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I. Introduction

A physician walks into your office seeking legal advice. She is highly regarded in the medical community. She holds leadership positions in several medical societies, teaches at a prominent medical school, and until recently held privileges at multiple hospitals.[1]

She informs you that her privileges were recently revoked by the peer review committee of one of the hospitals due to her unprofessional conduct. Then she begins to list the reasons why her conduct was considered unprofessional. She took a doughnut from the nurses' station. One of the nurses did not like the way she dressed. She used "blue" language, but this language was routine for the male physicians.

You start to consider what causes of action she may have. She may have a claim for breach of employment contract. You think there might be a discrimination action available. You tell her you will need to do some research but that you feel confident that she has some legal recourse. Soon after you begin researching, you find out that you could not have been more wrong. This doctor probably has no chance of recovering damages.

Congress passed the Health Care Quality Improvement Act of 1986 (hereinafter HCQIA) to encourage good faith peer review by providing immunity from damages to hospitals and physicians who participate in the peer review process.[2] In order to qualify for immunity, the peer

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1. *See generally* Bender v. Suburban Hosp., Inc., 758 A.2d 1090 (Md. Ct. Spec. App. 2000). This hypothetical is based on the facts in *Bender*.

2. *See generally* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 11101-11152 (2000). This Comment only addresses the HCQIA. Most states also have laws granting various immunities and privileges to health care entities engaged in

review process must meet four procedural standards that provide some protection for the physician under review.[3] However, courts have required very little from health care entities.[4] The result is that hospitals and peer review committees are virtually assured immunity from damages,[5] and the physician is left with no recourse.[6]

This Comment will examine how courts have interpreted the HCQIA and propose a reinterpretation that is more consistent with the language and intent of the Act. The proposed reinterpretation would provide physicians with more procedural fairness. Part II of this Comment will provide the context of the issue by describing the peer review process and the consequences of an adverse peer review. Part II will also provide a summary of the HCQIA. Part III will then examine judicial interpretations of the HCQIA and suggest alternative interpretations that would better effectuate the goals and intent of the Act.

II. Background

A. The Peer Review Process

Medical peer review is the primary process for evaluating patient care and weeding out low-quality physicians.[7] This process occurs in hospitals, managed care organizations, medical societies, and other settings.[8] Medical peer review committees analyze physicians' training, qualifications and experience.[9] The committees are generally made up of practicing physicians who have specialized knowledge necessary to

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peer review. *See generally* JONATHAN P. TOMES, MEDICAL STAFF PRIVILEGES AND PEER REVIEW 65-255 (1994) (cataloguing state laws regarding peer review immunities, confidentiality of peer review information, and duties to report adverse decisions).

3. *See infra* text accompanying notes 41-50; *see also* 42 U.S.C. § 11112 (establishing four requirements to qualify for immunity).

4. *See* Meyer v. Sunrise Hosp., 22 P.3d 1142, 1153 (Nev. 2001) (Shearing, J., concurring) (stating that hospitals only need to state "some minimal basis related to quality health care, whether legitimate or not," to be immune from damages).

5. *See* Clark v. Columbia/HCA Info. Serv., Inc., 25 P.3d 215, 222 (Nev. 2001) ("The presumption of immunity has been interpreted by the federal courts almost exclusively in favor of finding immunity. . . .").

6. *See infra* text accompanying notes 41-42.

7. Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit- Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 15 (1999). Other methods include medical malpractice and state licensing boards. *Id.* at 14. Additionally, hospitals are required to engage in peer review in order to participate in Medicare and Medicaid services. 42 C.F.R. § 482.22 (2005).

8. Kenneth R. Kohlberg, *The Medical Peer Review Privilege: A Linchpin for Patient Safety Measures*, 86 MASS. L. REV. 157, 157 (2002).

9. Lisa M. Nijm, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 543 (2003).

make accurate medical judgments.[10] Physicians are reviewed upon initial employment, every two years thereafter, and anytime a health care entity[11] has reason to believe quality concerns exist.[12]

After reviewing a physician, the medical peer review committee recommends whether the physician will receive or retain medical staff privileges.[13] The committee also recommends whether any limitations should be placed on a physician's privileges.[14] Although the governing body of the health care entity makes the ultimate decision as to what action will be taken, the peer review committee's recommendations serve as the basis for this decision.[15]

B. Consequences of an Adverse Peer Review Action

The consequences to a physician of an adverse peer review action[16] are severe.[17] An adverse peer review action often results in complete loss of medical staff privileges.[18] In order to maintain a practice, a physician needs hospitals and the technology and support structures that hospitals provide.[19] Therefore, loss of privileges is essentially the same

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10. *Id.*

11. National Practitioner Data Bank for Adverse Information on Physicians and Other Health Care Practitioners, 45 C.F.R. § 60.3 (2005) (defining a health care entity as a hospital or "an entity that provides health care services, and engages in professional review activity . . . or a committee of that entity"). Although the health care entity is usually a hospital, the definition is broad enough to cover many other entities. *See, e.g.*, Singh v. Blue Cross/Blue Shield, Inc. 308 F.3d 25, 44 (1st Cir. 2002) (granting immunity to insurance provider); *see also* H.R. REP. NO. 99-903, at 4 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6387 (stating that the bill would encourage hospitals, insurance companies, and other health care entities to report adverse actions in exchange for immunity).

12. *See* George E. Newton III, Commentary, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 723, 725 (2001).

13. *See id.*

14. *See* Christopher S. Morter, Note, *The Health Care Quality Improvement Act of 1986: Will Physicians Find Peer Review More Inviting?*, 74 VA. L. REV. 1115, 1117 (1988) (stating that peer review committees set the parameters of a physician's privileges).

15. Scheutzow, *supra* note 7, at 13.

16. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11151(1) (2000) (defining an adverse peer review action as one that reduces, restricts, suspends, revokes or fails to renew clinical privileges or membership in a health care entity).

17. *See* William J. Tabor, *The Battle for Hospital* Privileges, 249 JAMA 526, 526 (1983) (calling loss of privileges "an economic catastrophe"); Fred M. Zeder, *Defending Doctors in Disciplinary Proceedings,* ARIZ. ATT'Y, Jan. 2004, at 22, 23 ("doctor loses a livelihood"); *see also* Purgess v. Sharrock, No. 91 Civ. 0621(JSM), 1993 WL 426524, at *1 (S.D.N.Y. Oct 19, 1993) (finding that a physician's career is worth $4.6 million).

18. *See* TOMES, *supra* note 2, at 23 (noting that peer review committees recommend whether privileges should be reduced or revoked).

