dr. Patrick, and as a result Dr. Patrick's clinic was referred virtually no patients, even though the Astoria Clinic at times did not have a general surgeon on staff.[44] Over the following years, the relationship between the Astoria Clinic physicians and Dr. Patrick continued to deteriorate, finally culminating in complete collapse when a partner of the Astoria Clinic initiated peer review of Dr. Patrick in order to terminate his privileges at CMH.[45] The review hearing was held, with the case against Dr. Patrick focusing on only nine out of the 2,000 to 2,500 surgeries that the he had performed while working in Astoria.[46]

Dr. Patrick did not await the conclusion of the hearing and, after claiming that result of the hearing was preordained, and that the executive committee members were not paying attention, he resigned his privileges at the hospital.[47] Dr. Patrick then filed a lawsuit against CMH and the individual physicians, alleging violations of Sections 1 and 2 of the Sherman Act.[48] Upon the completion of litigation, the jury found that Dr. Patrick was the victim of a malicious peer review[49] and that there was an antitrust violation, and thus awarded Dr. Patrick $650,000, which was then trebled by the court.[50] It was in response to this decision, that Congress addressed the issue of encouraging peer review through statutory protections by the enactment of the Health Care Quality Improvement Act of 1986.[51] In fact, Representative Ron Wyden remarked during the introduction of the Act that the jury award in *Burget* was a precise example of the need for legal protection of those physicians who participate in a peer review process.[52] It should also be recognized the in addition to the HCQIA, each state and the District of Columbia has also passed its own peer review statutes that encourage the quality control of physicians practicing in the state.[53]

In essence, HCQIA was passed to address Congress's concern that, without legal protection, physicians would be hesitant to participate on peer review committees as a result of retaliatory antitrust lawsuits initiated by the reviewed physician.[54] The Health Care Quality Improvement Act is comprised of three basic elements: first, it provides immunity from liability any peer review activity that has met due process standards; second, HCQIA mandates that hospitals and insurance carriers report to a national data bank information that relates to the professional

competence of physicians, and thirdly, it requires hospitals to request information from the data bank for all physicians who apply for or have privileges at their institutions.[55]

However, the Act is considered to be more than an antitrust or peer review exemption; its advocates contend that the primary purpose of the Act was "*not* just to *protect* the peer review process, but rather to encourage *more aggressive* peer review to eliminate incompetent medical practice."[56] In fact, it was foreseen by those implementing the Act that the national data bank reporting system would actually increase litigation, thus it was imperative that peer review committees be granted immunity to ensure the vital and honest participation of physicians on those peer review committees.[57] It is important to note that HCQIA does not provide the hospital or physicians with immunity from suit or from civil rights actions, but instead limits their immunity to protection from money damages.[58] Additionally, the Act does not create a cause of action for those physicians who argue that a hospital has violated the Act, and the penalty of a hospital's failure to satisfy the peer review standards set forth in Act is that the peer reviewers lose the immunity from money damages.[59]

a. HCQIA's Peer Review Immunity

Under Section 11111(a)(1) of the Act, the scope of the immunity that the Act provides extends to those individuals participating in the peer review, including the hospital, its governing body, the committee conducting the review, any staff member to the review body, and any person under contract or agreement with the review body, as well as

anyone who assists or participates in the action.[60]

In addition, any witnesses or others, providing information to the review body are also protected, unless the information that was provided is false and individual providing the information knew it was false.[61] Furthermore, there are certain "reasonableness" standards the must be met for HCQIA immunity to apply. In order to qualify for immunity from damages, Section 11112(a) provides that the peer review action must have been taken (1) in the reasonable belief that the action was in furtherance of quality of care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts and after fair procedures were afforded to the physician.[62]

HCQIA also establishes a presumption that the peer review action meets the above criteria, "unless the presumption is rebutted by a preponderance of the evidence."[63] Critics of HCQIA contend that since the peer review committee only has to demonstrate the subjective requirement that a "reasonable belief that the action was warranted," the accused physician has a large hurdle to jump.[64]

b. HCQIA's National Practitioner Data Bank

In addition to providing immunity from damages for hospital members in the peer review process, HCQIA was also enacted to prevent

the ability of incompetent physicians from moving from state to state without revelation or discovery of the physician's prior incompetent or damaging actions.[65] Thus the National Practitioner Data Bank (NPDB) was created, and under HCQIA, hospitals and other health care entities that take professional review action against a physician are mandated to report their actions to the state board of medical examiners, and are subject to sanctions if they fail to do so.[66]

The various types of information that is required to be reported to the state board of medical examiners, who subsequently report to the NPDB, include: (1) any professional review that adversely affects the clinical privileges of the physician for longer than thirty days; (2) the surrender of clinical privileges by a physician while an investigation related to possible incompetence or improper professional conduct is underway; (3) the surrender of clinical privileges by a physician in return for the entity's not conducting an investigation; or (4) in the case of a professional society, a professional review action that adversely affects the membership of a physician in the society.[67]

