External Peer Review As A Risk Minimization Strategy:
A Legal Summary

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Peer review in the hospital setting is an activity that raises liability and litigation concerns to an ever-increasing degree. Incorporating external peer review into hospital practitioner performance evaluations whenever specified triggers are present can be an effective method of improving the quality of the review process and limiting litigation risk.

The concept of peer review as an activity enjoying certain legal protections and immunities stems from the idea that a physician's peers will exert influence on him or her to improve clinical skills and decision making and/or to modify behavior when the physician's skills, judgment or conduct endangers patients. Inherent in that idea are certain assumptions that may no longer be valid—if they ever were valid. To effectively address clinical deficiencies and behavior problems through internal peer review, there must be:

- A pool of competent, actual peers with the same specialty credentials
- Unquestioned integrity and judgment, free from conflict of interest
- Willful devotion of considerable time and effort to reviewing, analyzing and evaluating a colleagues' work and demeanor
- A willingness to conduct peer review without additional compensation
- Maintenance of one's own active clinical practice while keeping abreast of the latest development in one's specialty

These assumptions are unrealistic for many reasons. Physicians sometimes misuse the peer review process for their own political or economic ends—sham peer review of this nature has resulted in litigation and large awards in some cases. But even when peer review is undertaken for the legitimate purpose of improving the quality of health care, hospitals rarely have access to an adequate pool of physicians willing to engage in peer review, and the physicians who are willing may not be the best-equipped to serve as peers in a given case. In recent years the legal system has begun to recognize that peer review may not always be an objective, effective process that merits judicial deference. The traditional protections that shielded peer review documents have eroded. Hospitals have been found liable to patients when peer review did not effectively prevent harm, and physicians who have been subject to corrective action arising out of peer review have successfully asserted that the peer review was tainted by bias or incompetence. In addition, there is a recent trend toward state legislative action limiting peer review protections.

As a result, there is significant litigation risk associated with peer review. Yet, many states have statutes imposing an obligation on health care providers to monitor the quality of services through a mechanism like peer review. Similarly, hospital accreditation bodies impose a requirement that hospitals engage in regular quality review. Hospitals must continue to conduct peer review activities, but they can minimize their risk and improve the quality of the peer review process if they engage external peer reviews in certain identified circumstances.

Statutory Peer Review Protection Can Be Pierced

The Health Care Quality Improvement Act of 1986, P.L. 99-660, 42 U.S.C. 11101 et. seq., sought to encourage effective peer review and, in so doing, reduce medical malpractice and hinder the ability of incompetent physicians to escape a history of poor performance. To further these ends, the HCQIA protects a peer reviewer or witness in a peer review from

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Triggers for external peer review:

- Physicians available to assess a practitioner have conflicts of interest
- The case carries the risk of a medical malpractice or negligence claim
- The case carries the risk of a negligent credentialing claim
- A specialist is requesting new privileges but no one on the medical staff is competent to provide proctoring or evaluate his/her performance
- The hospital's action may result in corrective action against a medical staff member
- The hospital has difficulty adhering to Joint Commission requirements regarding focused and ongoing professional practice evaluations (FPPE and OPPE)
- Qualified physicians are unwilling to participate in peer review
- There are no peers with the same specialist credentials available to assess a particular physician's performance
- Internal staff workload prohibits timely responses to peer review requests
- Investigation of a sentinel event

civil liability arising from the results of the peer review (except in a proceeding under the federal civil rights law). In order to secure this protection, the peer review must be undertaken in the reasonable belief that the action was in the furtherance of quality health care and after a reasonable effort to obtain the facts of the matter. This good faith is presumed and can be overcome by a preponderance of the evidence. The HCQIA sets forth a number of procedural protections that a hospital should afford to a physician to establish that the review activity was undertaken in good faith, yet non-compliance with these procedures will not, in itself, constitute inadequate procedures. States are free to enact their own more protective statutes, and many have done so.

When physicians who are the subject of peer review bring lawsuits challenging the fairness of the proceedings or the propriety of the outcome, courts tend to afford the hospital's decision great deference–provided the procedure the hospital used appears fair.[1] However, the recent trend seems to be that courts will at least make inquiry into the process. Hospitals that can demonstrate that they made specific efforts to obtain outside reviews about the standard of a physician's care may be more likely to enjoy the protections of the HCQIA than hospitals that rely solely on the results of an internal peer review. A jury may not accept that a competitor or colleague can be objective in evaluating quality of care; particularly in light of the high profile sham peer review cases in recent years.

