HOSPITAL LIABILITY FOR DEFAMATION OF CHARACTER DURING THE PEER REVIEW PROCESS: STICKS AND STONES MAY BREAK MY BONES, BUT WORDS MAY COST ME MY JOB

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I. INTRODUCTION

The childhood saying implying that words will never hurt you has little meaning in the health care peer review arena. In fact, one derogatory or critical statement by a fellow physician could bring a medical career to a screeching halt. This is often the result because most hospitals have regulations requiring physicians to undergo a peer review process in order to receive or retain the privilege of using hospital facilities. The process itself is based upon the idea of self-regulation in that hospital physicians are asked to review and evaluate the performance of their co-workers and to restrict or deny various hospital privileges if necessary.

This peer review process can best be understood if it is first realized that in most cases doctors with hospital privileges are not employees of the hospital, but rather independent contractors who must be granted permission to admit patients and make use of the hospital’s resources.1 This permission is granted when a physician receives a vote of approval from his colleagues. “[U]nlike other forms of peer review, the medical staff privileges system has a direct

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coercive sanction to influence behavior: the denial or revocation of the right of access to facilities essential for an effective medical practice." 2

Of course, the hospital privileges system is geared towards improving the quality of health care and in this regard there have recently been some significant changes. On the national level an increased concern for quality health care is evidenced by the Health Care Quality Improvement Act of 1986 (HCQUIA) 3 and other recent legislation. 4 The driving force behind this legislation has been a concern for the effects of some recent cuts in funding and compensation in the health care industry which may negatively impact the quality of care provided.

However, attempts at improving health care are not unique to modern medicine. In 2000 B.C. the Code of King Hammurabi of Babylon required that a doctor who negligently killed a patient have his hand cut off. 5 Our more civilized and sophisticated methods today require that a doctor face judgment by his peers. The worst possible punishment today is the denial of privileges based upon a physician's poor performance, inferior qualifications or disruptive behavior. These findings can have devastating effects on a physician's career. In the past, a physician who had lost his privileges could quietly leave the hospital and seek employment elsewhere. Today, however, the possibility of finding gainful employment in the hospital setting after a poor review is slight due to the provisions of the HCQUIA. 6 This statute requires that doctors who have been

2. Id. at 554-55.
denied privileges be reported to a national service which keeps track of inadequate and poorly qualified physicians. Hospitals must check with the service before hiring a new physician to make sure that the physician has not been rejected by other health care facilities and does not pose a threat to the quality of care provided by the hospital.

Obviously, these requirements can be disastrous to the rejected physician. Once a doctor has been denied privileges in one hospital, it is highly unlikely that he will be hired by other accredited hospitals and medical facilities. The only option for such physicians is to enter private practice, an alternative which does not offer the substantial benefits of being associated with an established medical facility. Such scenarios have prompted increased litigation against the hospitals and medical staffs which deny privileges to the physicians.

Causes of action brought by physicians against Peer Review Boards, medical staffs, and hospitals include: violation of medical staff bylaws, breach of contract, violation of due process and equal protection, conspiracy, tortious interference with a contractual business relationship, intentional infliction of emotional distress, antitrust claims, and defamation. This last claim, defamation, is the focus of this note. Defamation of character is one of the more usual claims which has been raised in these suits and such actions have led to an increased fear of litigation by medical professionals participating in the review process. This apprehension has often resulted in a “code of silence” among the physicians. Although this silence may protect the physicians from suit, it defeats the primary goal of increasing the quality of health care.

This note will focus on the effects of the HCQUIA on hospitals, their medical staffs, and the ability of physicians who have lost or been denied privileges to seek legal remedies.

II. THE PEER REVIEW PROCESS

Traditionally, doctors are not entitled to membership on a medical staff of a hospital as a matter of right. “It cannot . . . be said

7. Id. at §§ 11131-34.
that all licensed physicians have a constitutional right to practice their profession in a hospital. . . .”

Although a license to practice a profession is a valuable right, deserving of protection by the laws, it is not afforded the same considerations as a constitutional or inherent right. However, hospitals cannot arbitrarily deny privileges.

At public hospitals a physician is either entitled to membership or to a hearing of the reasons for his refusal. “This right does not exist, however, in relation to a private hospital, which may, in its discretion, exclude any physician from its staff without being required to give any reason therefore.” As a general rule, a private hospital may act at its discretion in deciding whether to grant or deny medical privileges to a physician and the decision will not be subject to judicial review. In fact, a private hospital has an absolute right to exclude licensed physicians.