19. *See id.* at 13 (noting that only hospitals can provide the technology and support

as loss of employment.[20]

Moreover, due to national reporting requirements,[21] an adversely reviewed physician will have a difficult time reestablishing a practice at another hospital or clinic.[22] Any health care entity that the physician applies to would be on notice of the physician's prior substandard performance.[23] By hiring an adversely reviewed physician, a health care entity would expose itself to liability.[24] Given that few, if any, health care entities would be willing to assume this liability, an adversely reviewed physician would likely be unable to find a new clinic or hospital willing to grant privileges.[25]

An adverse peer review action may result in curtailment of a physician's privileges.[26] Physicians in this situation suffer economically,[27] as they are prevented from performing, and receiving compensation for, the curtailed procedures.[28]

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structure that physicians need in order to practice); Lee S. Goldsmith & Mary Bertolet, *The Present Status of Physician Privileges,* 27 MED. TRIAL TECH. Q. 121, 121 (1981) (noting that a physician without privileges is certain to become a physician without patients and that privileges in at least one hospital is necessary to survive professionally); *see also* Tabor, *supra* note 17, at 526 (discussing the need for hospital privileges to gain access to increasingly sophisticated tools); *cf.* Dennis Cauchon & Julie Appleby, *Hospital Building Boom in 'Burbs: Facilities Stress High-tech Care*, USA TODAY, Jan. 3, 2006, at A1 (noting that the hospital industry has spent more than $100 billion in the last five years on new facilities and technology).

20. Scheutzow, *supra* note 7, at 13.

21. *See infra* Part II.C.2 (describing the reporting requirements of the HCQIA).

22. *See* David W. Jorstad, Note, *The Legal Liability of Medical Peer Review Participants for Revocation of Hospital Staff Privileges*, 28 DRAKE L. REV. 692, 693 (1978-79) (stating that suspension of privileges at one hospital makes "it difficult, if not impossible, to obtain staff privileges at a new hospital"); *see also* JOINT COMMISSION ON ACCREDITATION OF HOSPITALS, ACCREDITATION MANUAL FOR HOSPITALS/1986 102 (1986) [hereinafter JCAH] (stating that it is strongly recommended that hospitals require an applicant to disclose previous loss of clinical privileges).

23. *See* The Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11135(b) (2000) (stating that a hospital is presumed to have knowledge of information reported to the national database).

24. *See* Braden v. Saint Francis Hosp., 714 P.2d 505, 507 (Colo. Ct. App. 1985) (stating that a hospital may be liable for a physician's negligence if the hospital knew or should have known of the physician's propensity to commit negligent acts); *see also*, McCall v. Henry Med. Ctr., Inc., 551 S.E.2d 739, 742 (Ga. Ct. App. 2002) (stating that a hospital has a direct responsibility to its patients to ensure staff physician's are qualified); Soentgen v. Quain & Ramstad Clinic, P.C., 467 N.W.2d 73, 79 (N.D. 1991) (stating that a hospital has a duty to provide the public with competent physicians).

25. *See* Jorstad, *supra* note 22, at 693 (stating that suspension of privileges at one hospital makes "it difficult, if not impossible, to obtain staff privileges at a new hospital"); *see also* JCAH, *supra* note 22, at 102 (stating that it is strongly recommended that hospitals require an applicant to disclose previous loss of clinical privileges).

26. *See* TOMES, *supra* note 2, at 23.

27. *See* Zeder, *supra* note 17, at 23 (noting that revocation or restriction of privileges affects a doctor's livelihood).

28. *See* Scheutzow, *supra* note 7, at 13 (granting physician privileges to attend

Even if an adverse peer review action does not result in loss or limitation of hospital privileges, the consequences are still severe.[29] Physicians who are placed on probation or receive a letter of reprimand may lose their malpractice insurance.[30] A physician must have malpractice insurance to maintain hospital privileges.[31] Therefore, the end result could be an actual loss of privileges and the consequences associated with such a loss.[32] Finally, an adverse peer review action damages a physician's reputation.[33] This damage affects the physician's income through loss of patients and loss of referrals.[34]

C. *Summary of the HCQIA*

Congress passed the HCQIA in response to the "increasing occurrence of medical malpractice," and the need to prevent incompetent physicians from moving between states without disclosure of their incompetence.[35] Congress believed that effective peer review could improve the nationwide quality of health care.[36] Furthermore, Congress believed that physicians' participation as peer reviewers was unreasonably discouraged by the threat of monetary liability.[37]

The HCQIA includes two main provisions.[38] The first provision

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vaginal birth but not Caesarean section births). For example, an obstetrician may lose privileges to perform Caesarean sections. Many patients may prefer Caesarean births or may require Caesarean births due to an emergency. This physician would have to hand off these patients and the fees paid by these patients to another physician who had cesarean privileges. Thus, the original obstetrician would lose income by not being able to perform the procedure.

29. *See* Zeder, *supra* note 17, at 23 (stating that discipline that does not affect privileges still has serious economic consequences).

30. *Id.*

31. JCAH, *supra* note 22, at 109; Zeder, *supra* note 17, at 24.

32. *See* Zeder, *supra* note 17, at 23-24.

33. *See* Bender v. Suburban Hosp., Inc. 758 A.2d 1090, 1100 (Md. Ct. Spec. App. 2000) (noting that the reputation of Dr. Bender, who taught at George Washington School of medicine and held privileges at multiple hospitals, suffered from her de-credentialing at one hospital); *see also* Zeder, *supra* note 17, at 23 (noting that adversely reviewed doctors lose the respect of their colleagues). Even a very short suspension can negatively impact a physician's reputation. *See* Wayne v. Genesis Med. Ctr., 140 F.3d 1145, 1147 (8th Cir. 1998) (suing for defamation because hospital disclosed short suspension).

34. *See* Boczar v. Manatee Hosp. & Health Sys., Inc., 993 F.2d 1514, 1518 n.10 (11th Cir. 1993) (stating that a negative peer review action can ruin a doctor's reputation and career and "a negative decision by one hospital could be tantamount to excluding a doctor from the profession as a whole" (internal quotations omitted)).

35. Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 (2000).

36. *Id.* § 11101.

37. *Id.*

38. *Id.* §§ 11111-37. The Act is officially divided into three parts. The third part is composed of definitions. *Id.* §§ 11151-52.

promotes professional peer review by granting immunity to medical peer review committees.[39] The second provision of the HCQIA requires medical peer review committees which take adverse action against a physician's privileges to report that action to a national database.[40]

1. Immunity

The HCQIA grants immunity from monetary damages[41] under any federal or state law.[42] The immunity extends to the professional review body, its members, and any person who contracts with, or participates with, the body with respect to the professional review action.[43] Immunity also extends to persons who provide information to the peer review committee, unless such persons knowingly provide false information.[44]

To qualify for immunity, the peer review committee must comply with four procedural standards.[45] First, the committee must act with a reasonable belief that the action will further the quality of health care.[46] Second, the committee must engage in a reasonable effort to obtain the

39. *Id.* §§ 11111-15.