Challenges to Peer Review Confidentiality Increasing

There is also concern among hospitals and individual physicians regarding the confidentiality of peer review and other information related to quality and performance, and liability that may attach if there is a disclosure. For example, although the HCQIA offers immunity protections to peer reviewers and others, it does not protect the peer review information itself from disclosure in civil suits (although many states have protective statutes meant to shield peer review information from discovery[2]). So a plaintiff may bring a lawsuit in federal court, alleging a violation of federal EMTALA or antitrust laws, for example, in order to compel disclosure of relevant peer review information. Furthermore, federal courts have made it clear that peer review information may be subject to limited disclosure if the plaintiff alleges employment discrimination, deprivation of civil rights or antitrust violations.[3] Courts also have permitted access to peer review documents if they were originally prepared for a purpose other than peer review and/or are available from a source other than a peer review file.[4]

[1] In Poliner v. Texas Health Systems, No. 3-00-CV-1007-P, 2006.US Dist LEXIS 13125 (N.D. Tex. Mar. 27,2006), a physician successfully asserted that his privileges were summarily suspended as a result of malicious, economically motivated peer review. A jury found against the hospital and several of Dr. Poliner's competitors and awarded Dr Poliner over $366 million in damages. An appeals court affirmed the jury's decision, although the court reduced the damage award. Key to the result of the Poliner case—he was required to refrain from exercising certain privileges while an investigation into his performance was ongoing, at a time when the hospital admits it did not have sufficient information to determine whether Poliner posed a threat to patients.

[2] But note that the Poliner court allowed the plaintiff limited access to peer review materials, holding that denying access in all cases "would effectively foreclose a wrongfully disciplined physician from being able to show that a peer review committee acted with malice, because he would be precluded from showing that the data upon which the committee acted did not support the sanction imposed." Poliner, 2001 U.S. Dist. LEXIS 13029, at ***3. See also Rdzanek v. Hosp. Svcs. Dist #3, No 03-32585, 2003 U.S,Dist. LEXIS 19336 (E.D.La 2003); Teasdale v. Marin Gen'l Hosp., No. C89-1879 SC, (N.D.Cal. 1991), US Dist LEXIS 11328; Nilavar v. Mercy Gen'l Health Sys.No. C-3-99-612, (S.D. Ohio, 2002) US Dist LEXIS 20046.

[3] For example: Adkins v. Christie, No. 06-13107, (US Dist Ct App. 11th Cir. 2007) 2007 US App LEXIS 13715; Viramani v. Novant Health, Inc. No. 00-2423(US Dist Ct App., 4th Cir. 2001) 2001 US App LEXIS 17123. Mem'l Hospital v. Shadur, No. 80-2815 (US Dist Ct App. 7th Cir. 1981) 1981 US App LEXIS 16003.

[4] See Brown v. Sun Healthcare Group Inc., No. 3:06-CV-240 (E.D. Tenn. Apr. 14, 2008) 2008 US Dist LEXIS 30517., a federal court in Tennessee held that a plaintiff in medical malpractice action filed on behalf of a deceased former resident of a nursing home was entitled to discovery of certain incident reports and quality information relating to the decedent's care at the facility "[T]o the extent that some alternate source for responsive documents exists, the documents are not protected under [the state's peer review statute] and it cannot bar discovery in this matter." Similarly, the court held that documents the nursing home was required to prepare and provide to regulators under the Tennessee Health Data Report Act were protected from discovery, reports of such incidents prepared for the nursing home's use internally were not so protected and were subject to discovery.

Recent developments in Florida, to the extent that they may be a harbinger of similar efforts in other states, also present cause for concern. In 2004 Florida voters passed Amendment 7 to the state constitution that required health care providers to allow health care consumers access to information about any "adverse medical incident" which is defined as, "medical negligence, intentional misconduct, or any other act, neglect, of default of a health care facility or health care provider that caused or could have caused an injury to a death of a patient, including, but not limited to...incidents that are reported to or reviewed by any health care facility peer review, risk management, quality assurance, credentials or similar committee."

The Florida legislature attempted to enact an implementing statute preserving the confidentiality of peer review materials and shielding it from discovery in medical malpractice cases.[5] After numerous lawsuits and a range of opinions in different Florida jurisdictions called the constitutionality of the implementing statute into question, the Florida Supreme Court agreed to consider two cases that best presented the issues. The court's decisions held that Amendment 7 clearly intended to expose peer review materials to public scrutiny for the purpose of encouraging informed selection of health care providers and informed purchase of health care services. Furthermore, the court held that application of Amendment 7 is retroactive; therefore peer review records generated when peer review information was believed sacrosanct is likewise subject to disclosure.[6]

In California, the legislature recently enacted legislation aimed at protecting whistleblowers at medical facilities, but that may have the effect of disrupting peer review processes and holding the proceedings up to judicial scrutiny.[7] The law establishes a refutable presumption that a hospital's disciplinary action against a medical staff member is retaliatory or discriminatory if the medical staff member has filed a grievance, made a report, or initiated or participated in an investigation by an accrediting or regulating body, and if the disciplinary action occurs within 120 days of the physician's complaint to the regulating or accrediting body. The law permits such physicians to challenge the disciplinary proceedings in court during the pendency of the matter, without the need to exhaust administrative remedies.

The Joint Commission and Peer Review: Complying With New FPPE & OPPE Standards

Erosions to the traditional protections afforded to peer review materials and proceedings will further discourage physicians who are already reluctant to participate in peer review. This creates a dilemma for hospitals since those who seek accreditation from The Joint Commission must now carry out an ongoing professional practice evaluation (OPPE) of each medical staff member.[8] Accredited facilities must continually assess physician performance and hospital processes to ensure quality and the competent exercise of clinical privileges. Compliance will require generation and an analysis of data, and an effective response when the data reveals matters of potential concern. In essence, compliance requires continuous peer review activity, rather than peer review only in response to sentinel events.

