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Hospital Quality Improvement: Are Peer Review Immunity, Privilege, and Confidentiality in the Public Interest?

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ABSTRACT

Participants in the hospital peer review process enjoy enormous protections under federal and state law. We contend that these protections—immunity, evidentiary privilege, and confidentiality—impede quality improvement in health care. As a result of these protections, the current peer review system produces both improper severity and improper leniency. We propose to reform the system by eliminating all federal and state statutory protections for the peer review process. A public process that is open to review and open to challenge by all interested parties will better promote health-care quality.

I. INTRODUCTION

Participants in the hospital peer review process enjoy enormous protections under federal and state law. The federal Health Care Quality Improvement Act of 1986 (HCQIA) provides qualified immunity to hospitals and members of peer review committees for "professional review action[s]" that may result in the loss of a doctor's clinical privileges.[1] The great majority of states have statutes that likewise provide some degree of peer review immunity.[2] The great majority of states also make peer review proceedings privileged—inadmissible in evidence and protected from discovery—and mandate that peer review proceedings be kept confidential.

In addition to providing immunity to participants in the peer review process, the HCQIA established a National Practitioner Data Bank (NPDB).[3] Hospitals must report to the NPDB when they take certain actions against doctors, such as revoking their clinical privileges.[4]

In this article, we argue that the federal and state protections lavished on the peer review process are inimical to that process, impede full and effective disclosure to the NPDB, and impede quality improvement in health care. The quality assurance function of the peer review

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[1] *See* 42 U.S.C. § 11111(a)(1) (2012).
[2] *See infra* Appendix.
[3] *See* 45 U.S.C. § 11134; 42 U.S.C. § 11133; 42 U.S.C § 11134 (2012).
[4] 45 U.S.C. § 11134(a). "The information required to be reported under sections 11131, 11132(a), and 11133 of this title shall be reported regularly (but not less often than monthly) and in such form and manner as the Secretary prescribes."

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system is undermined by two kinds of errors: improper severity and improper leniency.[5] Improper severity occurs when doctors are wrongly disciplined or wrongly denied clinical privileges for which they have applied.[6] Further, when these improperly severe disciplinary measures are reported to the NPDB, such reports can seriously damage a physician's ability to practice medicine, as employers and health insurance companies may be reluctant to hire or utilize practitioners with such adverse reports.[7]

Improper leniency occurs in a number of ways.[8] A peer review committee may wrongly exonerate a doctor. A credentialing committee may wrongly allow doctors to obtain or retain credentials. A peer review committee may fail to be convened, even in the face of apparent doctor misconduct and/or bad patient outcome. And hospitals may evade or violate the NPDB reporting requirements. Indeed, according to one study, the only measure that has affected the amount of adverse peer review action reporting in a state is the imposition of "a strong penalty for failing to report peer review actions."[9]

We contend that the current federal and state regulatory system increases the likelihood and frequency of all these errors, both the improperly severe and the improperly lenient. This multifaceted focus sets our article apart from previous work that is generally more concerned either with problems of improper severity[10] or with problems of improper leniency.[11] One major element of the current system that predisposes it to error is the use of internal, self-interested reviewers. The second element is the array of federal and state legal protections for peer review that throw a blanket of secrecy and immunity over the process, preventing scrutiny and thwarting legitimate challenges. Putting these elements together, we end up with legal incentives for both improper severity and improper leniency.

In Part I of this Essay, we give an overview of the hospital peer review process and the federal and state statutes that protect it. In Part II, we describe the problems of the current peer review system, explaining why it tends to produce both improper severity and improper leniency. Part II also examines the specific deficits of the current peer review process. In Part III, we propose to reform the system by eliminating all federal and state statutory protections for the peer review process. A public process that is open to review and open to challenge by all interested parties will better promote quality in health care.

II. REGULATORY BACKGROUND

Peer review in the hospital setting is the process by which doctors evaluate the professional competence and conduct of other doctors, both on an ongoing basis and in the context of poor patient outcome. Peer review is widely deemed one of the "pillars of quality

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[5] *See* discussion *infra* Parts II.B.1–2.
[6] *See infra* Part II.B.1.
[7] *See* discussion *infra* Part II.B.1.
[8] *See* discussion *infra* Part II.B.2.
[9] *See* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time For a Change?*, 25 AM. J.L. & MED. 7, 47 (1999).
[10] *See, e.g.*, Charles R. Koepke, *Physician Peer Review Immunity: Time to Euthanize a Fatally Flawed Policy*, 22 J.L. & HEALTH 1, 10–14 (2009); Yann H.H. van Geertruyden, Comment, *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, 268–69 (2001).
[11] *See, e.g.*, Scheutzow, *supra* note 9, at 20.

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assurance" in healthcare.[12] Hospitals are required to have a peer review system as a condition of participation in Medicare,[13] and peer review is also a requirement for accreditation by the Joint Commission, the organization that accredits hospitals.[14]

This article is mainly concerned with peer review addressing the quality of care rendered by a specific physician or for a specific patient. In such a proceeding, the members of the peer review committee are in most cases doctors who work at the same hospital as the doctor under review. External peer review is rare.[15]

Moore et al. list the three assumptions underlying the traditional practice of disciplinary peer review.[16] First, "due to their unique and specialized training, only physicians can properly evaluate and judge other physicians' medical practices and detect when colleagues pose a risk to patient care."[17] Second, "a milieu supporting candid communication is most likely to foster recognition of both exemplary and substandard care."[18] And third, "peer review participants are motivated to maintain high standards of care in their group or institution and act in good faith."[19]

The hospital credentialing process is also a peer review process. Hospitals use the credentialing process to determine whether a physician is qualified for employment or clinical privileges.[20] A doctor cannot provide medical care at a given healthcare facility if he or she lacks clinical privileges.[21] During the credentialing process, the hospital queries the NPDB and makes inquiries of various professional sources, seeking information such as the practitioner's "education and training, previous positions held, and malpractice actions and disciplinary sanctions."[22]

A. Federal Regulation Under the Health Care Quality Improvement Act (HCQIA)

The HCQIA provides qualified immunity to health care entities, members of a "professional review body," and associated persons from damages claims arising from a

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[12] Troyen A. Brennan, *Hospital Peer Review and Clinical Privileges Actions: To Report or Not Report*, 281 JAMA 381, 381 (1999).
[13] *See* 42 C.F.R. § 482.22 (2014).
[14] Scheutzow, *supra* note 9, at 20; *see Standards FAQ Details: Focused Professional Practice Evaluation*, JOINT COMMISSION, http://www.jointcommission.org/mobile/standards_information/jcfaqdetails.aspx?StandardsFAQId=467&StandardsFAQChapterId=74 (last revised Jan. 31, 2013).
[15] *See* Marc T. Edwards & Evan M. Benjamin, *The Process of Peer Review in U.S. Hospitals*, 16 J. CLINICAL OUTCOMES MGMT. 461, 463 (2009) (noting that in survey of hospitals, "[e]xternal peer review constituted less than 1% of total review volume for 87% of hospitals and less than 5% for another 8%").
[16] *See* Ilene N. Moore et al., *Rethinking Peer Review: Detecting and Addressing Medical Malpractice Claims Risk*, 59 VAND. L. REV. 1175, 1177 (2006).
[17] *Id.*
[18] *Id.*
[19] *Id.* We discuss later in the article the extent to which these assumptions are true under the current regulatory scheme governing disciplinary peer review. *See infra* Part II.
[20] Teresa M. Waters et al., *The Role of the National Practitioner Data Bank in the Credentialing Process*, 21 AM. J. MED. QUALITY 30, 31 (2006).
[21] Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging, The Joint Commission Accreditation: Ambulatory Care, *available at* http://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf. *See also id.;* Philip L. Merkel, *Physicians Policing Physicians: The Development of Medical Staff Peer Review Law at California Hospitals*, 38 U.S.F.L. REV. 301, 302-303 (2004).
[22] *See* Waters, *supra* note 20, at 31–32.