40. *Id.* §§ 11131-37; 45 C.F.R. § 60.9 (2005). This part of the HCQIA also requires reporting of medical malpractice payments by insurers and sanctions taken by Boards of Medical Examiners. 42 U.S.C. §§ 11131-32; 45 C.F.R. §§ 60.7-60.8 (2005).

41. 42 U.S.C. § 11111(a). The Act does not restrict a physician from seeking injunctive or declaratory relief. H.R. REP. NO. 99-903, at 9 (1986) *reprinted in* 1986 U.S.C.C.A.N. 6384, 6391; *see, e.g.,* Sugarbaker v. SSM Health Care, 190 F.3d 905, 918 (8th Cir. 1999) (holding there is no immunity from suits seeking injunctive or declaratory relief).

42. 42 U.S.C. § 11111(a)(1). This limitation on damages does not apply to damages under any law relating to civil rights. This section also does not prevent the United States or any state attorney general from bringing an antitrust action or any other action otherwise authorized. *Id.* Although the HCQIA allows damages in civil rights suits, a physician is often unable to recover under civil rights laws. *See* Alexander v. Rush N. Shore Med. Ctr., 101 F.3d 487, 488 (7th Cir. 1996) (holding that a physician who holds staff privileges at a hospital is not considered an employee and does not have standing to bring a Title VII action for unlawful discrimination); Bender v. Suburban Hosp., 998 F. Supp. 631, 637 (D. Md. 1998) (holding that physicians are not employees of privilege-granting hospitals); *see also,* 42 U.S.C. § 2000e- 2(a)(1) (2000) ("It shall be unlawful . . . for an employer . . . to discriminate against any individual . . . because of such individual's race, color, religion, sex, or national origin").

43. 42 U.S.C. § 11111(a)(1).

44. *Id.* § 11111(a)(2).

45. *Id.* §§ 11111-12.

46. *Id.* § 11112(a)(1). The "reasonable belief" standard is an objective standard. *See infra* text accompanying notes 72-76. The House Energy and Commerce Committee considered a "good faith" standard; however, the Committee did not want courts to require "only a test of the subjective state of mind" of the peer review body. H.R. REP. No. 99-903, at 10. The Committee intended the test to be satisfied if the peer review body, with the information available at the time of the action, believed that the action would restrict incompetent physicians or protect patients. *Id.*

facts.[47] Third, the committee must provide adequate notice and a hearing or other procedures which are fair under the circumstances.[48] The Act sets out guidelines for notice and hearing procedures which are deemed adequate, but failure to meet the guidelines is not automatically deemed failure to provide adequate notice and hearing procedures.[49] The final procedural requirement is that the peer review committee must act with a reasonable belief that the facts known after a reasonable investigation warrant the action taken.[50]

The notice guidelines call for the peer review committee to provide the accused physician with the following: notice that a peer review action has been proposed; the reasons for the proposed action; and a summary of the physician's rights, including the right to request a hearing and the time limit within which the hearing must be requested.[51] If the physician requests a hearing, the peer review committee should provide notice of the time, place, and date of the hearing and a list of witnesses expected to testify.[52]

The hearing guidelines specify the rights of the physician and the composition of the hearing committee.[53] The physician has the right to representation, to have a record of the proceedings made, and to receive a copy of the record.[54] Additionally, the physician has the right to call, examine, and cross-examine witnesses; to present relevant evidence; and to submit a written closing statement.[55] The hearing should be held before a mutually acceptable arbitrator, or the health care entity should appoint a hearing officer or panel.[56] If the health care entity appoints an officer or panel, neither the officer nor any individuals on the panel may be in direct economic competition with the physician being reviewed.[57]

The HCQIA creates a rebuttable presumption that the four standards are met.[58] In order to overcome this presumption, the physician must

47. 42 U.S.C. § 11112(a)(2).
48. *Id.* § 11112(a)(3).
49. *Id.* § 11112(b).
50. *Id.* § 11112(a)(4). The legislative history does not provide any guidance on how this standard is distinct from the first standard. *See generally* H.R. REP. NO. 99-903. Courts have routinely collapsed these two standards into one and hold that a reasonable belief that the peer review action would further the quality of health care satisfies both standards. *See, e.g.*, Singh v. Blue Cross/Blue Shield, Inc., 308 F.3d 25, 38 n.13 (1st Cir. 2002) (following the lead of other circuits by evaluating standards one and four together).
51. 42 U.S.C. § 11112(b)(1).
52. *Id.* § 11112(b)(2).
53. *Id.* § 11112(b)(3).
54. *Id.* § 11112(b)(3)(C).
55. *Id.* § 11112(b)(3)(C).
56. *Id.* § 11112(b)(3)(A).
57. *Id.* § 11112(b)(3)(A).
58. *Id.* § 11112(a). The legislative history indicates that this presumption only applies to the first standard. H.R. REP. NO. 99-903, at 10 (1986) *reprinted in* 1986

prove by a preponderance of the evidence that one or more standards were not met.[59]

2. Reporting Under the HCQIA

In order to qualify for immunity under the HCQIA, a health care entity must comply with the Act's reporting requirements.[60] The health care entity must report to the National Practitioner's Data Bank[61] any action that adversely affects a physician's clinical privileges for longer than thirty days.[62] Also, a health care entity must report a physician's surrender of clinical privileges while the physician is under investigation.[63]

III. Analysis

Although the HCQIA requires that medical peer review committees meet procedural standards to qualify for immunity,[64] courts grant immunity in almost every case, regardless of the procedures followed by the health care entity.[65] This Part discusses common interpretations of

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U.S.C.C.A.N. 6384, 6393. The statute, however, states that the presumption applies to all of the "standards." 42 U.S.C. § 11112(a).

59. 42 U.S.C. § 11112(a). The effect of this presumption is that the burden of proof at summary judgment falls on the physician opposing the motion. Therefore, courts ruling on a motion for summary judgment must determine whether the physician provided enough evidence for a reasonable jury to find that the physician had overcome, by a preponderance of the evidence, the presumption that the health care entity met the statutory standards. *E.g.*, Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318, 1334 (11th Cir. 1994) (focusing on whether plaintiff proved by a preponderance of the evidence that the procedures were not met).