A physician does have the ability to request from the NPDB the reported information concerning his or her conduct, and may also dispute the information reported by informing the Secretary of Health and Human Services and the reporting hospital, and the physician must also state the reasons for the dispute.[68] If the reporting hospital declines to revise the challenged information, then the Secretary is tasked with the responsibility of either noting the data as "disputed" and offer a statement as to the nature of the dispute, or in the alternative, correct

the information and forward the new report to those entities that have previously made inquiries concerning the disciplined physician.[69]

As will be discussed later, many critics argue that this method of challenging a peer review provides little in the way of correcting the harm done to a physician's reputation in the community. It should also be noted that there are a variety of court cases that extend HCQIA immunity to the actions of a health care entity that complies with the reporting requirements of the Act.[70] For example, in *Bearden v. Humana Health Plans*, where a physician was terminated for not meeting the employer's standard of care, sued for damage to his reputation following the employer's reporting of the incident as required by HCQIA, the court observed that the immunity provisions of the Act extended to the reporting of such conduct.[71]

However, the need for an effective physician peer review and a data bank of incompetent physicians is not disputed. Indeed, there are too many cases of incompetent and disruptive physicians in the medical community to eliminate either the database or the medical peer review system. For example, take the situation that occurred at Trinity Hospital; a middle-aged man arrived at Trinity Hospital complaining of chest pains, he was worried about his health, and expected the hospital to do its best to treat him and ease his worry.[72] Tests were run, and a coronary angiogram indicated the patient had partial blockage in several coronary blood vessels and that he was suffering a heart attack.[73] The man's doctor, looking out for his patient's best interests, requested a consultation with Dr. Magrinat, a cardiologist, who subsequently arrived

at the hospital a few hours later.[74] At this time, both doctors agreed coronary bypass heart surgery was ultimately the best treatment for the patient, but that conducting an immediate balloon angioplasty procedure to relieve the patient's symptoms was also warranted.[75]

To ensure patient safety, hospital policy requires a surgical backup team for balloon angioplasty, unless it is performed as an emergency procedure.[76] Complicating the situation was the fact that there was no backup team was available, yet Dr. Magrinat, who is qualified to perform the procedure, determined an emergency angioplasty was still needed.[77] However, the patient's family signed the appropriate consent forms requiring a backup surgery team for the angioplasty procedure.[78]

Thus, when Dr. Magrinat attempted to obtain the necessary equipment to perform the procedure, a hospital lab technician would not unlock the cabinet which contained the necessary supplies, because the consent documents did not authorize the emergency angioplasty without the surgical backup team.[79] Dr. Magrinat then became, as he said, "very upset."[80] Hospital staff members stated that Dr. Magrinat, in anger, grabbed a telephone receiver from a technician, "striking her in the eye or the face," and bruising her face in the process.[81] Dr. Magrinat then allegedly told the patient, referring to the hospital staff, that "they are going to kill you," and "they are going to let you die."[82] The patient, understandably, responded angrily by telling Dr. Magrinat that he was fired and asked for another cardiologist to perform the procedure.[83]

Of course one would hope that such cases were isolated incidences,

however even just one doctor like Dr. Magrinat dramatically explains why an aggressive peer review process for physicians is required to help remove incompetent physicians and protect the public's health and safety, and why it is important have the National Practitioner Data Bank in order to monitor the movements of incompetent doctors. Indeed, HCQIA has been described as creating a "national net in which to catch incompetent doctors."[84] However, many argue that this "national net" may catch more that it was designed to; for instance, those physician's similar to the hypothetical Dr. Adams, who are denied hospital privileges not because they are bad doctors, but for reasons that are not connected to quality of care issues, such as personal vendettas, and political and economic motives.[85]

Undeniably, it is disturbing to note that even if a physician was able to show that the peer review reached an incorrect conclusion, that error does not itself meet the burden of contradicting the existence of the reasonable belief that the committee was furthering the quality of health care, which is would be required to defeat the qualified immunity under HCQIA.[86] Therefore, despite the best intentions of the Health Care Quality Improvement Act, there are a number of critical flaws in the system that foster an environment of bad faith peer review, which ultimately could harm the reputation of competent physicians.