Peer review is the common method for exercising self regulatory competence and evaluating physicians for privileges. “Peer review can be defined as the evaluation by practicing physicians of the quality, efficiency and effectiveness of services ordered or performed by other physicians.” It is the ongoing review of competence through reappointment, quality assurance and risk management. Essentially, peer review is the credentialling process which assures that the medical staff is qualified. It applies to both new staff members and new privileges of current staff members. “Peer review is the procedure for evaluation by health care professionals of the quality and efficiency of services ordered or performed by other health care professionals . . . .”

10. Id. at 417.
14. Id. at 229, 140 S.E.2d at 457.
19. KUCERA & CALLAHAN, supra note 8, tab 4, at 5.
20. Id. at 1.
The 1988 Joint Committee on Accreditation of Hospitals (JCAH) Accreditation Manual for Hospitals\textsuperscript{22} indicated that medical staff bylaws should set forth the detailed procedures of peer review. Bylaws are the structural framework upon which the medical staff of the hospital is built.\textsuperscript{23} The typical hospital bylaws require a tri-part organizational structure.\textsuperscript{24} Overall responsibility rests with the hospital governing body,\textsuperscript{25} day-to-day operations are the responsibility of the administrative personnel,\textsuperscript{26} and the medical staff is responsible for the quality of professional services provided.\textsuperscript{27} However, the ultimate responsibility for the quality of the medical care rests with the governing body.\textsuperscript{28} According to JCAH standards, the governing body has authority to establish policy, maintain quality care, provide management planning, and adopt corporate bylaws.\textsuperscript{29} It is required to implement quality assurance programs through the medical staff.\textsuperscript{30} The hospital must have a well-defined credentialing process;\textsuperscript{31} and, ultimately, the governing body has final responsibility regarding credentialing decisions.\textsuperscript{32}

Despite the supreme authority vested in the governing body, the medical staff itself is considered a separate legal entity distinct from the hospital corporation and is capable of suing and being sued.\textsuperscript{33} It can be held liable for negligence in failing to exercise a reasonable

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\textsuperscript{23} W. Isele, supra note 18, at 26.
\textsuperscript{25} Id.
\textsuperscript{26} Id.
\textsuperscript{27} Id.
\textsuperscript{28} W. Isele, supra note 18, at 26.
\textsuperscript{29} JCAH Manual, supra note 22, at 47.
\textsuperscript{30} Kucera & Callahan, supra note 8, tab 4, at 3.
\textsuperscript{31} "The governing body acts on recommendations concerning medical staff appointments, reappointments, terminations of appointments, and the granting of clinical privileges within a reasonable period of time, as specified in the bylaws of the medical staff." JCAH Manual, supra note 22, at 49.
\textsuperscript{32} "The governing body requires a process or processes designed to assure that all individuals who provide patient care services, but are not subject to the medical staff privilege delineation process, are competent to provide such services." Id.
\textsuperscript{33} W. Isele, supra note 18, at 4.
standard of care in reviewing credentials. In recognizing the importance of staff members in the general quality of care provided, a federal court in Wisconsin stated that "members of the medical staff of a hospital are obviously the key to the quality of the hospital's performance . . . . [I]n general, members of the medical profession are the best qualified judges of the professional performance of other members of the medical profession." The American Medical Association (AMA) says "the basic concept of peer review is as old as organized medicine itself," and "[t]he process is undoubtedly the greatest guardian of the health and well-being of patients."

In order for a hospital to receive JCAH accreditation, it must show that it has an adequate peer review process to oversee the quality of patient care. Not only is peer review a prerequisite for accreditation by the JCAH, but it is also required by most state laws. Key factors in accreditation include whether "an organized governing body or designated person so functioning, is responsible for establishing policy, maintaining quality patient care, and providing for institutional management and planning." The hospital governing body usually delegates much of this responsibility to the medical staff.

Under JCAH standards there must be a "single organized medical staff that has the overall responsibility for the quality of the professional services provided by the individual with clinical privileges, as well as, the responsibility of accounting therefore to the governing body." In addition, there must be an ongoing quality assurance program which evaluates the quality of patient care.