60. 42 U.S.C. § 11133(c). A health care entity is only disqualified from receiving immunity by the Secretary of Health and Human Services. The Secretary must conduct an investigation, provide the health care entity notice of noncompliance and opportunity to comply, and provide an opportunity for a hearing. If after following these procedures, the Secretary determines that the health care entity failed to report the required information, the Secretary publishes the name of the health care entity in the Federal Register and the health care entity is no longer entitled to immunity under the HCQIA. *Id.* § 11111(b).

61. *Id.* § 11133; 45 C.F.R. § 60.5 (2005). The National Practitioner's Data Bank is an information clearing house that contains reports of adverse peer review actions, medical malpractice payments, disciplinary sanctions, and license suspensions and revocations. The information is confidential, and generally, the information may only be disclosed to professional review authorities. Julie Barker Pape, Note, *Physician Data Banks: The Public's Right to Know Versus the Physician's Right to Privacy,* 66 FORDHAM L. REV. 975, 977 (1997); *see* 45 C.F.R. § 60.11 (2005) (listing authorities authorized to access information).

62. 42 U.S.C. § 11133(a).

63. *Id.*

64. *See supra* Part II.C.1.

65. *See* Clark v. Columbia/HCA Info. Serv., 25 P.3d 215, 222 (Nev. 2001) (stating that only two federal courts have reversed an order of summary judgment granting

each of the four procedural standards and proposes an interpretation that is more faithful to the legislative intent and language of the HCQIA. The organization of this section mirrors the layout of the Act. First, this section will address judicial interpretations of whether an action was taken in the reasonable belief of furthering the quality of health care.[66] Second, this section will discuss judicial interpretations of what is a reasonable effort to obtain the facts.[67] Third, this section will discuss judicial interpretations of what is a fair hearing under the circumstances.[68] Fourth, this section will address the reasonable belief that the action was warranted by the known facts standard. Since the fourth standard is routinely treated as the same as the first standard,[69] there are few cases that analyze the fourth standard.[70] However, this section does contain a discussion of how the fourth standard should be treated differently from the first.[71]

A. Reasonable Belief the Action Furthers Health Care Quality

When determining whether a peer review action was taken in the reasonable belief that it would further the quality of health care, the courts apply an objective test.[72] This objective test originated in *Austin v. McNamara*.[73] The *Austin* court decided that the test must be objective in order to comply with the legislative intent of resolving questions of immunity through summary judgment.[74] Under this objective test, courts generally eliminate any consideration of the peer review committee's subjective intent.[75] By eliminating subjective intent, courts allow peer review actions taken in bad faith to stand.[76]

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immunity because the physician demonstrated that the procedural requirements were not met).

66. *See infra* Part III.A.

67. *See infra* Part III.B.

68. *See infra* Part III.C.

69. *See supra* note 50.

70. *But see* Brader v. Allegheney Gen. Hosp., 167 F.3d 832, 843 (3d Cir. 1999) (analyzing fourth requirement); Mathews v. Lancaster Gen. Hosp. 87 F.3d 624, 638 (3d Cir. 1996) (analyzing fourth requirement).

71. *See infra* Part III.D.

72. *See, e.g., Mathews*, 87 F.3d at 635 (agreeing with sister circuits that the reasonable belief test is objective).

73. *See* Austin v. McNamara, 979 F.2d 728, 734 (9th Cir. 1992) (adopting an objective test so that immunity can be resolved as early in the litigation as possible).

74. *Id.*

75. *See, e.g.*, Meyers v. Logan Mem'l Hosp., 82 F. Supp. 2d 707, 716 (W.D. Ky. 2000) (reasoning that "the test is an objective one, so bad faith is immaterial" (quoting *Austin*, 979 F.2d at 734)).

76. *See* Bender v. Suburban Hosp., Inc., 758 A.2d 1090, 1100 (Md. Ct. Spec. App. 2000) (stating that even sexual discrimination by a peer review committee "which would be considered illegal in the context of employment [is] irrelevant when challenging a

Perhaps the most egregious example of a court disregarding the subjective intent of a peer review committee occurred in *Wieters v. Roper Hospital, Inc.*[77] Dr. Wieters introduced into evidence a letter written by the chairman of the peer review committee.[78] The letter complained about the process by which the inquiry into Dr. Wieters was made and stated that the process was "the result of a vendetta against Dr. Wieters."[79] The court held that despite the evidence of a vendetta, a reasonable jury could not conclude that Dr. Wieters had overcome the presumption that the peer review committee did not act in the furtherance of quality health care.[80]

The legislative history of the HCQIA does not support this interpretation of the Act. Congress initially considered a good faith test;[81] however, it was concerned that such a test would be "misinterpreted by courts as requiring *only* a test of the subjective state of mind" of the peer review committee members.[82] Therefore, Congress adopted the "*more* objective 'reasonable belief' standard."[83] Furthermore, Congress still intended the HCQIA to "encourage good faith professional review activities of health care entities."[84] Congress titled the chapter containing the immunity provisions: "Encouraging Good Faith Professional Review Activities."[85] Thus, Congress contemplated that subjective intent would be relevant to the question of whether the committee objectively acted in the reasonable furtherance of quality health care.[86]

Including an inquiry into the subjective intent of the peer review committee members furthers the intent of the HCQIA. As discussed, the legislative history of the Act supports a good faith requirement.[87] Additionally, the main focus of the Act is to improve the quality of

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medical peer review process").

77. *See* Wieters v. Roper Hosp., Inc., 58 F.App'x 40, 46 (4th Cir. 2003) (holding that a reasonable jury could not conclude that the evidence of a vendetta would overcome the presumption that the action was taken to improve health care).

78. *Wieters*, 58 F.App'x at 45. The court noted that it was not clear whether this letter was in the record when summary judgment was granted. However, the circuit court considered the letter in determining whether the peer review action was taken to further the quality of health care. *Id.* at 46.

79. *Id.* at 45-46.

80. *Id.* at 46.

81. H.R. REP. NO. 99-903, at 10 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6384, 6392.

82. *Id.* (emphasis added).

83. *Id.* (emphasis added).

84. *Id.* at 1.

85. *See generally* Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 1101-52.

86. *See* Austin v. McNamara, 979 F.2d 728, 741 (9th Cir. 1992) (Pregerson, J., dissenting) (noting that Congress's intent was to encourage good faith peer review).

87. *See supra* text accompanying notes 81-86.

medical care and restrict the ability of incompetent physicians to relocate without disclosure of their prior incompetent performance.[88] A peer review action taken in bad faith does not further this goal and should not be afforded immunity.

