

2021

State Peer Review Laws as a Tool To Incentivize Reporting to Medical Boards

Nadia N. Sawicki

Loyola University Chicago School of Law, nsawicki@luc.edu

Follow this and additional works at: <https://scholarship.law.slu.edu/jhlp>



Part of the [Health Law and Policy Commons](#)

Recommended Citation

Nadia N. Sawicki, *State Peer Review Laws as a Tool To Incentivize Reporting to Medical Boards*, 15 St. Louis U. J. Health L. & Pol'y (2021).

Available at: <https://scholarship.law.slu.edu/jhlp/vol15/iss1/6>

This Symposium Article is brought to you for free and open access by Scholarship Commons. It has been accepted for inclusion in Saint Louis University Journal of Health Law & Policy by an authorized editor of Scholarship Commons. For more information, please contact [Susie Lee](#).

**STATE PEER REVIEW LAWS AS A TOOL TO INCENTIVIZE
REPORTING TO MEDICAL BOARDS**

NADIA N. SAWICKI*

ABSTRACT

State medical boards have been stymied in their ability to take disciplinary action against physicians who engage in serious misconduct, in part because hospitals and other health care organizations rarely report such misconduct. This Article offers a proposal for incentivizing hospital reporting of physician misconduct, inspired by an existing but flawed model in the federal Health Care Quality Improvement Act. This Article proposes that state legislatures link state medical practice act reporting requirements with state laws establishing an evidentiary privilege for peer review activities.

* Georgia Reithal Professor of Law, Co-Director of the Beazley Institute for Health Law and Policy, Loyola University Chicago School of Law. Thanks to Elizabeth Pendo and the Saint Louis University Journal of Health Law & Policy for offering me the opportunity to contribute to this symposium, as well as all the symposium speakers for their insightful remarks. Many thanks to Loyola Law student Josh Wiedner for his valuable research assistance, and for the generous support of the Loyola University Chicago School of Law Summer Research Grant Program.

I. INTRODUCTION

State medical boards (SMBs) have a responsibility to ensure that licensed physicians do not endanger patients and take corrective action when patients are harmed as a result of physician misconduct. SMBs, however, are stymied in their ability to do this, in large part because they lack the information necessary to identify dangerous physicians. SMBs have limited resources to investigate allegations of misconduct and rely largely on hospital reports and patient complaints to identify situations where disciplinary action may need to be taken.

Despite state laws requiring hospitals and other health care organizations to report physician misconduct to SMBs, underreporting is very common. Participants in this symposium have addressed the reasons why hospitals fail to share this information with SMBs and have suggested proposals for incentivizing hospital reporting, including increasing financial penalties for non-compliance with reporting laws.

This Article offers another proposal for incentivizing hospitals to report physician misconduct to SMBs. It is inspired by an existing model in the federal Health Care Quality Improvement Act of 1986 (HCQIA) that, unfortunately, has failed to achieve the goal of increasing hospital reporting. This Article suggests that states could remedy the flaws of the federal model by linking state medical practice act reporting requirements with laws establishing an evidentiary privilege for peer review activities.

II. HOSPITALS' FAILURE TO REPORT PHYSICIAN MISCONDUCT

Hospitals are subject to both state and federal laws that require reporting of serious physician misconduct. Hospitals, however, frequently fail to comply with these reporting requirements, which stymies both public and private actors' ability to protect patients from harm. The reasons for non-reporting range from the cultural to the practical, but one consistent theme is that hospitals lack meaningful incentives to report and are rarely (if ever) penalized for non-reporting. Furthermore, neither state nor federal actors have sufficient resources to investigate hospital compliance with reporting requirements. As a result, physicians who engage in serious misconduct can continue to practice, and potentially continue to harm patients, with limited consequences or oversight.

A. *State and Federal Reporting Requirements*

At the state level, nearly every state's medical practice act imposes reporting requirements on hospitals to help medical boards identify and respond to issues of physician misconduct and patient safety.¹ According to the Federation of

1. Elizabeth Pendo et al., *Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 7, 28 (2022) ("Nearly all states require hospitals and other health care organizations within the state to report possible

State Medical Boards (FSMB),² most states have established reporting requirements similar to those set forth in the FSMB's *Essentials of a State Medical and Osteopathic Practice Act*.³ The model language drafted by the FSMB requires "hospitals and other health care organizations" to promptly report "any possible violation of the [state medical practice] act or of the Board's rules and regulations by a licensee," including "any information that indicates a licensee is or may be dyscompetent, guilty of unprofessional conduct, or mentally or physically unable to engage safely in the practice of medicine; and any restriction, limitation, loss or denial of a licensee's [sic] staff privileges or membership that involves patient care."⁴ It also requires reporting of a licensee's voluntary resignation or limitation of staff privileges "while the licensee is under formal or informal investigation . . . for any reason related to possible medical incompetence, unprofessional conduct, or mental, physical, alcohol or drug impairment."⁵ That said, reporting requirements vary by state, and Pendo et al. recommend that state statutes more clearly identify what information hospitals are required to report.⁶

In addition to the reporting requirements in state medical practice acts, hospitals also have a duty under federal law to report adverse actions taken against physicians who are on their medical staff. The HCQIA requires "health care entities"⁷ to report information relating to certain investigations and actions taken against physicians.⁸ Specifically, they must report any "professional review action that adversely affects the clinical privileges of a physician for a

violation(s) of the state medical practice act or SMB rules and regulations by a licensed physician." In 2016, the Federation of State Medical Boards House of Delegates adopted a policy urging hospitals and others to "be proactive in reporting instances of unprofessional behavior to medical boards whenever it is suspected." FED'N OF STATE MED. BDS., U.S. MEDICAL REGULATORY TRENDS AND ACTIONS 8 (2018), <https://www.fsmb.org/siteassets/advocacy/publications/us-medical-regulatory-trends-actions.pdf>.

2. FED'N OF STATE MED. BDS., POSITION STATEMENT ON DUTY TO REPORT 1–2 (2016), <https://www.fsmb.org/siteassets/advocacy/policies/position-statement-on-duty-to-report.pdf>.

