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Abstract

In 1987, the Washington legislature enacted RCW 7.71, and adopted the Health Care Quality Improvement Act of 1986 (HCQIA), 42 U.S.C. §§ 11101-11152, to protect medical peer review. RCW 7.71 also created a private cause of action for physicians “occasionally hurt by peer review decisions”, because the Legislature concluded that peer review decisions “based on matters unrelated to quality and utilization review need[ed] redress”. RCW 7.71 sought to balance the benefits of peer review to the public against the harms caused by peer review decisions not related to a physician's competence or professional conduct.

In Cowell v. Good Samaritan, the Washington Court of Appeals destroyed this balance, and joined other jurisdictions that have protected abuses of the peer review process under HCQIA by holding defendants immune for a peer review action that did not comply with HCQIA's fairness and reasonableness standards. The court also construed RCW 7.71 to permit defendants, held immune under HCQIA, to recover attorneys’ fees and costs under the mandatory fee-shifting provision of RCW 7.71.030(3). The court's construction of RCW 7.71 is inconsistent with the plain language of the statute, will deter physicians from even attempting to defend themselves against questionable peer review actions, and defeats the remedial purpose of RCW 7.71.

This article argues that RCW 7.71 can and should be amended not only to prevent misapplication of the statute’s fee-shifting provision but also to prevent peer review abuses from being protected under HCQIA. This can be achieved by amending the definitional and fee-shifting provisions of the statute. Since legislative intent is the touchstone of the U.S. Supreme Court's preemption analysis, the legislative history of HCQIA is reviewed to demonstrate that Congress repeatedly cut back the immunity provisions in the original bill to ensure that HCQIA would not be used to protect peer review abuses. This legislative history, and respect for federalism, make it extremely unlikely that the U.S. Supreme Court would construe HCQIA as preempting state laws intended to protect physicians from abuses of the peer review process. The article concludes by arguing that RCW 7.71 should be amended to prevent peer review abuses because the legal protection currently being afforded these abuses under HCQIA not only harms competent physicians but is detrimental to the peer review process itself, and ultimately to public safety.

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In 1987, the Washington legislature enacted RCW 7.71, and adopted the Health Care Quality Improvement Act of 1986 (HCQIA) as part of a statutory scheme to protect medical peer review. At the same time, the legislature created a private cause of action for physicians “occasionally hurt by peer review decisions”, because it concluded that peer review decisions based on matters “unrelated to quality and utilization review need[ed] redress.” A statutory remedy was required because there was no action at common law for improper or unwarranted peer review actions, and HCQIA did not create a remedy for peer review actions that did not meet its statutory standards for immunity.

HCQIA merely provides a defense to liability for money damages under state and federal law for ‘professional review actions’ by hospitals against physicians that meet the reasonableness and fairness standards of the statute. The defense is referred to as ‘immunity’, and that convention will be followed in this article, but the defense is not a true immunity, and the word immunity does not appear in the statute. Unlike the qualified immunity government officials have from civil rights actions under 42 U.S.C. § 1983, which is immunity from suit as well as civil damages, HCQIA does not provide immunity from suit. HCQIA applies broadly to 'professional review bodies', and individuals who participate in, or assist these bodies with their peer review actions, but does not apply to state or federal civil rights laws. The statute creates a presumption that peer review actions meet HCQIA’s statutory standards, and physicians have the burden to rebut the presumption of immunity by a preponderance of the evidence.

“Any...matter that does not relate to the competence or professional conduct of a physician” is excluded from HCQIA's definition of professional review action. This catchall provision was intended to apply to any action not genuinely motivated by quality of care concerns. The provision was added because lawmakers were concerned that actions taken for illegitimate reasons may not appear as such on their face. However, courts have ignored this legislative history, and have held that the motives underlying peer review actions are irrelevant to whether hospitals are immune under HCQIA.

RCW 7.71.030(1) created a private cause of action where none existed before “for any action taken by a professional peer review body of health care providers... that is found to be based on matters not related to the competence or professional conduct of a health care provider.” The remedies available are limited to injunctive relief and earnings lost from the peer review action during the period the action was taken and subsequently reversed. The statute has a mandatory fee-shifting provision, and a one-year statute of limitations. The limited nature of the remedy was intended “to balance carefully” the benefits of peer review to the public against “the rights of those who are occasionally hurt by peer review decisions.”

These remedies are available only for peer review actions that are not based on a physician's competence or professional conduct, whereas HCQIA
applies only to actions based on competence or professional conduct. Therefore, RCW 7.71 and HCQIA cannot apply to the same claims. Nevertheless, in Cowell v. Good Samaritan, the Washington Court of Appeals allowed defendants, held immune under HCQIA, to recover their attorneys' fees and costs under RCW 7.71. The decision sent shock waves through Washington's medical community because it adumbrated that hospitals held immune under HCQIA in Washington would be able to recover attorneys' fee and costs under the mandatory fee-shifting provision of RCW 7.71.030(3) instead of HCQIA's fee-shifting provision, which requires proof that the plaintiff's claim was "frivolous, unreasonable, without foundation, or brought in bad faith." This is exactly what has come to pass. In Perry v. Rado, decided four months after Cowell, Division III of the Washington Court of Appeals affirmed a Benton County trial court's decision holding the hospital defendants immune under HCQIA, and awarding the defendants attorney's fees, costs and expenses under RCW 7.71. Two trial courts have also awarded attorneys' fees and costs to hospital defendants under RCW 7.71 subsequent to Cowell, notwithstanding that before the Cowell decision each court had held RCW 7.71 inapplicable to the case because the hospital's peer review action was based on the physician's competence or professional conduct.

The plaintiff's causes of action in Cowell were not based on the alleged wrongfulness of the termination of her privileges but on incidental torts committed during the peer review process. The court granted defendants' motion for summary judgment on these claims because it held defendants immune under HCQIA. The court then awarded most of defendants' attorneys' fees under RCW 7.71.030(3). Defendants claimed they were entitled to recover attorney's fees under RCW 7.71.030(3) because Dr. Cowell's request for an injunction and legal claims related to a "common core of facts and circumstances," they had segregated their attorney's fees, and further segregation was not possible. Defendants contended that under the Washington Supreme Court's holding in Travis v. Horse Breeders, they could recover fees and costs they ostensibly could not segregate either under RCW 7.71.030 or 42 U.S.C. § 11113.

Most of plaintiff's claims in Perry, by contrast, were based on the wrongfulness of the hospital's peer review action itself, which Dr. Perry claimed denied him due process, breached a duty of good faith and fair dealing, and violated RCW 7.71, notwithstanding that the hospital's action on his privileges was based on his competence and professional conduct. The court dismissed these claims under CR 12(b)(6), because it held that they were outside the remedies allowed by RCW 7.71. The court did not hold, as it had ten years earlier in Morgan, that RCW 7.71 did not apply because the hospital's action was based on the physician's competence or professional conduct, and awarded all attorney's fees under RCW 7.71.030 because "all claims for relief relied on 'a common core of facts and circumstances', as in Cowell.

To justify awarding hospitals, held immune under HCQIA, attorneys' fees and costs under RCW 7.71.030(3), Cowell and its progeny have turned RCW 7.71...
on its head by basing the applicability of the statute on the nature of the plaintiff's allegations instead of the reasons for the defendants' actions against the plaintiff, as the statute's plain language requires. Whether the plaintiff's underlying claims are based on the alleged wrongfulness of the peer review action itself, as in Perry, or on independent torts committed during the peer review process, as in Cowell, determines only whether RCW 7.71.030(1) provides the exclusive remedy for the plaintiff's claims, not whether the statute applies to the case at all. Cowell and Perry conflated whether the statute applies, with what remedies are available if the statute applies.

By its plain language, the RCW 7.71 applies only if the underlying action was not based on a physician's competence or professional conduct. A finding that defendants are immune under HCQIA is tantamount to a finding that their actions against the plaintiff were based on the plaintiff's competence or professional conduct, and, therefore, RCW 7.71 cannot have any application. Even if the physician alleges that the hospital's actions were pretextual, and not actually based on competence or professional conduct, it is what the court finds the action to have been based on, not what the plaintiff alleged that it was based on, that determines whether the statute applies to the case at all.

The Cowell court's interpretation of RCW 7.71 leads to a result the Washington legislature could not have intended. The Washington legislature enacted RCW 7.71 to provide equitable and legal relief to physicians harmed by peer review decisions "not related to quality." But Cowell and its progeny have left physicians worse off than they would have been had the Washington legislature never enacted RCW 7.71 to provide them a remedy.

Under HCQIA, prevailing defendants may recover attorneys' fees and costs only if the plaintiff's action or conduct of litigation was "frivolous, unreasonable, without foundation, or in bad faith." By permitting prevailing defendants to recover under RCW 7.71.030(3)'s mandatory fee-shifting provision, and circumvent these preconditions for recovering attorneys' fees and costs, Cowell will deter physicians from even attempting to defend themselves against improper peer review actions by the threat that the mandatory fee-shifting provision of RCW 7.71 will be automatically triggered if the hospital is held immune under HCQIA. By denying petition for review in Cowell and Perry, the Washington Supreme Court has effectively approved this new interpretation of RCW 7.71 that flies in the face of the statute's plain language.

The decisions in Cowell and Perry come at a time when the need to protect physicians from improper peer review actions is far greater than it was when RCW 7.71 was enacted. Lower federal courts have interpreted HCQIA inconsistently with its plain language and legislative history. These interpretations have led to protection of peer review abuses, and are raising growing concern. Lower federal court interpretations of federal law do not bind state courts, and the U.S. Supreme Court has not granted petition for certioriari in a single case involving HCQIA to date. Nevertheless, as the following concurrence by two justices of the Nevada Supreme Court indicates, lower federal court interpretations of HCQIA are being followed even by state courts that recognize that the interpretations protect and encourage peer review abuses, and
leave physicians without any viable remedy:

“I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to a hospital's so-called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, **whether legitimate or not, they are immune from liability.** Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care. **This is particularly probable** since most courts have indicated that the legislative history of HCQIA bars consideration of the subjective motives or biases of peer review boards

Here, hospital administrators, immediately upon recognizing a public relations problem, decided that Dr. Meyer was to be the hospital's scapegoat for the unfortunate death of a patient...Unfortunately, the immunity provisions of HCQIA sometimes can be used, not to improve the quality of medical care, but to **leave a doctor who is unfairly treated without any viable remedy.**”.53 (Boldface added).

Other courts are also protecting unjustified actions against competent physicians for similar reasons, even if they have not explained them as explicitly. For example, the Maryland Special Court of Appeals held a hospital immune for revoking the privileges of a physician who, the court admitted, had an “excellent professional reputation”, a “legitimate gripe”, and who “put patient welfare above all else”, “not for want of a wrong”, but because “to her misfortune” her claims against the hospital brought “the HCQIA into play”, and, “as reprehensible as some of [the peer reviewer's] actions may have been, they succeed as a matter of law”.54 In the majority of cases, however, as in Cowell, the unreasonable or pretextual nature of the peer review action is not be apparent from the face of the court opinions.

This article argues that the Washington legislature can and should amend RCW 7.71 to restore its remedial purpose, and protect physicians in the State of Washington from peer review abuses. Parts I reviews, the legislative history of HCQIA, and the amendments made by the House Committee on Energy and Commerce (HCEC),55 and subsequently by the Subcommittee on Civil and Constitutional Rights of the House Committee on the Judiciary (House Judiciary Committee or HJC),56 that cut back the scope of the original immunity to ensure that it could not be used to shield peer review actions taken for illegitimate reasons.57 Courts have completely ignored these second round of amendments.58 Part II reviews the constructions of legislative history and intent that have caused lower federal court to interpret and apply HCQIA in a way that protects peer review abuses.