III. Defects in the Peer Review Process

It is reasonably safe to assume that the majority of peer review committees are honest evaluations of a physician's performance and are not predisposed to the negative targeting and disciplining of a certain

type of physician.[87] However, some critics contend that due to state immunity laws and federal law, it is accurate to suggest that the current peer review process allows peer review members the ability to practice arbitrary peer review with little fear of repercussion.[88] As noted earlier, the consequences of a bad faith peer review can be very harsh for the accused physician. Therefore, it is essential to ensure that peer reviews are fair and impartial. Some of the potential consequences include the loss of hospital privileges, which has already been mentioned as very likely to be disastrous to the success of the physician's practice; the reporting of the physician's name and infraction to the National Practitioners Data Base; the notification to insurance/HMO/Medicare entities; and perhaps most destructive of all, the harm to the physician's reputation in the community.[89]

Indeed, it can be argued that whether or not the disciplinary action of the peer review is overturned, it is wholly foreseeable that the damage to a physician's reputation will have a longstanding effect on the physician's marketability.[90] For example, fellow physicians in the community may hesitate to refer patients to the falsely accused physician, and patients themselves may not feel comfortable with a physician who has an unjustly tarnished or questionable record.[91] Interestingly, it appears that many of the sufferers of bad faith peer reviews share many of the same qualities that can make them an easy target for those seeking to unjustly or maliciously disqualify them.[92] For instance, solo practitioners, typically not having much political support, are frequently the victims of bad faith peer reviews, as are physicians who are new to a staff and have not yet made the necessary

political contacts needed for protection from bad faith peer reviews; and also included in the vulnerable group are physicians who practice procedures that are new or out of the mainstream.[93]

While it is arguable that the peer review process can be efficient and effective only if the individuals involved can participate in an open and honest discussion without fear of retaliatory lawsuits,[94] critics maintain that the current peer review process is highly political and can be easily manipulated to achieve economic or power-driven gains by those on the peer review committees, or by physicians with a personal or professional vendetta against a colleague.[95] In addition, there are few options that an accused physician has regarding a peer review. The Health Care Quality Improvement Act, as well as some state statutes, establishes the procedures that a peer review must follow, and these procedures are incorporated into a hospital's bylaws.[96] Adding to the distortion of the peer review process is the tendency of some hospitals to draft the bylaws for their benefit and protection; including the drafting of provisions that limit a physician's ability to have an attorney at the proceeding.[97]

Such provisions, and others, make it extremely difficult for the disciplined physician to prevail in challenging a peer review decision. In addition, HCQIA itself tends to make it difficult for a disciplined physician to prevail, especially due to its broad "reasonableness" requirements. For example, Section 11112(a)(1) of the Act merely requires that the peer review be taken "in reasonable belief that the action was in furtherance of quality health care."[98] This broad standard enables hospitals to create

options to protect themselves from an antitrust lawsuit, including the drafting of a provision in the hospital's bylaws stating that "the committee's recommendation's to the Hospital Board in no way precludes the Board from exercising its own judgment; or a hospital could rely on pro-competitive justifications."[99]

As a result, such drafting permits a hospital to avoid litigation by "claiming they are doing everything they can to remain objective."[100] Primarily, there are at least two areas that concern critics of the current peer review process: the barrier to the discovery of the deliberations of the peer review committee for use in a civil trial, and the perceived lack of due process available to the reviewed physician.[101]

While a "bad faith" peer review is not protected by HCQIA,[102] in many cases, overcoming the large burden of proving a malicious or bad faith peer review depends upon the physician's ability to obtain the information that was disclosed in the peer review hearing.[103] This issue of the discoverability of peer review hearing documents is one of the primary problems of the HCQIA. There is a split of authority regarding whether Section 11137(b)(1) of the Health Care Quality Improvement Act specifically, or if the Act generally, "creates a federal peer review privilege that will protect documents, statements, or information used in physician peer review from discovery in a civil action."[104]

Furthermore, while this report is focused on the discovery limits of HCQIA, it is important to note that a majority of the states, including South Dakota,[105] have statutes that prevent discovery of peer review proceedings. In a case where the peer review privilege was not found,

the court in *LeMasters v. Christ Hospital* rejected the defendant hospital's claim that the peer review information desired by the plaintiff physician was protected by a peer review privilege under HCQIA.[106] The court's decision was based on state law, which states that the information was discoverable under its laws, and thus, pursuant to Section 11137(b)(1) that the information from the peer review hearing is to remain confidential unless its disclosure is allowed under state law. [107] Therefore, the court held that since the information was discoverable under state law, then HCQIA did not apply and thus the hospital's argument of a federal peer review privilege had failed.[108]

There exists other cases that also hold that HCQIA does not provide a federal discovery privilege that protects peer review information from discovery in a civil lawsuit.[109] However, there are also a variety of cases that do support the existence of a federal statutory privilege under HCQIA.[110] In *Cohn v. Wilkes General Hospital*, a chiropractor brought a federal antitrust claim against the hospital as a result of the denial of hospital privileges.[111] Here, the court held that the plaintiff could not receive the requested information from the defendant hospital's peer review process due to the immunity provisions of HCQIA.[112] Also, in *Wei v. Bonner*, the court there held that the principles behind HCQIA, referring specifically to the Congressional Findings in the Act, as well as the public policy behind the protection of the peer review process as privileged, supported the conclusion that the protection, the court said "in addition to state privilege, there is a federal statutory peer review privilege. 42 U.S.C. § 11137(b)(1). The Act provides that, with some exceptions, information reported under…the Health Care Quality