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"professional review action."[23] A "professional review action" is one that is "based on the competence or professional conduct of an individual physician" and that may adversely affect the physician's clinical privileges.[24]

HCQIA immunity applies to damages claims arising under state law as well as federal law.[25] It does not apply to civil rights claims, however.[26] Also, it does not bar claims for injunctive relief.[27]

In order to be entitled to HCQIA immunity, a "professional review action" must meet a number of requirements. It must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).[28]

Congress justified the HCQIA's grant of immunity to participants in the peer review process based on congressional findings that "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review"[29] and that 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."[30]

As noted in the Introduction, the other major component of the HCQIA is the establishment of the National Practitioner Data Bank (NPDB or "the Data Bank").[31] A health care entity (such as a hospital) must make a report to the NPDB if it "takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days," if it "accepts the surrender of clinical privileges of a physician . . . while the physician is under . . . investigation . . . [for] incompetence or improper professional conduct," or "in return for not conducting such an investigation or proceeding."[32] The HCQIA also requires state

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[23] *See* 42 U.S.C. § 11111(a)(1) (2012).
[24] *Id.* § 11151.
[25] *See id.* § 11111(a)(1).
[26] *Id.*
[27] *Id.*
[28] *Id.* § 11112(a).
[29] *Id.* § 11101(5).
[30] *Id.* § 11101(4).
[31] The term "National Practitioner Data Bank" is not actually used in the HCQIA; it is found in the implementing regulations, 45 C.F.R. §§ 60.1–.22 (2015).
[32] *See* 42 U.S.C. § 11133(a)(1) (2012); *see also* 45 U.S.C. § 11134(a).

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medical licensing boards to report to the NPDB when they impose sanctions on physicians,[33] and it requires insurance companies to report medical malpractice payments to the NPDB.[34]

If a hospital persistently fails to make its required reports to the NPDB, the Secretary of Health and Human Services can in theory move to revoke its HCQIA immunity for the peer review proceedings it conducts.[35] However, this sanction has never been applied.[36]

The HCQIA requires hospitals to query the NPDB when a doctor applies for clinical privileges at the hospital and every two years thereafter.[37] Normally, doctors are re-credentialed, or have their clinical privileges reviewed, every two years.[38]

To justify the NPDB requirements, the HCQIA contains a Congressional finding that "[t]here 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."[39] Prior to the HCQIA, it was common for hospitals to quietly rid themselves of incompetent doctors, who then found other positions, sometimes in another state. The HCQIA attempted to fix this problem by establishing the NPDB, requiring sanctioning hospitals to report adverse actions to the NPDB, and requiring hiring hospitals to query the NPDB before granting or renewing clinical privileges.[40]

B. The Varying Levels of State Protection: Immunity, Privilege, and Confidentiality

Most states provide additional protections to the peer review process that are not preempted by the HCQIA.[41] State statutory protection of peer review comes in three forms: immunity, evidentiary privilege, and confidentiality. There are differences in the level and form of protection extended.

Every state but California, Nevada, New Hampshire, Oregon provides some statutory immunity to participants in the peer review process.[42] Many states provide greater immunity than the HCQIA with respect to state-law claims because they do not require the peer review process to satisfy all the prerequisites set forth in the HCQIA.[43] In Illinois, for example, participants in the peer review process are immune from damages for all "conduct in connection with their duties on such committees, except those involving willful or wanton misconduct."[44]

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[33] *See* § 11132(a)(1); § 11133(a)(1).
[34] *See id.* § 11131(a).
[35] *See id.* § 11133(c)(1).
[36] ALAN LEVINE & SIDNEY WOLFE, PUB. CITIZEN, HOSPITALS DROP THE BALL ON PHYSICIAN OVERSIGHT 8 (2009), *available at* http://www.citizen.org/documents/18731.pdf; *see also* Scheutzow, *supra* note 9, at 37.
[37] *See* 42 U.S.C. § 11135(a) (2012).
[38] Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging, The Joint Commission Accreditation: Ambulatory Care, *available at* http://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf.
[39] *Id.* § 11101(2).
[40] *See supra* notes 32–33, 37 and accompanying text. Professor Van Tassel questions how common the "state hopping" part of this problem was. *See* Katharine Van Tassel, *Using Clinical Practice Guidelines and Knowledge Translation Theory to Cure the Negative Impact of the Hospital Peer Review Hearing System on Healthcare Quality, Cost, and Access*, 40 PEPP. L. REV. 911, 924 (2013).
[41] *See* 42 U.S.C. § 11115(a) (2012); *infra* notes 42–46 and accompanying text.
[42] *See infra* Appendix. The attached Appendix updates information presented in Scheutzow, *supra* note 9, at app. A.
[43] *See infra* Appendix. *See also* 42 U.S.C. § 11112(a).
[44] 225 ILL. COMP. STAT. 60/5 (2014).

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Except for New Jersey, every state and the District of Columbia have some form of privilege for the peer review process,[45] which means evidence concerning peer review proceedings is inadmissible in court and not subject to discovery. There is no analogous federal statutory privilege for peer review proceedings. The main significance of the state-level privilege statutes is to prevent medical malpractice plaintiffs from using evidence generated by the peer review process.

Finally, all but ten states protect the confidentiality of peer review information.[46] "Confidentiality laws differ from privilege laws in that . . . privilege . . . appl[ies] to [the] discoverability and admissibility of evidence as part of a judicial proceeding[, while] confidentiality generally applies to the release of peer review information to third parties outside of the judicial context."[47] "Only a few states[, however,] provide civil or criminal penalties for a breach of confidentiality."[48] State privilege and confidentiality protections hold even when peer review results are reported to the NPDB.[49]

III. ORIGIN AND DEFECTS OF THE CURRENT SYSTEM

A. *The Federal and State Legislative Intents Behind Peer Review Protections*

To understand the incentives of hospitals to conduct and report peer review actions, one must understand the intent behind peer review's statutory protections. At the federal level, Congress passed the HCQIA in "response to the medical malpractice crisis of its day."[50] At the time, there was the perceived threat to "physicians and hospital administrators that they [would] be sued" in response to a planned adverse privilege decision,[51] and the Subcommittee on Health and the Environment even received testimony indicating that the threat of these suits was having a "chilling effect" on peer review.[52] [H]ospitals and peer review committees were hesitant to accuse physicians lest they become the target of retaliatory and costly litigation, and would frequently accept "voluntary" resignations to avoid litigation.[53] Not only that, but "state medical boards would engage in a form of . . . plea bargaining" where they would "accept[] the 'voluntary' surrender of [the] physician's license" in return for the physician ceasing to practice in their state.[54]

Congress found that "[t]here 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."[55] Hence, the HCQIA requires hospitals to

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[45] *See infra* Appendix.

[46] These states do not address the issue of confidentiality: Arkansas, California, Florida, Missouri, Montana, Nevada, New Jersey, Utah, Virginia, Wisconsin. *See infra* Appendix.

[47] Scheutzow, *supra* note 9, at 17.

[48] *Id.* at 35–36.

[49] GERALD N. ROGAN ET AL., HOW PEER REVIEW FAILED AT REDDING MEDICAL CENTER, WHY IT IS FAILING ACROSS THE COUNTRY AND WHAT CAN BE DONE ABOUT IT 30 (2008), *available at* http://roganconsulting.com/docs/Congressional_Report-Disaster_Analysis_RMC_6-1-08.pdf (referring to the NPDB as "the Data Bank").

[50] Koepke, *supra* note 10, at 5 (internal quotation mark omitted).

[51] *Id.*

[52] *Id.*

[53] *Id.*

[54] *Id.* at 5–6.

[55] 42 U.S.C. § 11101(2) (2012).

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report physicians to the NPDB under certain circumstances, chiefly in the event of an adverse peer review outcome.[56] Next, the HCQIA grants those who participate in the peer review process immunity from damages provided that an action is 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 . . . , (3) after adequate notice and hearing are afforded to the physician involved . . . , and (4) in the reasonable belief that the action was warranted by the facts known . . . .[57]

The HCQIA's legislative history indicates that Congress believed limited immunity was essential to ensure both that physicians would participate in peer review and that hospitals would report errant physicians to the NPDB.[58]

The HCQIA sought to encourage doctors to perform peer review by protecting them from suits by disciplined physicians and treble antitrust damages.[59] This reasoning is not far removed from state peer review protection statutes, which have a variety of similar rationales. The predominant rationale for state protections is the belief that doctors are the most familiar with the relevant standard of care, and hence are best able to judge their fellow physicians, but the fear of litigation discourages them from participating.[60] Therefore, physicians and legislatures conclude, the best way to encourage peer review is to provide greater protection for it.[61]

[56] The HCQIA provides in pertinent part:

> Each health care entity which—
> (A) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;
> (B) accepts the surrender of clinical privileges of a physician—
> (i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or
> (ii) in return for not conducting such an investigation or proceeding; or
> (C) in the case of such an entity which is a professional society, takes a professional review action which adversely affects the membership of a physician in the society,
> shall report to the Board of Medical Examiners.

Id. § 11133(a)(1). "The term 'adversely affecting' includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." *Id.* § 11151(1).

[57] *Id.* § 11112(a). For participating in the peer review process, the HCQIA protects

> (A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under a contract or other formal agreement with the body, and (D) any person who participates with or assists the body with respect to the action . . . [from liability for] damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

Id. § 11111(a)(1). This also applies to individuals providing information to the peer review body. *See id.* § 11111(a)(2).