3. FED'N OF STATE MED. BDS., ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT 3 (2015), <https://www.fsmb.org/siteassets/advocacy/policies/essentials-of-a-state-medical-and-osteopathic-practice-act.pdf>.

4. *Id.* at 26–27. The model act also requires medical malpractice insurance carriers and others to report malpractice judgments, settlements, and awards made on behalf of the licensee. *Id.* at 27.

5. *Id.* at 27.

6. Pendo et al., *supra* note 1, at 29.

7. 42 U.S.C. § 11151(4)(A) (defining health care entities).

8. 42 U.S.C. § 11133(a). HCQIA also requires state medical boards to report the information hospitals report to them, as well as any "known instances of a health care entity's failure to report." 42 U.S.C. § 11133(b). Further information about this reporting requirement can be found in the enacting regulations, 45 C.F.R. § 60.12 (2013); *see also NPDB Guidebook, Chapter E: Reports, Reporting Adverse Clinical Privileges Actions*, NAT'L PRAC. DATA BANK, <https://www.npdb.hrsa.gov/guidebook/EclinicalPrivileges.jsp> (last updated Oct. 2018) (describing the reporting obligations of hospitals and other health care entities with formal peer review processes).

period longer than 30 days,”⁹ as well as instances where a physician has surrendered clinical privileges in connection with a pending or proposed investigation of “possible incompetence or improper professional conduct.”¹⁰

The HCQIA requires reporting of such adverse actions to the National Practitioner Data Bank (NPDB), which was established by Department of Health and Human Services (HHS) regulations in 1989.¹¹ The HCQIA authorized the establishment of the NPDB as a repository of information about physicians, particularly information that might speak to their professional competence (such as data about malpractice payments and adverse actions by health care institutions and medical boards) that would help SMBs and hospitals determine whether to license a physician or grant clinical privileges.¹² The HCQIA does not, however, require hospitals to report adverse actions directly to SMBs.¹³

B. Evidence of Failure to Report

Pendo et al. explain that there is ample evidence demonstrating that hospitals rarely satisfy their reporting requirements under state law.¹⁴ The FSMB has also “heard complaints from its member boards that hospitals and health organizations regularly ignore reporting requirements, find ways to circumvent them, or provide reports that are too brief and general to equip the board with

9. 42 U.S.C.A. § 11133(a)(1)(A).

10. 42 U.S.C.A. § 11133(a)(1)(B).

11. *NPBD History*, NAT’L PRAC. DATA BANK, <https://www.npdb.hrsa.gov/topNavigation/timeline.jsp> (last visited Sept. 25, 2021).

12. For discussion of the history of the National Practitioner Data Bank, see Katharine A. Van Tassel, *Blacklisted: The Constitutionality of the Federal System for Publishing Reports of “Bad” Doctors in the National Practitioner Data Bank*, 33 CARDOZO L. REV. 2031, 2051 (2012) (discussing HCQIA’s mandatory reporting requirements in terms of their connection to the NPDB); Kristin M. Madison, *From HCQIA to the ACA: The Evolution of Reporting as a Quality Improvement Tool*, 33 J. LEGAL MED. 63, 63–65 (2012) (discussing the development of the NPDB following the passage of the HCQIA).

13. Because the text of the HCQIA was drafted before the creation of the NPDB, the statute itself requires that reporting entities report information to “the Board of Medical Examiners, in accordance with section 11134(a) of this title” 42 U.S.C. § 11133(a)(1). In turn, Section 11134(a) distinguishes between the reporting requirements by different reporting entities. Reporting directly to state medical boards is required only for malpractice insurance companies and other payors (which must report malpractice payments made on behalf of physicians), and medical boards themselves (which must report information they have received from hospitals, as well as known instances of a hospital’s failure to report). 42 U.S.C. § 11134(c). However, adverse actions by health care entities and state medical boards must only be reported to “the Secretary, or, in the Secretary’s discretion, to an appropriate private or public agency which has made suitable arrangements with the Secretary,” which today is the NPDB. 42 U.S.C. § 11134(b).

14. Pendo et al., *supra* note 1 (“Despite mandatory reporting laws, failure to detect and report physician wrongdoing on the part of hospitals and other health care entities is a longstanding problem.”); see also RUTH HOROWITZ, IN THE PUBLIC INTEREST: MEDICAL LICENSING AND THE DISCIPLINARY PROCESS 84 (Rima D. Apple & Janet Golden eds., 2012) (discussing a 1996 Citizen Advocacy Center conference on hospital nonreporting to state medical boards).

relevant information for carrying out its regulatory functions.”¹⁵ A widely-cited 2011 report by Public Citizen that compared the number of NPDB adverse action reports to the number of state board actions taken against physicians similarly concluded that “hospitals may not be sending such reports to all of the appropriate state licensure board(s) where the doctor is known to be licensed.”¹⁶

At the federal level, there is also evidence of significant non-compliance with the HCQIA’s reporting requirements. One study found that between 1991 and 1995, only 34.2% of hospitals had reported any adverse actions to the NPDB and that the number of actions reported was decreasing over time.¹⁷ A 1995 Office of Inspector General report found that seventy-five percent of all hospitals failed to make a single NPDB report during a similar period.¹⁸ As of 1999, the NPDB found that sixty percent of hospitals had never made an adverse action report.¹⁹ Even the Department of Veterans Affairs (VA) medical facilities, which are presumably well versed in federal reporting requirements, fail to meet them. A 2017 Government Accountability Office study of five VA medical facilities found that eight out of nine health care providers who had

15. POSITION STATEMENT ON DUTY TO REPORT, *supra* note 2, at 2. According to the FSMB, “there is evidence that demonstrates that reporting [to state medical boards] often does not occur,” despite the reporting requirements in state medical practice acts. *Id.* “Boards have reported having to resort to subpoenaing hospital medical directors, threatening disciplinary action to obtain information, and resorting to civil sanctions. In some instances, failures to report by physicians and hospitals have resulted in additional avoidable adverse events to patients.” *Id.* at 2.