Improvement Act of 1986 is confidential and cannot be disclosed."[113] However, it is important to note that the court went on to state that while it did find a federal privilege, it would not be applicable in a federal antitrust suit; the court stated that "the legislative history of the statute makes it clear that the statute does not cover a federal antitrust suit. The legislative history indicates that the privilege is qualified rather than absolute."[114]

As mentioned previously, in addition to the federal privilege from discovery of peer review information, there also exists the barriers of state law that the reviewed physician must overcome in order to obtain the information used in the physician's peer review hearing. While some states have made exceptions to the discoverability of peer review information, not all states have done so.[115] In fact, in *Grande v. Lahey Clinic*, the Appeals Court of Massachusetts considered whether the reviewed physician could depose an expert used in a peer review action in a defamation suit.[116] The plaintiff in the case, Dr. Grande, was cleared in the peer review action and subsequently sought to depose the expert who testified at the peer review action to determine if she was aware of any bad faith activity at the hearing.[117]

The court held that the state's non-discoverable peer review protection applied to the expert's testimony, and therefore, Dr. Grande was denied the discovery of any potentially damaging testimony that would have supported his defamation suit.[118] Thus, regardless of whether it is federal law or state law that limits discovery, the result is that the reviewed physician has a large hurdle to jump in proving to a

court that there was a malicious or bad faith peer review. It is maintained by some that due to the discovery privileges, an accusatory physician involved in the peer review process is able to manipulate the process to achieve ulterior motives, for example by eliminating the economic competition in a particular practice field.[119]

Following the United States Supreme Court's ruling in *Patrick v. Burget*, and the enactment of the Health Care Quality Improvement Act of 1986, there have been very few courts that have permitted a physician to overcome the immunity and confidentiality protections afforded peer review hearings.[120] Nevertheless, there are a few cases where the court has upheld a verdict where proof of deliberate and extreme bad faith was present.[121] For example, in *Brown v. Presbyterian Health Care Services*, in which a jury determined there had been an element of bad faith involved in the peer review of the disciplined physician, the court of appeals affirmed the jury's decision, and held that the hospital was not entitled to the immunity provisions under HCQIA.[122] However, this was a case where there was an obvious element of bad faith involved in the peer review process, since, as the court found, there was a direct link between the accusing physician who initiated the peer review action and the ultimate influence on the peer review committee and governing board – especially since the accusing physician was on the same governing board which made the decision to terminate the accused physician's privileges.[123]

In the case of Z*amanian v. Christian Health Ministry*, the evidence of a direct link between malice and the peer review action was not as

obvious, yet the accused physician was able to overcome the defendant's claims of immunity.[124] In that case, the court of appeals reversed the district court's summary judgment after ruling found that there existed evidence that the hospital had financial and economic reasons to discipline Dr. Zamanian, primarily because he allowed patients to remain in the hospital for a longer period of time than Medicare authorized, which resulted in a financial loss for the hospital.[125]

However, after the jury found that a bad faith peer review was conducted by the defendant hospital and awarded Dr. Zamanian $6 million in damages, emphasizing how great the barriers are for an accused physician to prevail in a bad faith peer review case, a civil district judge reversed the jury decision and set aside the award, finding that the peer review process was indeed entitled to immunity under state and federal laws.[126] It seems very apparent that even if a physician is able to prove that bad faith or malice is involved, the physician must still be prepared expend a great deal of time and money for the cost of a lengthy legal process. Indeed, few cases even manage to persist this far into the legal process; in fact, this was the first case of its kind to reach a jury trial in the state of Louisiana.[127]

Besides the issue of the discovery protection of peer review under HCQIA, there is also the problem of a lack of due process for the reviewed physician. The accused physician that finds themselves at the wrong end of a peer review recommendation is has very few due process options to appeal the final decision of the governing board.[128] While the Act does require that the peer review hearing be held before a

mutually acceptable arbitrator, the hospital is not required to provide appellate review of the decision following every hearing.[129] Section 11112(b) of HCQIA provides a "safe harbor" to those health care entities that correctly adhere to the statutory notice and hearing provisions of the Act.[130] That section provides that a "health care entity must give the physician involved notice of any adverse professional review action proposed to be taken, a statement for the reasons of the proposed action, and the time within which the physician or dentist may request a hearing (which may not be less than thirty days)."[131]

In addition, the notice is required to provide a summary of the rights involved in the hearing, including the right to legal representation; the right to cross-examine witnesses; the right to present relevant evidence; to submit a written statement at the conclusion of the hearing; the right to have a record of the hearing; and to receive a written recommendation and the decision, and the reasons for each.[132] Critics argue however, that once the governing board makes its final determination, the accused physician is left with virtually no option to appeal the decision of the board, except perhaps attempting to take the hospital, and the accusing physicians, through an expensive and time-consuming costly trial.[133]

