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The Health Care Quality Improvement Act of 1986: What Every Surgeon Needs to Know

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Editorial

In the 1980's a number of bills were introduced in the United States Congress which were designed to address "the medical malpractice crisis". At that time, medical malpractice cases were increasing in number, and the size of medical malpractice claims were becoming larger. Although the medical malpractice crisis has been disputed by several observers, clearly, in the 1980's the increasing number of medical malpractice cases posed a significant concern to the Lawmakers. The increase in the number and the size of malpractice claims has been attributed to unrealistic public expectations, physician overestimation of expected results, expanded tort liability, and a lack of meaningful governmental oversight of "bad actors. At the same time, members of Congress were concerned about the increasing number of lawsuits which were brought against peer review groups by physicians whose privileges had been restricted at hospitals, medical societies, and state medical licensing boards. The Congress perceived that the lawsuits against peer review groups had a "chilling effect" on the existentially important peer review process and its role in self-policing of the medical profession.

The response of the Congress to these concerns was the passage of Health Care Quality Improvement Act of 1986 (HCQIA) which was signed into effect on November 14th, 1986, and became fully operational on September 1st, 1990. HCQIA was designed to protect the health and safety of the public by 1) enhancing the Peer Review process through protection for peer review members from lawsuits, and 2) providing a national repository for reported information regarding medical malpractice payments and adverse actions involving physicians, which among other things, would monitor the movement of incompetent or unprofessional physicians.

HCQIA

HCQIA is comprised of two parts

Part A: Immunity for Professional Review Activity: HCQIA provides peer review members, and those individuals who provide information to the peer review committee, with qualified immunity from private suits under both state and federal laws. In order to provide immunity, HCQIA stipulates compliance with the Act's requirements which are outlined in section 11112 (a) and are:

1. Peer review action must have been undertaken in the reasonable belief that the action would further the quality of healthcare

2. Peer review action must have been undertaken after reasonable efforts to obtain the facts

3. Peer review action is in compliance with adequate due process requirements for notice, and an impartial fair hearing

4. Peer review action must have been undertaken with the "reasonable" belief that the facts warranted the action.

It is important to emphasize that the intent of HCQIA was to encourage self-policing by the medical profession by protecting physicians who participated as members of the peer review committee, or as witnesses in such proceedings, from retaliatory lawsuits. As a result, the immunity protection provided by HCQIA is broad and only requires adherence to "fundamental fairness" for the process to satisfy the Act.

In order for a physician to challenge Peer Review, Congress adopted the "preponderance of evidence" standard for the peer review proceedings.

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HCQIA does not provide immunity to hospitals outside the peer review process in terms of being named as codefendants in a malpractice lawsuit, or liability for negligence in granting of staff privileges.

Part B: Reporting to the National Practitioner Data Bank: HCQIA stipulated that as of September 1st, 1990, adverse actions taken against physicians in terms of professional review actions and curtailment of clinical privileges for greater than 30 days, and malpractice payments, were to be reported to the National Practitioner Data Bank (NPDB).

In order to further the goal of strengthening the confidential peer review process, HCQIA does not provide the public with access to NPDB. However, HCQIA grants attorneys access to information contained in NPDB after two elements are met: 1. A medical malpractice action or claim is filed against both hospital and the practitioner, and 2. Evidence is produced at the hospital failed to request in NPDB information on the practitioner as required by law.

General and Present-Day Concerns

A 35-year fast forward since the enactment of HCQIA reveals unintended yet professionally threatening consequences of the law. Over time it has become apparent that HCQIA requires some amendments.

The original purpose of HCQIA was to improve the health and safety of the public by encouraging reporting of incompetence and unprofessional behavior by physicians. To achieve this goal, peer review groups are granted qualified immunity from damages and suits brought by physicians under federal and state law. The act is further facilitated by the establishment of NPDB. However, since its inception, HCQIA has been the subject of controversy.

HCQIA became law as the medical system was undergoing a significant organizational change. In the years which preceded the Congressional hearings in 1986, most physicians were private practitioners who practiced in hospitals by virtue of holding "privileges" at that hospital. In the 1980's, there was effectively an organizational and administrative wall between Medical Staff Office Governance and the Hospital Administration. With this level of separation in the business interests of the hospital, from the patient care interests of the medical staff, the Peer Review process was a time-honored method of physician self-policing. Therefore, protecting the sanctity of the Peer Review and providing an even playing field was paramount for the health and safety of the public.