Hospitals, of course, deny that they abuse the peer review process. Therefore, to demonstrate that Cowell involved an unjustifiable peer review action that is not apparent from the face of the court's opinion, Part III first reviews the peer review process to explain why it can be so easily manipulated
and made to appear legitimate, and Part IV reviews some of the evidence that created genuine issues of material fact about the reasonableness and fairness of the hospital’s action, but that were omitted from, misstated in, or contradicted by “findings” in the court’s opinion that were made up out of whole cloth. The relevant portions of the Clerk’s Papers that were before the court are cited to permit these facts to be independently verified.

Part V describes the amendments to RCW 71.71 that would safeguard physicians from peer review abuses now protected under HCQIA, and argues that the U.S. Supreme Court is highly unlikely to construe them as preempted by HCQIA. Part VI argues that RCW 7.71 should be amended because the adverse consequences of protecting peer review abuses extend beyond the harms inflicted on physicians to the peer review process itself. It demonstrates, by reference to the facts of Cowell, that when hospitals use the peer review process as a pretext to blame physicians for adverse events, dangerous systemic factors that jointly contribute to adverse events will not be addressed, will remain in the system, and continue to pose a risk to patients. It is concluded that consideration of patient safety, no less than the harms inflicted on competent physicians, justify legislation to stop the legal protection of peer review abuses.

I. THE LEGISLATIVE HISTORY OF HCQIA, AND THE REASONS CONGRESS ENACTED THE STATUTE.

A. Legislative History.

The bill eventually enacted into law as HCQIA was first introduced in the HCEC as H.R. 4390 by Representative (now Senator) Wyden from Oregon. At the time, Congress was debating “a crisis in medical malpractice...that threatens to drive physicians out of practice, leaving their patients stranded without care.” During these debates, an Oregon jury returned a verdict for a physician on his antitrust claim against a hospital and peer reviewers, which, when trebled, yielded an award of almost two million dollars, and caused one peer reviewer's income to be garnished for several months. Lawyers representing hospital groups seized on the Patrick verdict to convince lawmakers that “doctors participating in peer review face the tremendous risk...that they will be sued for their actions against a colleague.” However, they subsequently conceded during their testimonies before Congress that “plaintiff-physicians rarely have prevailed in these cases”, and that “hospitals are, with only rare exceptions, successful in defending such cases.” Nevertheless, the bill was amended, and reintroduced in the HCEC as H.R. 5110 by Representatives Wyden, Waxman, Madigan and Tauke, debated in the HCEC on March 18 and July 15, 1986, reintroduced again as H.R. 5540 on September 18, 1986 after further amendments, and voted out of the HCEC on September 26, 1986 with the recommendation that the bill be adopted.

Before H.R. 5540 was voted out of the HCEC, the scope of immunity was narrowed to protect against anticompetitive conduct. However, peer review actions improper in other respects could still satisfy the standards of § 11112(a),
and would be protected. Therefore, the scope of immunity was narrowed further following hearings in the House Judiciary Committee on October 8 and 9, 1986. Although discriminatory actions against racial minorities most concerned lawmakers, they were equally emphatic that actions based on "turf battles", the type of patients treated, or the style of a physician's practice were just as unacceptable, and would not obtain immunity under HCQIA. The immunity that remained was intended to "provide very limited immunity from liability for allegations of antitrust violations by disciplined physicians".

The House Judiciary Committee held hearings on H.R. 5540 "to provide a more complete record of the implications of the immunity and due process provisions set forth in title I [the immunity provisions] of H.R. 5540." The HJC recommended deleting Title I based on the concerns that the immunity was unnecessary, could be misused to protect improper actions against physicians, and provided no actual incentive to engage in effective peer review. Two days after H.R. 5540 was reported out of the HCEC, these concerns were vindicated by the Ninth Circuit's decision in Patrick.

The Ninth Circuit described the peer reviewers' conduct in Patrick as "shabby, unprincipled and unprofessional", and found "substantial evidence that the defendants acted in bad faith in the hospital's peer review process". To assuage the concerns of HCQIA's opponents in the House Judiciary Committee, Representative Waxman, the floor manager of the bill, repeatedly emphasized that "bad faith peer review activities permitted by the Patrick case would never obtain immunity under H.R. 5540," and explained that the extensive revisions made to the bill had cut back the scope of the immunity to preclude abuses:

"These provisions have undergone a number of revisions in the legislative process. I stress this because most of the objections raised about earlier versions of H.R. 5540 (and its predecessor H.R. 5110) have been addressed in recent drafts, and particularly in the provisions that are now before the House." Representative Waxman was referring to the extensive revisions made to H.R. 5540 following hearings in the HJC after H.R. 5540 was voted out of the HCEC. Courts have completely ignored these amendments.

B. Congress' primary purpose in enacting HCQIA.

The primary reason Congress enacted HCQIA was to prevent "a small - but deadly - group of incompetent and unprofessional physicians who cause[d] serious injury and needless death" from being able to conceal their records, move from state to state, and continue to practice and injure patients. HCQIA's proponents believed that this "small - but deadly - group of incompetent and unprofessional physicians" contributed significantly to the perceived medical malpractice crisis, and that preventing these physicians from practicing was the "first step in a national malpractice strategy". Lawmakers recognized that the
problem created by these physicians was not that no one knew who they were, but that "[t]ypically they cut a deal with the hospital to leave town - - carrying good references in return for not suing the hospital." Instead of sanctioning hospitals that engaged in these practices, HCQIA's proponents established a "reporting system" - Title II of the bill - that became the National Practitioner's Data Bank (NPDB).

The reporting system received bipartisan support in the House Judiciary Committee, but the immunity provisions of the bill were rejected as directed at a "phantom problem". None of the 22 witnesses who provided oral or written testimonies to Congress in support of HCQIA presented any evidence that physicians were deterred from engaging in peer review by the threat of legal liability, and simply asserted this belief in conclusory fashion. No one cited any case in which a physician prevailed on an antitrust claim based on a hospital's peer review action prior to Patrick, and there appear to have been no such cases. Physicians asserted federal antitrust claims in the first place because most states had immunity statutes that protected peer reviewers from state law claims who had acted in good faith. Moreover, good faith was often presumed, and had to be rebutted by clear and convincing evidence.

C. Amendments made to H.R. 5540 following hearings in the House Judiciary Committee.

Representative Waxman attempted to persuade members of the House Judiciary Committee that H.R. 5540, as voted out of the HCEC, was neither intended to protect, nor could protect, peer review abuses, and, therefore, needed no further amendment, but the HJC rejected his reassurances. Numerous amendments were made to the bill following hearings in the HJC, three of which are relevant here: (1) reduction in the burden of proof required to rebut the presumption of immunity; (2) amendment to the definition of "professional review action" in § 11151(9); and (3) amendment to the fee-shifting provision of § 11113.

1. The burden of proof to rebut the presumption of immunity was reduced to the preponderance of the evidence.

The burden of proof required to rebut § 11112(a)'s presumption of immunity was reduced from clear and convincing evidence to the preponderance of the evidence standard following hearings in the HJC. The clear and convincing evidence standard is "reserved to protect particularly important interests", whereas the preponderance of the evidence standard " is employed... when an incorrect finding of fault would produce consequences as undesirable as...an incorrect finding of no fault." Therefore, by reducing the physician's burden of proof, Congress sent a clear signal that it was as important to avoid falsely accusing physicians of incompetence as to identify incompetent physicians. Reinforcing this clear signal were the repeated and emphatic
reassurances of Representative Waxman and HCQIA's other proponents that “abuses of the peer review system" cannot be tolerated, and that HCQIA applied only to actions "undertaken with the clear motive to improve the quality of health care and carried out giving the physician every opportunity to defend his or her record." 

2. **The definition of professional review action was amended to ensure that pretextual actions would not be protected.**

Under H.R. 5110, immunity extended to any professional review action taken "in good faith in furtherance of quality health care". When the HCEC amended and reintroduced H.R. 5110 as H.R. 5540, it replaced this original “good faith” standard with the more objective “reasonable belief” standard. The HCEC explained that the change was made in response to concerns that ‘good faith' might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional review action.

Nevertheless, members of the House Judiciary Committee remained concerned that “actions brought for illegitimate reasons may not appear as such on their face”, and that the peer reviewers’ stated reasons for their actions may not have been the actual reasons for their action. Therefore, § 11151(9) was amended, and a catchall provision added to make it clear that HCQIA did not apply to "any... matter that does not relate to the competence or professional conduct of a physician." 

Representative Waxman explained that the catchall provision was intended to “avoid the inference that any matters not listed in this subsection are necessarily based on competence or professional conduct.” This catchall exclusion was specifically intended to apply to

"[t]he more serious issues [which] arise when actions are stated to be for legitimate reasons, but are challenged as not genuinely based on the competence or professional conduct of an individual physician.”

Representative Waxman made it clear that pretextual actions “would not be covered by this bill”, whether the motivation underlying the pretextual action was the type of patients treated or the physician's style of practice, no less than if the motivation was anticompetitive or discriminatory.

“The immunity provisions have been restricted so as not to protect illegitimate actions taken under the guise of furthering the quality of health care." 

The amendments to §§ 11112(a) and 11151(9), and the reasons them,
indicate that Congress intended the reasonableness and fairness standards of § 11112(a) to apply only to actions taken because of genuine concerns about a physician's competence or professional conduct. If an action was pretextual, and not genuinely motivated by a desire to further the quality of health care, HCQIA would not apply at all. But the mere fact that peer reviewers were genuinely motivated by a desire to further the quality of healthcare was also not sufficient to immunize them for their actions. For immunity to attach, even actions taken in good faith had to be objectively reasonable.

HCQIA's other sponsors also emphasized that the statute would only apply to properly motivated peer review actions:

"The Health Care Quality Improvement Act provides carefully defined immunity...for peer review actions undertaken with the clear motive of improving the quality of care and carried out in manner giving the physician under review every opportunity to defend his or her record...We drafted, redrafted, and then drafted again to provide that (1) the protection is afforded only to quality of care motivated reviews of physicians.»111 (Italics added)

These reassurances, and the fact that without them the House would not have passed the immunity provisions of HCQIA,112 further indicate that Congress intended HCQIA to apply only to actions genuinely motivated by quality of care concerns. Nevertheless, lower federal courts have repeatedly held that the motives underlying peer review actions are irrelevant to immunity under HCQIA.113 They based their holding on the fact that the standard of review under § 11112(a) is objective, but this is a non-sequitur. Motivation is relevant to whether HCQIA applies at all, not to whether the presumption that the standards of § 11112(a) were met have been rebutted.114 Motivation is a factual question. Lawmakers on both sides of the house conceded that why a peer review action was taken may not be apparent from the face of the action itself, and the reasons hospitals give for their actions may not have been their actual reasons.115

3. Amendments to the fee-shifting provision of § 11113.

Award of reasonable attorneys' fees and costs to a prevailing defendant was compulsory under H.R. 5110.116 In the version of H.R. 5540 voted out of the HCEC, the compulsory language was changed, but no express conditions were placed on awarding attorney's fees to a prevailing defendant.117 Section 11113 was amended following hearings in the House Judiciary Committee, and prevailing defendants permitted to recover reasonable attorneys' fees and costs only "if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation or in bad faith."118

The fee-shifting provisions of § 11113 and RCW 7.71.030 are very different. Section 11113 permits an award of attorneys fees only to prevailing defendants, and only if the defendants prove that the conditions in the statute were met.119 The award of attorneys' fees and costs under RCW 7.71.030(3) to the
prevailing party, if any, is mandatory. Current efforts by hospitals in the State of Washington, held immune under HCQIA, to recover of attorneys' fees and costs under RCW 7.71.030 are an obvious attempt to circumvent HCQIA's conditions for recovering costs and attorney's fees by prevailing defendants.