Unquestionably, the probability of an unemployed or negatively affected physician, faced with the legal burden of proving bad faith and having to contend with the confidentiality and immunity protections provided by HCQIA and state laws, pursuing a civil claim in court is very unlikely.[134] Therefore, since it is also argued that the hearing and

notice guidelines of HCQIA offer the accused physician only a limited appellate procedure, a necessary reform in these appellate procedures is drastically needed and would provide the physician a neutral forum in which to have his peer review properly evaluated for fairness and impartiality.[135]

IV. Defects in the National Practitioner Data Bank

More difficulties, in addition to the hardships of defeating a bad faith peer review's presumption of validity, await the accused physician. The physician is also confronted with the hospital's mandatory duty to report the negative action to the National Practitioner Data Bank. As stated previously, under HCQIA, a hospital has the mandatory duty of reporting of credentialing actions, malpractice payments and licensure actions.[136] Again, as stated in the "Findings" of the Act, one of the primary purposes of the NPDB is to prevent those physicians that have had their hospital privileges terminated from merely moving to another state or another hospital and continuing to practice without disclosure of their incompetence.[137] The information submitted to the NPDP is meant to be strictly confidential, and is meant to be only accessible by hospitals and other health care entities to alert them to physicians who have had adverse actions taken against them that has resulted in the loss of their privileges or licenses.[138]

However, many contend that the information has become easily accessible to attorneys, and members of the media, thereby diminishing the confidentiality of the information that the NPDB was meant to provide.[139] In addition, following the submission of a report, valid or

not, to the NPDB, any hospital to which the disciplined physician attempts to gain privileges will be made aware of the adverse action, and thus, in effect, the reviewed physician is essentially "blacklisted."[140] While an appeals process does exist for the reviewed physician to dispute the accuracy of the report, by contacting the Secretary of Health and Human Services, it is important to note that this is not "an appellate procedure of the actual peer review action; it is simply an appeal of the reported information."[141]

Moreover, at times this review of the information submitted to the NPDB may be too damaging, and extremely difficult for the physician to overcome; for instance, in cases involving a summary suspension, by the time a doctor even receives a hearing on the matter, the damage has already been done.[142] Therefore, at times the mere perception or allegations that a physician may have had a negative peer review action against them is enough stop the physician from obtaining privileges at another hospital, thereby ruining their economic and professional opportunities.[143] Additionally, to make the situation even worse, some who have undergone the peer review process, whether or not found innocent of the allegations made against them, may still be victims of unequal treatment by hospitals. Thus, "although the NPDB was originally intended to monitor problem physicians, many in the medical community are concerned that it has accomplished the complete opposite, leading to the unintended consequence of destroying the careers of many qualified physicians."[144]

V. Suggested Remedies

There are a variety of remedies that are available that can alleviate many of the flaws currently found in the medical peer review process. Such possible remedies include the expansion of the peer review appeals process; individual state action by increasing the exceptions to the non-discoverability statutes; the early and watchful intervention by hospital administrators in identifying malice driven peer reviews; and the implementation and emphasis on a more open dialogue between physicians and hospitals.

Many argue that a large amount of the problems of the current peer review process is due to a deficient appeals process for the accused physician.[145] Thus, it would be beneficial to the goal of eliminating the current environment that fosters bad faith peer review by establishing a procedure of permitting the sanctioned physician to appeal the decision to an independent review board outside of the hospital; such a process would improve much of the uncertainty and ambiguity that is tainting the current peer review system.[146] It is very likely that an independent analysis of the facts by independent review board would defuse much of the pressure regarding the peer reviewers as well as those physicians being reviewed.[147] The establishment of an independent review board would both ensure the dependable application of generally accepted medical standards, as well as provide the reviewing physicians with the added protection of an extra layer of review, thus strengthening the validity of the original peer review committee's findings if the independent board confirms the original findings justifying the revocation of privileges or sanctions.[148]

Additionally, since hospital privileges have become such an invaluable advantage for today's physicians, it is reasonable to suggest that state government should have an increasing role in the oversight of hospital privileges.[149] Such a state oversight could possibly consist of a review panel of doctors from around the state who would review the peer review committee's findings, and "could even relieve the hospital of any supervisory activity by simply allowing all peer review actions to be controlled by the state."[150] Furthermore, if a state is disinclined to accept such responsibility, then, in the alternative, the state should then allow the sanctioned physician to have immediate access to the state courts to appeal the governing board's decision.[151] It certainly does not offend one's sense of justice to allow a sanctioned physician the opportunity to present his case to an independent and impartial court of law.