Even with an inquiry into the committee's subjective intent, litigation could still be decided at the summary judgment stage.[89] Since the HCQIA creates a presumption that the peer review action was taken in reasonable furtherance of quality health care, the burden is on the plaintiff-physician to prove otherwise.[90] At the summary judgment stage, plaintiffs will have had time for discovery and a chance to seek out facts that would support allegations of bad faith.[91] Therefore, to overcome the presumption, plaintiffs should be required to prove, by a preponderance of the evidence, that there are facts that support their allegations of bad faith.[92] Absent a showing of these facts, courts could still grant the health care entity immunity and end the litigation at summary judgment.[93] Thus, courts could enforce the Act as Congress intended,[94] and health care entities would still retain the efficiency benefits of deciding immunity early in the litigation.[95]

B. Reasonable Effort to Obtain the Facts

A physician who shows flaws in the fact finding process does not rebut the presumption that there was a reasonable effort to obtain the facts.[96] In *Singh v. Blue Cross/Blue Shield,* the peer review committee sent a non-random sample of files to an independent reviewer.[97] The

88. 42 U.S.C. § 11101.

89. *But see Austin*, 979 F.2d at 734 n.5 (stating that a subjective test would frustrate Congress's intent to decide immunity as early in the litigation as possible).

90. 42 U.S.C. § 1112(a).

91. *See* FED. R. CIV. P. 15(C) (stating that answers to interrogatories, depositions, and affidavits should be considered when rendering summary judgment); Celotex Corp. v. Catrett, 477 U.S. 317, 322 (1986) (stating that adequate time for discovery is precondition of granting summary judgment).

92. *See* Anderson v. Liberty Lobby, Inc., 477 U.S. 242, 248 (1986) ("[A] party opposing a properly supported motion for summary judgment may not rest upon the mere allegations or denials of his pleadings, but . . . set forth specific facts showing there is a genuine issue for trial." (internal quotations and citations omitted) (second alteration in original)).

93. *See id.*

94. *See supra* notes 81-86 and accompanying text.

95. *See* Iannelli v. Burger King Corp., 761 A.2d 417, 419 (N.H. 2000) ("Summary judgment affords savings in time, effort and expense").

96. *E.g.,* Singh v. Blue Cross/Blue Shield, Inc., 308 F.3d 25, 43 (1st Cir. 2002) (holding that no reasonable jury could find that the audit flaws could overcome the presumption that the investigation was reasonable).

97. *Id.* at 30. This review was the second audit conducted in this case. The first audit resulted in a separate peer review action against Dr. Singh and was the impetus for

sample contained all of the files in which Dr. Singh prescribed narcotics and also erroneously contained the files of four patients who were not patients of Dr. Singh.[98] The reviewer was not told that the sample was weighted toward narcotics files, and he incorrectly assumed that the sample was randomly selected.[99] The court noted that Blue Cross should have told the reviewer that the sample was weighted, but the court found that the weighted sample did not affect the reviewer's findings because the reviewer engaged in a case-by-case analysis.[100]

This reasoning, however, fails to recognize that during his case-by-case review, the reviewer could have been influenced by the large percentage of narcotics prescriptions he saw in the files. Additionally, the reviewer's comments on the narcotics cases were, at worst, mildly negative.[101] The court held that a plaintiff is entitled only to a reasonable investigation, and the flaws in the audit process did not rebut the presumption that the peer review committee engaged in a reasonable effort to obtain the facts.[102]

Courts should be more willing to scrutinize a peer review committee's effort to obtain the facts. Courts are fact-finders.[103] This practical experience means courts are uniquely suited to review fact finding processes.[104] Additionally, this issue does not require medical expertise, so there is no reason for courts to adopt a deferential approach

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the second audit. *Id.* Although the court upheld immunity for the first peer review action and considered the first audit relevant to the effort to obtain the facts during the second peer review action, the results of the first audit were mixed. The first auditor praised Dr. Singh for his holistic approach to diagnosis and careful treatment of low-income patients. The first auditor did note over-utilization issues and commented that the standard of care was somewhat below the recognized standard. *Id.* at 29.

98. *Id.* at 30.

99. *Id.*

100. *Id.* at 43. The court also noted that the reviewer's report contained criticisms that did not focus on the Dr. Singh's overuse of narcotics. *Id.*

101. *See id.* (quoting the audit as saying "[m]ost internists" would have tried to avoid or limit narcotics prescriptions). The auditor's comments regarding some other treatments were substantially more critical. *See id.* (stating that Dr. Singh "failed to meet minimal standards" in his treatment of patients with emotional disorders, and he "failed to deliver quality care" to asthma patients).

102. *Id.* Dr. Singh also asserted that the audit was not reasonable because it was overly narrow. The audit focused only on one type of case. The court found no merit in this argument and stated that an audit is unreasonably narrow only if it fails to cover a sufficient sample size. *Id.* at 42. *Compare* Brown v. Presbyterian Health. Serv., 101 F.3d 1324, 1334 (10th Cir. 1996) (finding that a review of only two files was not a reasonable effort to obtain the facts), *with* Egan v. Athol Mem. Hosp., 971 F. Supp. 37, 40 (D. Mass. 1997) (finding a review of six files was a reasonable effort to obtain the facts).

103. *See* People v. Matheny, 46 P.3d 453, 459 (Colo. 2002) (stating that "fact identification is clearly the prerogative of trial courts or juries").

104. *See* People v. Robarge, 262 P.2d 14, 17 (Cal. 1953) (stating that in jury trials, the court's duty is to see that the fact finding function of the jury is intelligently and justly performed).

to their review of the investigation.[105] Instead this issue requires procedural expertise, which courts possess.[106] Therefore, while keeping in mind that the plaintiff has the burden of proof,[107] courts should scrutinize defects in the fact finding process more closely at the summary judgment stage and allow disputed questions of reasonableness to go to the jury.[108]

C. *Fair Hearing Procedures Under the Circumstances*

The third procedural requirement is that the health care entity must provide the physician with adequate notice and hearing procedures that are fair under the circumstances.[109] First, this Section will address courts' condoning the participation of economic competitors in the peer review process. Then, this Section will address courts' failure to consider hospital bylaws as part of the circumstances surrounding the hearing.

1. Participation by Economic Competitors

The HCQIA guidelines for what constitutes an adequate hearing state that a hearing officer or panel member should not be in economic competition with the physician who is under review.[110] Despite the statute, courts routinely allow economic competitors of a physician to be included on the physician's peer review committee.[111] In *Wayne v.*

105. *See* Chevron, U.S.A., Inc. v. Natural Res. Def. Council, Inc., 467 U.S. 837, 844 (1984) (deferring to agency when issue depends on "more than ordinary knowledge"); Patricia Mitchell, *Jurisdictional Conflict and Judicial Restraint,* MD. BAR J., Jan.-Feb. 2006, at 54, 57 (stating that agency expertise is the source of judicial deference to agency decisions).