II. FLAWED CONSTRUCTIONS OF HCQIA AND ITS LEGISLATIVE HISTORY HCQIA HAVE CAUSED PROTECTION OF PEER REVIEW ABUSES.

Courts are protecting peer review abuses because they are applying an incorrect standard to review evidence offered to rebut HCQIA's presumption of immunity on motions for summary judgment. The standard of review being applied in most jurisdictions was developed by lower federal courts based on incorrect interpretations of legislative intent. Courts misconstrued the balance Congress struck between protecting physicians engaged in peer review, and physicians harmed by improper peer review actions, as skewed in favor of protecting peer reviewers because they disregarded the legislative history of H.R. 5540 after it was voted out of the HCEC. They also conflated the so called non-review doctrine that antedated HCQIA's enactment with the standard of review under § 11112(a), and erroneously concluded that Congress intended physicians harmed by improper peer review actions to seek injunctions, not monetary relief. An alloyed, deferential standard of review emerged under which courts do not actually consider whether the evidence is sufficient to permit a reasonable jury to conclude that the hospital's action was unreasonable, language to the contrary notwithstanding. They ask instead only whether there is sufficient evidence to conclude that the hospital's action was reasonable. If the answer is affirmative, as it always will be, courts infer that no reasonable jury could find for the physician as a corollary. This is a non-sequitur. Under this inquiry physicians harmed by improper peer review actions can rarely prevail, because the hospital's action is always deemed reasonable and fair under § 11112(a). Treating immunity under HCQIA as a question of law for the court to decide has contributed to the development of this incorrect standard.

A. The non-review doctrine does not modify the standard of review under § 11112(a), which is not deferential.

The non-review doctrine stands for the principle that courts will not reverse the staffing decisions of private hospitals on equitable grounds. Physicians sought injunctions to enjoin hospitals from taking allegedly improper actions on their hospital privileges because there was no action at common law on which relief could be granted for such actions. Since an injunction is a remedy, not a cause of action, these physicians were effectively asking courts to create a cause of action on which an injunction could be granted. Courts declined to find legal theories on which to grant injunctions because they felt unqualified to decide the merits of the staffing decision, and, therefore, whether
The non-review doctrine applied only to the credentialing or staffing decisions of a hospital. It did not affect the adjudication of incidental legal claims arising under tort, contract or other legal theories. Therefore, if, for example, the peer reviewers committed a tort or breached a contract during the peer review process, the non-review doctrine did not impair the physician's ability to recover in tort or contract.

The principal that the staffing decisions of private hospitals are entirely discretionary, and courts are without legal authority to review them, was first rejected by the New Jersey Supreme Court in 1963 on public policy grounds. The doctrine has since been modified in most jurisdiction, and courts will review denial or revocation of hospital privileges, without implementing legislation, to ensure either that the hospital complied with its bylaws or that its action was supported by sufficient or substantial evidence. Nevertheless, injunctions have still only been granted in rare and exceptional cases, and only on a temporary basis.

HCQIA provides a defense to legal claims to which the non-review doctrine had no application. HCQIA does not apply to injunctions, and, therefore, does not change the status quo ante with respect to injunctions or the non-review doctrine. Nevertheless, lower federal courts have taken the inconsistent positions that, by enacting HCQIA, Congress simultaneously intended to "reinforce the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise", and that physicians seek injunctions, not monetary relief, from improper peer review actions. However, conflating the standards of review under HCQIA and the non-review doctrine has affected not the standard for granting injunctions, but how evidence offered to rebut HCQIA's presumption of immunity is reviewed.

A judicially created prudential doctrine cannot modify the procedural rules of the forum under which motions for summary judgments are reviewed, or impair the constitutional right to a jury trial. Nor can it supplant "the statutory regime governing the peer review process enacted by the Legislature." Therefore, the non-review doctrine can neither modify the standard for immunity under § 11112(a), nor modify how evidence is reviewed under the forum's summary judgment statute to determine if the presumption of immunity under § 11112(a) has been rebutted.

Nevertheless, courts have construed the standards of § 11112(a) as embodying the reluctance to grant injunctions under the non-review doctrine. This reluctance to grant injunctions has translated into a reluctance to find peer review actions unreasonable, and peer review processes unfair, within the meaning of 11112(a). Because courts deferred to peer reviewers under the non-review doctrine, they now defer to peer reviewers to determine what is reasonable under § 11112(a). The practical result has been that courts accept as reasonable and fair under § 11112(a) whatever the peer reviewers actually did in a
particular case.

Nothing in the plain language of HCQIA authorizes deference to peer reviewers. Lawmakers expressly rejected subjective good faith as sufficient for immunity, and amended § 11151(9) out of concern that the peer reviewers' stated reasons for their action may not have been their actual reasons for the action. These amendments to H.R. 5540 evidence an intent that reasonableness and fairness under § 11112(a) be judged by objective, not deferential, standards. To defer to the very individuals who took the action as to what is reasonable is to invite the kind of abuses lawmakers were emphatic HCQIA was not intended to protect, and is inconsistent with legislative intent.

B. Whether evidence is sufficient to rebut HCQIA's presumption of immunity is a factual question, not a question of law.

The Eleventh Circuit first held that HCQIA was a question of law for the court to decide in Bryan v. James E. Holmes Regional Medical Center. However, questions of law “do not depend on the satisfaction of evidentiary burdens.” Since a hospital's immunity depends on the sufficiency of the physician's rebuttal evidence, “it is clear that the reasonableness or adequacy of a particular review action is a question of fact, to be resolved by the trier of fact.” Bryan's holding was based on an invalid analogy between HCQIA's immunity and the qualified immunity government officials have against civil rights actions under 42 U.S.C. § 1983. The two immunities are not analogous.

Immunity from § 1983 actions is a question of law for two reasons. First, the immunity against § 1983 actions is an affirmative defense to suit. Therefore, whether there is immunity is a threshold question of whether the defendant can be made to stand trial at all, and a jury cannot decide whether a defendant should stand trial. Second, the immunity hinges on the objective reasonableness of a government official's action in the light of legal rules that were clearly established when the action was taken. Whether a legal rule was clearly established at a given point in time is a quintessentially legal question that does not depend on any case specific facts.

HCQIA immunity, by contrast, is a defense to liability for money damages, not a defense to suit. The immunity depends on the reasonableness of a professional review action based on facts known when the action was taken, not legal rules. “There is no comparable legal question involved in the immunity analysis under HCQIA” as there is in the analysis of immunity from § 1983 actions. Therefore, as the First Circuit explained, juries can decide the question of immunity under HCQIA because, although peer review actions are not within the common experience of jurors, they are not so esoteric that they cannot be fairly evaluated by jurors, perhaps with the assistance of expert witnesses. Also, we routinely ask jurors to evaluate the quality of medical care in medical malpractice cases. As this case illustrates, the quality of medical care is often at the core of a peer review dispute under the HCQIA. Therefore, we see no
reason why juries should be excluded entirely from immunity determinations under the HCQIA.\textsuperscript{169}

A test to determine the sufficiency of evidence offered to rebut § 11112(a)'s presumption of immunity was first formulated by the Ninth Circuit in \textit{Austin v. McNamara}.\textsuperscript{170} Under this test, the court asks: “Might a reasonable jury, viewing the facts in the best light for the plaintiff, conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?”\textsuperscript{171} All courts nominally apply this test. However, this test cannot be applied by courts that treat HCQIA immunity as a question of law, because a court cannot simultaneously ask whether a jury could conclude that the action was unreasonable, and at the same time decide itself what is reasonable.\textsuperscript{172} The court can determine that the evidence of reasonableness is so one sided that no reasonable jury could find for the defendants,\textsuperscript{173} but that is not the same thing as the court itself deciding what is reasonable. Under Bryan's holding, juries are permitted to decide only “subsidiary issues” related to the question of immunity, “such as whether the physician was given adequate notice of the charges.”\textsuperscript{174} They are never permitted to determine whether a particular action was unreasonable in the light of facts known at the time the action was taken.\textsuperscript{175}

\textbf{C. Courts are not evaluating evidence offered to rebut HCQIA's presumption of immunity correctly.}

On a motion for summary judgment, courts cannot resolve factual disputes or decide which of two versions of events to believe without abrogating the non-moving party's right to trial by jury,\textsuperscript{176} unless no reasonable person could believe one of the versions of events.\textsuperscript{177} If a jury could reasonably find for either the moving or the non-moving party, summary judgment would be improper.\textsuperscript{178} Therefore, to defeat a motion for summary judgment the non-moving party needs only to prove that a jury could find in its favor. The nonmoving party does not have to prove that a jury could not render a verdict for the moving party.

The very purpose of the right to a jury trial is to have juries, not judges, decide who prevails on a legal claim when reasonable minds could come to different conclusions on that question. The obvious corollary is that where the nonmoving party presents sufficient evidence to allow a jury to render a verdict in its favor, the evidence will also be sufficient to allow a jury to render a verdict in the moving party's favor. If it were otherwise, and the evidence proved that a jury could not render a verdict for the moving party, the nonmoving party would be entitled to summary judgment.

To determine if the nonmoving party has presented sufficient evidence to allow a jury to find in its favor, the court must accept as true all the non-moving party's evidence, and draw all reasonable inferences from the evidence in a light most favorable to the non-moving party.\textsuperscript{179} The defendant's denials and contrary arguments are irrelevant to this determination.\textsuperscript{180} Although the court should review the record as a whole, it should consider only evidence offered by the moving party that a jury would be \textit{required} to believe.\textsuperscript{181} No element of discretion is involved in this evaluation.\textsuperscript{182}
Evidence must be evaluated in this way to preserve the constitutional right “that questions of fact in common law actions shall be settled by a jury, and that the court shall not assume directly or indirectly to take from the jury or to itself such prerogative”. Only if the court constructs what amounts to a best case scenario of the evidence that represents the best light in which a jury could reasonably view the evidence from the nonmoving party's perspective, and a jury could not reasonably render a verdict for the nonmoving party based on this best case scenario, does summary judgment pass constitutional muster.

Evidence presented to defeat a motion for summary judgment based on HCQIA immunity cannot be evaluated any differently, because Congress cannot abrogate the right to a jury trial. How courts actually decide motions for summary judgment based on HCQIA is rarely apparent from the face of the decided cases because courts couch their analysis in boilerplate language that does not reveal how the record in a particular case was actually evaluated. Nevertheless, it is apparent that on a motion for summary judgment based on HCQIA immunity courts consider only whether the evidence is sufficient for a jury to conclude that the hospital's action was reasonable, and not whether the evidence is sufficient to allow a jury to conclude that the hospital's action did not comply with one or more of the standards of § 11112(a).

For example, the *Reyes* court held “what is relevant, and dispositive, is whether there existed an objectively reasonable basis for the defendant's actions.” But this is a statement of what is required for immunity, not a correct statement of what is required to defeat the presumption of immunity on summary judgment. The requirements for immunity, and the requirement to rebut the presumption of immunity, are not the same.

To ask only whether there is sufficient evidence for a jury to conclude that the hospital's action was reasonable is to ask only whether a jury could render a verdict for the moving party. The dispositive question on summary judgment, however, is whether a jury could reasonably render a verdict for the non-moving party - the physician. The fact that a jury *could* conclude that the hospital's action was reasonable does not necessarily mean that a jury could not conclude that the action was unreasonable. Only “if the evidence of reasonableness...is so one-sided that no reasonable jury could find that [the hospital's action was not reasonable would] the entry of summary judgment do[] no violence to the plaintiff's right to a jury trial.”

