Health Care Quality Improvement Act (HCQIA) of 1986. What is it? Why was it established? Is it working?

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The healthcare system in America today has come under attack for a multitude of reasons, including charges that the system has become corrupt due to the advent of HMOs, PPOs, and other "managed" care systems. Many of the criticisms leveled against our system are grounded in the manner in which citizens are afforded treatment by physicians who try to function in the best possible way in today's healthcare system. The actions of some physicians may warrant the criticism they receive for overutilization of health care or providing inadequate health care. Others, on the other hand, clearly do not deserve the abuse and maltreatment visited on them by the current Peer Review system utilized in virtually every hospital in America today.

Ask most physicians about the Health Care Quality Improvement Act of 1986, and the majority will have no clue whatsoever. They may start to understand this Act better after they receive a letter from the Quality Assurance Department of the local hospital and/or the Medical Executives Committee reviewing a case from that physician. One of the interesting things about that letter they receive will be that somewhere in the letter, the term "privileged and confidential" will be either typewritten or stamped. The original intent of the HCQIA and the peer review system was a shield: The principal legislation which created the "peer review system" in America today is the Health Care Quality Improvement Act of 1986 (HCQIA), which was enacted under the Reagan Administration to reduce the number of medical malpractice suits hospitals faced with by eliminating incompetent physicians. Unfortunately, it has now been transformed into a sword. Since the advent of managed health care in this country, physicians are now motivated by everything from the accumulation of vast numbers of patients to the formation of large medical groups whose sole purpose is to monopolize the health care market in a single geographic area. These large medical groups often possess a significant number of physicians who either dominate powerful committees or control the fate of economic competitors by using a hospital peer review system to deny other physicians medical staff privileges. By exerting

enough influence on the existing hospital power structure, many excellent physicians – approximately 500 per year – are being professionally destroyed, with their careers maliciously ruined by most allegations regarding the quality of patient care through the abuse of the peer review system. As a result, a once well-intentioned principle of physicians monitoring other physicians has been transformed into a means of assassinating one's economic and political rival.

Similarly problematic is the National Practitioner Data Bank (NPDB) which was also promulgated by the HCQIA of 1986. The NPDB was intended to serve as a repository for the names of physicians who had reported instances of true negligence and malpractice. The NPDB, however, has now operated in such a way as to deprive physicians of basic rights afforded even to criminals. A reporting agency such as a hospital controlled by a dominant medical group can report a physician for little more than "concerns regarding patient care and/or questionable technical abilities." Such a report remains within the NPDB, even if a physician is exonerated of any and all wrongdoing. Even the local state medical board is unable to remove an adverse report from the NPDB. The only parties that can request a physician's name be removed from the NPDB are the reporting entities themselves. Needless to say, this almost never happens.

The peer review system and the NPDB once served a useful purpose. However, that purpose and its original intent, unfortunately, have been lost and forgotten over the past years. This once noble intention could be recaptured if changes were made in the peer review system and the NPDB. Currently peer review panels are manned by physicians from the same entity seeking to suspend or terminate a physician's medical staff privileges. The hearing is frequently called in response to a summary suspension, a frequently used and abused maneuver of tagging the target physician and bringing his practice to a sudden halt.

Often, this physician knows nothing about the basis for his suspension and has very little time to respond to the allegations. The physicians sitting on these committees are from completely different medical specialities. The physicians have little or no familiarity with the standards of patient care from the physician's area of practice; any more than a neurosurgeon would know a dentist's practice. The unfortunate result of this scenario is that the peer review committee, rather than conducting an independent investigation, simply rubber-stamps the findings of the physician's accusers, who often are their direct competitors. Most physicians are not against peer review, so long as it is a fair panel that is composed of workable, impartial, and unbiased participants—as opposed to insiders who merely promote and perpetuate the injustices of the system, making the judge, jury, and accusers all the same. This problem can be corrected if the peer review committee were to employ the services of outside experts to advice as to the proper evaluation and treatment of the accused physician. However, this effort is for the most part never made. As a result, the peer review hearings are often simply kangaroo courts that pay lip service to due process. Once these committees rubber-stamp the predetermined outcomes of the peer review hearing, the physician's name is provided by that entity to the NPDB. Regardless of the merits, the physician is effectively barred from any other hospital because he or she has been the subject of an adverse recommendation that is reported and thus appears on the NPDB – even when there is no rational basis. Furthermore, if a physician applies for privileges at another facility and the application is denied, the new entity once again reports to the NPDB because it has denied the physician's application. The worst-case scenario, which has occurred in several areas of this country, is when one hospital conducts a sham peer review and reports the

practitioner to the NPDB. The next hospital, controlled by a dominant medical group, will cite the previous hospital's decision and the NPDB report without conducting its own independent investigation. Eventually, as one sees, a domino effect is achieved and the physician is unable to obtain privileges or practice medicine anywhere in this country.

The media has chronicled true stories of physicians who have gone astray before being disciplined; in any profession there are "bad apples" that have fooled the system. However, many more innocent doctors are currently being victimized for clinical differences of opinion which are equally acceptable in mainstream medicine. The fact is alarming, given the rapidly changing practice of medicine and new techniques associated with different surgical procedures. Unless a physician is a member of the "old guard," he or she is in peril of losing their livelihood. This reality is borne out by the fact that approximately 80% of hospital peer review hearings are politically or economically motivated. The offending hospitals and physicians perpetuating these heinous acts on their colleagues are beyond reproach, because those who make such accusations and abuse the peer review hearing process claim that these actions and communications, no matter how egregious, are immune from formal traditional legal recourse. These individuals act with impunity and receive complete protection under state and federal law. Federal courts, however, are currently deciding the extent to which members of these committees will enjoy full immunity. The status of the federal HCQIA currently is in question and the legitimacy of such extreme treatment of healthcare professionals today is in serious jeopardy.