[58] H.R. REP. NO. 99-903, at 3 (1986).

[59] *See generally* 42 U.S.C. § 11101 (2012).

[60] *See* Leigh Ann Lauth, Note, *The Patient Safety and Quality Improvement Act of 2005: An Invitation for Sham Peer Review in the Health Care Setting*, 4 IND. HEALTH L. REV. 151, 167 (2007).

[61] *See* Scheutzow, *supra* note 9, at 17.

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Another postulated rationale is to allow an "institution to learn from its mistakes and . . . make amends with [the] affected parties, which may . . . curb litigation."[62] The ideal outcome would be for doctors to self-report mistakes to the peer review committee.[63] Self-reporting would "allow the peer review committee to investigate the situation, attempt to settle grievances with the patient, and provide education to other health care providers in order to reduce the occurrence of such mistakes in the future."[64] This enables the doctor to self-report without the "fear that this information will be used by the hospital or the patient against him."[65]

B. Defects of the Current System

The immunity granted to the peer review process by the Healthcare Quality Improvement Act of 1986, together with state protections of immunity, privilege, and confidentiality, have the paradoxical effect of undermining the quality assurance function of peer review. These protections produce both improper severity and improper leniency.

I. Improper Severity

One serious problem of the current system is bad-faith, or "sham," peer review. Sham peer review occurs when a physician is disciplined not because of an honest determination as to his competence or conduct, but for some other improper motive. Evidence of this problem, indeed, may have been present at the birth of the HCQIA. In enacting the HCQIA, Congress was influenced by the Supreme Court's holding in *Patrick v. Burget*.[66] In *Patrick*, a doctor, Timothy Patrick, had left a medical practice in Astoria, Oregon, and had become a competitor of the doctors in that practice.[67] Patrick's competitors then initiated peer review proceedings against him, and may have been able to control those proceedings.[68] Rather than have his hospital privileges revoked, Patrick resigned from the hospital with which he and his competitors were affiliated.[69] He then sued for antitrust violations and recovered treble damages.[70]

One conclusion observers might have drawn from *Patrick* is that the peer review process, where competitors serve as both prosecutors and judges, is susceptible to considerable abuse, and that legal remedies must be available to deter such abuse. Instead, in a triumph of public relations for the hospital industry, Congress concluded that the entire institution of peer review was jeopardized by suits like that in *Patrick*, saying "[t]he 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."[71]

The HCQIA provides that in order to qualify for immunity, a peer review proceeding cannot use reviewers who are "in direct economic competition with the physician involved."[72] The sham peer review that may have occurred in the *Patrick* case, therefore, presumably would

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[62] Lauth, *supra* note 60, at 166.
[63] *See id.*
[64] *Id.*
[65] *Id.*
[66] 486 U.S. 94 (1988); *see generally* Van Tassel, *supra* note 40, at 919–21 (giving an excellent summary of *Patrick* and discussing congressional response to it).
[67] *See Patrick*, 486 U.S. at 96.
[68] *See id.* at 97.
[69] *See id.*
[70] *Id.* at 97–98.
[71] 42 U.S.C. § 11101(4) (2012).
[72] *Id.* at § 11112 (b)(3)(A)(iii).

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not be protected today under the HCQIA. Nevertheless, it is not always clear when a peer reviewer can be characterized as a direct economic competitor of the physician under review.[73] Direct competitors also can have influence on the peer review process even when they do not serve as reviewers themselves, such as where hospital bylaws prevent direct competitors from participating in a review committee or a fair hearing panel, but do not prohibit them from participating in the peer review process in a different capacity.[74]

Since the adoption of the HCQIA, a considerable body of evidence has grown appearing to demonstrate that the current federal-state regulatory scheme shields the peer review process from challenge and scrutiny.[75] Some care is needed when evaluating this evidence. There are two sides to every case, and public accusations of sham review are often accompanied by no comment from the hospital, or only the most vague and anodyne denial. Still, we are convinced, from reviewing the various reports and from our own anecdotal experience, that sham peer review is indeed a serious problem. Simple common sense dictates that if people have the motive and ability to get rid of an unwanted coworker for illegitimate reasons, with little expectation of being called to account, they will sometimes do so. Perhaps a worse indictment of the current peer review process is that there is simply no way to assess the validity of peer review either for individual cases or institution-wide.

The desire to eliminate competitors is not the only improper motive that figures in sham peer review. The accused doctor may be the victim of a personality conflict. The internal reviewers may be acceding to the will of hospital administrators, who have their own improper motives. Most troubling of all, the hospital administrators and/or internal reviewers may desire to rid themselves of a whistleblower.

There are many reported examples of hospitals using disciplinary peer review, or the threat of peer review, to retaliate against doctors who raise questions about health care quality. As stated in one journalistic account: "In medical centers as small as Centre Community Hospital in State College [Pennsylvania] and as prestigious as Yale and Cornell, doctors who step forward to warn of unsafe conditions or a colleague's poor work say they have been targeted by hospital administrations or boards."[76] The wide perception among doctors that whistleblowers may be punished with sham peer review has, of course, an *in terrorem* effect, discouraging doctors from challenging hospital administrators on issues of health care quality. Ironically, fear of sham peer review or other discipline leads doctors to avoid criticizing the work of colleagues when they believe such criticism may be unwelcome to hospital administrators: precisely the opposite of the hoped-for effect of HCQIA immunity.

When a doctor is wrongfully deprived of hospital privileges, there is enormous social waste. If the loss of privileges is for more than thirty days, the adverse action must be reported to

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[73] *See, e.g.*, Pierson v. Orlando Health, No. 6:08-cv-466-JA-GJK, 2010 U.S. Dist. LEXIS 115101, at *42–46 (M.D. Fla. Oct. 27, 2010).

[74] Such as being a witness for the hospital, "participat[ing] in the board meetings regarding the adverse action against" a doctor, "participat[ing] in the board meetings during which [a doctor]'s peer review was discussed," or "present[ing] the executive committee's case before [a] review committee [or] the fair hearing panel." Doe v. Delnor Cmty. Health Sys., No. 2-10-0880, 2011 Ill. App. Unpub. LEXIS 2418, at *43 (Ill. App. Ct. Sept. 29, 2011).

[75] *See, e.g.*, Koepke, *supra* note 10, at 6–8; William M. Johnston, *Shammed I Am, in Peer Review: Due Process Does Not Apply for Physicians Facing Sham Peer Review*, GEN. SURGERY NEWS (Aug. 8, 2004), http://www.generalsurgerynews.com/Opinions-Letters/Article/08-04/Shammed-I-Am-in-Peer-Review/3894. Additional examples are cited in Van Tassel, *supra* note 40, at 954–55.

[76] Steve Twedt, *The Cost of Courage: How the Tables Turn on Doctors*, PITTSBURGH POST-GAZETTE, Oct. 26, 2003, at A1.

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the NPDB.[77] Often, such a report seriously damages a doctor's career, as hospital employers and health insurance companies are reluctant to have the doctor serve as a preferred provider within their insurance networks.

To be sure, doctors who are victims of sham peer review do, in theory, have a legal remedy. Congress provided only qualified immunity to the peer review process, not absolute immunity. The immunity can be overcome, and a federal civil suit for damages can be maintained, if the disciplined doctor can show that the discipline was not taken "in the reasonable belief that the action was in the furtherance of quality health care," or that one of the other prerequisites of the HCQIA was not met.[78] Some suits alleging sham peer review have been successful even in the face of federal and state immunities. Nevertheless, these suits are now severely hampered, and often courts give enormous deference to the peer review process—possibly more deference than the immunity statutes intend.[79] In fact, out of 133 challenges to immunity under HCQIA by 2011, only seventeen (12.8%) were successful in vacating immunity.[80]

II. Improper Leniency

i. Peer Review Committees that are Biased in Favor of the Accused Doctor or not Convened at all

Just as improper motivations protected by immunity and secrecy can lead hospitals and self-interested reviewers to mete out unjustified punishment, these factors can also lead hospitals and self-interested reviewers to withhold justified punishment and whitewash a doctor's misconduct. Improper motives for leniency can include personal friendships and collaborative relationships with the accused doctor. Physician reviewers not in the same specialty as the doctor under review may lose patient referrals from that doctor.[81] Physicians in the same specialty may also have collaborative relationships; for example, they may cross-cover for the accused doctor to maintain hospital on-call coverage.[82] Once again, internal reviewers may simply accede to the will of hospital administrators who have their own improper motivations, this time in favor of the accused doctor.