34. Id.
37. Id.
38. JCAH Accreditation Manual for Hospitals, supra note 22.
40. JCAH Accreditation Manual for Hospitals, supra note 21, at 47.
41. Id. at 111.
42. Id. at 235.
Some courts suggest hospitals are run by the medical staff, especially in regard to peer review. The peer review committees themselves are generally made up of attending physicians who meet to review and evaluate the qualification and practices of their peers. Typically, they have the power to police peer activities with minimal interference from administration.

Overall, this process would appear to be a low-risk system for identifying inadequate caregivers. However, physicians participating in the review process can experience significant stress resulting from both the potentially devastating effects their review may have on a colleague's future and from the fear of involvement in litigation initiated by dissatisfied or injured patients or rejected physicians. "Constructive professional criticism cannot occur in an atmosphere of apprehension that one doctor's suggestion will be used as a denunciation of a colleague's conduct in a malpractice suit." 44

These fears are not unfounded as hospitals are increasingly faced with legal problems involving their medical staffs in the forms of vicarious or corporate liability. In many cases the hospital is ultimately responsible for the professional conduct of its physicians. 45 Darling v. Community Memorial Hosp., 46 the leading case in this area, holds hospitals responsible for failing to adequately screen, supervise, and review the performance of their physicians. Generally, hospitals are responsible for the negligence of their staff members. 47

Similarly, the theory of corporate negligence is premised on the hospital's duty of care to the patient. 48 Under the theory of "corporate liability," hospitals have a duty to ensure a reasonable process to review and evaluate the qualifications of medical staff

46. Id.
48. Comment, supra note 47, at 559.
members. The corporate liability doctrine dictates that the hospital’s governing body has the duty to use appropriate measures to ensure the competency of the medical staff through adequate assessment of competence, identification of deficiencies, and ultimately, proper action on the findings. "A major benefit of improving health care by rigorous peer review is a reduction of legal liability for medical malpractice and hospital corporate liability."

As a result of the increasing liability for hospitals, peer review organizations have become essential for protecting the public and the hospital from the ill effects of incompetent physicians and inadequate services.

Often, injured patients attack peer review members for being negligent in their review and allowing a physician to receive privileges or continue work at the hospital. There is a significant area of law relating to this type of litigation. However, this note will not address malpractice-related claims. Instead, the following discussion relates to the claims of defamation brought by the disgruntled physicians against the peer review boards.

51. Goldberg, supra note 39, at 155.
52. These review organizations include any committee or organization engaging in peer review, including a hospital utilization review committee, a medical audit committee, a tissue committee, a credentials committee, or an executive committee for the purposes of evaluating and improving the quality of health care rendered, reducing morbidity or mortality or establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. W. VA. CODE § 30-3C-1 (1986).
53. See Darling, 33 Ill. 2d 323, 211 N.E.2d 253.
54. See, e.g., Lilly v. Turecki, 112 A.D.2d 788, 492 N.Y.S.2d 286 (N.Y. App. Div. 1985) (action alleging hospital negligence in treating patients and in granting staff privileges to a physician); Shelton v. Moorhead Memorial Hosp., 76 N.C. App. 253, 332 S.E.2d 499 (1985) (patient alleged that hospital officials knew that physicians were incompetent and unfit to practice medicine and had violated hospital standards of care).
III. DEFAMATION

In order to encourage participation by qualified physicians, peer review entities receive protection through the special privileges of confidentiality and immunity from liability. There is a two-step premise which supports peer review protection: 1) special privileges result in increased peer review activity, and 2) increased peer review activity results in health care improvements. In fact, statutes in many states provide immunity for physicians on peer review committees. The purpose of this type of legislation is to ensure the effectiveness of professional self-evaluation in the interest of improving the quality of health care.

Notwithstanding the special privileges and immunities established for peer review, members of medical staff review boards have nevertheless been subject to defamation suits by rejected physicians based upon criticism of the physician's competence or qualifications. "Peer review is the type of activity in which committee participants are particularly susceptible to defamation actions, because '[a]ny process such as peer review that may result in a conclusion of unfitness for a profession, communicated to a third party, may result in a defamation action.'" Defamation law imposes liability for the publication of false information which injures the reputation of others. Damage to reputation is the basis of a defamation action.

55. Comment, supra note 47, at 552.
56. Id.
“The concept that a person’s reputation in the community is precious and should not be injured with impunity had been well established since ancient times.”

In very early English canon law, the only remedy for a complaint resembling defamation was a public apology. This method of clearing one’s good name provided some legal protection. However, it was not until the latter part of the 16th century that a remedy was recognized by common law.