One of the issues currently being brought up regarding the HCQIA is that the hospitals' actions can be factually wrong, yet still be completely immune from liability. This appears to completely contradict the training of practitioners, who were taught during medical school that the truth should prevail and that their ability to practice medicine should be based on fact, not fiction.

Several organizations have made note of improvements desperately needed in connection with the Health Care Quality Improvement Act. Most recently, the American Medical Association delivered a statement on March 2, 2002. The AMA discourages involvement in peer review proceedings by physician panel members who are economic competitors of the peer review physician, and discourages medical testimony by economic competitors when the proceedings may result in termination of the affected physician's privileges. Additionally, the AMA strongly recommends that to qualify for immunity, peer review action must meet specific criteria – in fact, the AMA has stated that the potential for abuse of peer review exists. They have publicly stated that personal agendas, competition or other reasons unrelated to quality care must not be the motivation for peer review actions. Furthermore, the AMA states that peer review that is not fair or objective can undermine the patient care for which it was initially developed, and that as a result, patient access as well as the physician's reputation are at risk. More importantly, failure to adhere to fair review process can erode the public confidence in the ability of the medical profession to adequately monitor itself. The AMA further urges all medical staffs to adopt and implement medical staff bylaws that comply with AMA policy II.375-983 as well as the HCQIA.

The following is a list of recommendations to improve upon the Health Care Quality Act of 1986:

1. The local state medical associations should stop bogus reviews of one physician by others who are compelled to find faults because of anti competitive motives.
2. State medical associations should provide advocacy to physicians and patients who are being victimized by sham peer review.
3. Both state and federal governments should support changes in hospital bylaws to rotate committee members, thereby lessening the chance of politicizing the positions on these hospital committees.
4. We should support changes in hospitals to equalize the playing field by placing "the burden of proof" on the hospital attempting to remove a physician, except in cases of drug and alcohol abuse. In the current system, the practitioner is considered guilty and has the burden to prove him/herself innocent.
5. Immunity should not be afforded to those physicians and administrators who attempt to maliciously injure a physician in a peer review hearing.
6. Hospitals and the accusers should be forced by the state medical boards to accept physicians who have been reported by these accusers and their peer review committees, particularly if they have been exonerated by the state. The proper treating of patients should supersede political agendas.
7. Hospitals should be required to do external peer review critique regarding any ad hoc committee meetings and/or questionable summary suspensions of a physician, except again those with obvious drug or alcohol problems. Additionally, hospital bylaws should be amended to give the final say of a peer review hearing to the hearing panel and not back to hospital administrators, trustees, or medical executive committees who include the principal accusers. Again, most hospital bylaws, do not give the hearing panel the final say, but instead the final say is given to your accuser. Again, the goal here is to have true due process and not a kangaroo court. Additionally, if one is to have a hearing, then all privileged information needs to be submitted and reviewed by the hearing panel at the time of any peer review hearing. Since the hearing itself is privileged and confidential, any privileged and confidential information should be allowed to be voiced and evaluated at that hearing.
8. The individual state licensing boards should be the only bodies authorized to submit physicians' name to the National Practitioners Data Bank. Again, if one truly feels that the State Board of Medical Examiners is the licensing body, then they should be the only ones that decide whether or not a physician's license should be in peril.
9. The state licensing boards should also require a hospital to remove any adverse decision from the National Practitioner Data Bank, particularly if the physician is exonerated by their state medical board.

The Health Care Quality Improvement Act of 1986 was initially intended to help physicians who care for their patients. As one can see, the original intent was valiant, but has unfortunately been abused over the past decade. The intended effect of achieving a decrease in malpractice claims on hospitals has not improved whatsoever, as witnessed by the malpractice crisis we are now currently experiencing. Additionally, if one reviews the peer review process and the malpractice cases overall, it is interesting to note that in a majority of peer review cases, the accused have actually had less of a malpractice history than his accusers. As a result, is the Act truly protecting patients from bad doctors, or are we just perpetuating a myth? The American public would be appalled to find out that when they enter a hospital thinking they are getting the best doctors

around, they may in fact, be getting only those doctors whom the “inner core” has allowed to practice. Once again, this is not to say that all hospitals are practicing this way. There are many good hospitals that truly attempt to utilize peer review as it was originally intended. This article is being written in order to wake up the physicians out there who feel that their actions will always be dealt with appropriately. There are obviously abuses that can occur under the current provisions of the Health Care Quality Improvement Act of 1986. It is up to us as physicians to level the playing field, so that if ever any of us are in this situation, we can feel comfortable knowing that due process is truly observed and we are not involved in a sham situation. Let us not perpetuate a system that is being abused. The Health Care Quality Improvement Act of 1986 was a good intention and a good start. It is now time for legislative action to be promoted by our local and state medical associations, as well as on the national scale, to beef up Health Care Quality Improvement Act to actually make it fair for everyone. Lawsuits have not decreased – this is obvious. Let’s not protect those individuals who are currently protected by peer review and who are in the majority of cases, the perpetrators of this malpractice crisis at the expense of other physicians who unfortunately have been involved in the politics of the healthcare system at their hospital.