Peer review bodies that are disposed to improper leniency are in a way more insidious than those that are disposed to improper severity. At least in the event of sham peer review, there is one party—the doctor under review—who has some idea what has occurred and may be motivated to contest the result. When a peer review body improperly exonerates the doctor, no one may be aware that something is amiss because the process is shrouded in secrecy.

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[77] *See* 42 U.S.C. § 11133(a)(1)(A) (2012).
[78] *See id.* § 11112(a).
[79] *See* Eleanor D. Kinney, *Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?*, 13 MICH. ST. U. J. MED. & L. 57, 67–68 (2009).
[80] Susan Lapenta, J.D., Horty, Spinger, and Mattern P.C., Peer Review Protections: Lessons Learned from Battles Lost Presentation at the American College of Obstetricians and Gynecologists' Quality and Safety for Leaders in Women's Health Care course (June 9-11, 2011).
[81] *See* ROGAN ET AL., *supra* note 49, at 30; *see also* Scheutzow, *supra* note 9, at 10–11.
[82] Telephone Interview with Michael Benson, Clinical Assoc. Professor, Nw. Univ. Feinberg Sch. of Med. (Feb. 16, 2012) ("Virtually all medical specialties that involve some sort of hospital presence require continuous 24/7 emergency availability, or on-call coverage.") This is a vital function of most specialties of medical practice. Physicians often cross-cover for each other across employment boundaries (i.e., the hospital-employed vs. private practice divide or among different private practice groups). *Id.*

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Because of the shroud of secrecy, it is impossible to prove how frequently such cases occur, but one indication of the danger can be seen in the dramatic failure of peer review in the Redding Medical Center scandal. At Redding Medical Center in Redding, California, two cardiac specialists, Drs. Moon and Realyvasquez, conspired to perform an enormous number of unnecessary heart surgeries between 1992 and 2002.[83] Moon, the director of cardiology, intentionally misdiagnosed patients as needing complicated surgery and referred them to Realyvasquez, the director of cardiac surgery.[84] As a result, patients died, but the two doctors were enriched, as was Redding Medical Center.[85] The hospital administrators, along with Moon and Realyvasquez, blocked peer review of the unnecessary surgeries, even though other doctors at Redding raised alarms.[86] If peer review were a public process, it would be difficult to get away with such a scheme, but due to the web of federal and state protections, no one knows what happens in the peer review process—and no one can find out.

ii. Thwarting the Negligent Credentialing Tort

Tort law provides one avenue that can potentially discourage hospitals from refusing to conduct necessary peer review, or from whitewashing a doctor's errors in a peer review proceeding that is biased in favor of the accused doctor. Many states allow a tort action for negligent credentialing.[87] In those states, a doctor's hospital privileges must be authorized and periodically reauthorized by credentialing committees.[88] If a doctor commits malpractice, the injured plaintiff can attempt to sue not only the doctor, but also the hospital under a number of theories. One of those theories is that the hospital negligently granted or extended hospital privileges to the doctor.[89] Such an action might also challenge the failure of the hospital to institute peer review of the doctor's past mistakes or claim that a peer review proceeding was biased in favor of the doctor.[90]

However, the very state statutes that protect the peer review process from claims by doctors that it was too harsh have also been used, at times, to defeat negligent credentialing actions alleging improper leniency. For example, in Tennessee and Colorado, appellate courts have decided that state peer review statutes barred claims for damages for negligent credentialing.[91]

It is even arguable that the HCQIA bars every negligent credentialing action, in every state.[92] The HCQIA extends its protection to "a professional review action . . . of a professional

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[83] ROGAN ET AL., *supra* note 49, at 4.
[84] *See id.* at 8–9.
[85] *See id.* at 7–9.
[86] *Id.* at 8–9.
[87] *See, e.g.*, Larson v. Wasemiller, 738 N.W.2d 300, 313 (Minn. 2007).
[88] Ambulatory Care Program: The Who, What, When, and Where's of Credentialing and Privileging, The Joint Commission Accreditation: Ambulatory Care, *available at* http://www.jointcommission.org/assets/1/6/AHC_who_what_when_and_where_credentialing_booklet.pdf.
[89] The plaintiffs bar already brings actions for negligent credentialing on behalf of patients. *See, e.g.*, Richard L. Griffith & Jordan M. Parker, *With Malice Toward None: The Metamorphosis of Statutory and Common Law Protections for Physicians and Hospitals in Negligent Credentialing Litigation*, 22 TEX. TECH L. REV. 157, 161–65 (1991).
[90] *See generally* Scheutzow, *supra* note 9, at 21–22.
[91] *See* Kauntz v. HCA-Healthone, LLC, 174 P.3d 813, 817 (Colo. App. 2007); Smith v. Pratt, No. M2008-01540-COA-R9-CV, 2009 WL 1086953, at *5 (Tenn. Ct. App. Apr. 22, 2009).
[92] *See* Scheutzow, *supra* note 9, at 23–25.

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review body" which meets the various requirements of the statute.[93] A credentialing committee would fit within this definition as well as a disciplinary peer review committee. The HCQIA does have a provision stating that it shall not be "construed as affecting in any manner the rights and remedies afforded patients under any provision of Federal or State law to seek redress for any harm or injury suffered as a result of negligent treatment or care by any physician, health care practitioner, or health care entity."[94] However, it is unclear whether a negligent credentialing claim is a claim seeking redress for "any harm or injury suffered as a result of negligent treatment or care." Indeed, the Texas Supreme Court has suggested, in *dicta*, that a negligent credentialing claim is not a claim of negligent treatment and therefore might be barred by the HCQIA.[95]

Even if the federal HCQIA is not interpreted to bar negligent credentialing claims, some state peer review statutes have been so interpreted. By removing the threat of these tort claims, courts have removed a major incentive for hospitals to avoid improper leniency.

iii. Underreporting to the NPDB

Perhaps the most striking irony of the web of protections that surrounds the peer review system is that it undermines the NPDB reporting system contained in the HCQIA. The NPDB reporting system is widely viewed as deficient, with substantial and perhaps massive underreporting of actions by hospitals against doctors affecting their clinical privileges.[96] A 2009 report by Public Citizen, titled *Hospitals Drop the Ball on Physician Oversight*, lays out some of the dimensions of the problem.[97] Before the HCQIA took effect, it was estimated that 5,000 to 10,000 hospital adverse actions per year would be reported to the NPDB.[98] However, between the years 1990 and 2007, an average of only 650 reportable incidents were submitted per year, and the number of adverse actions reported per year has been trending down over time.[99] As of December 31, 2007, forty-nine percent of U.S.-NPDB registered hospitals (2,845 out of 5,823) "had never reported a clinical privilege sanction to the NPDB."[100]

There are ways to get around reporting peer review actions to the NPDB. In an attempt to understand the variation in state reporting, the Health Resources and Services Administration (HRSA) funded a study in 1994 of 144 rural hospitals in the Pacific Northwest region.[101] In that study, approximately one-fifth of the hospitals increased activities that would enable them to avoid reporting to the NPDB, such as increased monitoring without restricting clinical privileges, requiring continuing medical education in lieu of restricting privileges, "having physicians resign or voluntarily surrender clinical privileges . . . , and imposing disciplinary periods [of shorter] than [thirty-one] days."[102] Of these various measures, only one formally violates the HCQIA:

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[93] *See* 42 U.S.C. § 11111(a)(1) (2012).
[94] *Id.* § 11115(d).
[95] *See* St. Luke's Episcopal Hosp. v. Agbor, 952 S.W.2d 503, 507 (Tex. 1997).
[96] *See, e.g.*, Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank: Clinical Privileges Action Reports*, 281 JAMA 349, 350–51 (1999); *see also* LEVINE & WOLFE, *supra* note 36, at 2–3; Waters et al., *supra* note 20, at 36.
[97] *See* LEVINE & WOLFE, *supra* note 36, at 5–9.
[98] *Id.* at 5.
[99] *Id.*
[100] *Id.* at 9.
[101] *Id.* at 16.
[102] *Id.* at 16; *see also* William E. Neighbor et al., *Rural Hospitals' Experience with the National Practitioner Data Bank*, 87 AM. J. PUB. HEALTH 663, 665 (1997).

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having physicians resign or voluntarily surrender clinical privileges under threat of peer review, without reporting this action.[103] However, it is a violation that is unlikely to be detected, due to the secrecy that surrounds the peer review process.