Defamation includes communications which tend to injure one’s occupation. It occurs when a communication “tends to so harm the reputation of another as to lower him in the estimation of the community or to deter third persons from associating or dealing with him.” Obviously, a rejection of privileges by a peer review could have the requisite damaging effects.

A person’s standing in the community with his friends, neighbors and prospective acquaintances is of great value and he is entitled to have his relations with them unimpaired by defamatory harms. The regard of those about him more completely conditions his behavior than any other one factor, and it likewise adds more to his stature as a person than any other one factor. This interest has long been identified and valued as reputation.

It has been said that a good reputation is the most precious possession a man can have. “[T]he right of the private citizen to secure his reputation always must remain one of the most sacred of rights.” This right is also protected in the West Virginia

65. Id.
66. Id.
68. Restatement (Second) of Torts § 559 (1976). Defamation is “that which tends to injure ‘reputation’ in the popular sense; to diminish the esteem, respect, goodwill or confidence in which the plaintiff is held, or to excite adverse, derogatory or unpleasant feelings or opinions against him.” W. Keeton, D. Dobbs, R. Keeton, D. Owen, Prosser and Keeton on Torts § 111 at 773 (5th ed. 1984) [hereinafter Prosser and Keeton].
69. L. Eldredge, supra note 64, at 12 (quoting Green, Malone, Pedrick & Rahl, Injuries to Relations 332 (1959)).
70. L. Eldredge, supra note 64, at 13 n.40 (quoting Roth v. Greensboro News Co., 217 N.C. 13, 20, 6 S.E.2d 882, 887 (1940)).
constitution by a provision which establishes that every person shall have remedy by law for injury to his person, property, or reputation. In West Virginia, the essential elements of a defamation claim include: 1) defamatory statements, 2) non-privileged communication to a third party, 3) falsity, 4) reference to the plaintiff, 5) negligence on the part of the publisher, and 6) resulting injury.

Normally, there are two types of defenses available in defamation actions—1) truth and 2) privilege. Truth is recognized as a complete defense. "In any action for defamation, the defendant may justify by alleging and proving that the words spoken or written were true . . . ." Although the West Virginia Supreme Court has not decided the issue of "substantial truth" as a defense in civil libel actions, a district court opinion predicted that "substantial truth" would constitute an absolute defense in common law defamation actions brought by private persons against non-media defendants in West Virginia.

There are also two types of privileges available to defamation defendants. An absolute privilege precludes defamation actions,
whereas a qualified privilege may be defeated. 81 An absolutely privileged communication has been defined by the West Virginia courts as one for which no remedy can be had in a civil action, regardless of the effect on the person who claims to be injured, even though it may have been made maliciously. 82 Such a privilege "is limited to those situations where there is an obvious policy in favor of permitting complete freedom of expression without any inquiry as to the defendant's motives." 83 Absolute privileges are usually limited to legislative, judicial, and quasi-judicial proceedings and other state actions. 84 Not surprisingly, it has been held that hospital peer review committees do not qualify as quasi-judicial proceedings. 85

Qualified privileges are more relevant to the peer review process. "Qualified privileges are based upon a public policy that it is essential that true information be given whenever it is reasonably necessary for the protection of one's own interests, the interests of third persons or certain interests of the public." 86 Such privileges exist when statements are made in good faith regarding a subject matter in which the publisher has an interest or duty and the statements are limited to persons who have a legitimate interest in the matter. 87 The essential elements of a conditional or qualified privilege include: good faith, public policy, an interest in the subject matter, proper occasion, and publication in a proper manner to proper parties. 88 A communication is qualifiedly privileged where it is fairly made by a person in the discharge of some public or private duty upon