16. ALAN LEVINE ET AL., STATE MEDICAL BOARDS FAIL TO DISCIPLINE DOCTORS WITH HOSPITAL ACTIONS AGAINST THEM 1, 1, 3 (PUB. CITIZEN, 2011), <https://www.citizen.org/article/state-medical-boards-fail-to-discipline-doctors-with-hospital-actions-against-them> (finding “that of a total of 10,672 physicians in the data bank with one or more clinical privilege actions . . . 45% also had one or more state licensing actions[, but] 5,887, or 55% . . . — more than half — had no state licensing actions.”); *see also* Howard S. Wolfson & Edward P. Gilbert, *Statutory Immunity for Reports Filed with the National Practitioner Data Bank - What Is “Accurate” Reporting for Purposes of Immunity?*, 18 HEALTH LAW., Aug. 2006, at 24, 24 (noting that “54% to 60% of hospitals . . . have never reported a single adverse action taken against physicians to the NPDB”); JUNE GIBBS BROWN, OFF. OF INSPECTOR GEN., OEI-12-99-00250, LEGISLATIVE RECOMMENDATION TO IMPROVE HOSPITAL REPORTING TO THE NATIONAL PRACTITIONER DATA BANK 3 (1999) (citing a HRSA-funded study by the University of Washington Medical School raising the concern that “hospitals are not fully reporting adverse peer review actions to appropriate governmental agencies and stronger laws are needed. . .”).

17. Laura-Mae Baldwin et al., *Hospital Peer Review and the National Practitioner Data Bank, Clinical Privileges Action Reports*, 281 JAMA 349, 351 (1999) (finding, however, that the severity of adverse actions taken increased during this time period).

18. DEP’T OF HEALTH & HUM. SERV., OFF. OF INSPECTOR GEN., OEI-01-94-0005, HOSPITAL REPORTING TO THE NATIONAL PRACTITIONER DATA BANK (1995).

19. U.S. GOV’T ACCOUNTABILITY OFF., GAO-01-130, NATIONAL PRACTITIONER DATA BANK: MAJOR IMPROVEMENTS ARE NEEDED TO ENHANCE DATA BANK’S RELIABILITY (2000); *see also* Baldwin et al., *supra* note 17 (finding that between 1991 and 1995, only 34.2% of hospitals reported one or more clinical privileges actions to the NPDB).

adverse action taken against them were never reported, either to the NPDB or the SMB.²⁰

As a result of these reporting failures, SMBs, federal agencies, and health care facilities lack important information about physicians whose behavior poses a risk to patient safety.²¹ When hospitals fail to report allegations of physician misconduct to SMBs, SMBs have no opportunity to investigate and, if appropriate, take corrective action. When hospitals fail to report adverse clinical privileges actions to the federal NPDB, other hospitals and SMBs are deprived of important information that affects their decision about whether to credential or license a physician.

C. *Reasons and Recommendations*

There are various reasons as to why hospitals fail to report physician misconduct to SMBs (as required by state law) and to the NPDB (as required by the HCQIA).²² Prominent among these are well-documented cultural factors within the medical profession that hinder reporting of colleagues' misconduct.²³ Moreover, health care institutions may face significant financial and reputational risks when they report physician misconduct.²⁴

With respect to NPDB reporting in particular, hospitals' reluctance to report may be grounded in the threat of legal challenge by a physician hoping to avoid the negative professional consequences associated with having an NPDB report on the physician's record.²⁵ There is also evidence to suggest that when

20. U.S. GOV'T ACCOUNTABILITY OFF., GAO-18-260T, VA HEALTH CARE: IMPROVED OVERSIGHT NEEDED FOR REVIEWING AND REPORTING PROVIDERS FOR QUALITY AND SAFETY CONCERNS (2017).

21. Pendo et al., *supra* note 1 (noting that "failures to report have resulted in avoidable harms to patients") (citing POSITION STATEMENT ON DUTY TO REPORT, *supra* note 2).

22. Elizabeth Chiarello, *Barriers to Medical Board Discipline: Cultural and Organizational Constraints*, 15 ST. LOUIS U. J. HEALTH L. & POL'Y 55, 78 (2022).

23. *Id.*; see also E. Haavi Morreim, *Am I My Brother's Warden? Responding to the Unethical or Incompetent Colleague*, HASTINGS CTR. REP., May–June 1993, at 19, 20, 22–23, <https://www.jstor.org/stable/pdf/3563363.pdf> (describing various cultural reasons why physicians are reluctant to "police their own"); Eric G. Campbell et al., *Professionalism in Medicine: Results of a National Survey of Physicians*, 147 ANNALS INTERNAL MED. 795, 795 (2007) (in a survey of over 3500 practicing U.S. physicians, finding that "although 96% of respondents agreed that physicians should report impaired or incompetent colleagues to relevant authorities, 45% of respondents who encountered such colleagues had not reported them"); BROWN, *supra* note 16, at 2–3 (citing a 1997 HRSA-funded study by the Citizen Advocacy Center which found "indications of non-compliance with State mandatory reporting laws," and identified "a cultural aversion to reporting a colleague ('snitching')" as one of four likely reasons for non-compliance).

24. Pendo et al., *supra* note 1, at 28–29.

25. OEI-01-94-0005, *supra* note 18, at 5 (noting that the "higher stakes associated with Data Bank reporting" may lead to more physician challenging adverse action taken against them, the anticipated defense of which may make hospitals "less inclined to take any action at all"); Wolfson & Gilbert, *supra* note 16 (concluding that low levels of reporting to NPDB "can be traced, among

physician misconduct occurs, hospitals may choose to impose minor penalties that fall below the threshold for NPDB reporting.²⁶ Sometimes, this occurs as a result of negotiations between the physician and hospital, whereby “practitioners . . . offer[] concessions to avoid having a reportable action taken against them.”²⁷ In some cases, when physicians sue hospitals for taking adverse action against them, the parties may negotiate a settlement whereby the hospital agrees to not report the action to the NPDB or agrees to specified language to be used in the report.²⁸

However, one of the most prominent explanations for widespread non-compliance with reporting requirements is that the reporting laws themselves are flawed, lack appropriate incentives and disincentives, and are rarely enforced.²⁹

other things, to the retaliatory lawsuits filed by physicians who are reported to the NPDB,” and noting that “health care entities often choose to ignore the [reporting] mandate of the HCQIA in an effort to avoid the possibility of costly litigation”).