Underreporting by hospitals to the NPDB is a problem of incentives. First, there is no effective sanction for underreporting at the federal level. Through a laborious process, the Secretary of Health and Human Services has the power to revoke the HCQIA immunity of hospitals that engage in a pattern of non-reporting, but this sanction has never been imposed.[104] Public Citizen urges that the HCQIA be amended to allow the imposition of civil fines for each failure of a health care entity "to report an adverse action to the [NPDB]."[105]

We agree with this recommendation.[106] We contend, however, that the major incentive for underreporting is the shroud of secrecy and immunity surrounding the peer review process, which makes it too easy for hospitals to violate their reporting obligations without detection. Others share this concern, though they may make the point in a more understated way. For example, in a 2006 article, Waters et al. state:

> [T]he inability of regulatory authorities to police reporting permits and may even facilitate institutional failure to report these reportable actions. Regulatory agencies generally do not have easy access to the universe of peer review and disciplinary actions by institutions to compare with those that are reported because such actions are considered confidential and shielded by many state statutes. While such restrictions are often cited as necessary to protect patient confidentiality and practitioner reputation, they make it extremely difficult to hold institutions accountable for meeting reporting requirements.[107]

In 2002, as described in the Public Citizen report, a failed study attempted to gauge hospitals' and HMOs' compliance with their NPDB reporting obligations.[108] Even though the health organizations selected to participate in the study were offered amnesty for violations and other incentives, they still refused to participate, unwilling to disclose their peer review records.[109] The study was thus abandoned.[110]

This abandoned study was initiated by PricewaterhouseCoopers (PwC) on behalf of the Health Resources and Services Administration.[111] In its report, PwC recommended that "HRSA . . . seek legislative authority and funding for conducting compliance reviews of clinical privilege reporting, including authority to access peer review records."[112]

Although we are convinced that the secrecy surrounding the peer review process is the main impediment to fuller compliance by hospitals with their reporting obligations, this is once again hard to prove. A great deal of useful information about NPDB reporting can be gleaned

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[103] *See* 42 U.S.C. § 11133(a)(1)(B)(ii) (2012).
[104] LEVINE & WOLFE, *supra* note 36, at 8.
[105] *Id.* at 32.
[106] Other commentators also propose giving regulatory authorities greater flexibility to sanction hospitals. *See, e.g.*, ROGAN ET AL., *supra* note 49, at 31–32; Kinney, *supra* note 79, at 84.
[107] Waters et al., *supra* note 20, at 38.
[108] *See* LEVINE & WOLFE, *supra* note 36, at 28.
[109] *See id.* at 28–29.
[110] *Id.* at 29.
[111] *Id.* at 28.
[112] *Id.* at 29. Public Citizen supported this recommendation. *Id*. at 32.

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from the University of Washington (UW) study presented by Scheutzow, concerning the effect of state laws on NPDB reporting.[113] The UW study found that—controlling for various factors that might influence reporting of adverse events to the NPDB—the strength of state immunity and privilege statutes had an unexpected *negative* effect on reporting: states with stronger protection for the peer review process had less reporting.[114] Confidentiality laws, the study found, had no effect on reporting.[115]

The UW study did find that the three states that imposed substantial penalties for failure to report adverse events to the state licensing board (events that would also have to be reported to the NPDB) had increased reporting to the NPDB.[116] This finding underlines the fact that hospitals now have insufficient incentive to report adverse events to the NPDB. As deterrence is a function both of the strength of the penalty and the likelihood of getting caught, we believe the finding of increased NPDB compliance in high-penalty states supports our argument that making it harder for hospitals to hide their peer review activities would increase adverse event reporting. The finding of increased NPDB compliance in high-penalty states also supports the proposal—advanced by Public Citizen and other commentators—that additional non-reporting penalties, such as fines, be added to the HCQIA.

It might be thought that our argument is undermined by the UW study's finding that the strength of confidentiality laws has no effect on reporting. If secrecy discourages reporting, as we argue, would not stronger confidentiality laws actually *decrease* reporting? However, the dual protection afforded to the peer review process by federal and state laws has resulted in a level of secrecy that is universally high, regardless of state confidentiality laws. The strength of the culture of secrecy is illustrated by the failed PwC study described above.

iv. The NPDB as a Disclosure-Based Regulatory Scheme

At its heart, the system for reporting adverse peer review actions is a disclosure-based regulatory scheme.[117] A Harvard study examined several such disclosure systems: SEC financial disclosure, nutrition labeling, reporting of medical mistakes, toxic release disclosure, publication of patterns of mortgage lending, and disclosure of unions' financial information.[118] The study found that successful schemes had three characteristics: "strong . . . intermediaries representing information users," a benefit to information disclosers from good disclosure, and standards that allow information to be understood and compared.[119]

The NPDB reporting system may not be completely comparable to some other disclosure-based systems, but it is still instructive to consider to what extent the current NPDB system exhibits the characteristics of a successful disclosure-based regulatory system. We contend that the current NPDB system falls short on all three counts. Under the current system, there is insufficient benefit to hospitals from full disclosure because there is little prospect that a hospital failing to make full disclosure will be penalized. Also under the current system, there are

[113] *See generally* Scheutzow, *supra* note 9, at 39–47.
[114] *See id.* at 43.
[115] *See id.*
[116] *See id.* at 44.
[117] *See generally* Archon Fung et al., *The Political Economy of Transparency: What Makes Disclosure Policies Sustainable?* (Harvard Univ. John F. Kennedy Sch. of Gov't Faculty Research Working Paper Series, Paper No. RWP03-039, 2003), *available at* http://ssrn.com/abstract=384922.
[118] *See id.* at 6.
[119] *See id.* at 38–40.

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no strong intermediaries benefiting information users. The hospital controls the process, which is secretive.

As to the comparability of information, it is ostensibly standardized: a hospital that queries the database can tell whether a doctor has had his clinical privileges revoked, suspended for sixty days, and so on.[120] Yet, because the current system of peer review is so prone to error, as argued above, the information is not truly comparable. Some disciplined doctors have shown serious incompetence, while others have been the victims of "sham peer review."[121] The penalty is comparable, but the quality of the peer review process itself is not comparable due to the federal and state protections of the process.

In enacting the HCQIA, Congress was far more concerned with reducing improper leniency than with reducing improper severity. The immunity in the HCQIA, and in parallel state statutes, allows peer review bodies to impose discipline without much fear of litigation, even though this immunity makes it easier to conduct sham peer review. The NPDB system spreads reports of discipline nationwide, even though this reporting system magnifies the effect of sham peer review and may drive good doctors out of the profession.

The Congressional emphasis on reducing improper leniency is evident in the Congressional findings set forth in the HCQIA.[122] Given this predominant concern with reducing improper leniency, it might be thought—or it might once have been thought—that increasing improper severity was a necessary price worth paying. Experience has shown, however, that the dual federal-state system of peer review protections has not resulted in a trade-off in which improper leniency was reduced at the cost of increasing improper severity. Rather, as we have shown, the system tends to increase both kinds of errors: improper leniency as well as improper severity.

We earlier listed the three assumptions underlying the practice of traditional disciplinary peer review, according to Moore et al.[123] The third assumption is that "peer review participants are motivated to maintain high standards of care in their group or institution and act in good faith."[124] Experience has shown that this assumption, in particular, is naive. Doubtless peer reviewers often have noble motivations and often act in good faith, but they also often have self-interested motivations disposing them toward improper severity or improper leniency: motivations that are magnified, rather than inhibited, by the current regulatory scheme.

IV. OPENING UP THE SYSTEM

Our proposed solution to the problems of hospital peer review is to open up the system: to eliminate completely all immunity, privilege, and confidentiality under federal and state law. We realize how radical this proposal is.[125] It is an idealized vision, not a proposal that we necessarily expect to be adopted any time in the near future.

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[120] *See* U.S. DEP'T OF HEALTH & HUMAN SERVS., HEALTH RES. & SERVS. ADMIN., NPDB GUIDEBOOK, at E-1 to -5, E-30 to -31 (2015), *available at* http://www.npdb.hrsa.gov/resources/npdbguidebook.pdf/.
[121] *See* Koepke, *supra* note 10, at 10–13.
[122] *See* 42 U.S.C. § 11101 (2012).
[123] *See supra* Part I.
[124] Moore et al., *supra* note 16, at 1177.
[125] Which is not to say it is completely original. *See, e.g.*, Koepke, *supra* note 10 (focusing mainly on the problem of sham peer review); van Geertruyden, *supra* note 10.

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The elimination of privilege, immunity and confidentiality would mean that hospitals (and peer reviewers, internal and external) could be sued by doctors alleging sham peer review. Hospitals could be sued by patients who allege negligence in credentialing and in allowing doctors to retain clinical privileges. Medical malpractice plaintiffs having a claim against a doctor could monitor any disciplinary peer review of the doctor's behavior and could use information thus obtained in their cases.[126] Instead of being insulated from liability on all sides, the peer review process would be open to challenge from all interested parties and open to examination by those parties. Opening up the process in this way should reduce both kinds of errors to which the current system is subject: improper severity and improper leniency.