81. Id.
82. Id. at 78 (quoting City of Mullens v. Davidson, 133 W. Va. 557, 563, 57 S.E.2d 1, 6 (1949) (quoting 33 Am. Jur., Libel and Slander § 125 (1941)).
83. Id. at 77.
84. Id. at 78. See, e.g., Parker v. Appalachian Elec. Power Co., 126 W. Va. 666, 672, 30 S.E.2d 1, 4 (1944).
85. A minority of states have established an absolute privilege based upon the theory that the peer review process is a quasi-judicial proceeding. Dimiceli v. Klieger, 58 Wis. 2d 359, 206 N.W.2d 184 (1973). In fact, one jurisdiction has gone so far as to declare that "peer review is a complete defense to an action for defamation." Lew v. Kona Hosp., 754 F.2d 1420, 1425 (9th Cir. 1985).
86. Crump, 320 S.E.2d at 77.
87. Id.
88. Mayfield v. Gleichert, 484 S.W.2d 619, 625 (Tex. Civ. App. 1972). The question of whether a privilege exists is a question of law for the court. Id. at 626; Crump, 320 S.E.2d at 81. Once a privilege is established, however, abuse of the privilege must be considered by the jury as a question of fact. Crump, 320 S.E.2d at 81.
any subject matter in which that person has an interest, and where it is made to a person with a corresponding interest or duty. Remarks made during the peer review process meet this definition of a qualifiedly privileged communication because they involve statements made by hospital officials about matters of concern to the hospital and the statements are made pursuant to a duty to inform persons with an interest in the matter. Therefore, it is proper that such reviews are protected by these legal privileges.

However, “[d]efamatory statements, motivated by ill-will or malice, have no place in a forum convened to determine the qualifications of an individual to continue in the practice of his profession.” In recognition of that principle, qualified privileges do not provide absolute immunity, but merely negate the presumption of malice and place the burden of proof on the plaintiff. Therefore, in cases where the plaintiff physician is able to prove that the remarks were made with malice, he may prevail in a defamation suit.

Generally courts have recognized that medical staff peer review boards are assisting the hospital in meeting its credentialling and quality assurance requirements. Therefore, such boards gain the protection of immunity and are insulated from personal liability because they are acting under the authority of the hospital. The immunity available in these cases usually takes the form of a qualified priv-

92. In order to prove malice, the plaintiff must show “personal spite, ill will, culpable recklessness or negligence.” Id. A qualified privilege exists in the law of defamation when the communications are made in good faith without actual malice, when there are reasonable or probable grounds for believing the communications to be true or when the subject matter is one in which the author of the communications has an interest or in respect to which he has a personal or public duty of either a legal, judicial, political, moral or social nature, and the communication is made to the person having a corresponding interest or duty. Mayfield, 484 S.W.2d at 626. A qualified privilege may be defeated by actual malice, intentional publication of defamatory material, publication of false defamatory material in reckless disregard for its truth or falsity, publication to persons who have no reason to receive the information and publication with a primary purpose which is unrelated to the privileged purpose. Crump, 320 S.E.2d at 78.
ilege. Such a privilege is limited to remarks made by those participating in the peer review process, solely for the purpose of the peer review and without any indication of malice. Although there are limits to the availability of this immunity, most states do recognize the importance of providing this protection.

IV. STATE ACTION

Courts have generally been unwilling to create privileges for peer review where legislatures have failed to enact them. The first statute adopted for such protection was in Illinois in 1961. The purpose of many of the early statutes was to protect physicians from malpractice actions brought by patients. Today, the primary purpose is to encourage peer review in an attempt to improve the quality of health care.

State legislatures have created these privileges when particular relationships have been considered so valuable to society that it is necessary to preserve the confidentiality of the relationship. Many states have enacted statutes for the purpose of striking a balance between the right of the physician being reviewed to be free from defamation, and the right of the physician doing the reviewing to be free from liability for defamation or other claims. These statutes range from providing qualified immunity to providing absolute immunity from civil defamation actions.

West Virginia is in the majority of states which have granted a conditional or qualified privilege to physicians participating in the review process. Indeed, this state has a series of statutes devoted specifically to the protection of Health Care Peer Review Organi-

94. Goldberg, supra note 39, at 152.
95. Id. at 153.
96. Id.
97. See Jenkins, 102 Ill. 2d 468, 468 N.E.2d 1162 (1984).
100. Id. at 694.
The actual immunity is established in section 30-3C-2 of the West Virginia Code which provides that "no person providing information to any review organization shall be held . . . to be civilly liable under any law unless, (1) such information is unrelated to the performance of the duties and functions of such review organization, or (2) such information is false . . . ." The statute originally required due care, however, an amendment in 1980 substituted "an absence of malice" as the standard.103

As in West Virginia, many states have enacted a qualified privilege for the peer review process which can be overcome by a showing of malice.104 "A frank and open discussion which is fundamental to peer review cannot occur when the participants are concerned about the possibility of . . . lawsuits claiming malicious defamation."105 However, the immunity must be conditional or qualified in order to afford the reviewed physician the protection from malicious defamation.