The incorrect standard described by *Reyes* is widely applied. The *Meyer* concurrence implicitly adopted this standard by opining that if there is some minimal basis for the hospital's action, that is sufficient for immunity. The *Cowell* court also confused the proper inquiry, and implied that if a reasonable person could conclude that the plaintiff had done what she had been accused of doing - i.e. that the hospital's allegations were true - that was enough for immunity. These interpretations are not merely incorrect constructions of a statute, they violate the constitutional right to trial by jury.

In *Singh*, the First Circuit rejected the plaintiff's argument that he was denied a right to a jury trial because the court, not the jury, decided the reasonableness of the defendants' actions, but only because the court rejected
Bryan's construction of HCQIA that confines the role of the jury to deciding subsidiary questions of fact. This leaves unanswered whether the majority of courts that follow Bryan are deciding motions for summary judgment based on HCQIA immunity in a constitutionally permissible manner, and implies that they are not.

Misunderstandings about the legal effect of HCQIA's presumption seems to have contributed to the constitutionally questionable manner in which courts are reviewing evidence offered to rebut HCQIA's presumption of immunity. A true legal presumption is a presumption about facts based on proof of other facts (called the basic facts). Section 11112(a) makes no assumptions about facts. Its presumption is merely a burden-shifting device, rather like "presumption of innocence". It shifts the burden to prove that the defendants were not acting in compliance with the standards of § 11112(a) onto the plaintiff-physician, rather than require the defendants to prove that their actions complied with the standards of § 11112(a) as an affirmative defense. The presumption essentially adds an added element to the plaintiff's causes of action, in the same way that, for example, proof of falsity became an added element of a cause of action for defamation following "constitutionalization" of the law of libel by New York Times v. Sullivan and its progeny.

Courts consistently refer to the presumption of immunity as creating an "unusual twist", and appear to construe the presumption as increasing the physician's burden of proof. For example, despite the fact that the physician's burden to rebut the presumption of immunity is by a preponderance of the evidence, the lowest burden known to the law, the Western District of Pennsylvania, quoting Third Circuit precedents, stated

"The statutory presumption that a peer review action is valid unless proved otherwise results in an 'unusual standard' for granting summary judgment to a defendant, as 'the plaintiff bears the burden of proving that the peer review process was not reasonable...In this way, 'the HCQIA places a high burden on a physician to demonstrate that a professional review action should not be afforded immunity'."

This is incorrect. Who has the burden of proof is unrelated to what the burden of proof is. Therefore, HCQIA's presumption of immunity does not affect the non-moving party's burden of proof.

III. THE PEER REVIEW PROCESS CAN BE READILY MANIPULATED.

"Peer review" consists of retrospective review of patients' medical records selected on the basis of outcome indicators such as complications, reoperations, or readmissions to hospital within 30 days. The process is highly subjective, and different physicians, reviewing the same cases, usually disagree over specific
aspects of care, the global quality or appropriateness of care, or the cause(s) of adverse outcomes. Therefore, the reproducibility of peer review, even under optimal research conditions, is low, and barely more than would be expected by chance. Surprisingly, agreement is not significantly improved by extensive training of the reviewers, the use of objective criteria for review, or by having disagreeing reviewers discuss the cases.

The low rate of agreement between peer reviews in a research context has been attributed to wide variation in practice norms, and the inability to avoid hindsight and outcome biases, but additional factors are implicated in an adversarial setting. One court, commenting on expert testimony in the medical malpractice context, opined “[w]e know from our judicial experience that many such able persons present studies and express opinions that they might not be willing to express in an article submitted to a refereed journal of their discipline or in other contexts subject to peer review.”

Like all judgments, the evaluation of medical care can be greatly influenced by what information is provided to the reviewers, and how their tasks are defined and structured. A negative impression can be created in the minds of reviewers about the physician under review before they actually review anything at all, by the nature of the cases selected for review, and by what questions the reviewers are asked to address about those cases. These impressions in turn create expectations that will greatly influence how the medical records are reviewed, what facts are attended to and remembered, what assumptions are made, what inferences are drawn, and what conclusions reached.

For example, two external reviewers, who reviewed the same 26 cases without each other’s knowledge for two different, unaffiliated hospitals, criticized 14 (61%) of 23 uncomplicated, randomly selected controls between them, none of which had been previously criticized. That the reviewers had not simply detected problems missed in the ordinary course of peer review was evident from the fact that they criticized completely different cases, and even the one case they both criticized, they criticized for completely different reasons.

Peer review is a multi-tiered process, and a substantial paper record is created by the time the process has run its course. This record can create the surface impression that several committees, comprised of different individuals, reviewed the same information, and independently came to similar conclusions. The record tends to validate itself by making it appear that for the hospital’s action to be unwarranted would require collusion between an improbable number of physicians. This impression is illusory. The same information is not reviewed independently by several individuals, and the process can be manipulated without any widespread collusion among members of the medical staff.

Information on which peer review actions are based enters the process at the lowest tier, and the accuracy, validity, and completeness of the information are rarely checked at higher levels. The Board of Trustees (Board) ultimately decides who is granted privileges at a hospital, but the de facto decision maker is the Medical Executive Committee (MEC) to which the Board almost always defers on medical matters. However, with rare exceptions, the MEC does not
gather and review the medical facts on which it bases its recommendations to the Board. This is done by an ad hoc, investigating committee (IC). Hospitals can greatly influence an IC’s recommendation, and, therefore, the information that gets passed up the peer review decisional chain, by the individuals they select to conduct investigations, and by how they are briefed about what they are to investigate. This is how the hospital seems to have manipulated the IC’s investigation in Cowell.

In Cowell, an IC was appointed to investigate allegations about Dr. Cowell’s clinical practice in a Request for Corrective Action (RFCA). However, the IC was not informed that it was appointed to investigate the allegations in a RFCA, and it neither investigated them or even knew that a RFCA had been made until after its investigation was concluded. The IC was steered into investigation allegations on which the RFCA was not based and that were ultimately used to justify terminating Dr. Cowell’s privileges, by being asked to review a table compiled in the medical staff office that summarized select aspects of all previous reviews of Dr. Cowell’s cases. However, the IC was not provided with all the relevant information or documents about these prior investigation or their findings. Nor did the IC understand why it was being asked to re-review past investigations.

Although an IC will usually review some medical records itself, most of what an IC reviews is second- and third-hand information consisting of external reviews, incident reports, and the minutes of standing committees. The IC almost invariably accepts the information it is provided as accurate and reliable without any independent investigation. This is also what the IC did in the Cowell case.

Hospitals can also influence the outcome of an investigation by having lawyers write the IC’s report, rather than have the IC’s dictations transcribed in the medical staff office. In this way, the hospital can bring to the committee's attention information it would otherwise have disregarded as unimportant or irrelevant, and lead it to conclusions the IC would not otherwise have drawn. This also occurred in the Cowell case. The hospital's lawyers drafted the IC’s report, which contained factual assertions that were not true, that could not have originated with the IC, but that the IC simply accepted as true without any independent verification.

Opting in and opting out are not cognitively equivalent processes. Individuals will generally not “opt out” of agreements or commitments they would not have opted into. This lack of invariance is caused by cognitive biases that influence decisions, permit choices to be manipulated, and present many opportunities to influence the recommendations an IC makes to the MEC.

The MEC almost always accepts the recommendations of an IC without any independent investigation. Most members of the MEC are not sufficiently knowledgeable about medical standards in the specialty of the physician under review to make independent quality judgments in specific cases because only one or two MEC members will be in the same specialty as the physician under review. Although physicians are entitled to a hearing on any adverse recommendation by
the MEC, the Board is not required to accept the recommendation of the hearing panel, if this differs from the MEC’s recommendation.\(^{233}\)

Hospital hearings can also be manipulated to deny physicians a full and fair opportunity to defend themselves. For example, at the first hearing on Dr. Cowell’s suspension, the hospital failed to disclose key witnesses or produce documents prior to the hearing as required by the bylaws.\(^{234}\) Physicians have no subpoena power, they have no discovery rights, and they cannot speak with any witnesses identified by the hospital prior to the hearing.\(^{235}\) Good Samaritan also prejudiced Dr. Cowell at the first hearing by failing to call key witnesses, and by discouraging witness from testifying whom Dr. Cowell wished to call.\(^{236}\)

The hospital also controls what is done with the HC’s findings. For example, Good Samaritan did not provide either the reports of HCs or the hearing records to the MEC, as required by the medical staff bylaws.\(^{237}\) The way the bylaws are structured can further preclude any meaningful consideration of the MEC’s - and, hence the IC’s - original adverse recommendation. For example, Good Samaritan’s medical staff bylaws do not state what the MEC is to do with the information contained in the HC’s report, should that information be inconsistent with its earlier recommendation.\(^{238}\) There is also no appeal from the MEC’s recommendations, only appeal from the HC’s subsequent recommendations, and the Board is required to give equal weight to the recommendation by the MEC and the HC.\(^{239}\)

The summary information provided to the Board can also be censored. Appeals from adverse recommendations are usually heard by an Appellate Review Committee (ARC), not the full Board, and the Board relies on the ARC’s report. In Cowell, the lawyers who represented the hospital at the hearings, i.e. one of the parties to the dispute, wrote the ARC’s report on which the Board relied to terminate Dr. Cowell’s privileges.\(^{240}\) The ARC adopted the report verbatim,\(^{241}\) without checking the accuracy or completeness of the statements it contained.\(^{242}\) The Board also accepted the ARC’s report without conducting any independent investigation.\(^{243}\) Material information was withheld from the report,\(^{244}\) and the report was embellished with factual assertions that were not the findings of any committee.\(^{245}\)

**IV. COWELL v. GOOD SAMARITAN: PROTECTION OF UNWARRANTED PEER REVIEW UNDER HCQIA.**

*Cowell* involved the unjustified termination of a physician's hospital privileges on pretextual grounds after she proved that all allegations about her clinical practice “lacked a substantial factual basis”. The hospital's actions were unprecedented to judge by the decided cases. Good Samaritan Hospital (GSH) repeatedly investigated Dr. Cowell, and summarily suspended her hospital privileges, for one reason, and then permanently terminated her privileges for completely different and unrelated reasons, and concealed all information favorable to Dr. Cowell that was inconsistent with the termination from the MEC and the Board. However, this cannot be gleaned from the court’s opinion because the opinion omitted, misstated and even made up material “findings” from whole
cloth to reject Dr. Cowell's evidence, and justify holding the hospital immune under HCQIA.246

Dr. Cowell, a board certified/recertified obstetrician-gynecologist (Ob-Gyn) with over 30 years of clinical experience, was repeatedly investigated over a five year period, notwithstanding that all her cases had good outcomes,247 and, unlike some of her peers,248 she was repeatedly found not to be an outlier on quality outcome indicators.249 These investigations were all based on allegations about Dr. Cowell's clinical care, and all the allegations were found by a Hearing Committee (HC) to lack a substantial factual basis.250

Good Samaritan nevertheless terminated Dr. Cowell's privileges on April 17, 2007, for completely different reasons. The hospital alleged that Dr. Cowell had exceeded the scope of her surgical privileges by performing four operations called LAVHs251 before she had been granted privileges to perform LAVHs, and that she failed to cooperate with the peer review process by "disregarding" requests to videotape her laparoscopic procedures, and that these actions endangered patients.252 No one had ever made such allegations before. The allegations were made up by the IC during its investigation ostensibly into a RFCA that was not based on these allegations.253 Nor were the allegations based on new facts discovered during the investigation into the RFCA. However, no one reading the Cowell opinion could know these facts because the opinion contains the following, contrary "findings" that were made up out of whole cloth:

"the record contains abundant evidence of concerns about Cowell's performance of procedures beyond the scope of her privileges and her inability to have her procedures properly videotaped and monitored. In the light of this record, Cowell's claim that such concerns were "shifting justifications for disciplinary action" lacks merit."254

"In sum, the MEC's recommendation and the Board's decision were based on long-standing concerns that Cowell's conduct - namely, her performance of LAVHs without privileges and her failure to comply with videotaping and monitoring requirements - negatively impacted patient care",255

These assertions were not true. There was no basis for them in the record, and they were contradicted by testimonies of the hospital's own agents or former agents in the record before the court. For example, the Chairman of the IC, and former Director of Quality management, testified, respectively, as follows:

Q. And you did not come across, did you, any document, peer review, letters, or anything from anybody suggesting that Dr. Cowell had -- telling her that she had exceeded the scope of her privileges, correct?