26. Baldwin et al., *supra* note 17, at 352 (e.g., “monitoring professional activities or requiring continuing medical education without restricting privileges and imposing privileges actions of <31 days”); OEI-01-94-0005, *supra* note 18, at 5; William E. Neighbor et al., *Rural Hospitals’ Experience with the National Practitioner Data Bank*, 87 AM. J. PUB. HEALTH 663, 665 (1997); BROWN, *supra* note 16, at 2.

27. Baldwin et al., *supra* note 17, at 352 (“A . . . survey of 807 hospitals and 76 health maintenance organizations found that in the prior 2 years 9.4% of hospitals and 13.1% of health maintenance organizations reported that practitioners had offered concessions to avoid having a reportable action taken against them”), citing U.S. Department of Health and Human Services, *National Practitioner Data Bank: User Satisfaction with Reporting and Querying and Usefulness of Disclosure Information for Decision Making 1992-1994*. Rockville, Md.: Health Res. & Servs. Admin., U.S. Dep’t of Health & Hum. Servs. (1995).

28. Shirley P. Morrigan, National Practitioner Data Bank: Practical Issues—NPDB Language, 2007 Health L. Handbook § 5:14 (updated May 2013). *See, e.g.*, *Hoffman v. Spring Valley Hosp. & Med. Ctr.*, No. 52813, 2010 WL 3341802, at *1 (Nev. 2010) (discussing settlement agreement between hospital and physician that specified agreed-upon language for reporting to NPDB); *Rosenberg v. Advoc. Health & Hosps. Corp.*, No. 2-12-0903, 2013 WL 160376, at *9 (Ill. App. Ct. Jan. 8, 2013) (discussing settlement agreement between hospital and physician in which hospital agreed not to report the revocation of doctor’s lab privileges to the NPDB); *Lai v. Gottlieb Mem’l Hosp.*, No. 1-14-2319, 2015 Ill. App. LEXIS 1107, at *6 (Ill. App. Ct. May 22, 2015) (discussing agreement that in return for the dismissal of plaintiff’s lawsuit without prejudice, Defendant also agreed not to make any report to the NPDB until the parties settled or the court made a decision on plaintiff’s request for injunctive relief). That said, according to one commentator, “NPDB authorities have stated that any provision in a settlement that purports to prohibit reporting to the NPDB or in any way purports to prevent a reporter from filing a complete and legally sufficient narrative description of the allegations or other circumstances of the cases is invalid under federal law.” Morrigan, *supra*. Moreover, even when such settlement agreements are in place, courts cannot order hospitals to violate their HCQIA reporting requirements. *See, e.g.*, *Hoffman*, 2010 WL 3341802, at *3; *Diaz v. Provena Hosps.*, 817 N.E.2d 206, 213 (Ill. App. 2d Dist. 2004); *Ex parte Ala. State Bd. of Pharm.*, 253 So. 3d 972, 982 (Ala. Civ. App. 2017).

29. A 1997 HRSA-funded study by the Citizen Advocacy Center found “indications of non-compliance with State mandatory reporting laws” and identified several possible reasons. These included “(1) a cultural aversion to reporting a colleague (‘snitching’); (2) deficiencies in reporting

As Pendo et al. have found, state laws vary significantly in terms of who is required to report, what information must be reported, and the evidentiary threshold for reporting.³⁰ Moreover, many reporting laws are vague or difficult to interpret, making it difficult for hospitals to identify what types of conduct they must report to SMBs.³¹ There are also limited consequences for non-reporting. Pendo et al. found that only twenty-four states impose financial penalties against hospitals for failure to report physician misconduct.³² Enforcement of these reporting requirements is lax because SMBs do not have the resources to investigate hospital non-compliance with reporting requirements,³³ and when they discover physician misconduct that has gone unreported, they understandably prioritize investigation of the physician rather than the non-reporting institution.

Accordingly, one common proposal for improving the frequency of hospital reporting is to impose greater financial penalties for non-compliance.³⁴ Others have recommended linking compliance with reporting requirements to institutional accreditation and certification, such as through Centers for

laws; (3) lax enforcement; and (4) lack of knowledge on the part of hospitals about their duty to report.” BROWN, *supra* note 16, at 2–3.

30. Pendo et al., *supra* note 1, at 29–30.

31. For example, many state medical practice acts requires reporting of “unprofessional conduct.” Nadia N. Sawicki, *Character, Competence, and the Principles of Medical Discipline*, 13 J. HEALTHCARE L. & POL’Y 285, 293 (2010) (noting that “most states authorize discipline under a broad category of ‘unprofessional conduct,’ which may include violations of codes of medical ethics, conduct that brings the medical profession into disrepute, or other unspecified forms of ‘dishonorable conduct,’ including criminal acts (typically felonies or ‘crimes of moral turpitude’)”).

32. Pendo et al., *supra* note 1, at 27, 42–44; *see also* Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 9 (1999) (finding that the number of adverse actions reporting to the NPDB were higher in states that had strong financial penalties for failure to report); BROWN, *supra* note 16 (citing a HRSA-funded study which found that “hospitals in States with strong penalties were 40 percent more likely to have reported an adverse action . . . than hospitals in States with no penalties,” and recommending “that HRSA propose legislation that would establish a civil money penalty of up to \$10,000 for each instance of a hospital’s failure to report to the Data Bank,” which is “consistent with the current civil money penalty sanction that can be imposed for failure to report a malpractice settlement or judgement [sic].”).

33. DEP’T. HEALTH & HUM. SERVS., OFF. OF INSPECTOR GEN., OEI-01-93-00020, FEDERAL INITIATIVES TO IMPROVE STATE MEDICAL BOARDS (1993) (“Their capacity to be effective is often hampered by lack of resources. Funding for boards is not always a high priority for State legislatures. While boards often raise substantial amounts of money through licensure and registration fees, in many States large proportions of these funds go into general revenues rather than the boards’ own budgets. Budget crises in many States in recent years have not helped this situation. Because of this and other limitations, boards have not been at the forefront of quality assurance efforts.”).

34. *See, e.g.*, Pendo et al., *supra* note 1, at 29. ESSENTIALS OF A STATE MEDICAL AND OSTEOPATHIC PRACTICE ACT, *supra* note 3, at 28 (noting that any failure could include higher penalties for intent, e.g., “willful failure”); BROWN, *supra* note 16.