In this respect, defamation actions for peer review activities are not totally abolished.106 If a physician can demonstrate malice in the review process, he may still prevail in the defamation cause of action. However, a recent Fourth Circuit decision recognized the strong policy reasons behind the granting of qualified privileges to the peer review process, and, at least impliedly, admitted that a plaintiff physician might have a difficult time establishing that malice was present during the review. The court stated that "[i]f a conditional privilege should ever operate, indeed if there is one instance where society should encourage uninhibited communication, it is in the review of the competency of medical professionals."107

102. Id.
103. "A review organization or any member, agent or employee thereof who, in the absence of malice and gross negligence, acts upon or furnished counsel, services or information to a review organization shall be immune from liability for loss or injury to the person whose activities are being reviewed." Id.
105. Id.
107. Sibley, 871 F.2d at 484 (emphasis in original). There also appears to be recognition of a conditional privilege at common law. DeLeon, 871 F.2d at 1237. Communications which arise in the employment context or by a common interest in the subject matter are also privileged. Id. at 1238.
The majority of states have accepted this policy argument and have elected to provide some type of immunity for peer review. Such legislation is essential because the United States Supreme Court has ruled that peer review immunity is available only to the extent that any individual state has established the immunity.\textsuperscript{108} In \textit{Patrick v. Burget}, the Court implied that hospitals and physicians can not expect special treatment from the judicial system simply because they are engaged in an important function in society.\textsuperscript{109} However, as mentioned earlier, the recently enacted the HCQUIA,\textsuperscript{110} which came after \textit{Patrick}, may have provided the type of national uniformity that has been lacking in this area of law. In fact, HCQUIA has gone a step further in precluding this type of litigation by essentially immunizing peer review action from liability if it is done with the reasonable belief that it is in the furtherance of quality health care.

V. Health Care Quality Improvement Act of 1986

Congress finally recognized the need to "encourag[e] good faith professional review activities" in the medical arena.\textsuperscript{111} Nationwide concern had mounted over increasing medical malpractice actions and the need to improve the overall quality of health care.\textsuperscript{112} In order to improve these national problems, it was necessary to implement a system which would restrict the ability of incompetent physicians to continue to practice and deliver poor health care.\textsuperscript{113} Congress recognized that this goal could be accomplished through effective professional peer review, only if the threat of liability for physicians participating in the peer review process was eliminated.\textsuperscript{114} A national need existed "to provide incentives and protection for physicians engaging in effective professional peer review."\textsuperscript{115}

\textsuperscript{109} Id. at 105 n.8 (Congress has insulated certain peer review activities and it is up to the state to make further provisions.)
\textsuperscript{110} 42 U.S.C. §§ 11101-52.
\textsuperscript{111} Id.
\textsuperscript{112} Id. at § 11101(1).
\textsuperscript{113} Id. at § 11101(2).
\textsuperscript{114} Id. at § 11101(4).
\textsuperscript{115} Id. at § 11101(5).
Such were the findings that initiated the HCQUIA,\(^{116}\) which was passed to eliminate incompetent medical care and to provide a broad-based immunity to hospitals and individuals engaging in peer review. The Act deters the current wave of litigation regarding the granting and denying of medical staff privileges. Its stated purpose is to "improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior."\(^{117}\) "Under this bill, hospitals and physicians . . . will be protected from damages in suits by physicians who lose their hospital privileges . . . ."\(^{118}\)

As defined in the Act, "[p]rofessional review action means an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges or membership in a professional society of the physician."\(^{119}\) Professional review activity also includes any activity of a health care entity with respect to an individual physician to determine whether a physician is entitled to have clinical privileges, to determine the scope of such privileges, or to change his privileges.\(^{120}\) The Act requires that considerations in the review process not be based upon the physician's association, or lack of association with a professional society or organization, the physician's fees or advertising practices, or "any other matter that does not relate to the competence or professional conduct of the physician."\(^{121}\)

Most importantly to hospitals and their staffs, the HCQUIA provides immunity from civil liability under any federal or state law.

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\(^{116}\) *Id.* at § 11101.


\(^{118}\) *Id.*

\(^{119}\) 42 U.S.C. at § 11151(9).

\(^{120}\) *Id.* at § 11151(10). Changes that adversely affect privileges include reducing, restricting, suspending, revoking, denying or failing to renew privileges or membership in the health care entity. *Id.* at § 11151(1).