Scheutzow would remove immunity on one side of the process, but not on the other.[127] She urges states to allow negligent credentialing suits and Congress to "take steps to ensure that the [HCQIA] cannot be interpreted to provide immunity for negligent credentialing matters."[128] But having protected the right to sue for negligent credentialing, Scheutzow would retain "immunity from lawsuits brought by those physicians adversely affected by the process."[129]

We disagree: all immunities related to the peer review process must be eliminated. If hospitals are subject to liability for improper leniency (through negligent credentialing suits) but not for improper severity, their incentives will be tilted even more strongly toward improper severity. Opening up the process to claims from both doctors and injured patients will encourage peer review decisions that are properly balanced and correct: neither improperly lenient nor improperly severe.

A. Peer Review Not Discouraged

We now examine in detail the likely effects of our radical proposal and respond to a number of objections. An obvious objection is that opening up the system will discourage peer review. This objection must be clarified, however: discourage peer review in place of what? There are two basic ways in which hospitals might reduce the practice of peer review, and each requires a somewhat different analysis. First, hospitals could forego any discipline of doctors, allowing them to retain clinical privileges even in the face of clear misconduct. Second, hospitals could deprive doctors of clinical privileges, but without conducting peer review.

The unduly permissive practice of allowing doctors to retain privileges without going through peer review, even after they endanger patient health, is one that exists now for doctors who receive favoritism from their hospitals and colleagues.[130] This permissiveness will most likely decrease once the system is opened up. Injured patients will demand peer review and will be able to verify whether it is taking place. Hospitals will face the possibility that, if they improperly fail to conduct peer review, future patients who are injured by a doctor will sue the hospital for negligently allowing the doctor to remain credentialed.

True, the hospital will also lose its immunity to suits by doctors who claim they have been wrongly deprived of their clinical privileges. But the balance of incentives should still lead hospitals to conduct peer review when it is warranted. The prospect of a strong negligent credentialing suit by a future patient, with its attendant negative publicity, should outweigh the

[126] Though the evidence may be barred by Rule 407 of the Federal Rules of Evidence or state analogues as a "subsequent remedial measure." *See* Fox v. Kramer, 994 P.2d 343, 351–53 (Cal. 2000).
[127] *See* Scheutzow, *supra* note 9, at 56.
[128] *Id.*
[129] *Id.*
[130] *See* discussion *supra* Part II.B.2.

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prospect of a weak suit by a doctor who really does deserve to lose his privileges. Conversely, if peer review is not warranted, or discipline after peer review is not warranted, the balance of incentives in an open system should lead hospitals *not* to deprive doctors of their clinical privileges: the prospect of a strong suit by the doctor (no longer barred by immunity) should outweigh the prospect of a weak negligent credentialing suit by a future patient.

The other way in which hospitals might reduce the practice of peer review under an open system is by depriving doctors of clinical privileges *without* peer review. This also happens under the current system, and results in underreporting to the NPDB.[131]

Hospitals can coerce doctors into surrendering their privileges under threat of sham peer review, then fail to report this action to the NPDB, even though by law such a surrender of privileges under threat of peer review must be reported.[132]

Once again, however, such practices would be less likely under an open system. Without the immunity that often protects sham peer review, doctors will not be so easily cowed into surrendering their privileges; they will demand peer review. In short, we are not convinced by the objection that an open system will lead hospitals to reduce the use of peer review, either by allowing doctors to retain privileges without going through peer review or by depriving them of privileges without peer review.

B. Increased Use of External Reviewers

Most peer review proceedings involve internal review: the physician is judged by colleagues who are affiliated with the same hospital.[133] As argued above, conflicts of interest are inherent in such a process. The use of external reviewers would greatly alleviate these conflicts.[134]

Opening up the system as we propose would encourage hospitals to use external reviewers in the peer review process. If a hospital is sued because of its peer review results, whether by a doctor or a patient, its defense will be significantly more credible if it can show that it followed the decision of external reviewers. Following the decision of external reviewers would certainly tend to negate the inference of improper bias, either for or against the doctor being reviewed. Once the peer review system loses its shield of immunity, hospitals will more often decide that they need the greater credibility of external review.

An increased use of external reviewers would likely improve the quality of peer review not only because of the avoidance of bias, but because external reviewers will be compensated at market rates. Internal peer reviewers are generally uncompensated; peer review is a duty they must fulfill in order to maintain staff privilege at the hospital.[135] Of course, a process in which individuals are compelled to donate their time is likely to be short-changed on time and effort.

Ironically, many physicians who act as internal reviewers without compensation are able to earn hundreds of dollars per hour for performing a similar function: providing reviews as

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[131] *See, e.g.*, LEVINE & WOLFE, *supra* note 36, at 16; Baldwin et al., *supra* note 96, at 351; Waters et al., *supra* note 20, at 37; discussion *supra* Part II.B.2.c.
[132] *See* 42 U.S.C. § 11133(a)(1)(B)(ii) (2012).
[133] *See* Edwards & Benjamin, *supra* note 15, at 462.
[134] External reviewers should be required to make a formal declaration of any potential conflict of interest. Presumably, hospitals would avoid using conflicted external reviewers.
[135] Robert Marder, *Peer Review Monthly: Why is Peer Review Hard to Do?*, HCPRO (Oct. 8, 2008), http://www.hcpro.com/MSL-221119-871/Peer-Review-Monthly-Why-is-peer-review-hard-to-do.html.

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expert witnesses in medical malpractice cases.[136] Quality of care would be served by spending some of this money up front while the case is being reviewed in a medical context—before it gets to a courtroom.

Hopefully, the removal of immunity, privilege, and confidentiality would lead eventually to the creation of a cadre of professional, compensated, and specifically trained and credentialed peer reviewers. If there were an accrediting organization for peer reviewers, it would probably be best for that organization to select the external reviewers for each case, rather than leaving that function in the hands of the hospital. External selection of the external reviewers would further minimize the ability of hospitals to manipulate the results of the review process.[137]

C. Effect on Internal Reviewers

A major justification given for peer review immunity in the existing system is that *internal* reviewers would not participate if they risked getting sued.[138] Opening up the system, as we propose, would admittedly discourage internal reviewers from participating. That, however, is not a telling objection to our proposal; rather, it is an advantage. Our proposal would move toward a system in which the external reviewer is more common and the internal reviewer is rarer; we would not be disappointed if the internal reviewer disappeared entirely.

Nevertheless, even if all our proposals were adopted, hospitals would likely still continue to use at least some internal reviewers; after all, internal reviewers were used before all the immunities and other peer review protections that now exist were written into federal and state law. Hospitals would likely address the internal reviewers' fear of liability by providing them with insurance from an insurance company or by having the hospital itself agree to defend and indemnify them against resulting litigation. Even with insurance, the removal of immunity should have a salutary effect on the way internal reviewers perform their function, giving them greater incentives to avoid both improper severity and improper leniency.

D. Effect on NPDB Underreporting

Opening up the peer review system would likely reduce NPDB underreporting to a considerable degree. With peer review proceedings public, it will be much harder to hide adverse actions that should be reported to the NPDB.[139] Hospitals will be wary of evading NPDB reporting by imposing too minimal sanctions (such as educational requirements or a suspension of less than thirty days), for fear of provoking negligent credentialing suits. And we have already noted that hospitals will be less able to coerce doctors to surrender their privileges by threatening peer review; if the doctor believes he deserves to retain his clinical privileges, he will be more likely to have faith in the peer review process and to demand that the process be followed.

But we have an additional proposal that should promote accurate NPDB reporting to an even greater extent. If there is a failure in NPDB reporting at one hospital that leads to a doctor gaining clinical privileges at a second hospital and then injuring a patient through malpractice,

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[136] *Id.*; *see generally Expert Witness Fee Study*, SEAK, INC., http://www.seak.com/Expert_Witness_Fees.html (last visited Feb. 4, 2016).

[137] Professor Kinney has suggested that Quality Improvement Organizations (QIOs) provide external reviewers. *See* Kinney, *supra* note 79, at 84–85. "QIOs are physician-dominated organizations [that] conduct reviews of the quality of medical care provided to Medicare beneficiaries." *Id.* at 84. However, we believe that these organizations, as part of the Medicare system, are too focused on issues of cost to reliably fill the role of selecting external reviewers.

[138] *See* 42 U.S.C. § 11101(4) (2012).

[139] *See* discussion *supra* Part II.B.2.

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the injured patient should have a cause of action against the first hospital as well as any other appropriate defendants. Enforcing the NPDB reporting obligations through a private right of action should magnify the incentive of hospitals to comply fully with those obligations.