Medicare and Medicaid Services (CMS) Conditions of Participation, the Joint Commission, or state licensing.³⁵

III. THE HCQIA MODEL FOR INCENTIVIZING REPORTING

Federal law offers a helpful model for thinking about how states might more effectively incentivize hospital reporting of serious physician misconduct. The HCQIA, described in Section II-A, imposes NPDB reporting requirements on hospitals, and it conditions an important protection—protection from liability in damages for peer review activities—on compliance with reporting requirements.³⁶ While this incentive has not been as effective as originally anticipated, better understanding the merits and flaws of the HCQIA approach can offer guidance for improving state-level reporting.

The HCQIA was passed in 1986 in an effort to manage the problem of incompetent physicians who move between states or between hospitals.³⁷ Congress found that this problem could be addressed through strengthened professional peer review, as well as reporting of problematic physicians to a national database, so SMBs and hospitals could learn about prior disciplinary actions before granting physicians a right to practice.³⁸ In order to facilitate and incentivize professional peer review and reporting, however, Congress needed to eliminate the threat of liability for participation in peer review.³⁹ Most often, the threat of liability arises when a peer review committee takes adverse action against a physician, and the physician then alleges violations of employment law, antitrust law, tort law, or anti-discrimination law.⁴⁰

The HCQIA establishes that professional review bodies and participants that take adverse professional review action against a physician “shall not be liable in damages under any law of the United States or of any State . . . with respect

35. Pendo et al., *supra* note 1, at 31; OEI-01-94-0005, *supra* note 18, at 7–8; *see also* Baldwin et al., *supra* note 17, at 351 (finding that hospitals accredited by JCAHO were more likely to report adverse actions than nonaccredited hospitals).

36. *See supra* Section II.A.

37. 42 U.S.C. § 11101(2).

38. 42 U.S.C. § 11101(3); *see also* Madison, *supra* note 12, at 66–68 (describing policymakers’ commentary and concerns leading to the passage of the HCQIA).

39. 42 U.S.C. § 11101(4).

40. *Id.* (“The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.”); *see also* Scheutzow, *supra* note 32, at 17 (noting “there is widespread belief among physicians and policy-makers that those who testify against colleagues in a peer review setting may find themselves under attack for defamation and other actions, and that absent such laws, physicians will be reluctant to sit on peer review committees.”); Charles R. Koepke, *Physician Peer Review Immunity: Time to Euthanize a Fatally Flawed Policy*, 22 J.L. & HEALTH 1, 5 (2009) (“One of the largest deterrents to effective peer review at that time [the HCQIA was passed] was the perceived threat looming over physicians and hospital administrators that they may be sued by a doctor that they were planning to discipline.”).

to the action.”⁴¹ A peer review action is presumptively immune from liability if it satisfies the four requirements set forth in the HCQIA.⁴² In effect, this provision immunizes hospitals and peer reviewers from liability under both state and federal law if they engage in a legitimate peer review action.⁴³

There is, however, another condition hospitals need to satisfy in order to benefit from HCQIA immunity—the HCQIA expressly ties hospitals’ compliance with NPDB reporting requirements to the peer review immunity privilege. Indeed, the legislative history of the HCQIA suggests that the penalty of loss of immunity was established precisely to incentivize compliance with reporting requirements.⁴⁴ Perhaps surprisingly, loss of peer review immunity is the only penalty associated with non-compliance with reporting requirements.⁴⁵ This little-known provision of the HCQIA provides that a “health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 11111(a)(1) of this title.”⁴⁶ That said, the loss of peer

41. Health Care Quality Improvement Act, 42 U.S.C. § 11111(a)(1).

42. 42 U.S.C. § 11112(a) (to qualify for immunity, “a professional [peer] 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).”).

43. Michael D. Benson et al., *Hospital Quality Improvement: Are Peer Review Immunity, Privilege, and Confidentiality in the Public Interest*, 11 NW. J.L. & SOC. POL’Y 1, 4 (2016) (noting that “HCQIA immunity applies to damages claims arising under state law as well as federal law,” but that “it does not apply to civil rights claims” or “claims for injunctive relief”).

44. *See* Goldsmith v. Harding Hosp., Inc., 762 F. Supp. 187, 189 (S.D. Ohio. 1991) (“The legislative history reveals that the purpose of §§ 11111 and 11112 is to foster compliance with the reporting requirements by alleviating the threat of litigation through a grant of immunity.”); *Anderson v. E. Conn. Health Network, Inc.*, No. 3:12–CV–00785 (RNC), 2015 WL 4393552, *8 (D. Conn. 2015), *aff’d sub nom. Anderson v. E. CT Health Network, Inc.*, 668 F. App’x 378 (2d Cir. 2016) (“Congress thought reporting so important to the HCQIA that it immunized health care entities against suits arising out of reports made in good faith, 42 U.S.C. § 11137(c), offered a more limited form of immunity for professional review bodies and their members in suits arising out of professional review actions, 42 U.S.C. § 11111(a)(1), and authorized sanctions against health care entities that fail to observe their reporting obligations, 42 U.S.C. § 11133(c)(1).”). *Manion v. Evans*, No. 3:89CV7436, 1991 WL 575715, at *12–13 (N.D. Ohio. 1991) (citing the House Committee’s discussion of the HCQIA, H.R.Rep. No. 903, 99th Cong., and noting that “Congress was absolutely clear in expressing its intention that health care entities which fail to report physicians whom they feel are incompetent do not get the protection provided in § 11112 of the HCQIA.”).

45. Although civil monetary penalties for hospital non-compliance with adverse action reporting requirements have been proposed, they have never been adopted. *See* Letter from Sidney M. Wolfe & Joan Stleber, Pub. Citizen’s Health Rsch. Grp., to June Gibbs Brown, Inspector Gen., Dep’t of Health & Hum. Servs. (Jan. 9, 1995) (recommending that HRSA initiate a legislative proposal for a civil money penalty of up to \$10,000 for each instance of a hospital’s failure to report an adverse action to the NPDB).