In addition to the expansion of the appeals process, another possible solution to the flaws in the current peer review process is to call for an additional number of states to expand their non-discoverability statutes. As of 2001, seventeen states have adopted exceptions to their non-discoverability peer review statutes.[152] In these states, the statutes allow physicians to obtain access to peer review materials when challenging the curtailment, suspension, termination or denial of staff privileges.[153] At this time, the Health Care Quality Improvement Act does not carry any such protection for disciplined physicians, and as a result, there is a great burden on the disciplined physician in obtaining any evidence that could prove that there was malice present at the peer review hearing, and thus making it exceedingly difficult for the physician

to make a case for bad faith peer review and survive a motion for summary judgment in favor of the hospital.[154]

Indeed, "it is vital to remove the immunity veil that physicians are able to hide behind, which allows them to manipulate the peer review process in order to achieve politically or economically motivated goals."[155] Consequently, with the expansion of the accused physician's ability to obtain discovery of the peer review hearings, and by removing the immunity shields, peer review committees will be required to rely more on medical doctrine and principles and less on "personally driven agendas."[156]

There is also a role that hospital administrators can play in helping to prevent the continuation of bad faith peer reviews. Hospital administrators that oversee peer review actions can, early on in the process, be aware of factors that can have the tendency to appear "malicious," and thus prevent a bad faith peer review from being initiated or continuing, and thus spare a physician an unjust attack on his or her reputation and livelihood.[157] For instance, one hint that a peer review was initiated in bad faith or with malice is if the complaint originated outside of the normal course of peer review quality assurance functions.[158] If the hospital's quality assurance system is operating properly, any pattern of questionable judgment or malpractice will be identified, thus any complaint that originates from outside the normal quality assurance system should be viewed with skepticism, and scrutinized for any improper motivations and indications of malice.[159]

Additionally, situations where the hospital's initial action is the

expulsion of the physician from the hospital should also be viewed with skepticism.[160] Normally, the initial procedure of the hospital to any complaint of a physician's competency should be to investigate the matter, and following the investigation if there are concerns about the physician's abilities, the hospital would be wise to correct the problem via training and education, consultation with other physicians, or limitations on the physician's procedures, before any sanctions are considered.[161] By following such procedures, hospital administrators can prevent any unjust and malicious peer review hearings, and ultimately prevent any subsequent litigation against the hospital. Indeed, critics of the NPDB argue that continued education and training is a better alternative than merely submitting the physician's name to the national data bank.[162]

These critics maintain that the NPDB imposes strict reporting requirements with consequences that encourage hospitals not to report actions taken, and thus instead of attracting public exposure to potential problems at the hospital, hospitals will "instead seek out alternative corrective measures to avoid reporting."[163] "An alternative approach to the peer review process that has been advocated by many in the medical profession views quality of care not from an adversarial, aggressive standpoint, but rather from a theory of continuous improvement used by health care entities should be the goal of the NPDB; further education and training should be the rule, rather than permitting a simple submission of a name to a data bank that would effectively end the career of a physician."[164]

Hospital administrators should also be aware of alert to any sign of

unequal or disparate treatment of a physician in comparison with one of his or her colleagues, and any such indication of unequal conduct should alert hospital administrators that malice might be involved.[165] A physician should not be subjected to a peer review action merely because of the physician, like the hypothetical Dr. Adams, chooses to follow a different school of thought than their seniors or committee members.[166] Physicians are allowed to follow a variety of medical schools of thought, and "any time a physician is singled out for disciplinary action based not on the quality of care he or she provides but rather on what is, in effect, the discriminatory preferences of peer review participants, the actions should be suspect."[167] As all these factors indicate, there is a large role that hospital administrators can play in reducing or eliminating malicious or bad faith peer reviews.

VI. Conclusion

Most Americans expect the best quality health care available for themselves and their families, and they expect their physician's to be competent and skilled. The Health Care Quality Improvement Act of 1986 is, ostensibly, meant to protect the public from incompetent physicians by allowing those physicians on peer review committees to communicate in an open and honest environment and thus weed out incompetent physicians, without the specter of a retaliatory lawsuit by the reviewed physician. However, the consequences of the Act have instead helped promote an environment that protects those physicians on a peer review committee when they distort the review process for their own gain, by maliciously disciplining those physicians that may be in political or

economic competition.

What is to become of the hypothetical Dr. Adams when there is no avenue for just and equitable relief from a malicious peer review? Indeed, after years of schooling and incurring huge student loan debt, is Dr. Adams to merely give up and quit her profession, or in the alternative engage in the costly and uphill legal battle of proving that the peer review was held maliciously or in bad faith? Perhaps one or all of the remedies that are available, such as the expansion of the peer review appeals process, or the state action of increasing the exceptions to the non-discoverability statutes, or the intervention by hospital administrators in identifying malice driven peer reviews; or the implementation and emphasis on a more open dialogue between physicians and hospitals can begin to help Dr. Adams and repair the problems that exist in the current system.

Whichever remedy is used, it is imperative to the success of the primary goal of HCQIA, the improvement of the quality of health care in America, that some relief be available to those physicians who have been unjustly maligned through the bad faith peer review process. The failure to change and improve the current system will continue to result in the loss of qualified and skilled physicians from their profession due to others who maliciously pervert the current peer review process for their own selfish motives.