106. *See* Charles H. Koch, Jr., *An Issue-Driven Strategy for Review of Agency Decisions*, 43 ADMIN. L. REV. 511, 542 (stating that judges are experts in procedures).

107. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11112(a) (2000) (assigning the plaintiff the burden of disproving the presence of the four procedural standards); Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318, 1333 (11th Cir. 1994) (stating that the "presumption language in the HCQIA means that the *plaintiff* bears the burden of proving the peer review process was *not* reasonable" (emphasis in original)); *see also* Gabaldoni v. Wash. County Hosp. Assoc., 250 F.3d 255, 260 (4th Cir. 2001) (adopting summary judgment standard that asks "whether a reasonable jury, viewing the facts in a light most favorable to [the plaintiff], could conclude" that a preponderance of the evidence shows that the peer review committee did not make a reasonable effort to obtain the facts).

108. *See* Singh v. Blue Cross/Blue Shield, Inc., 308 F.3d 25, 33-34 (1st Cir. 2002) (stating that the "statutory scheme contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity[,]" and "a jury could be asked to decide the ultimate issue of reasonableness").

109. 42 U.S.C. § 11112(a)(3).

110. 42 U.S.C. §11112(b)(3)(A).

111. *See* Wieters v. Roper Hosp., Inc., 58 F.App'x 40, 46 (4th Cir. 2003) (finding it

Genesis Medical Center, Dr. Wayne's privileges were suspended because she removed pages from her own medical chart.[112] The committee that suspended Dr. Wayne contained two physicians in direct competition with Dr. Wayne.[113] The court held that the participation by direct economic competitors did not rebut the presumption that the procedure was fair under the circumstances.[114] The court noted that since the suspending committee was not acting as a hearing panel, the presence of economic competitors was irrelevant as the HCQIA only addresses economic competitors in the context of hearing officers or membership on hearing panels.[115]

The *Wayne* court was correct in stating that the HCQIA only specifically addresses economic competitors' participation on hearing panels,[116] but the court did not recognize that the HCQIA specifically calls for fair procedures under the circumstances.[117] Given that the committee that suspended Dr. Wayne had members who were her economic competitors,[118] the procedure was not "fair to the physician under the circumstances."[119]

Although the HCQIA does not strictly prohibit participation by economic competitors, its safe harbor provision for adequate hearing procedures requires that a hearing panel not contain economic competitors of the physician being reviewed.[120] Additionally, Congress anticipated that "the hearing panel or officer be impartial and fair" and that the health care entity "will make every reasonable effort to find appropriate . . . members of the panel, even if this requires bringing in reviewers from out of town or using physicians of a different

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fair for the suspending committee to include economic competitors of Dr. Wieters); Sugarbaker v. SSM Health Care, 190 F.3d 905, 914 (8th Cir. 1999) (holding that economic competitors did not disqualify the peer review panel from immunity because the physician did not object to their inclusion at the time of the peer review hearing); Wayne v. Genesis Med. Ctr., 140 F.3d 1145, 1149 (8th Cir. 1998) (allowing economic competitors on the peer review committee because the members were not acting as hearing officers); Mathews v. Lancaster Gen. Hosp., 87 F.3d 624, 637 (3d Cir. 1996) (noting that the HCQIA does not prevent participation by economic competitors).

112. *Wayne*, 140 F.3d at 1147. Her privileges were reinstated after she returned the pages. *Id.*

113. *Id.* at 1149.

114. *Id.*

115. *See id.*; *see also* 42 U.S.C. § 11112(b)(3).

116. *See* 42 U.S.C. § 11112(b)(3)(A) (describing the hearing and notice standards).

117. *Id.* § 11112(a)(3).

118. *Wayne*, 140 F.3d at 1147. Dr. Wayne was not without fault. She was notified of the committee meeting in which her issue was to be reviewed. She was invited to participate, but she declined to attend. *Id.*

119. 42 U.S.C. § 11112(a)(3).

120. *Id.* § 11112(b)(3)(ii)-(iii).

specialty."[121]

Courts should not allow economic competitors to participate in medical peer review. This solution is consistent with the language of the statute and the legislative intent.[122] Additionally, it is a fundamental principle of due process that a decision-maker cannot have a financial interest in a case.[123] Not allowing economic competitors to participate in the peer review process would increase the appearance of fairness and the overall legitimacy of the peer review process.[124]

2. Failure to Follow Hospital Bylaws

When considering whether a peer review committee's procedures were fair under the circumstances, courts often ignore hospital bylaws.[125] Hospital bylaws govern the relationship between medical practitioners and the hospital.[126] These bylaws also frequently set out the procedure for the peer review process and the appeal process when physicians are denied privileges.[127] Additionally, a hospital's bylaws are a contract

121. H.R. REP. NO. 99-903, at 11 (1986) *reprinted in* 1986 U.S.C.C.A.N. 6384, 6393. The legislative history is replete with examples of concern that the Act would be a shield for anti-competitive economic actions. *Id.*; *see also* Statement on Signing the State Comprehensive Mental Health Plan Bill, 2 PUB. PAPERS 1553, 1554 (Nov. 14, 1986) (noting President Reagan's concerns that the immunity provisions may increase anticompetitive behavior).

122. *See* 42 U.S.C. § 11112(3) (stating that economic competitors should not be on hearing panel); H.R. REP. NO. 99-903, at 11 (stating that Congress's intent is that "physicians receive fair and unbiased review to protect their reputations and medical practices").

123. *See* Estes v. Texas, 381 U.S. 532, 551 (1965) (stating that "a fair trial in a fair tribunal" is a fundamental principle of due process and American law has always sought to avoid even the probability of unfairness); Tumey v. Ohio, 273 U.S. 510, 523 (1927) (stating that due process requires that a judge not have a direct pecuniary interest in the case); Dr. Bonham's Case, (1606) 77 Eng. Rep. 638, 652 (K.B.) (striking down a law that granted the Royal College of Physicians the right to collect fines from the cases it adjudicated); *see also* MAGNA CARTA at 40, *reprinted in* A.E. DICK HOWARD, MAGNA CARTA: TEXT & COMMENTARY 45 (rev. ed. 1998) ("To no one will We sell, to none will We deny or delay, right or justice.").

124. *See Estes*, 381 U.S. at 551 ("justice must satisfy the appearance of justice").

125. *See* Wieters v. Roper, 58 F.App'x 40, 46 (4th Cir. 2003) (stating that nothing in the HCQIA makes immunity dependent on a hospital following its bylaws); Meyers v. Logan Mem'l Hosp., 82 F. Supp. 2d 707, 715 (W.D. Ky. 2000) (stating that the HCQIA does not require a hospital to follow its bylaws). *But see* Islami v. Covenant Med. Ctr., 822 F. Supp. 1361, 1377 (N.D. Iowa 1997) (finding that if hospital had followed bylaws, it would have provided fair notice and hearing).