46. 42 U.S.C. § 11133(c)(1).

review immunity for failure to report is not automatic. Rather, the HCQIA and its enacting regulations establish that this sanction will only occur if the hospital's noncompliance with the reporting requirement is investigated and confirmed by the Secretary of HHS, and the Secretary publishes the hospital's name in the Federal Register.⁴⁷

Because losing HCQIA immunity protections is quite significant, one might imagine that hospitals would be diligent about reporting adverse actions to avoid this penalty. However, as noted in Section II-B, there is ample evidence that hospitals underreport adverse actions to both the NPDB and SMBs.⁴⁸ Despite that fact, researchers have found that no hospital has ever lost its HCQIA immunity for failure to report to the NPDB.⁴⁹ Most recently, a 2009 Public Citizen report on hospital oversight and reporting of physicians found that “[a]lthough [the Health Resources and Services Administration (HRSA)] has investigated a small number of cases of non-compliance, as of November 2008, 18 years after the NPDB began, no hospital has ever been penalized through the loss of peer review immunity.”⁵⁰

47. *Id.* (“A health care entity that fails substantially to meet the requirement of subsection (a)(1) shall lose the protections of section 11111(a)(1) of this title if the Secretary publishes the name of the entity under section 11111(b) of this title.”). Health Care Quality Improvement Act, 42 U.S.C. § 11111(b) (“If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the entity in the Federal Register.”). 45 C.F.R. § 60.12(c)(1) (2013) (“If the Secretary has reason to believe that a health care entity has substantially failed to report information in accordance with this section, the Secretary will conduct an investigation. If the investigation shows that the health care entity has not complied with this section, the Secretary will provide the entity with a written notice describing the noncompliance, giving the health care entity an opportunity to correct the noncompliance, and stating that the entity may request, within 30 days after receipt of such notice, a hearing with respect to the noncompliance. . . . If a hearing is denied, or, if as a result of the hearing the entity is found to be in noncompliance, the Secretary will publish the name of the health care entity in the Federal Register. In such case, the immunity protections provided under section 411(a) of HCQIA will not apply to the health care entity for professional review activities that occur during the 3-year period beginning 30 days after the date of publication of the entity’s name in the Federal Register.”).

48. *See supra* Section II.B.

49. Scheutzow, *supra* note 32, at 37 (“[N]o hospital has ever lost its HCQIA immunity because it failed to report information to the NPDB,” citing a 1998 “conversation with Robert Oshel, Ph.D., Associate Director for Research and Disputes of the Division of Quality Assurance, Health Resources and Services Administration, U.S. Department of Health and Human Services”); ALAN LEVINE & SIDNEY WOLFE, HOSPITALS DROP THE BALL ON PHYSICIAN OVERSIGHT: FAILURE OF HOSPITALS TO DISCIPLINE AND REPORT DOCTORS ENDANGERS PATIENTS 8 (Pub. Citizen eds., 2009), <https://www.citizen.org/wp-content/uploads/migration/18731.pdf>.

50. LEVINE & WOLFE, *supra* note 49.

One reason for this may be because HRSA has limited resources to monitor compliance with HCQIA reporting requirements. Hospitals are required to attest to their compliance with NPDB reporting requirements every two years when they renew their NPDB registration.⁵¹ But while HRSA tracks SMBs' compliance with reporting requirements and publishes its findings, it does not do so for hospitals.⁵² Even in cases where HRSA does investigate a hospital for non-compliance, hospitals have an opportunity to correct any errors and avoid penalties.⁵³ It appears, then, that the Secretary of HHS has never been in a position to publish the name of a non-compliant hospital in the Federal Register, which would explain why the penalty of loss of peer review immunity has never occurred. Indeed, in several cases where physician-plaintiffs argued that defendant-hospitals should lose their HCQIA immunity on the grounds of their failure to make a required report, courts have rejected those arguments by pointing to the fact that the defendant had not been identified as non-compliant in the Federal Register.⁵⁴

Even if HRSA were more active in investigating non-compliance with reporting requirements, such that the Secretary would have grounds to publicly identify non-compliant hospitals, the implications of that are far from clear. There are two elements of the HCQIA's immunity provisions that courts have interpreted in ways that are arguably inconsistent with the statutory text. This leaves two important open questions about when and how a hospital's failure to report might result in loss of peer review immunity.

The first point of uncertainty is what it means for a hospital to "fail[] substantially to meet the requirement of subsection (a)(1)[.]"⁵⁵ The HCQIA and its enacting regulations do not specify what is required for a hospital to be found "substantially" non-compliant with reporting requirements. As a definitional matter, however, the use of the term "substantially" suggests that a hospital's failure to report must be significant and ongoing for it to be penalized.⁵⁶ Indeed, some commentators have interpreted the HCQIA to require "a pattern of noncompliance" rather than a single incident of failure to report.⁵⁷ It seems

51. *What is Attestation?*, NAT'L PRAC. DATA BANK, <https://www.npdb.hrsa.gov/faqs/att1.jsp> (last visited Sep. 14, 2021).

52. *See Compliance*, NAT'L PRAC. DATA BANK, <http://www.npdb.hrsa.gov/resources/aboutCompliance.jsp> (last visited Sept. 14, 2021).

53. 45 C.F.R. § 60.12(c)(1) (2013); *see also* LEVINE & WOLFE, *supra* note 49, at 8 n.14 ("According to HRSA staff, after identifying hospitals, usually through media reports or public court records, and contacting these hospitals, HRSA has always received a report or a satisfactory explanation of why no report was required.").

54. *See infra* notes 59, 62 (identifying courts that have stated that peer review immunity would be denied if a hospital's failure to report results in an investigation by the Secretary and publication of the hospital's name in the Federal Register).

55. 42 U.S.C. § 11133(c)(1).

56. *Substantial*, BURTON'S LEGAL THESAURUS (5th ed. 2013).