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[1] Pauline M. Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 Loy. L.A. L. Rev. 357 (1993). According to Rosen, Dr. Adams is a fictional

plaintiff and her situation was taken from a combination of cases and stories expressed during congressional hearings in 1986.

[2] *Id.* at 358.

[3] *Id.*

[4] *Id.*

[5] *Id.*

[6] *Id.*

[7] Rosen, s*upra* note 1, at 358.

[8] *Id.* at 360.

[9] *Id.*

[10] *Id.*

[11] *Clark v. Columbia/HCA Information Services, Inc.*, 25 P.3d 215, 218 (NV 2001).

[12] *Id.*

[13] *Id.*

[14] *Id.* at 219.

[15] *Id.* at 221.

[16] *Id.* at 222.

[17] *Clark v. Columbia/HCA Information Services, Inc.* at 222.

[18] Scott M. Smith, J.D., *Construction and Application of Health Care Quality Improvement Act of 1986*, 121 A.L.R. Fed. 255 (1994).

[19] Yann H.H. van Geertruyden, *The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community*, 18 J. Contemp. Health L. & Pol'y 239, 240 (2001).

[20] American Bar Association, Section of Antitrust Law, *Practical Applications of the Health Care Quality Improvement Act*, (Roxane C. Busey, ed., ABA, 1994), p. 5.

[21] van Geertruyden at 242.

[22] *Practical Applications of the Health Care Quality Improvement Act,* p. 5.

[23] van Geertruyden at 243.

[24] Smith, *supra* note 18, at 15.

[25] *Id.*

[26] Josephine M. Hammack, *The Antitrust Laws and the Medical Peer Review Process*, 9 J. Contemp. Health L. & Pol'y 419, 437 (1993).

[27] *Id*. at 419.

[28] van Geertruyden, *supra* note 19, at 242.

[29] *Id*.

[30] *Id*. at 241.

[31] *Id*.

[32] Smith, *supra* note 18, at 15.

[33] Lawrance A. Manson, *Maintaining the Peer Review Privilege*, *Anti-Trust Developments in Evolving Health Care Markets*, (Howard Feller, ed. Section of Antitrust Law, American Bar Association), p. 189, *citing* 15 U.S.C. § 1.

[34] *Id*.

[35] Smith at 15.

[36] Hammack, *supra* note 26, at 420.

[37] *Id*. at 422.

[38] Smith, *supra* note 18, at 15.

[39] *Practical Implications of the Health Care Quality Improvement Act*, p. 17. *Note*: HCQIA has been amended by the Public Health Services Amendment of 1987, and the Omnibus Budget Reconciliation Act of 1989, see Pub. L. No. 100-177 (Dec. 1, 1987) and Pub. L. No. 101-239 § 6103(e)(6) (Dec. 19, 1989) respectively.

[40] 42 U.S.C. § 11101.

[41] Hammack, *supra* note 26, at 433.

[42] *Patrick v. Burget*, 486 U.S. 94, 96 (Ore. 1988).

[43] *Id*.

[44] *Id*.

[45] *Id*.

[46] *Practical Implications of the Quality Health Care Improvement Act*, p. 15.

[47] *Id*.

[48] *Id*.

[49] van Geertruyden, *supra* note 19, at 245.

[50] *Practical Implications of the Quality Health Care Act of 1986*, p. 15. *Note*: The remainder of the $2.2 million jury award was on the state law claims.

[51] van Geertruyden at 245.

[52] *Practical Implications of the Quality Health Care Act of 1986*, p. 17.

[53] van Geertruyden at 245.

[54] *Practical Implications of the Quality Health Care Act of 1986*, p. 17.

[55] Mark A. Colantonio, *The Health Care Quality Improvement Act of 1986 and its Impact on Hospital Law*, 91 W. Va. L. Rev. 91, 92 (1988).

[56] M. Elizabeth Gee, *Health Care Quality Improvement Act Immunity: An Antitrust Help or Hindrance?*, *Antitrust Problems and Solutions in a Changing Health Care System*, (H. Suzanne Smith, ed., Section of Antitrust Law American Bar Association, p. 105, 1994).

[57] *Practical Implications of the Quality Health Care Improvement Act* , p. 17.

[58] 40A Am. Jur. 2d § 26, p. 444, *referencing* 42 U.S.C. § 11111(a)(1).

[59] *Id.*

[60] Colantonio, *supra* note 55, at 94.

[61] *Id.*

[62] *Id.*

[63] van Geertruyden, *supra* note 19, at 247, *quoting* 42 U.S.C. § 11112(a).

[64] *Id.*

[65] 40 Am. Jur. 2d § 26, p. 443 *referencing* 42 U.S.C. § 11101.

[66] *Id.*

[67] *Practical Implications of the Health Care Quality Improvement Act of 1986*, p. 62, *referencing* 42 U.S.C. § 11133(a)(1).