126. John Hulston, Don Jones & Tim Gammon, *Do Hospital Medical Staff Bylaws Create a Contract?*, 51 J. MO. BAR 352, 352 (1995).

127. *Id.*; *see also* JCAH *supra* note 22, at 104 (stating that hospital bylaws must have "[f]air-hearing and appellate review mechanisms . . . for individuals holding clinical privileges and for applicants for such membership or privileges.").

between the hospital and the physician.[128]

Consideration of hospital bylaws would further the intent of the HCQIA. One way this interpretation is consistent with the statute is that it encourages good faith peer review by requiring health care entities to provide the hearing procedures that they contractually agreed to provide.[129] Secondly, requiring health care entities to follow their bylaws is what is fair under the circumstances.[130] Although the HCQIA does not require any specific procedures,[131] and it allows health care entities to tailor procedures to the specific circumstances, the procedures must still be fair under the circumstances.[132] Given that bylaws create a contractual relationship, it is only fair to require the health care entity to follow the procedures agreed to in the bylaws.[133] Furthermore, when courts allow health care entities to breach their bylaws and still get immunity, the physician is left without recourse for the breach of contract because the health care entity is immune from damages.[134]

D. Action was Warranted Based on the Known Facts

The fourth procedural requirement for immunity to attach is that the action was taken in the reasonable belief that it was warranted based on the known facts.[135] Courts generally treat this test as mirroring the test

128. Pariser v. Christian Health Care Sys. Inc., 816 F.2d 1248, 1251 (8th Cir. 1987); Posner v. Lankenau Hosp., 645 F. Supp. 1102, 1106 (E.D. Pa. 1986). *But see* Munoz v. Flower Hosp., 507 N.E.2d 360, 365 (Ohio Ct. App. 1985) (holding that hospital staff bylaws create a contract only when the bylaws express an intent that both parties be bound); *cf.* Hulston et al., *supra* note 126, at 352 (1995) (discussing open question of whether medical staff bylaws constitute a contract in Missouri). *See generally* JCAH *supra* note 22, at 103 (stating that the bylaws are "adopted by the medical staff and approved by the governing body prior to becoming effective[,]" and the bylaws create a "framework within which medical staff members can act with a reasonable degree of freedom and confidence.").

129. *See* RESTATEMENT (SECOND) OF CONTRACTS § 205 cmt. a (1981) ("Good faith performance or enforcement of a contract emphasizes faithfulness to an agreed common purpose and consistency with the justified expectations of the other party[.]"); *see also* Kham & Nate's Shoes No.2 v. First Bank of Whiting, 908 F.2d 1351, 1357 (7th Cir. 1990) ("Unless pacts are enforced according to their terms, the institution of contract, with all the advantages private negotiation and agreement brings, is jeopardized.").

130. *See Islami*, 822 F. Supp. at 1377 (discussing the hospital's bylaws and fair procedures under the circumstances).

131. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11112(b)(3) (2000) (stating that failure to meet the safe harbor hearing procedures in the HCQIA does not constitute failure to provide adequate hearing procedures).

132. *See id.* § 11112(a)(3) (requiring hearing procedures to be fair under the circumstances).

133. *See* U.C.C. § 1-201(12) (2005) (defining contract as "total legal obligation" that results from the agreement).

134. *See* 42 U.S.C. § 11111 (creating immunity from damages under any law).

135. 42 U.S.C. § 11112(a)(4).

for the first standard.[136] However, since Congress wrote the first and fourth standards as separate and distinct standards, it must have intended that inquiries under each standard were separate and distinct.[137] This section contains two suggestions for an appropriate and distinct test under the fourth standard.

1. Action Tailored to the Known Facts

The fourth procedural requirement's language, "warranted by the facts known," requires that a peer review action be tailored to solve the specific issue identified by the peer review committee.[138] This interpretation would create a distinct inquiry from the first procedural requirement which focuses on furthering the quality of health care.[139] In practice, the first and fourth requirements would end up working in concert, but they would still be distinct inquiries. First, a court would analyze whether an action could reasonably be believed to further the quality of health care.[140] If an action passed this test, then the court could inquire, under the fourth requirement, whether the action was too expansive.[141]

Consider the following hypothetical. A surgeon performs all surgeries at an acceptable level of competence, except for one procedure.[142] Because of the surgeon's mistakes in performing this procedure, multiple patients have died in the operating room.[143] Now assume that the hospital takes one of the following actions. The hospital

136. *See supra* note 50.

137. *See* U.S. v. Menasche, 348 U.S. 528, 538-39 (1955) (stating that a court's duty is to give effect to every clause in a statute rather than to "emasculate an entire section"); FRANK E. HORACK, STATUTES AND STATUTORY CONSTRUCTION BY J.G. SUTHERLAND § 4705 (Callaghan & Co. 1943) (stating that a statute must be interpreted "so that effect is given to all its provisions, so that no part will be inoperative or superfluous . . . and so that one section will not destroy another"); *see also* Reiter v. Sonotone, Corp., 442 U.S. 330, 339 (1979) (construing a statute to give effect to every word used).

138. *See* Brader v. Allegheny Gen. Hosp., 167 F.3d 832, 843 (3d Cir. 1999) (noting that suspending a doctor's privileges to perform a certain procedure was narrowly tailored and reasonable; thus, the action was warranted by the known facts).

139. *Compare* 42 U.S.C. § 11112(a)(1) (requiring a reasonable belief that the action would further the quality of health care), *with* § 11112(a)(4) (requiring the action to be taken in the reasonable belief that it was warranted by the known facts).

140. *See Brader*, 167 F.3d at 840; Mathews v. Lancaster Gen. Hosp., 87 F.3d 624, 634-35 (3d Cir. 1996).

141. *See Brader*, 167 F.3d at 843 (finding action was narrowly tailored); *Mathews*, 87 F.3d at 638 (finding action tailored to the health concern).

142. *See Brader*, 167 F.3d at 836 (finding deficiencies in Dr. Brader's standard of care through an internal review of one type of procedure). Dr. Brader was subsequently suspended from all privileges due to unprofessional conduct. *Id.* at 837.