57. LEVINE & WOLFE, *supra* note 49.

surprising, then, that courts regularly entertain claims by physician-plaintiffs that a single instance of non-compliance—namely, the hospital’s failure to report an adverse action against the physician-plaintiff challenging that adverse action—should result in the loss of peer review immunity.⁵⁸ Despite the prevalence of such claims, no court has analyzed whether a single instance of failure to report could qualify as substantial non-compliance; rather, courts defer to factual findings about whether or not the Secretary actually published a non-compliant hospital’s name in the Federal Register.⁵⁹

The second point of uncertainty is what impact a finding of substantial non-compliance would have in terms of peer review immunity. Although the HCQIA itself does not elaborate on exactly what “[loss of] the protections of section 11111(a)(1)” means, the HCQIA’s enacting regulations describe the loss of peer review immunity as being prospective rather than retrospective.⁶⁰ The regulations establish that a non-compliant hospital whose name is reported in the Federal Register will lose its HCQIA immunity “for professional review activities that occur during the 3-year period beginning 30 days after the date of publication of the entity’s name in the Federal Register.”⁶¹ However, as described above, courts are frequently faced with claims that a hospital should retrospectively lose HCQIA immunity in a suit challenging adverse action taken against a physician if the hospital failed to report that action to the NPDB.⁶²

58. *See infra* notes 59, 62 (identifying courts that have stated that peer review immunity would be denied if a hospital’s failure to report results in an investigation by the Secretary and publication of the hospital’s name in the Federal Register).

59. Nearly every case addressing this issue has stated that immunity would be denied only if the hospital’s failure to report the adverse action results in an investigation by the Secretary and publication of the hospital’s name in the Federal Register. *See, e.g.*, *Imperial v. Suburban Hosp. Ass’n, Inc.*, 37 F.3d 1026, 1028 (4th Cir. 1994); *Benjamin v. Aroostook Med. Ctr.*, 937 F. Supp. 957, 975 (D. Me. 1996), *aff’d sub nom. Benjamin v. Aroostook Med. Ctr., Inc.*, 113 F.3d 1 (1st Cir. 1997); *Wood v. Archbold Med. Ctr., Inc.*, 738 F. Supp. 2d 1298, 1359 (M.D. Ga. 2010); *Fox v. Good Samaritan Hosp. LP*, 467 F. App’x 731, 735 (9th Cir. 2012). However, in *Manion v. Evans*, No. 3:89CV7436, 1991 WL 575715, at *9, 11–12 (N.D. Ohio 1991), a court allowed the question of a hospital’s HCQIA immunity to go to a jury when the hospital admitted that it failed to report the adverse action against the physician-plaintiff. Although the court cited the statutory text of 11133(c)(1) in full in its opinion—including the language regarding the Secretary’s publication of hospital non-compliance—it did not address whether or not such publication had taken place in this case. In effect, this court seems to have read non-compliance as leading to a loss of immunity even without a formal determination by the Secretary.

60. 42 U.S.C. § 11133(c)(1); 45 C.F.R. § 60.12(c)(1) (2013).

61. 45 C.F.R. § 60.12(c)(1).

62. *See, e.g.*, *Austin v. McNamara*, 731 F. Supp. 934, 942–43 (C.D. Cal. 1990) (finding, in an antitrust action by a neurosurgeon against a hospital and individual physicians, that because the defendants satisfied their HCQIA reporting requirements regarding the adverse action taken against the plaintiff, they did not forfeit their HCQIA immunity), *aff’d*, 979 F.2d 728, 737 (9th Cir. 1992); *Manion*, 1991 WL 575715, at *3, *13 (finding, in a suit by a physician against the hospital that restricted his staff privileges, that because the hospital did not report this adverse action to the state medical board, the issue of its HCQIA immunity could go to a jury); *Imperial*, 37 F.3d at 1027,

Even though courts typically reject these claims on the grounds that there has been no finding of substantial non-compliance by the Secretary,⁶³ no court has rejected such a claim on the grounds that the claimant is requesting retrospective, rather than prospective, loss of immunity.

In summation, there are three likely reasons why the HCQIA's provision regarding loss of peer review immunity on the grounds of failure to report adverse action has never been actualized. First, investigation of hospital non-compliance with the HCQIA's reporting requirements does not appear to be a priority for HRSA and the Secretary. Second, even if such investigations were initiated, it is unclear whether a single instance of failure to report could lead to loss of peer review immunity, or whether the HCQIA requires a more consistent pattern of non-compliance. Finally, although the text of the HCQIA suggests that loss of peer review immunity is prospective, litigants routinely interpret its language to mean that non-reporting of adverse action against a physician would lead to a retrospective loss of immunity in a subsequent suit by that physician. If the reporting goals of the HCQIA are to be achieved, each of these three issues need to be addressed.

1030 (finding, in a claim by a physician against a hospital and doctors that took adverse action against his clinical privileges, that the conditions for loss of immunity were not satisfied because there was no evidence that the hospital was investigated by the Secretary or that its name was ever published in the Federal Register); *Benjamin*, 937 F. Supp. at 962, 974 (finding, in a claim by a physician against the hospital and peer review committee staff who terminated his staff privileges, that the hospital retained its immunity because the Secretary had not listed the hospital "among the list of delinquent health care entities as required under the statute"); *Johnson v. Greater Se. Cmty. Hosp. Corp.*, No. CIV.A. 90-1992, 1996 WL 377147, at *5, 9–10 (D.D.C. June 24, 1996) (finding that the plaintiff-physician bears the burden of proving a hospital's non-compliance with reporting requirements regarding adverse action taken against him, and that because the plaintiff failed to make this showing, the hospital was entitled to HCQIA immunity); *W.S.K. v. M.H.S.B.*, 922 N.E.2d 671, 674, 690 (Ind. Ct. App. 2010) (finding, in a suit by a physician against a hospital that denied his application to join the medical staff, that the physician bears the burden of proving that the hospital failed to comply with its reporting requirements and is therefore not entitled to immunity); *Wood*, 738 F. Supp. 2d at 1359–60 rejecting plaintiff-physicians' argument that the hospital had waived its HCQIA immunity because there was no evidence that the hospital was investigated by the Secretary or that its name was published in the Federal Register); *Fox*, 467 F. App'x at 735 (finding that defendant-hospital's failure to report adverse action against the plaintiff does not foreclose HCQIA immunity because the Secretary had not published its name in the Register). See discussion *infra* Section IV.C, noting that many commentators criticize the NPDB reporting requirements as being too strict and causing reputational and dignitary harm. But for a physician-plaintiff to benefit from the provisions of 11133(c)(1), he must affirmatively challenge the hospital for failing to report to the NPDB the adverse action that he claims was improperly taken.