\(^{121}\) *Id.* at § 11151(9)(a)-(e).
for peer review of physicians.\textsuperscript{122} The peer review immunity for federal actions was effective on November 14, 1986.\textsuperscript{123} Immunity for state actions became effective on October 14, 1989 if a state had taken no legislative action precluding the immunity established by the HCQUIA.\textsuperscript{124} A state could choose when the immunity became effective, and could opt-in for the immunity prior to October 14, 1989.\textsuperscript{125} State legislatures may also elect to avoid the immunity provisions.\textsuperscript{126} If no state legislative action was taken, the immunity became automatic as of October 14, 1989.\textsuperscript{127}

The West Virginia Legislature did not take any action on the HCQUIA provisions, and therefore, the state immunity became effective as of October 14, 1989. In anticipation of this result, hospitals around the state have amended their bylaws to meet the standards required to receive immunity.

The immunity applies to hospitals which: 1) are licensed; 2) meet the definition of hospitals contained in The Public Health And Welfare title of the U.S. Code;\textsuperscript{128} 3) meet due process requirements;\textsuperscript{129} and 4) are not published in the Federal Register for failing to meet the reporting requirements of HCQUIA.\textsuperscript{130} If these conditions are met then immunity is granted to the hospital, the governing body of the hospital, the medical staff conducting the review, and any person who participates or provides information in the review of a physician.\textsuperscript{131}

There are also certain requirements or standards applicable to the review process itself which must be met in order for the hospital

\begin{itemize}
\item \textsuperscript{122} \textit{Id.} at §§ 11111(a)(1), 11151(9), 11151(10).
\item \textsuperscript{123} \textit{Id.} at § 11111(c)(1).
\item \textsuperscript{124} \textit{Id.}
\item \textsuperscript{125} \textit{Id.} at § 11111(c)(2).
\item \textsuperscript{126} \textit{Id.} at § 11111(c)(2)(B).
\item \textsuperscript{127} \textit{Id.}
\item \textsuperscript{128} 42 U.S.C. § 1395x(e)(1)-(7).
\item \textsuperscript{129} Public hospitals must comply with the constitutional principles of due process. However, private hospitals are not subject to the same constitutional due process requirements. \textit{See Pepple,} 511 N.E.2d 467.
\item \textsuperscript{130} 42 U.S.C. at §§ 11111(a), 11151.
\item \textsuperscript{131} \textit{Id.} at § 11111(b).
\end{itemize}
to take advantage of the immunity provided by HCQUIA. In order to receive protection the professional review must be taken

in the reasonable belief that the action was in the furtherance of quality health care, after a reasonable effort to obtain the facts of the matter, 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 in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain the facts . . . .\textsuperscript{132}

Although the immunity created by the HCQUIA is fairly broad, there are certain circumstances it will not cover.\textsuperscript{133} Peer review immunity does not apply to a violation of civil rights;\textsuperscript{134} an action by the United States or the Attorney General, including actions brought under the Clayton Act;\textsuperscript{135} a situation involving false information;\textsuperscript{136} or actions brought for injunctive or declaratory relief.\textsuperscript{137} In addition, those hospitals which are listed in the Federal Register for failing to report information as required by HCQUIA will lose their peer review immunity.\textsuperscript{138}

As a quid pro quo for the immunity, hospitals are required to report any action taken by the hospital which "revokes or suspends (or otherwise restricts) a physician's license or censures, reprimands, or places on probation a physician for reasons relating to the physician's professional competence or professional conduct . . . ."\textsuperscript{139} A health care entity which fails to comply with these reporting requirements will lose its protection.\textsuperscript{140} If this happens, the Secretary of Health and Human Services will publish the name of each non-complying health care entity in the Federal Register and the immunity will not apply for a three-year period beginning 30 days after the date of publication in the Federal Register.\textsuperscript{141}