143. *See id.* at 836 (noting that fifty percent of the hospital's mortalities in abdominal aortic aneurysm surgeries were Dr. Brader's patients).

could suspend the surgeon's privileges completely,[144] or the hospital could permit the surgeon to retain general privileges, but suspend the surgeon's privilege to perform the procedure in question.[145]

Now consider a court's review of the actions. Both actions would be considered to reasonably further the quality of health care as each would prevent future operating-room fatalities. Since the existing interpretation of the fourth standard mirrors the first standard, both actions would also be presumed to be warranted by the known facts. However, using the interpretation proposed by this Comment, only the second action would be warranted based on the known facts.[146] Complete suspension of privileges would be too broad, as there is only concern with one procedure. Thus, the blanket suspension would not be warranted by the facts known.[147] Suspension of the privilege to perform the specific procedure would be warranted by the facts known, because it is sufficient to address the issue of concern.[148]

The proposed interpretation of the fourth requirement would provide substantial protection for physicians and further the goals of the HCQIA.[149] This interpretation still allows peer review panels to further the quality of health care by preventing a physician from performing procedures that the physician is not competent to perform.[150] Additionally, health care would be furthered by allowing physicians to continue to treat patients and perform those procedures with which their level of care is acceptable.[151] Finally, this interpretation would protect physicians from overly zealous peer review committees since the committees' actions would be required to be narrowly tailored to address specific issues.[152]

144. *See* Meyer v. Sunrise Hosp., 22 P.3d 1142, 1146 (Nev. 2001) (suspending all privileges due to treatment of one patient).

145. *See Brader*, 167 F.3d at 836 (suspending surgeon's privileges to perform one type of surgery).

146. *See supra* notes 138-141 and accompanying text.

147. *Id.*

148. *See Brader*, 167 F.3d at 843 (finding that the suspension of Dr. Brader's abdominal aortic aneurysm surgery privileges was warranted by the facts known because it was narrowly tailored to address the health care concern).

149. *See* Islami v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361, 1379 (N.D. Iowa 1992) (recognizing the HCQIA's goals of encouraging peer review and protecting physicians who are reviewed by peer review committees).

150. *See Brader*, 167 F.3d at 837 (suspending Dr. Brader's privileges to perform abdominal aortic aneurysm procedures in order to prevent imminent harm to patients).

151. *See* Tabor, *supra* note 17, at 526 (noting that when a physician's privileges are completely revoked, patients lose their "traditional right to a physician of choice").

152. *See* Wayne v. Genesis Med. Ctr., 140 F.3d 1145, 1147 (8th Cir. 1998) (suspending all privileges because Dr. Wayne removed pages from her personal medical file).

2. Subjective Intent

The fourth standard of the immunity test should require courts to consider the subjective intent of the peer review committee members. Congress intended that health care entities should be given immunity only for good faith peer review actions.[153] Good faith requires an inquiry into the subjective intent of the peer review committee's members.[154] Since courts have eliminated subjective intent inquiries under the first standard,[155] courts should consider subjective intent under the fourth standard.[156]

Both the first and fourth standards require a "reasonable belief."[157] Since courts have interpreted "reasonable belief" to be an objective test under the first standard,[158] they must also interpret "reasonable belief" to be an objective test under the fourth standard.[159] However, this does not mean that subjective intent is completely eliminated from the calculus.[160]

The language "warranted by the facts known" requires courts to determine whether a reasonable person, given the facts known at the time of the peer review action, would have determined that the action was warranted.[161] Often, there are facts known at the time of the peer review action that indicate bad faith on the part of one or more of the committee members.[162] Therefore, when a plaintiff introduces facts that show bad

153. *See supra* notes 81-86 and accompanying text.

154. *See* BLACK'S LAW DICTIONARY 713 (8th ed. 2004) (defining good faith as a "state of mind consisting in . . . honesty or belief in purpose").

155. *See supra* Part III.A.

156. *See* Austin v. McNamara, 979 F.2d 728, 741 (9th Cir. 1992) (Pregerson, J., dissenting) ("Evidence of motive and intent is relevant to show whether the [peer review committee] possessed a reasonable belief that the [action] was warranted by the facts known.").

157. *See* Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11112(a) (2000).

158. *See supra* Part III.A.1.

159. *See* Atl. Cleaners & Dryers, Inc. v. United States, 286 U.S. 427, 433 (1932) (stating that there is "a natural presumption that identical words used in different parts of the same act are intended to have the same meaning . . . [b]ut the presumption is not rigid and readily yields" when the context indicates that the word was used "with a different intent"); United States v. Cent. Pac. R.R. Co., 118 U.S. 235, 240 (1886) (stating that the Court "cannot, consistently with the rules of construction, give a different meaning to substantially the same words").

160. *See Austin*, 979 F.2d at 741 (Pregerson, J., dissenting) (arguing that motive and intent are relevant).

161. *See, e.g.*, Sugarbaker v. SSM Health Care, 190 F.3d 905, 917 (8th Cir. 1999) (reasoning that the conclusions of expert witnesses were not relevant because they were not known at the time of the peer review action).

162. *See* Wieters v. Roper Hosp. Inc. 58 F.App'x 40, 46 (4th Cir. 2003). In *Wieters*, a doctor on the peer review panel wrote a letter at the time of the peer review activities complaining about the process and stating that Dr. Wieters was a good physician. *Id.* The same doctor also stated that the peer review action was the result of a vendetta

faith on the part of the peer review committee, the proper inquiry by the court should be: Were there facts known at the time of the peer review action that show bad faith on the part of the peer review committee members, such that an objectively reasonable person would not think the action was warranted?[163] If the answer to this question is yes, courts should not grant immunity to the health care entity.

IV. Conclusion

Peer review is an important tool in improving the quality of health care. To encourage peer review and improve health care quality, Congress passed the HCQIA and granted immunity to hospitals and physicians who participate in the peer review process. Congress intended that health care entities would only engage in good faith peer review. Thus, Congress made immunity contingent on health care entities' providing some procedural protections for physicians who are under review.

Courts, however, have not interpreted the HCQIA in a manner that facilitates both goals. Instead, courts have uniformly favored health care entities and virtually always granted immunity. This liberal grant of immunity allows health care entities to engage in bad faith peer review and provide little procedural protection for physicians.

Unfortunately, adversely reviewed physicians are left without their career and without a way to recover damages for their loss. To prevent this injustice, courts should reinterpret the HCQIA in a manner consistent with the language and legislative intent of the Act. A proper reinterpretation would still allow health care entities broad immunity from damages and encourage physicians to act as peer reviewers, but it would also provide appropriate procedural protections for the physicians under review.

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against Dr. Wieters. *Id.* While it is not clear that the second statement was made at or before the time the peer review action occurred, it is still evidence of what the doctor believed at the time of the peer review action.

163. *See Austin*, 979 F.2d at 740 (Pregerson, J., dissenting) ("Any inquiry into the reasonableness of the reviewers' beliefs should at least consider any evidence of bias or ulterior motive even though an objective standard ultimately applies.").