As we earlier observed, the NPDB system can be seen as a disclosure-based regulatory system.[140] Research has shown that such a regulatory system, if successful, has three characteristics: strong intermediaries representing information users, a benefit to information disclosers from good disclosure, and standards that allow information to be understood and compared. The current peer review system does not display these characteristics, but our proposals would go far to remedy its defects.

To repeat, under the current system, there is insufficient benefit to hospitals from full disclosure because there is little prospect that a hospital failing to make full disclosure will be penalized. Also under the current system, there are no strong intermediaries benefiting information users. The hospital controls the process, which is secret. The penalties reported to the NPDB are ostensibly comparable, but the peer review proceedings resulting in those penalties are not comparable: no one can tell whether the doctor was justifiably disciplined or was the victim of a sham peer review.

Under our proposed reforms, by contrast, the NPDB reporting system would have the characteristics of a successful disclosure-based regulatory scheme. Hospitals would have greater incentive to comply fully with their NPDB reporting obligations because it would be much harder for them to conceal actions that they are obliged to report. As noted above, in addition to opening up the peer review system, we support making additional sanctions available for non-reporting, such as civil fines, and we support the creation of a new private right of action against hospitals that violate their NPDB reporting obligations. These reforms would give hospitals even greater incentives to comply with their NPDB reporting obligations.

An open peer review system would have a variety of strong intermediaries promoting full NPDB reporting. These would include external reviewers, who would not want to be associated with deficient peer review systems, and medical malpractice plaintiffs and their attorneys, who would focus public attention on allegations of serious medical incompetence being heard by the peer review system. If our proposal for a private right of action against hospitals violating their NPDB reporting obligations were adopted, additional strong intermediaries promoting disclosure would be added.

An open and public peer review system would also produce results that are comparable. The methodology and format of the most credible reviews would be expected to become standard.

There has always been something paradoxical about the attempt to create a transparent and public database of physician discipline by channeling into it reports from an impenetrably secret and virtually unchallengeable closed peer review system. There is certainly no guarantee that an open system will improve NPDB reporting, but that result seems very likely to us.

E. Problems of Cost

Our proposals would add a number of visible costs to the peer review system. At least initially, litigation that is now barred or discouraged by peer review protections would likely increase. More doctors would challenge the results of an adverse peer review, more patients would sue hospitals for negligent credentialing, and more patients would bring malpractice cases based on information obtained from a public peer review process.

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[140] *See* discussion *supra* Part II.B.2.d.

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The peer review process itself would also become more expensive for hospitals. They would substantially increase the number of external reviewers they use, and each external reviewer would probably receive a higher fee, reflecting the increased risk of being sued and the increased cost of insurance to the external reviewer. The cost of insuring and/or indemnifying internal reviewers would also rise, and hospitals might even find themselves compensating internal reviewers for their time. Arguably, all of these additional costs of an open peer review system could cause some rise in the cost of health care.

Despite the increased visible costs of an open system, we contend that improving the results of peer review, through our proposals, would improve the quality of care and would reduce social costs overall. "Sham" peer review would no longer drive good doctors out of the profession at great social cost. Nor would "sham" peer review deter legitimate criticism and "whistleblowing" by doctors, as it does now. Bad practices and bad doctors would be caught more quickly in an open system that is subject to challenge by all interested parties, reducing great damage that would otherwise be done. In short, liability exposure to all interested parties would cause the quality of care to improve. With improved quality, the malpractice costs of hospitals and doctors could actually decline over time.

Even in the short term, opening up the peer review system to challenge from all sides may not produce a litigation explosion. The immediate improvement in the peer review process, due to increased use of external reviewers and loss of immunity, should limit the number of cases brought by doctors alleging "sham" or bad-faith peer review. As to malpractice cases, when peer review finds a culpable error, plaintiffs will certainly be eager to use that ammunition in their court cases. Often, however, peer review will not find that the doctor is at fault. In such cases, the enhanced credibility of the peer review process may discourage litigants from bringing a malpractice case.

Moreover, a significant percentage of malpractice claims are brought by patients because they feel that the hospital or physicians are hiding something.[141] Although it is conceded that in many of these cases facts may actually be hidden, in many other cases they are not. Publicly accessible peer review records would go a long way toward reassuring patients and their families that they have all the facts.[142]

V. CONCLUSION

The well-intended immunity from civil liability for peer review established by the HCQIA, along with state immunity, privilege, and confidentiality, have the paradoxical effect of shielding hospital quality improvement processes from outside scrutiny and discouraging mandated reporting of adverse actions against hospital physicians. These legal protections should be removed. The resulting market forces can be expected to create a more credible and robust peer review process that will result in improved hospital quality and reporting. It is both ironic and unsettling that the court system—with its use of discovery available to all parties, and compensated medical experts that practice in the same field as the care provider—creates a more

[141] *See, e.g.*, Kathleen Shostek & Christine Clark, *Communication Plays Key Role in OB Patient Expectations*, J. HEALTHCARE RISK MGMT., Autumn (Fall) 2008, at 29, 29; Richard A. Spector, *Plaintiff's Attorneys Share Perspectives on Patient Communication*, 29 J. HEALTHCARE RISK MGMT., no. 3, 2010, at 29, 30.

[142] One study has shown that lawsuits and legal costs decrease when disclosure programs are implemented. *See* Allen Kachalia et al., *Liability Claims and Costs Before and After Implementation of a Medical Error Disclosure Program*, 153 ANNALS INTERNAL MED. 213, 217 (2010) (finding that disclosure-and-offer program reduced frequency of lawsuits and liability costs at the University of Michigan Health System).

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credible peer review product than the health care industry. We contend that it would be better for this level of effort to occur first as a hospital activity rather in the courts. Repeal of peer review immunity, privilege, and confidentiality is a large and necessary first step.

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Summary of State Peer Review Protections

State	Immunity	Privilege	Confidentiality	Comments
Alabama	ALA. CODE § 34-24-58 (2013); *see also* ALA. CODE § 6 6-5-333(A) (2013).	ALA. CODE § 34-24-60 (2013); *see also* ALA. CODE § 6-5-333(D) (2013).	See Privilege.	
Alaska	ALASKA STAT. ANN. §§ 18.23.010, 18.23.020 (West 2013).	ALASKA STAT. ANN. § 18.23.030 (West 2013).	See Privilege.	
Arizona	ARIZ. REV. STAT. ANN. § 36-445.02 (2013).	ARIZ. REV. STAT. ANN. § 36-445.01 (2013).	See Privilege.	
Arkansas	ARK. CODE ANN. § 20-9-502 (West 2013).	ARK. CODE ANN. § 20-9-503(a) (West 2013).	None.	
California	None.	CAL. EVID. CODE § 1157 (West 2013).	None.	California opted out of the peer review provisions of the HCQIA but not the reporting requirements to the NPDB. CAL. BUS. & PROF. CODE § 809 (West 2013).
Colorado	COLO. REV. STAT. ANN. § § 12-36.5-105 (West 2013); *see also* COLO. REV. STAT. ANN. § 25-3-109(6) (West 2013).	COLO. REV. STAT. ANN. § § 25-3-109(4) (West 2013).	COLO. REV. STAT. ANN. § 25-3-109(1) (West 2013).	"[I]mplementation of quality management functions to evaluate and improve patient and resident care is essential . . . [so it] is necessary that the collection of information and data by such licensed or certified health care facilities be reasonably unfettered. COLO. REV. STAT. ANN. § 25-3-109 (West 2013).
Connecticut	CONN. GEN. STAT. ANN. § 19a-17b(b) (West 2013).	CONN. GEN. STAT. ANN. § 19a-117b(d) (West 2013).	CONN. GEN. STAT. ANN. § 19a-17c (West 2013).	

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Delaware	DEL. CODE ANN. tit. 24, § 1768(A) (West 2013).	DEL. CODE ANN. tit. 24, § 1768(B) (West 2013).	See Privilege.	
Washington, D.C.	D.C. CODE § 44-803 (2013).	D.C. CODE § 44-805 (2013).	See Privilege.	
Florida	FLA. STAT. ANN. § 395.0193(5) (West 2013).	FLA. STAT. ANN. § 395.0193(8) (West 2013).	None.	
Georgia	GA. CODE ANN. § 31-7-132 (West 2013).	GA. CODE ANN.. § 31-7-133 (West 2013).	See Privilege.	
Hawaii	HAW. REV. STAT. §6331.7 (2013).	HAW. REV. STAT. §624-25.5 (2013).	See Privilege.	
Idaho	IDAHO CODE § 39-1392c (West 2013).	IDAHO CODE § 39-1392b (West 2013).	See Privilege.	
Illinois	225 ILL. COMP. STAT. 60/5 (2013).	735 ILL. COMP. STAT. 5/8-2101 (2013*); see also* 735 ILL. COMP. STAT. 5/8-2102 (2013).	735 ILL. COMP. STAT. 5/8-2101 (2013).	735 ILL. COMP. STAT. 5/8-2105 (2013). (Improper disclosure is a misdemeanor)
Indiana	IND. CODE §§ 34-30-15-15–20 (2013).	IND. CODE § 34-30-15-1 (2013).	IND. CODE § 34-30-15-8 (2013).	
Iowa	IOWA CODE § 147.135(1) (2013).	IOWA CODE § 147.135 (2) (2013).	See Privilege.	
Kansas	KAN. STAT. ANN. §65-4909 (2013).	KAN. STAT. ANN. §65-4915(B) (2013).	See Privilege.	Such goals may be achieved by requiring a system which combines a reasonable means to monitor the quality of health care with the provision of a reasonable means to compensate patients for the risks related to receiving health care rendered by healthcare providers licensed by the state of Kansas. Kan. Stat. Ann. §65-4914 (West).