[68] Colantonio, *supra* note 55, at 98.

[69] *Id.* at 99.

[70] Smith, *supra* note 18, at 33.

[71] *Id. referencing Bearden v. Humana Health Plans*, 1992 WL 245604, N.D. Ill. (1992).

[72] *Magrinat v. Trinity Hospital*, 540 N.W.2d 625, 626 (N.D. 1995).

[73] *Id.* at 627.

[74] *Id.*

[75] *Id.*

[76] *Id.*

[77] *Id.*

[78] *Magrinat v. Trinity Hospital*. at 627.

[79] *Id.*

[80] .*Id.*

[81] *Id.*

[82] *Id.*

[83] *Id.*

[84] Rosen, *supra* note 1, at 361.

[85] *Id.*

[86] Smith, *supra* note 18, at 23 *citing Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999).

[87] van Geertruyden, *supra* note 19, at 252.

[88] *Id.*

[89] *Id.*

[90] *Id.*

[91] *Id.*

[92] *Id.*

[93] van Geertruyden, *supra* note 19 at. 252.

[94] Smith, *supra* note 18, at 1.

[95] van Geertruyden at 252.

[96] *Id.* at 264.

[97] *Id.* at 264.

[98] van Geertruyden,, *supra* note 19, at 265, *quoting* 42 U.S.C. 11112(a)(1).

[99] Hammack, *supra* note 26, at 449.

[100] van Geertruyden at 266.

[101] *Id.* at 253.

[102] Daniel M. Warner, *Understanding and Defending Against Medical Professional Peer Review Antitrust Claims*, 22 U. Balt. L. Rev. 269, 282 (1993).

[103] van Geertruyden, p. 260.

[104] Smith, *supra* note 18, at 18.

[105] *See* South Dakota Codified Law § 36-4

[106] Smith, *supra* note 18, at 18, *citing LeMasters v. Christ Hospital*, 791 F. Supp. 188 (SD, Ohio 1991).

[107] *Id.*

[108] *Id.*

[109] *Id.* at 19. *See Also Teasdale v. Marin General Hospital,* 138 F.R.D. 6691, (N.D. Cal, 1991), *and Pagano v. Oroville Hospital*, 145 F.R.D. 683 (E.D. Cal, 1993).

[110] *Id.* at 20.

[111] *Id.* at 21 *referencing Cohn v. Wilkes General Hospital*, 127 F.R.D. 117, (W.D. NC, 1988).

[112] Manson, *supra* note 33, at 197.

[113] *Id. Quoting Wei v. Bodner*, 127 F.R.D. 91, 97 (D.N.J. 1989).

[114] Smith, *supra* note 18, at 19, *quoting Wei v. Bodner*, 127 F.R.D. 91, 91, (D.N.J. 1989).

[115] van Geertruyden, *supra* note 19, at 264.

[116] *Id.*

[117] *Id.*

[118] *Id.*

[119] *Id.*

[120] *Id.*

[121] van Geertruyden, *supra* note 19, at 259.

[122] *Id.*

[123] van Geertruyden, *supra* note 19, at 260, *citing Brown v. Presbyterian Health Care Services*, 101 F.3d 1324 (1996).

[124] *Id.*

[125] *Id.* C*iting Zamanian v. Christian Health Ministry*, 715 So.2d 57 (La. App. 4th Cir. 1998).

[126] *Id.* at 261.

[127] *Id.* at 262.

[128] *Id.* at 254.

[129] Colantonio, *supra* note 55, at 95.

[130] *Practical Implications of the Health Care Quality Improvement Act of 1986*, p. 38

[131] *Id.*

[132] *Id.*

[133] van Geertruyden, *supra* note 19, at 253.

[134] *Id*. at 256.

[135] *Id*.

[136] *Id*. at 257.

[137] *Practical Implications of the Health Care Quality Improvement Act*, p. 17.

[138] van Geertruyden, *supra* note 19, at 247.

[139] *Id*.

[140] *Id*. at 257.

[141] *Id*. at 258.

[142] *Id*.

[143] *Id*.

[144] van Geertruyden, *supra* note 19, at 258.

[145] *Id*. at 267.

[146] *Id*.

[147] *Id*.

[148] *Id*.

[149] *Id*.

[150] van Geertruyden, *supra* note 19, at 268.

[151] *Id*.

[152] *Id*.

[153] *Id*.

[154] *Id*.

[155] *Id*.

[156] van Geertruyden, *supra* note 19, at 268.

[157] Rosen, supra *note* 1, at 381.

[158] *Id*.

[159] *Id*.

[160] *Id*.

[161] *Id*.

[162] van Geertruyden, *supra* note 19, at 269.

[163] *Id*.

[164] *Id.*

[165] Rosen, *supra* note 1, at 389.

[166] *Id.* at 391.

[167] *Id.*