A. Correct.256

> Q. ... Did you hear anyone ever say, in any committee, that Dr. Cowell had exceeded the scope of her privileges?
A. No.

Q. Was ever any determination made, while you were there, in connection with her reapplication for privileges, that Dr. Cowell had practiced outside the scope of her privileges?

A. No. 257

Dr. Cowell performed the four LAVHs at issue under the supervision of a Dr. Michaelson, who had privileges to perform LAVHs,258 because Dr. Kornberg, Chairman of Surgery, asked Dr. Cowell to provide more documentation of her experience with LAVHs before he would credential her for these procedures.259 Dr. Michaelson executed an affidavit in which he described his role as that of a “mentor”, and stated that he took responsibility for each LAVH, would have intervened had Dr. Cowell performed anything incorrectly, and that the patients were exposed to no greater risk than had they been his patients.260 Dr. Cowell suggested that Dr. Michaelson bill as the surgeon but because he had not evaluated the patients preoperatively and would not be following them post-operatively, he declined, which is why he was listed as an “assistant” in the operative reports.261

Nevertheless, the court's opinion implied that Dr. Michaelson was only an observer by stating that Dr. Cowell “rele[d] on evidence showing that she performed the four LAVHs in the presence of Dr. J. Michaelson”.262 The court's opinion also made up the following “findings” out of whole cloth:

“The IC further noted that, even if another physician had been in the operating room to watch or assist Cowell, operating on a patient as an attending surgeon without privileges was a violation of the bylaws.”263

This statement was also not true. The IC's report contains no such statements.264 The IC's report did not even state that Dr. Cowell performed the LAVHs with Dr. Michaelson.265

The fact that all the allegations about Dr. Cowell's clinical practice were found by a HC to lack a substantial factual basis was withheld both from the MEC and Board.266 The testimonies of Dr. Don Russell, a member of the MEC, and Mr. Michael Nelson, one of three Board members who voted for termination, indicated that the information withheld from the MEC and Board was material. Dr. Russell testified that had he known that all the allegations about Dr. Cowell's clinical practice were found to lack a substantial factual basis, he would not have voted to recommend termination.267 Mr. Nelson testified that if the information provided to him at his deposition but omitted from the Appellate Review Committee (ARC) report on which he relied, were true, it called into question the termination.268

Again, no one reading the Cowell opinion could know these facts because the opinion stated only that that the HC found insufficient evidence that Dr. Cowell's practice failed to meet accepted standards, and omitted that all allegations about Dr. Cowell's patient care were found to lack a substantial factual
basis. The court's opinion also stated only that Dr. Russell and Mr. Nelson were not aware of some of the HC's findings, and omitted that the information withheld from them would have caused them to vote differently or question the termination.

The testimony omitted was material to the dispositive question of whether a jury could reasonably have concluded that the termination of Dr. Cowell's privileges was unreasonable under § 11112(a)(4). If a member of the MEC, who voted to recommend termination, would have voted differently had he known the information that was withheld from the MEC, and if a member of the Board, who voted to adopt the recommendation, stated that the information withheld from the Board called into question the termination, it would be arbitrary and capricious to infer that no reasonable jury could conclude that termination of Dr. Cowell's privileges was unreasonable based on the information withheld from the MEC and Board.

The court's contention that the fact that the HC recommended revocation of Dr. Cowell's surgical privileges, if not all her privileges, undercuts the inference that the Board might have voted differently had it been fully apprized of the facts is a non-sequitur. Mr. Nelson was aware of the HC's recommendation. This was recited in the ARC's report on which the Board relied, and the reasons for the recommendation were even embellished in the report by "findings" the HC never made. Yet, Mr. Nelson still concluded that the information withheld from the Board called into question the termination. Moreover, although the HC credited the IC's conclusions about Dr. Cowell exceeding the scope of her privileges, the HC, like the IC, disregarded that Dr. Cowell had performed the LAVHs with Dr. Michaelson. Dr. Rose, a member of the HC, subsequently conceded that a physician on staff at the hospital who did not have privileges to perform a procedures for which she did have privileges could perform the procedure with her.

This summary by no means exhausts the material facts omitted from the court's opinion, or made up out of whole cloth. Several representations in the opinion were also not "facts", understood as "an event, an occurrence, or something that exists in reality...what took place, an act, an incident, a reality as distinguished from supposition or opinion." They were recitations of allegations in the IC's report that a HC subsequently found to "lack a substantial factual basis" by a HC, or the court's interpretations of facts or of events from which all details favorable to Dr. Cowell were omitted.

A. Evidence that termination of plaintiff's hospital privileges was unreasonable under § 11112(a)(4).

Dr. Cowell presented evidence from which a jury could reasonably conclude that she did not exceed the scope of her surgical privileges, and, therefore, that termination of her privileges was unreasonable under § 11112(a)(4). Dr. Kornberg, who had declined to credential Dr. Cowell for LAVHs until she could demonstrate more experience, attended a Surgery Committee Meeting on June 17, 2002, at which the first LAVH that Dr. Cowell performed with Dr. Michaelson was presented, and he said nothing about Dr.
Cowell exceeding the scope of her privileges or being unauthorized to perform LAVHs even with Dr. Michaelson. On the contrary, Dr. Eun, Chairman of Ob-Gyn, who also attended the meeting, determined that Dr. Cowell had practiced within the scope of her privileges when he subsequently recommended her for reappointment to the GSH medical staff in March, 2003. The operating room also knew that Dr. Cowell had not yet been granted privileges in LAVHs, but did not prevent her from performing these operations with Dr. Michaelson.

The IC’s report, the HC’s report, and the ARC’s report on which the Board relied, all omitted to state that Dr. Cowell had performed the four LAVHs with Dr. Michaelson. This information was critical because Dr. Cowell proved through the testimonies of the hospital’s own agents and former agents, as well as an outside expert, that a physician on staff at a hospital, including GSH, who does not have privileges to perform a procedure can perform that procedure with another physician on staff at the hospital who does have privileges to perform the procedure, and, therefore, that she had not exceeded the scope of her privileges.

Dr. Rose, a member of the HC, and Dr. Smith, a member of the IC, both testified that a physician on the Good Samaritan medical staff who did not have privileges to perform a procedure could perform that procedure with them if they had privileges to perform the procedure. Maureen Guzman, and Dr. Joseph Sanfilippo, an Ob-Gyn with extensive experience in peer review and credentialing, both reviewed Dr. Michaelson’s affidavit, and testified that Dr. Cowell did not exceed the scope of her privileges by performing the four LAVHs with Dr. Michaelson. Guzman further testified that Dr. Donald Mott, Good Samaritan’s Vice President of Medical Affairs, performed a knee operation with another physician long after Dr. Mott had relinquished his surgical privileges at Good Samaritan, indicating that senior hospital administrators were aware that a physician can perform a procedure for which he or she does not have privileges with another physician who does.

B. Evidence that the peer review process violated § 11112(a)(3).

Dr. Cowell contended that the hospital’s procedures violated § 11112(a)(3) because material information was concealed from the Board, which effectively denied her a proper opportunity to be heard. No matter how much process a person receives, if material information is concealed from the ultimate decision maker then the person has been denied an opportunity to be heard in the only forum, and by the only individuals, that matter. Although the court acknowledged this argument, it never addressed it, or acknowledged that material information was withheld from the Board.

The court held that HCQIA does not require any level of appellate review, and appeared to imply that, therefore, it was irrelevant whether or not material information was withheld from the Board. But even if HCQIA does not require an appeal, it does not follow that a hospital that chooses to provide physicians an appeal can misuse the process to conceal information from the
ultimate decision maker. Even if there had been no appeal, GSH would still have been required to inform the Board of the HC's findings, and if it had withheld information from the Board in the way it withheld information from ARC's report, the process would not have passed muster under § 11112(a)(3).

V. HOW RCW 7.71 SHOULD BE AMENDED.

To give effect to RCW 7.71's original remedial purpose, and safeguard physicians from peer review abuses currently being protected under HCQIA, the definitional and fee-shifting provisions of the statute need to be amended. HCQIA does not preempt these amendments.

A. Amendments to RCW 7.71.010.

The purpose of RCW 7.71 was to balance the public benefits against the private harms that medical peer review can create. The harms caused by peer review result from improper and unjustified peer review actions. The legislature did not define the harms for which it intended RCW 7.71 to provide a remedy in terms of improper or unwarranted peer review actions. The statute was drafted in language that merely indicated that RCW 7.71 applied to actions to which HCQIA did not apply. However, since the legislative history of HCQIA available at the time the Legislature enacted RCW 7.71 made it clear that HCQIA was never intended to apply to improper peer review actions, it can be inferred that RCW 7.71 was intended to provide a remedy for harms caused by such actions.

Any statutory private cause of action intended to protect physicians against improper and unjustified actions that is defined as a remedy for actions not based on a physician's competence or professional conduct will be a nullity, because hospitals always claim their actions against physicians are based on their competence or professional conduct. Therefore, RCW 7.71.010 needs to be amended to clarify its purpose. This can be readily achieved by specifying that the intent of the statute is to protect physicians harmed by improper and unwarranted peer review actions, rather than by actions “not based on competence or conduct”. Improper or unwarranted actions should be defined as

“any action by a professional review body that is not supported by substantial evidence or motivated by a genuine and objectively reasonable belief that the action was necessary to prevent an incompetent or unprofessional health care provider from practicing, or that is not based on articulable reasons why the action was necessary to protect patients from unreasonable risk of harm”.

RCW 7.71.010 should also be amended to clarify that the statute provides the exclusive remedy only for claims based on the peer review action itself, and does not preempt relief for independent torts or breaches of contract committed during the peer review process. This can also be readily accomplished by adding language to the effect that the provisions of RCW 7.71 “shall not be deemed to impair or affect any other rights or remedies provided that they are not based on a
peer review action itself”.

Finally, the statute needs to state expressly that the legislature intends that the nature of a peer review action, that is, whether it is improper or unwarranted, to be treated as factual questions to be decided consistent with Washington’s constitution and procedural rules.