\begin{footnotesize}
\textsuperscript{132} Id. at § 11112(a)(1)-(4). The necessary standards for protections are presumed to have been met unless the presumption is rebutted by a preponderance of the evidence. Id. at § 11112(a).
\textsuperscript{133} Id. at § 11111(a).
\textsuperscript{134} Id.
\textsuperscript{135} Id.
\textsuperscript{136} Id. at § 11111(a)(2).
\textsuperscript{137} Id.
\textsuperscript{138} Id. at § 11111(b).
\textsuperscript{139} Id. at § 11132(a).
\textsuperscript{140} Id. at § 11133.
\textsuperscript{141} Id.
\end{footnotesize}
In addition to the reporting requirements, each hospital must also obtain information relating to its current physicians and new physicians applying to the hospital. A failure to request the appropriate information results in a presumption that the hospital has knowledge of any information that has been reported concerning a physician. This may also result in negating the immunity established for peer review. A national physicians data bank has been proposed as a clearinghouse for this information. HCQUIA authorizes the Secretary of Health and Human Services to establish a national data bank to collect and release the information relating to the professional competence and conduct of physicians, dentists, and other health care practitioners. However, this national data bank has not yet been put into effect. Its implementation is still awaiting final approval by the Office of Management and Budget at the Department of Health and Human Services. Once approval has been granted and the proposal has been published in the Federal Register, the national physicians data bank will become a reality and the reporting requirements will go into effect. The target date for the opening of the national data bank was April 1990.

The advent of the data bank may prompt additional litigation from rejected physicians since the effects of the reporting requirements to the national bank could act as a total bar from the practice of medicine in the hospital setting of those incompetent medical professionals. This premise is based on the theory that no accredited hospital would want to risk hiring a doctor who has previously been denied privileges or had his privileges revoked by another hospital. It is also important to note that although the Act requires hospitals to report and request certain information concerning its physicians, there is no express provision requiring hospitals to act in accordance with the information obtained from the data bank. However, it may

142. Id. at § 11135.
143. Id.
144. Johnson v. Misericordia Community Hosp., 99 Wisc. 2d 708, 301 N.W.2d 156 (1981) (hospital presumed to have knowledge regarding physicians' qualifications and malpractice history if reasonable investigation would have disclosed this information).
seem obvious that no hospital would risk the liability associated with having a physician with questionable qualifications on its staff. The question then arises as to what reports a hospital may disregard or take into consideration when hiring a new physician.

In addition to HCQUIA, in West Virginia there is a statute that requires the reporting of information relating to the "practice or performance of any physician ...." According to the statute, the chief executive officer of the hospital is to report such information to the State Medical Board within 60 days after the hospital privileges have been "revoked, restricted, reduced or terminated for any cause ...." The report must also include any formal disciplinary action taken against a physician by the hospital regarding "professional ethics, medical incompetence, medical malpractice, moral turpitude or drug or alcohol abuse." The statute further provides that any health care entity or review board member who acts without malice and without gross negligence in investigating or preparing a report while serving on such a committee is immune from civil or criminal liability.

In addition to the protection provided to peer review organizations in a majority of the states, the provisions of the HCQUIA go one step further in denying a state cause of action involving peer review by the medical staff.

VI. CONCLUSION

The ultimate purpose of the peer review process in hospitals is to improve the quality of health care provided by the medical institutions. This is of special concern for those living in the small communities in West Virginia. In order to achieve this increased level of quality care, the physicians must be subjected to a heightened level of scrutiny. And, there can be no tolerance for the incompetent physician.

148. Id. at § 30-3-14(b).
149. Id.
150. Id. at § 30-3-14(m).
Although this notion has not changed much through the years, the attitude concerning the review process has been altered. Prior to recent legislation, physicians participating in the review process could often be caught in a very tenuous position. If they pressed on for improving health care, physicians became the targets of litigation by rejected physicians. On the other hand, if they opted to protect their colleagues through a "code of silence", the litigation might then be initiated by injured patients.

Legislatures have come to recognize this no-win situation and have developed laws to protect physicians from suits arising out of the peer review process. Undoubtedly, the law is harsh when applied to the rejected physicians and there is no room for mistake. The provisions of HCQUIA must not be abused as a means to discharge disliked physicians or discriminate against any class of physicians. Once a reputation has been tainted by the peer review process, it is likely that a career in the hospital setting may come to an end. Therefore, decisions must be fairly and cautiously made, and hopefully the ultimate result will be a society with improved medical care quality.

It is clear that HCQUIA is designed to improve the quality of health care. However, it is not yet evident that its provisions will fulfill these goals. While it appears that the protection offered to the peer review participants and the strict reporting requirements of this Act would indeed increase quality awareness, the final outcome will not be ascertainable until all of the provisions are actually in effect in all states. Even without the full effect of the Act, it seems most hospitals would not risk the liability associated with hiring a physician with a questionable background.

When all is said and done, there is little remedy for the rejected physician under HCQUIA in the form of defamation actions. Words can indeed hurt.

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