[5] §381.028, Florida Statutes
[6] Supreme Court of Florida, No. SC06-688 Florida Hospital Waterman, Inc., v. Buster; No. SC06-012, Notami Hospital of Florida v. Bowen, March 6, 2008.
[7] California AB 632, signed into law October 14, 2007, amends California Health and Safety Code § 1278.5 to bar health care facilities from discriminating against or retaliating against a member of the medical staff because he or she has made a grievance, complaint or report to an accrediting body, regulating agency or the medical staff, or because he or she initiated, participated or cooperated in an investigation or proceeding relating to the quality of care at the facility conducted by a regulatory or accrediting body.
[8] Joint Commission Standard MS 4.40

The standard requiring OPPE has been in effect only since January '08, and there is little specific information available about how hospitals are implementing it. As yet there is little guidance about how much review the Joint Commission requires, and how often a hospital must conduct a review in the absence of a specific concern. Are quality committees meeting regularly to review data? Are department heads conducting random chart reviews frequently?

Whatever guidance the Joint Commission eventually provides, many hospitals will likely struggle to meet the burden of conducting OPPE properly and effectively. It will be difficult to find qualified personnel willing to analyze outcomes data and review medical records on an ongoing basis in the absence of a specific concern.

New Joint Commission standards requiring focused professional practice evaluations (FPPE) of physicians new to the medical staff and evidence-based credentialing may compound the problem.[9] Complying with this standard will likely require members of the medical staff to devote more time to monitoring and evaluating physicians who are new to the staff or who are exercising new privileges. These experienced physicians have less time to devote to other peer review functions, such as OPPE/FPPE activities.

Joint Commission-accredited hospitals will need to devise methods to comply with the standard without over-burdening their medical staff leaders. Failure to comply with Joint Commission standards not only may lead to accreditation consequences but it presents pretext for plaintiff attorneys to assert negligence. Outsourcing some or all FPPE and OPPE activities to an external peer review organization may be an effective solution for some facilities.

Responding to Barriers to Effective Internal Peer Review

It is obvious that engaging external peer reviewers is wise when contemplating corrective action with a medical staff member or when sentinel events occur. But external peer review can mitigate risk in other circumstances, as well.

Resolve conflicts of interest and establish objectivity.
Conflicts of interest frequently arise in peer review situations, as reviewers often have economic, professional, social or family ties with the reviewed physician. Many hospitals do not have a sufficient number of practitioners in a given specialty to assign a reviewer without such ties. In cases where the review is the result of an incident or pattern that may lead to litigation or corrective action, hospitals may wish to consider engaging an objective outside expert sooner, rather than later. An objective outside determination can mitigate the threat of allegations of biased peer review. It can also identify problems in hospital processes or procedures that should be corrected to reduce the likelihood of similar problems in the future. Finally, an objective outside determination can help establish a paper trail supporting the reasonableness of the hospital's position.

Provide true peer for accurate evaluation.
A sub-specialist, or any physician working with new technology or performing a new procedure, may not have any peers in his or her hospital community – or all such peers may be either partners or direct competitors. Many hospitals will turn to an academic medical center for help in such a case, but the practice environment of an academician is much different than that of a community hospital. A hospital, and its physicians, may be better served by turning to an external peer reviewer with similar training and expertise, working in a similar practice environment.

Bolster inadequate internal resources.
External peer review is often an effective solution for hospitals that lack adequate physician resources to conduct performance analysis in a timely fashion. The sheer volume of performance and quality data that many hospitals now collect can create a risk for a hospital. If there is evidence of a problem with a particular physician's practice, but there is a delay in identifying that problem because data was not analyzed promptly, a patient who suffered harm as a result may have a negligence claim against the hospital that a jury may find persuasive. Similarly, hospitals should consider engaging external peer review when a review of a physician who is the subject of an investigation cannot be completed within a specified

[9] Joint Commission Standard MS 3.40

period—perhaps 30 days—using in-house resources.

Meet unique hospital needs.
Finally, each hospital should develop procedures to turn to external peer review as required by its own particular circumstances. Hospitals with high volume and few willing or qualified reviewers may decide to outsource all cases in a particular specialty, or a certain number of cases per year. Cases where internal reviewers cannot reach a conclusion or a consensus should be subject to external review, as should unresolved quality issues related to a particular department, procedure, or practitioner. And cases where physician behavior or demeanor may have had an impact on clinical outcomes benefit from objective outside review by a peer with no prior personal knowledge of the physician.

In summary, hospitals should realistically assess the efficacy and quality of their internal peer review procedures, keeping in mind the significant litigation risk associated with peer review activities, and consider how to incorporate external peer review as an integral part of their overall risk management strategies.

For more information about the hospital peer review services offered by AllMed, please visit the company website at www.allmedmd.com, or contact AllMed at 800-400-9916.