B. Amendments to RCW 7.71.030(3).

The fee-shifting provision of RCW 7.71.030(3) needs to be amended to clarify who counts as a prevailing party. The statute provides that “[r]easonable attorneys’ fees and costs as approved by the court shall be awarded to the prevailing party, if any, as determined by the court”.301 Although the statute expressly contemplated that there may not be a prevailing party, and authorized courts to determine if there is one or not, it gives no guidance as to how this determination is to be made.302

All language in a statute must be given effect, and no portion construed as meaningless or superfluous,303 but it is unclear in what factual circumstances the Legislature intended that there would be no prevailing party. If a statute is ambiguous, courts construe the statute to effectuate the legislature’s intent “within the context of the entire statute”,304 and in the light of “all that the Legislature has said in the statute and related statutes.”305 Words cannot be added that the legislature chose not to use,306 but literal construction of statutory language should be avoided “if it would result in unlikely, absurd or strained consequences”, and the “purpose of an enactment should prevail over express but inept wording.”307

The fee-shifting provision of RCW 7.71.030(3) makes sense only if “prevailing party” is understood to mean a party who recovers under RCW 7.71.030(1). In other words, to prevail means prevail under RCW 7.71, not prevail on the lawsuit as a whole. Under this construction, defendants can never be a prevailing party, and could never recover attorneys’ fees and costs under RCW 7.71.030(3), because hospitals and peer reviewers cannot recover under RCW 7.71.030(1). This construction is entirely consistent with the purpose of RCW 7.71 and the overall statutory scheme the Legislature adopted.308

The purpose of RCW 7.71 was to create a private right of action for physicians, not hospitals or peer reviewers, and provide relief for physicians harmed by improper and unreasonable peer review decisions.309 RCW 7.71 does not apply to hospitals or peer reviewers who engage in appropriate peer review. It applies to physicians harmed by peer review. It was the purpose of HCQIA and other state statutes, not RCW 7.71, to protect hospitals and peer reviews engaged in legitimate peer review.310 To interpret RCW 7.71 as applying to hospitals and peer reviewers, as well as physicians under review, is to destroy its remedial purpose, and to upset the careful balance the Legislature adopted between the harms and benefits of peer review.

If a physician challenges a hospital’s action as not genuinely based on his or her competence or professional conduct, and the court finds that the action was indeed pretextual, the plaintiff is a prevailing party, and would be entitled to attorneys’ fees under RCW 7.71.030(3).311 If the physician prevails, it would be
equitable to make an award of reasonable attorneys' fees and costs mandatory because under the proposed definition of improper peer review, the physician could only prevail if the hospital's action was not supported by substantial evidence or was improperly motivated, that is, if the action was "without foundation" and in "bad faith", which mirror the requirements for awarding attorneys' fees and costs to defendants under § 11113.

If, however, the court finds that the action was based on the physician's competence or professional conduct, RCW 7.71.030(1) has no application.312 There is then no prevailing party under the statute because the statute does not apply to the action at all. If the court further finds that the physician fails to rebut the presumption that the action was reasonable and fair under § 11112(a), the defendants will be able to recover their attorneys' fees and costs under § 11113, as long as the plaintiff's claims were "frivolous, unreasonable, without foundation or in bad faith." 313 To permit defendants held immune under HCQIA to recover under RCW 7.71.030(3) instead of 42 U.S.C. § 11113 is tantamount to compelling courts to award of attorneys' fees and costs for non-frivolous challenges to peer review actions brought in good faith, which would deter challenges to questionable peer review actions, and defeat the remedial purpose of RCW 7.71.

C. HCQIA does not preempt the amendments to RCW 7.71 required to safeguard against peer review abuses.

A state can provide greater immunity to hospitals and peer reviewers than HCQIA provides, but it cannot provide less.314 RCW 7.71 created a private right of action to provide relief to physicians harmed by peer review decisions.315 RCW 7.71 did not create immunity for hospitals or peer reviewers for appropriate peer review actions.316 That was the purpose of HCQIA and other state statutes. 317 Nothing in HCQIA preempts state laws intended to protect physicians from the harms caused by abuses of the peer review process.

Only the U.S. Supreme Court's interpretations of federal law bind the States.318 The Court's precedents and respect for federalism make it highly unlikely that it would construe HCQIA as preemption of State laws intended to protect physicians from abuses of the peer review process. The Court "will interpret a statute to preempt the traditional state powers only if that result is 'the clear and manifest purpose of Congress'."319 Since HCQIA does not create a private cause of action,320 it obviously does not have the "clear and manifest purpose" of limiting state statutes that do create a private cause of action to protect physicians from abuses of medical peer review.

The Court's starting presumption is that State law is not preempted.321 This presumption against preemption is greatest "where federal law is said to bar state action in fields of traditional state regulation."322 Healthcare is a field traditionally regulated by the States.323 Therefore, because HCQIA regulates healthcare, the U.S. Supreme Court will presume "that state and local regulation related to [HCQIA]...can normally coexist with federal regulations."324 The Court would be highly unlikely to hold that this presumption is defeated by a state
statute that provides relief from improper peer review actions.

The Court considers Congressional intent as the “ultimate touchstone of pre-emption analysis”.325 Nothing in the language of HCQIA,326 or the purpose for which it was enacted,327 expressly prohibits States from protecting physicians from abuses of the peer review process masquerading as actions based on competence or conduct, or from prescribing what shall constitute an improper peer review action within their jurisdictions. On the contrary, the legislative history of HCQIA makes it unambiguously clear that Congress never intended to protect such abuses.328 Courts protect peer review abuses by granting summary judgment to defendants whose peer review actions were unreasonable or improperly motivated. States can protect against improper findings of immunity under HCQIA through procedural rules because HCQIA does not specify how courts should decide motions for summary judgment based on HCQIA.329 Nor does HCQIA “explicitly state what effect the plaintiff's failure to produce any rebuttal evidence would have.”330 This is consistent with the general principle, repeatedly approved by the U.S. Supreme Court, that federal law takes state courts as it finds them.331 If, therefore, a State had no statute authorizing summary judgment, HCQIA would not compel the State to dismiss a law suit related to a peer review action even if the action complied with HCQIA's statutory standards for immunity. Motions for summary judgement based on HCQIA are reviewed under the procedural law of the forum.332 The U.S. Supreme Court cannot tell States how to administer their own court rules and procedures that do not violate rights protected by the Fourteenth Amendment,333 or abrogate federal rights of recovery,334 and, as noted, HCQIA creates no right of action.

VI. WHY RCW 7.71 SHOULD BE AMENDED.

Termination of a physician's hospital privileges is tantamount to professional capital punishment335 because it not only devastates the physician professionally and financially, but stigmatizes the physician in ways only the criminal law usually can.336 Such actions can be justified only by substantial evidence of incompetence or unprofessional conduct. Bad outcomes, or even mistakes, are not in themselves evidence of incompetence. Subjective opinions about the causes of bad outcomes or mistakes, as about most medical matters, vary, and an adverse subjective opinion alone does not establish incompetence or provide a justification for what are frequently career ending decisions by hospitals.

The understanding of medical errors has advanced significantly since HCQIA was enacted. HCQIA's “bad apples” premise - that a small but deadly group of physicians cause most of the needless iatrogenic injuries and deaths, and account for most of the medical malpractice suits337 - although beguiling, is now considered deeply flawed.338 There are undoubtedly unscrupulous and incompetent physicians who harm patients, but they are rare.339 The causes of medical errors are multifactorial, and almost always involve jointly necessary "enabling conditions" without which errors could not have occurred.340 Although
it is easier and more satisfying to blame individuals, health care cannot be made safer by simply blaming individuals when things go wrong. To improve safety, hospitals must design safer operating conditions that make errors less likely. This was the fundamental recommendation of the highly influential, Institute of Medicine’s report, To Err is Human.

Most preventable adverse events are caused by competent doctors who face significant adverse consequences for bad outcomes, and, therefore, already have significant extra-professional incentives to avoid them. As the Harvard surgeon, Atul Gawande, put it, “The real problem isn't how to stop bad doctors from harming, even killing their patients; it's how to prevent good doctors from doing so”. One thing all safety experts agree on is that this cannot be achieved by blaming, shaming, punishing and admonishing physicians:

[A] “culture of blame [which is] operationalized in terms of pursuit of culprits, threats of disciplinary actions, and threats of stigmatization degrades performance, cooperation and learning...[and] blame [even if disguised as accountability] drives out information about systemic vulnerabilities, stops learning, and undermines the potential for improvement.”

Hospitals that misuse peer review are usually plagued with intractable systemic problems that place patients at risk. They respond to adverse outcomes by either dismissing them as unavoidable mishaps or blaming specific physicians, and the route they choose is based on factors unrelated to the quality of medical care. Either way, the enabling conditions that allowed the error to occur remain in the system, and continue to pose a threat to patients. 

The attack on Dr. Cowell's clinical practice in the IC's report was based almost entirely on her management of what was referred to as the Jehovah's Witness case or JW. This was not a case on which the RFCA was based, but occurred three weeks after the investigation into the RFCA should have been completed. The IC devoted nine pages of its 17-page, single-spaced report to this one case, and its allegations were replete with factually false assertions that were flatly contradicted by the patient's medical records. The HC rejected all these allegations as “lacking a substantial factual basis”, but these findings were omitted from the court's opinion.

The IC's most serious criticism was that JW went into shock in the recovery room following surgery, and that everyone except Dr. Cowell had recognized this. In fact, no one claimed JW was in shock, and the HC rejected this allegation as lacking a substantial factual basis because excessively rapid administration of the narcotic, Fentanyl, by a recovery room nurse, not continued bleeding that Dr. Cowell had missed, caused JW's blood pressure to fall in the recovery room.

Two system flaws jointly caused this medication error. First, the preprinted “range” order for Fentanyl signed by the Director of the Surgery Center, pursuant to which the recovery room nurse administered Fentanyl at
an excessively rapid rate,\textsuperscript{356} did not specify how frequently individual doses of the drug could be repeated in adults.\textsuperscript{357} Second, nurses received inadequate instructions on how to administer Fentanyl pursuant to this range order.\textsuperscript{358}

Preprinted orders are regularly reviewed and revised. In August, 2007, eight months after the HC determined that excessively rapid administration of Fentanyl had caused JW's blood pressure to fall in the recovery room,\textsuperscript{359} the preprinted range order pursuant to which the Fentanyl was administered was revised.\textsuperscript{360} However, the deficiency in the range order was not corrected,\textsuperscript{361} even though the range order violated JCAHO standards,\textsuperscript{362} and Good Samaritan had already been cited for using improper range orders in the past.\textsuperscript{363} The nurses also received no remedial instructions. The nurse who gave the maximum dose of Fentanyl over 10 minutes in April, 2006, testified in May, 2008 that she did not believe that she had given the Fentanyl at an excessively rapid rate, and that she could in fact have given the maximum does at an even faster rate - over eight minutes.\textsuperscript{364}

Several months before the JW case, an hospital-employed Ob-Gyn lacerated the internal iliac artery during a laparoscopic procedure, which he failed to recognize, and, therefore, required reoperation, but the complication was dismissed as a mishap.\textsuperscript{365} A year before the JW case, the external reviewer at the University of Washington, who reviewed five of Dr. Cowell's cases, recommended that Good Samaritan have its Obstetrical Unit reviewed by ACOG, not that Dr. Cowell be disciplined.\textsuperscript{366} His recommendations were not followed, notwithstanding that data collected for the review revealed that several physicians, although not Dr. Cowell, were outliers on quality indicators.\textsuperscript{367} Important opportunities to improve the quality of care were lost by each decision.

Destruction of Dr. Cowell's practice, and legal protection of the hospital's action against her, have clearly not made Good Samaritan a safer hospital at which to be treated or encouraged effective peer review. The legal protection accorded Good Samaritan's actions have merely perpetuated systemic deficiencies that pose a genuine risk to patients. The knowledge that Washington courts will protect the kind of peer review action Good Samaritan took against Dr. Cowell will undoubtedly embolden hospitals to use the peer review process more readily in the future to further ends unrelated to improving the quality of health care.