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Kentucky	KY. REV. STAT. ANN. § 311.377(1) (2013).	KY. REV. STAT. ANN. § 311.377(2) (2013).	See Privilege.	Instead of offering immunity to the reviewers, the statute instead says that anyone who applies for/is granted privileges waives any claim to damages that may result from peer review.
Louisiana	LA. REV. STAT. ANN. § 13:3715.3(B)–(C) (2013).	LA. REV. STAT. ANN. § 13:3715.3(A) (2013).	See Privilege.	
Maine	ME. REV. STAT. ANN. tit. 24, § 2511 (West 2013); ME. REV. STAT. tit. 32, § 3293 (West 2013).	ME. REV. STAT. ANN. tit. 32, § 2599 (West 2013).	ME. REV. STAT. ANN. tit. 24, §§ 2510, 2510-A (West 2013).	
Maryland	MD. CODE ANN., HEALTH OCC. § 1-401(f) (West 2013).	MD. CODE ANN., HEALTH OCC. § 1-4001(d) (West 2013).	See Privilege.	
Massachusetts	MASS. GEN. LAWS ANN. ch. 231, § 85N (West 2013).	MASS. GEN. LAWS ANN. ch. 111, § 204 (West 2013).	See Privilege.	
Michigan	MICH. COMP. LAWS ANN. § 331.351 (West 2013).	MICH. COMP. LAWS ANN. §331.533 (West 2013).	See Privilege.	
Minnesota	MINN. STAT. §§ 145.62–63 (2013).	MINN. STAT. § 145.64(1) (2013).	See Privilege.	Penalty for disclosure is a misdemeanor. MINN. STAT. § 145.66 (2013).
Mississippi	MISS. CODE ANN. § 41-63-5 (West 2013).	MISS. CODE ANN. § 41-63-9 (West 2013).	See Privilege.	"[E]xpressed legislative purpose of promoting quality patient care through medical and dental peer review activities." MISS. CODE ANN. § 41-63-9 (West 2013).
Missouri	MO. REV. STAT. § 537.035 (3) (2013).	MO. REV. STAT. § 537.035 (4) (2013).	None.	

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Montana	MONT. CODE ANN. § 37-2-201(1) (2013).	MONT. CODE ANN. § 37-2-201(2) (2013).	None.	
Nebraska	NEB. REV. STAT. §71-7911 (2013).	NEB. REV. STAT. §71-7912 (2013).	See Privilege.	Nebraska changed its peer review laws in 2011. The new statute is more restrictive in that the grant of confidentiality and privilege of the peer review records is absolute. By comparison, the old statute allowed for the veil of privilege to be pierced if the patient waived confidentiality
Nevada	None.	NEV. REV. STAT. § 49.265 (2013).	None.	
New Hampshire	None.	N.H. REV. STAT. ANN. § 151:13-a (2013).	See Privilege.	
New Jersey	N.J. STAT. ANN. § 2A:84A-22.10 (West 2013).	None.	None.	
New Mexico	N.M. STAT. ANN. §§ 41-9-3–4 (West 2013).	N.M. STAT. ANN. §41-9-5 (West 2013).	See Privilege.	Unauthorized disclosure is a "petty misdemeanor and shall be punished by imprisonment for not to exceed six months or by a fine of not more than one hundred dollars ($100), or both." N.M. STAT. ANN. § 41-9-6 (West 2013).
New York	N.Y. PUB. HEALTH LAW § 2805-m (3) (McKinney 2013).	N.Y. PUB. HEALTH LAW § 2805-m(2) (McKinney 2013).	N.Y. PUB. HEALTH LAW § 2805-m(1) (McKinney 2013).	
North Carolina	N.C. GEN. STAT. ANN. § 131E-95(a) (West 2013).	N.C. GEN. STAT. ANN. § 131E-95(b) (West 2013).	See Privilege.	

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North Dakota	N.D. CENT. CODE § 23-34-06 (West 2013).	N.D. CENT. CODE § 23-34-03 (West 2013).	N.D. CENT. CODE § 23-34-02 (West 2013).	
Ohio	OHIO REV. CODE ANN. § 2305.251 (West 2013).	OHIO REV. CODE ANN. § 2305.252 (West 2013).	See Privilege.	
Oklahoma	OKLA. STAT. ANN. tit. 76, §§ 25–26 (West 2013).	OKLA. STAT. ANN. tit. 63, § 1-1709.1 (West 2013).	OKLA. STAT. ANN. tit. 63, § 1-1709.1 (West 2013).	
Oregon	None.	OR. REV. STAT. § 441.055 (West 2013) (all data is privileged pursuant to OR. REV. STAT. § 41.675 (West 2013)).	OR. REV. STAT. § 441.055 (West 2013) (pursuant to OR. REV. STAT. §§192.501–192.505, 192.690 (West 2013)).	
Pennsylvania	63 PA. STAT. ANN. § 425.3 (West 2013).	63 PA. STAT. ANN. § 425.4 (West 2013).	See Privilege.	
Rhode Island	R.I. GEN. LAWS § 23-17-25 (West 2013); *see also* R.I. GEN. LAWS § 5-37.3-7 (West 2013).	R.I. GEN. LAWS § 23-17-25 (West 2013).	R.I. GEN. LAWS § 5-37.3-7 (West 2013).	Disclosure of confidential penalties subject to civil and criminal (misdemeanor) liability. R.I. GEN. LAWS § 5-37.3-9 (West 2013).
South Carolina	S.C. CODE ANN. § 40-70-10 (2013).	S.C. CODE ANN. § 40-71-20 (2013).	See Privilege.	
South Dakota	S.D. CODIFIED LAWS § 36-4-25 (2013).	S.D. CODIFIED LAWS § 36-4-26.1 (2013).	See Privilege.	

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Tennessee	TENN. CODE ANN. § 68-11-272(d) (West 2013).	TENN. CODE ANN. § 68-11-272(c) (West 2013).	See Privilege.	"It is the policy of this state to encourage the improvement of patient safety, the quality of patient care and the evaluation of the quality, safety, cost, processes and necessity of healthcare services by hospitals, healthcare facilities and healthcare providers. Tennessee further recognizes that certain protections must be available to these entities to ensure that they are able to effectively pursue these measures. TENN. CODE ANN. § 68-11-272 (West 2013).
Texas	TEX. OCC. CODE ANN. §§ 160.010 (West 2013).	TEX. OCC. CODE ANN. §§ 160.006; 160.007 (West 2013).	See Privilege.	
Utah	UTAH CODE ANN. § 58-13-5 (West 2013).	UTAH CODE ANN. § 26-25-3 (West 2013).	None.	
Vermont	VT. STAT. ANN. tit. 26, § 1442 (West 2013).	VT. STAT. ANN. tit. 26, § 1443 (West 2013).	See Privilege.	
Virginia	VA. CODE ANN. § 8.01-581.16 (West 2013).	VA. CODE ANN. § 8.01-581.17 (West 2013).	None.	
Washington	WASH. REV. CODE ANN. § 4.24.250 (West 2013).	WASH. REV. CODE ANN. §§ 4.24.250, 70.41.200 (West 2013).	WASH. REV. CODE ANN. § 70.56.050 (West 2013).	
West Virginia	W. VA. CODE § 30-3C-2 (2013).	W. VA. CODE § 30-3C-3 (2013).	See Privilege.	
Wisconsin	WIS. STAT. ANN. §146.37 (2013).	WIS. STAT. ANN. §146.38 (2013).	None	
Wyoming	WYO. STAT. ANN. § 35-17-103 (West 2013); *see also id.* § 33-26-408.	WYO. STAT. ANN. § 35-17-105 (West 2013); *see also id.* § 33-26-408.	WYO. STAT. ANN. § 33-26-408 (West 2013)	

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