Fast forward to the drastic changes in the health care system since 1986. In 2022, healthcare has been consolidated into increasingly larger Hospital Organizations, payment for health care services has become consolidated under more powerful governmental and private insurance carriers, and the majority of physicians are now "employed". These changes have given rise to concerns that the HCQIA may have become antiquated and used unfairly by some hospitals to effectively engage in anti-competitive behavior against opposing physicians by using "Sham Peer Review". Although "Sham Peer Review" remains a matter of interpretation, the mere concern about this concept has taken the legitimacy of Peer Review, the cornerstone of self-policing of physicians, back to 1986.

Nowadays, Peer Review committee members are no longer independent. Members are typically hospital-employed physicians that have signed an agreement to make decisions (including those about peer review) that comport with expectations, metrics and targets of the administration of the healthcare system. At times, this requires members to accept the political or strategic goals of a CEO who may want to exploit Sham Peer Review for the hospital administration's purposes. A CEO that selects this route becomes immune under HCQIA from any lawsuits by a terminated physician merely by labeling those actions "Peer Review". Most hospital bylaws grant the hospital the right to remove members that are unwilling to comply with such capricious decisions. While the original intent of immunity was to protect the judgments of physician reviewers about the medical competency of their peers, it has now been also coopted to protect political decisions such as in terminating "difficult" physicians.

In addition, most hospital-appointed Peer Review committee members lack specific training and are not experts in that specific field. Hospitals shy away from true and fair Peer Review by mutually agreed-upon national experts because they do not necessarily align with the goals of hospital administration. However, the judgments of hospital-appointed members are at significant risk of being biased by personal or professional ties and administrative expectations. These "unfair" issues add up to investigations that are often incompetently performed with tremendous adverse consequences to the practitioner.

Currently, the remedy for an accused physician facing grave professional consequences as the result of a violation of his constitutional rights is to file a lawsuit against perceived Sham Peer Review. But the hospital has a very potent ace-in-the-hole. Its legally guaranteed immunity as per HCQIA allows hospitals to keep their actions confidential and information privileged from legal discovery. It also allows hospital administrators to officially distance themselves from the accused physician for several reasons and from a process they know was corrupt or fear of being blamed for a negative outcome.

Although legal claims for retaliatory or "Sham" Peer Review, have had little success, a recent California Supreme Court decision may have lasting ramifications. In Bonni v. St Joseph Health System, California Medical Association filed an amicus curiae brief which sought to ensure protection for physicians on both sides of the Peer Review process and to preserve the maintenance of high professional standards and the protection of patient welfare. The brief sought to provide the court with a practical, realistic depiction of the problems with the Peer Review system and presented a solution that protected physicians due process rights while also insulating medical staffs and medical executive committees from harassing frivolous lawsuits. In its decision the California Supreme Court concluded that peer review is a protected activity, but those protections are limited to speech and petitioning activity taken in conjunction with peer review. The court proposed a balanced position stating that while protection extends to statements made in the peer review proceeding and to the required reporting of any decision to the medical board, the protection does not apply to final disciplinary decisions. The court reasoned that such disciplinary decisions are disconnected from speech and petitioning activities thereby giving physicians who claim to be victims of "Sham Peer Review" their day in court.

Some authors have proposed that the notion of fairness in the medical community will never be achieved unless the provisions of HCQIA are amended to respond to the changing times. Seven areas of change have been proposed: 1) the burden of proof should be placed on the accusers, 2) "absolute immunity" should be withdrawn from the members of the peer review committee who are proven

to have acted in malice, for anticompetitive purpose, or engaged in fraudulent behavior, 3) standardize guidelines from the literature and relevant clinical practice should be mandated to be used by the peer review committees, 4) peer review committees should be comprised of physicians in the same specialty as the physician undergoing review. 5) "Due Process" as is mandated under the US Constitution and is used in other legal proceedings, and the presumption of innocence until proven guilty, should be afforded to every physician undergoing peer review 6) physicians under review should have the right for representation by an attorney in all stages of the peer review process, 7) state medical boards should be mandated to review all hospital adverse actions toward physicians, and that adverse action only be reported after the state board proceedings.

In summary, improving HCQIA through appropriate and present-day amendments as outlined will benefit not only physicians and hospitals but quality and safety standards in all aspects of healthcare.

Conclusion

The Peer-Review Process is a fundamental aspect of medicine. It allows the profession to maintain the highest standards of quality and professional behavior and insures the highest level of quality and safety for patients. Most physicians are not familiar with the provisions of HCQIA, and unfortunately only become aware of the law and its provisions if they become a subject of peer review. Given the existential nature of the reporting of adverse actions, it is crucial for every physician to be familiar with HCQUA and work to improve it with the goal of fairness for all physicians, and the highest standards of quality for the profession. The time has come to correct HCQIA deficiencies and loopholes and make peer review truly objective and fair as the original intention was.