CONCLUSION

HCQIA is a flawed statute because it creates no incentives to engage in effective peer review, its immunity provisions are unnecessary, and the purported need for them was never supported by empirical evidence. The problems HCQIA has created, however, are not the result of these deficiencies. They have resulted from interpretations of the statute that are inconsistent with its purpose, plain language and legislative history. These interpretations have done nothing to improve the quality of care, reduce the frequency of medical malpractice claims or improve public safety. They have only protected and encouraged abuses of the peer review process, inflicted great hardships on competent physicians, and have likely retarded the adoption of more effective quality oversight systems by hospitals like Good Samaritan.
The Cowell court's interpretation of RCW 7.71 has made this situation considerably worse by allowing hospitals held immune under HCQIA to recover attorneys' fees and costs under the mandatory fee shifting provisions of RCW 7.71.030(3). This will have the effect of deterring physicians from even challenging questionable peer review actions, and will undoubtedly encourage more blatant abuses of the peer review process in the future.

The Washington legislature can redress the antisocial consequences that have resulted from the misapplication of HCQIA by amending RCW 7.71 to ensure that pretextual peer review actions do not receive immunity, and attorneys' fees and costs are not awarded for non-frivolous but unsuccessful challenges to peer review actions. The U.S. Supreme Court is highly unlikely to construe HCQIA as preempting state statutes whose purpose to protect physicians against

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2 See Wash. Rev. Code § 7.71.010 (2010), which provides:

"The legislature finds the assurance of quality and cost-effectiveness in the delivery of health care can be assisted through the review of healthcare by health care providers. It also recognizes that some peer review decisions may be based on factors other than competence or professional conduct. Although it finds that peer review decisions based on matters unrelated to quality and utilization review need redress, it concludes that it is necessary to balance carefully the rights of the consuming public who benefit by peer review with the rights of those who are occasionally hurt by peer review decisions based on matters other than competence or professional conduct.

The legislature intends to foreclose federal antitrust actions to the extent Parker v. Brown, 317 U.S. 341 (1943), allows and to permit only those actions in RCW 7.71.020 and 7.71.030."  

3 See Rao v. Board of County Comm'rs, 80 Wn.2d 695, 686, 497 P.2d 591, 592 (1972) ("private hospitals have the right to exclude licensed physicians from the use of their facilities, such exclusion resting within the discretion of the managing authorities") (citing Health Coop. of Puget Sound v. King County Med. Soc'y, 39 Wn.2d 586, 497 P.2d 591 (1951)).

4 Hancock v. Blue Cross-Blue Shield of Kan., Inc., 21 F.3d 373, 374-75 (10th Cir. 1994); Bok v. Mut. Assurance, Inc., 119 F.3d 927, 928-29 (11th Cir. 1997); Wayne v. Genesis Med. Ctr., 140 F.3d 1145, 1147 (8th Cir. 1998).

5 42 U.S.C. § 11151(9) defines 'professional review action' as

"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. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

(A) the physician's association, or lack of association, with a professional society or association,

(B) the physician's fees or the physician's advertising or engaging in other competitive acts intended to
solicit or retain business, 
(C) the physician's participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis, 
(D) a physician's association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or 
(E) any other matter that does not relate to the competence or professional conduct of a physician.  

See 42 U.S.C. § 11112(a) (2010), which provides: 

(a) In general. For purposes of the protection set forth in [42 U.S.C. § 11111(a)], a professional review action must be taken—

(1) in the reasonable belief that the action was in the furtherance of quality health care, 
(2) after a reasonable effort to obtain the facts of the matter, 
(3) 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 
(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in [42 U.S.C. § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence. 

See 42 U.S.C. § 11111(a)(1), Limitations on damages for professional review actions.

"If a professional review action (as defined in [42 U.S.C. § 11151(9)] of a professional review body meets all the standards specified in [42 U.S.C. § 11112(a)], except as provided in subsection (b)—

(A) the professional review body,
(B) any person acting as a member or staff to the body,
(C) any person under a contract or other formal agreement with the body, and
(D) any person who participates with or assists the body with respect to the action, 
shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 4C of the Clayton Act [15 U.S.C. § 15c] where such an action is otherwise authorized.  


Decker v. IHC Hosps., Inc., 982 F.2d 433, 436 (10th Cir. 1992) (“The HCQIA's legislative history supports our conclusion that the act establishes immunity from liability only.”); Manion v. Evans, 986 F.2d 1036, 1042 (6th Cir. 1993) (holding that HCQIA does not confer a right not to stand trial); Singh v. Blue Cross/Blue Shield of Massachusetts, Inc., 308 F.3d 25, 35 (1st Cir. 2002). (“Moreover, immunity under the HCQIA is immunity from damages only...”). In Mathews v. Lancaster Gen. Hosp., 87 F.3d 624, 632 (3d Cir. 1996), the Third Circuit referred to the immunity as "immunity from suits for money damages", and other circuits have cited this language. See Poliner v. Texas Health Systems, 537 F.3d 368, 376 (5th Cir. 2008); Sugarbaker v. SSM Healthcare, 190 F.3d 905, 911 (8th Cir. 1999). However, HCQIA provides only a defense to liability, not immunity from having to stand trial. See infra note 20.

A "professional review body" is defined as:

"a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity". See 42 U.S.C. § 11151 (10) (2010).

See supra note 7. A separate subsection immunizes those who provide information to professional review bodies. See 42 U.S.C. § 11111(a)(2) (providing a defense from liability to persons who provide information to a professional review body, unless the information is false, and the person providing knew it was false).
See supra note 6.
See supra note 5, subsection(E).
See infra, § I.C.2.

*Id.*

See e.g. Sugarbaker v. SSM Health Care, 190 F.3d 905, 914 (8th Cir. 1999) ("In the HCQIA immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant"); accord Poliner v. Texas Health System, 537 F.3d 368, 379-80 (5th Cir. ("Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as do we.") (footnote and citations omitted).

See Wash. Rev. Code § 7.71.030(1) (2010) ("This section shall provide the exclusive remedy for any action taken by a professional peer review body of health care providers as defined in RCW 7.70.020, that is found to be based on matters not related to the competence or professional conduct of a health care provider.").

See Wash. Rev. Code § 7.71.030(2) (2010) ("Actions shall be limited to appropriate injunctive relief, and damages shall be allowed only for lost earnings directly attributable to the action taken by the professional review body, incurred between the date of such action and the date the action is functionally reversed by the professional peer review body.").

See Wash. Rev. Code § 7.71.030(3) (2010) ("Reasonable attorneys' fees and costs as approved by the court shall be awarded to the prevailing party, if any, as determined by the court.").

See Wash. Rev. Code § 7.71.030(4) (2010) ("The statute of limitations for actions under this section shall be one year from the date of the action of the professional review body.").

See supra note 2.
See supra note 17.
See supra note 5.

153 Wn.App. 911, 255 P.3d 294 (Wash. App. 2009). The appeal was transferred from Division II to Division I.


"In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 412(a) [42 USCS § 11112(a)] and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.").


*Id.* at 642-43, 230 P.3d at 211.

See Salama v. Overlake Hospital, et al., Case No.: 08-2-01897-1 (Wash. Sup. Ct. King County, April 9, 2010) (Judgment and Order, granting attorney's fees under RCW 7.71.030). The court previously denied summary judgment under HCQIA, and held that RCW 7.71 did not apply to the case. See Order, denying summary judgment, August 28, 2009 and Order, granting partial summary judgment, October 9, 2009. See also Smigaj v. Yakima Valley Mem. Hosp. Ass'n, Case No. 08-2-04305-2 (Wash. Sup. Ct. Yakima Cty, November 22, 2010) (Memorandum and Order, awarding attorneys' fees and costs under RCW 7.71 and 42 U.S.C. § 11113). Before Cowell was decided, the court had denied defendants' CR 12(b)(6) motion, and held RCW 7.71 inapplicable because the hospital's action was based on competence or conduct. See Memorandum and Order, April 9, 2009. After Cowell was decided, the Smigaj court held defendants immune under HCQIA, and granted summary judgement, see Memorandum and Order, September 9, 2010, and awarded attorney's fees, see Memorandum and Order, November 24, 2010, for a questionable peer review actions that had attracted local media attention. See Leah Ward, *Not What the Doctor Ordered*, Yakima-Herald Republic, January 24, 2009 (http://www.yakima-herald.com/stories/2009/01/24/not-what-the-doctor-ordered).

See CP 49-71 (First Amended Complaint). The tort claims were based on the publication of factually false,
defamatory statements about the plaintiff to peer review committees and the National Practitioner's Data Bank with knowledge of falsity. Dr. Cowell sought an injunction under RCW 7.71.030(1) in the event defendants were not found immune under HCQIA, notwithstanding that the termination of her privileges was ostensibly based on her professional conduct, because RCW 7.71 was a remedial statute, see Owner's Ass'n v. FHC, LLC, 166 Wn.2d 178, 205-06, 207 P.3d 1251, 1265 (2009), courts construe remedial statutes liberally “in order to effectuate the remedial purpose for which the statute was enacted”, see State v. Grant, 89 Wn.2d 678, 685, 575 P.2d 210, 213 (Wash. 1978), and RCW 7.71's purpose was to redress harms caused by "peer review decisions based on matters not related to quality". See supra note 2. Therefore, she argued that actions that do not comply with the standards of § 11112(a) should be treated constructively as not based on competence or professional conduct.

See CP 2001 (Order, July 25, 2008, awarding $296,656.50 of the total of $364,474.00 claimed under RCW 7.71.030). The court construed attorney's fees liberally to include all "expenses", and even allowed as "reasonable" a $95 dinner for one attorney on the night before an out-of-town deposition. See CP 1926. Defendants likely sought most of their fees and costs under RCW 7.71.030(3) because the Washington Court of Appeals declined to award attorneys' fees under 42 U.S.C. § 11113 to defendants it had held immune under § 11111(a)(1). See Morgan v. Peacehealth, 101 Wn. App. 750, 776, 14 P.3d 773, 787 (Wash. App. 2000).

See CP 2465 (Defendants' Motion for Attorneys' Fees, Expenses, Costs and Disbursements Pursuant to CR 54(1) and (2)).


This argument confused causes of action with remedies. There is no defense to an injunction separate from the challenge to the presumption of immunity. That is why the "defense" to the injunction consisted of two sentences, and relied on no facts learned through discovery. The "defense" consisted of the assertion that because defendants' actions were based on Dr. Cowell's competence and professional conduct, RCW 7.71 did not apply. See CP 2438 (“Moreover, because the professional review action undeniably related to plaintiff's competence or professional conduct, plaintiff's claims must be dismissed.”) (Defendants' Reply Brief in Support of CR 12(b)(6) and CR 56 Motions to Dismiss Plaintiff's Claims)).

See id. at 634, 230 P.3d at 207.

155 Wn.App at 632-34, 230 P.3d at 207 (termination based on violation of a performance agreement, which was imposed because of questionable judgment and management of bowel injuries during laparoscopic surgery).

Id. at 635, 230 P.3d at 208. The court also held the hospital immune under HCQIA, granted summary judgment on plaintiff's remaining claims. Id. These were for breach of contract and fraud, breaches of fiduciary duties, tortious interference, reinstatement of medical staff membership and clinical privileges; and declaratory relief. The court permitted the plaintiff to amend his complaint to seek an injunction, but he declined to do so. Id. The court did not hold defendants immune for the claim that the hospital tortiously interfered with Dr. Perry's privileges at another hospital, but the plaintiff did not pursue this claim. Id.

See supra note 2, § 7.71.010 (recognizing that "some peer review decisions may be based on factors other than competence or professional conduct...[and] that peer review decisions based on matters unrelated to quality and utilization review need redress") and supra note 17, § 7.71.030(1) (stating that statute provides exclusive remedy for any action taken by a peer review body...that is found not to be based on matters not related to competence or professional conduct of a health care provider.").

See supra note 2.

Id. (Using the phrase "competence or conduct" repeatedly to define the purpose of the statute).

See supra note 17, § 7.71.030(1).

State v. J.P., 149 Wn.2d 444, 450, 69 P.3d 318, 320 (2003) (courts must construe statutes consistent with their purpose to give effect to the legislature's intent, avoiding strained or absurd results in so doing).

See supra note 2 (stating that "peer review decisions based on matters not related to quality and utilization review need redress.").

See supra note 26.


See infra, § II.


See infra, § I.A.

Id.

See Horner, supra note 1 at 456 n.4 (summarizing the history of bill’s passage through Congress).


See 132 Cong. Rec. H 11590 (daily ed. Oct 17, 1986) (“in the Patrick case, the hospital dropped out [of] the lawsuit before the verdict was rendered, leaving the defendants doctors with no insurance whatsoever. As a result of the verdict, at least one doctor had 100 percent of his income garnished for months”). (Statements of Rep. Waxman).

See Cong. Rec. H 9963 (daily ed. Oct. 14, 1986) (statement of Rep. Wyden); accord statements of Rep. Tauke, id. (“one of the major deterrents to effective peer review [was] the threat hanging over physicians or hospital administrators involved in peer review that they may be sued under State and Federal antitrust, defamation and other statutes by a doctor they are planning to discipline or have disciplined, even when the review and disciplinary action are clearly motivated by concern over quality of care”). See also Steve Twedt, Rules of Fair Play Don’t Always Apply, Pittsburgh Post-Gazette, October 27, 2003

(“Pittsburgh lawyer John Horty, who is nationally known for his work on hospital legal issues, said the immunity provision in the health care act came out of discussions he’d had with former U.S. Rep. Ron Wyden, D-Ore., and later Rep. Henry Waxman, D-Calif., because of lawsuits such as the one brought by Oregon physician Dr. Timothy Patrick to overturn an unfavorable peer review ruling...Horty co-authored that section of the law [providing immunity to hospitals].” (http://www.post-gazette.com/pg/03300/234533-84.stm).

64 See Hearings on H.R. 5110 at 276 (testimony of Mr. Jack Owens, Executive Vice President, American Hospital Association).

Id. at 297 (testimony of Mr. John Horty, President of the National Council of Community Hospitals).

See supra note 55.

See Horner, supra note 1.


Id. at 9 (“Initially, the Committee considered establishing a very broad protection from suit for professional review actions. In response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls, however, the Committee restricted the broad protection.”)

Id. at 12 (“a court might determine at an early stage of litigation that the defendant has met the [§ 11112(a)] standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper.”)


Id. at H9961 (“The testimony presented to the Judiciary Committee shows that peer review often has the result if not the intent of discriminating against minority and foreign born doctors.”) (Statements of Rep. Edwards);
Hearings on 5540 at 29-31 (Letter from Assistant Attorney General Bolton presenting the “views of the Department of Justice on H.R. 5540” recommending against adopting the bill).

Hearings on H.R. 5510 at 348 (stating that standard for immunity “could present a considerable problem for a physician whose privileges are jeopardized in an action which not primarily based on his competence, but which may be the result of a ‘turf battle’ among medical practitioners”). (Statements submitted on behalf of the American Academy of Family Physicians).

132 Cong. Rec. H9959 (daily ed. Oct. 14, 1986) (“For example, an action taken against a physician because of a style of practice or a pattern of patients that do not generate sufficient revenue for the hospital would not be covered by this bill.”) (Statements of Rep. Waxman explaining Amendment No. 10).

See id. at H9962 (Statements of Rep. Madigan). Accord Mathews v. Lancaster General Hosp., 87 F.3d 624, 633 (3d Cir. 1996) (stating that HCQIA’s purpose was to “deter antitrust suits by disciplined physicians.”). HCQIA’s proponents anticipated that the bill’s reporting requirements would precipitate a surge of federal antitrust suits, and considered the “very limited immunity” that remained to be essential to protect peer reviewers from the threat of treble damages posed by federal antitrust suits. See 132 Cong. Rec. H9962 (daily ed. Oct. 14, 1986) (“the reporting mechanism established by this legislation is likely to lead to more litigation...”) (Statements of Rep. Madigan); 132 Cong. Rec. H11589 (daily ed. Oct. 17, 1986) (stating that “The immunity left after these modifications is very limited but essential.”) (Statements by Rep. Waxman).


Id. (“the bill, as reported and with the changes now recommended...does not create an incentive to more effective voluntary peer review, it would instead shield illegal peer review action from effective challenges brought by those doctors who find themselves improperly sanctioned by peer review committees.”) (statements of Rep. Edwards); id. at H9964 (“Perhaps most troubling, there is no mechanism in H.R. 5540 to guarantee that physicians will, in fact, participate in more peer review if the bill is passed.”) (statements of Rep. Rodino).

See Patrick, 800 F.2d at 1509.

See id. at 1507.

132 Cong. Rec. H11590 (daily ed. Oct 17, 1986) (statements of Rep. Waxman); Hearings on H.R. 5540 at 48-49 (“I appreciate that any form of immunity raises concerns about the potential for mischief that might be visited by doctors on their colleagues for improper reasons. But, let me say that numerous -- some might say endless -- discussions with those interested in, and affected by, our bill, to remove such cause for alarm. I am now convinced that we have addressed every legitimate objection that has been raised to the bill.”).

Id. at H11589.


Hearings on H.R. 5540 at 47 (Statement of Representative Waxman); § 11101(2).


132 Cong. Rec. H9963 (“Mr. Speaker, the bill before us today will create an important first line of defense against malpractice: ridding the profession of bad doctors is the first line of defense against malpractice. As such, it is the first step toward a national malpractice strategy.”) (Statements of Rep. Wyden). See also Hearings on H.R. 5540 at 58-60 (presenting statistics that a small minority of physicians account for a large proportion of malpractice claims - for example, 3% of physicians account for 48% of malpractice claims in Florida) (Statement of Sidney Wolfe for Public Citizen Health Research Group). The misplaced belief that HCQIA would have a salutary effect on medical malpractice claims, and, hence, malpractice insurance premiums, was the likely reason that so many medical organizations supported HCQIA. See e.g., 132 Congr. Rec. H (daily ed. 14, 1986) (Statement of Rep. Tauke that American Medical Association strongly supported H.R. 5540).

Hearings on 5110 at 191 (“When doctors identify another doctor as failing to meet professional standards, the all-too-common solution has been to say, ‘Quit practicing here and we won't tell anyone’.”) (Statement of Rep. Waxman); id. at 216 (Hospitals...often force impaired physicians to resign to avoid adverse publicity and fail to report those inadequacies known to them.”) (Statement of Wayne W. Alberts, M.D., Medical Director, Kaiser Foundation Health Plan of the Mid-Atlantic States); 132 Cong. Rec. H9957 (daily ed. Oct. 14, 1986) (“This bill focuses on those instances in which physicians injure patients through incompetent or unprofessional service, are identified as incompetent or unprofessional by their peers but are dealt with in a way that allows them to continue to injure patients. The reporting system in this legislation would virtually end the ability of incompetent doctors to skip from one jurisdiction to another without detection.”) (Statements of Representative Waxman).
89 See Hearings on H.R. 5540 at 83 (“I submit to the committee that somebody is running scared from a phantom problem. So far as I can determine from the legislative history, the real concern has been with antitrust litigation. Yet, in fact, the antitrust theory is pretty much a bust for doctors seeking retribution for wrongfully deprived privileges”) (statements of Victor Glasberg, Esquire).
90 Wayne W. Alberts, M.D., Medical Director, Kaiser Foundation Health Plan of the Mid-Atlantic States, acknowledged in response to questions by Rep. Taube that he had never been sued for providing references that mentioned quality of care issues, but claimed to know of “successful suits filed against less than exemplary references” and of “several suits in the Washington area at this time that are in progress because of references written about physicians”. Hearings on H.R. 5510 at 225. However, Dr. Alberts did not cite any specific case. Under the bylaws of most hospitals, physicians are not free to refuse committee assignments, and hospitals must have infection control, quality assurance and utilization review programs to receive accreditation by the Joint Commission on the Accreditation of Health Care Organizations (“JCAHO”). See e.g., The 1991 Joint Commission Accreditation Manual for Hospitals at 69-73, 215-21, 281-83.
91 A few plaintiffs have prevailed since HCQIA was enacted. See e.g., Brown v. Presbyterian Health Care Services, 101 F.3d 1324 (10th Cir. 1996). Some other plaintiffs defeated motions for summary judgment on antitrust claims after HCQIA became law, but these were short-lived victories that were reversed by the trial court itself or on appeal, based on antitrust principles, not HCQIA immunity. See Miller v. Indiana Hosp., 843 F.2d 139 (3rd Cir. 1988) (reversing a grant of summary judgment although four years later the court affirmed a grant of a renewed motion for summary judgment, see Miller, 975 F.2d 1550 (1992)); Nanavati v. Burdette Tomlin Memorial Hosp., 857 F.2d 96 (1988) (affirming grant of defendant’s motion j.n.o.v. reversing jury verdict for the plaintiff); accord Scott, supra note 38 at 352 (stating that “[n]o court, commentator or enforcement agency has ever suggested that in such a case [where the requirements of 42 U.S.C. § 11112(a) were met], peer review participants potentially face antitrust liability”); Boczar v. Manatee Hosps. & HealthSys. Inc., 993 F.2d 1514 (11th Cir. 1993) (reversing trial court's grant of motion j.n.o.v. reversing jury verdict for plaintiff).
92 Susan O. Scheutzow, State Medical Peer Review: High Cost But No Benefit - Is It Time for a Change? 25 Am. J. L. and Med. 7, 8 (1999); accord Horner, supra note 1 at 461 n.27 (stating that 44 states had passed statutes immunizing hospital boards from liability arising out of peer review actions by the time HCQIA was enacted). See also 132 Cong. Rec. H9961 (daily ed. October 14, 1986) (“It is very difficult, under existing state and federal law, to challenge fairly administered review actions...Therefore, peer review participants' fear of damage claims is unfounded.”) (Statements of Rep. Edwards); 132 Cong. Rec. H 11590 (daily ed. Oct. 17, 1986) (“Simply stated, State shield laws provide protection only for State - not Federal - causes of action. In fact, it is the very comprehensiveness of State shield laws that has led to so much federal litigation”) (Statements of Rep. Waxman). Accord Hearings on H.R. 5510 at 275 (“Early law suits against hospitals tended to assert constitutional bases for relied, e.g. property and liberty interests in the right to practice a profession...As these causes of action thus ceased to be effective, plaintiffs have pursued other bases for litigation, including federal and state antitrust statutes, as well as state common law of defamation”) (prepared statements of Mr. Owen).
93 See e.g., Wash. Rev. Code § 4.24.250 (2010) (stating that “Good faith presumed but subject to rebuttal by clear cogent and convincing evidence that information was knowingly false or deliberately misleading.”).
94 Hearings on H.R. 5540 at 47 (“I want to make it clear, however, that we fully agree that we cannot tolerate abuses of the peer review system, and that H.R. 5540 was never intended to protect such abuses...To reiterate: nothing in H. R. 5540, as currently drafted, would protect the type of abuses that I have referred to.”).
96 See 132 Cong. Rec. H9958-H9959 (daily ed. Oct. 14, 1986) (comments to “Amendment No. 7”). The presumption of immunity was originally applied only to the first standard, § 11112(a)(1), but extended to all four standards to avoid the inference that these were affirmative defenses that defendants had to prove rather than part of the plaintiff’s burden of proof. Id.