63. See *supra* note 59 (discussing how courts typically reject claims challenging a hospital's HCQIA immunity when adverse action is taken against a physician—but the hospital failed to report the action to the NPDB—on the grounds that there has been no finding of substantial non-compliance by the Secretary).

IV. A PROPOSAL TO INCENTIVIZE HOSPITAL REPORTING TO STATE MEDICAL BOARDS

Making peer review immunity contingent on a health care organization's compliance with reporting requirements is a promising option for incentivizing reporting of physician misconduct. Unfortunately, the HCQIA's implementation of this model leaves much to be desired, and the federal government's reliance on peer review immunity as a means of encouraging hospital reporting has not had its intended effect. Because states have an equally strong interest in ensuring that health care organizations report physician misconduct and adverse privileging actions to medical boards, they should consider similar state-level measures to achieve this goal.

Every state has its own peer review laws that protect individuals and organizations that participate in the medical peer review process. These laws typically establish protections beyond those established by the HCQIA and other federal laws, including evidentiary privileges shielding peer review materials from discovery in litigation. This Part argues that linking state peer review privilege laws with existing state board reporting laws might be an effective state-level tool for incentivizing hospital reporting.

A. *State Peer Review Laws and Federal Preemption*

Peer review activities in furtherance of medical quality are protected not only by the HCQIA, but also by state law. All fifty states and the District of Columbia have laws governing medical peer review, and every jurisdiction but Nevada⁶⁴ establishes immunity from liability for members of peer review committees (and often hospitals and their governing boards).⁶⁵

While the HCQIA's immunity provision only protects peer reviewers from liability for damages,⁶⁶ most states offer broader protections. Many state statutes

64. NEV. REV. STAT. § 49.265 (2005) (focusing only on the evidentiary rules regarding discovery of information from peer review actions but offering no immunity from liability to the peer review members).

65. *Hospital & Provider Regulation: Peer Review Protections*, BLOOMBERG L., <https://www.bloomberglaw.com/product/blaw/bbna/chart/43/10030> (select "All" jurisdictions; then select "Immunity: Review Board Conduct" and click "Create") (last visited Sept. 7, 2021).

66. "If a professional review action . . . of a professional review body meets all the standards specified in section 11112(a) of this title . . . (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." Health Care Quality Improvement Act, 42 U.S.C. § 11111(a)(1) (emphasis added).

reference immunity from liability in civil actions generally,⁶⁷ and some expressly reference immunity from both damages and other forms of relief.⁶⁸

All states also establish an evidentiary privilege that protects peer review materials from discovery in litigation.⁶⁹ The privilege generally shields these materials from discovery in civil and criminal suits. Some states establish exceptions to the privilege, most commonly in suits by physicians challenging adverse action by peer review committees and hospitals.⁷⁰ Thus, the peer review privilege is most relevant when claims are brought by injured patients—either

67. *Hospital & Provider Regulation: Peer Review Protections*, *supra* note 65 (select “All” jurisdictions; then select “Immunity: Providing Information to Board” and click “Create”) (last visited Sept. 14, 2021). *See, e.g.*, ARIZ. REV. STAT. ANN. §§ 36-2402(D)–(E), 36-2403(A) (2015); ARK. CODE ANN. § 17-1-102(a) (1975); COLO. REV. STAT. § 12-30-207(1) (2019); DEL. CODE ANN. tit. 24, § 1768(a) (2010); ME. STAT. tit. 24, § 2511 (1997); MICH. COMP. LAWS § 331.531(3) (2009); N.Y. EDUC. LAW § 6527(5) (McKinney 2021); N.C. GEN. STAT. § 90-21.22(e) (2016), N.C. GEN. STAT. § 131E-95(a) (2006); TEX. OCC. CODE ANN. § 160.010(c) (West 2005); UTAH CODE ANN. § 58-13-4(2) (West 2008); VA. CODE ANN. § 8.01-581.13(A) (2015); WASH. REV. CODE § 4.24.240(2) (2019); WIS. STAT. § 146.37(1g) (2017).

68. *See, e.g.*, D.C. CODE § 44-803 (1993) (“No peer review body or member thereof . . . shall be liable to any person for damages or equitable relief”); IDAHO CODE § 39-1392c (2003) (“The furnishing of information or provision of opinions to any health care organization or the receiving and use of such information and opinions shall not subject any health care organization or other person to any liability or action for money damages or other legal or equitable relief.”); N.H. REV. STAT. ANN. § 151:13-a (2003) (“No hospital, trustees, medical staff, employees, or other committee attendees shall be held liable in any action for damages or other relief arising from the providing of information to a hospital committee or in any judicial or administrative proceeding.”); ALASKA STAT. § 18.23.020 (1976) (“A person who is a member or employee of, or who acts in an advisory capacity to, or who furnishes counsel or services to a review organization is not liable for damages or other relief . . . by reason of the performance of a duty, function, or activity of the review organization . . .”); ARIZ. REV. STAT. ANN. § 36-441(A) (2002) (peer reviewers are “not subject to liability for civil damages or any legal action . . .”).

69. *Hospital & Provider Regulation: Peer Review Protections*, *supra* note 65 (select “All” jurisdictions; then select “Privilege/Confidentiality of Records and Proceedings” and click “Create”) (last visited Sept. 25, 2021); *Virmani v. Novant Health Inc.*, 259 F.3d 284, 290 (4th Cir. 2001) (recognizing that “all fifty states and the District of Columbia have recognized some form of medical peer review privilege.”).

70. *Hospital & Provider Regulation: Peer Review Protections*, *supra* note 65 (select “All” jurisdictions; then select “Privilege/Confidentiality of Records and Proceedings,” “Testimonial Privilege,” “Immunity: Review Board Conduct,” “Immunity: Providing Information to Board” and click “Create”) (last visited Sept. 25, 2021); *see, e.g.*, ALASKA STAT. § 18.23.010(b) (1976), ALASKA STAT. § 18.23.020 (1976), ALASKA STAT. § 18.23.030(b) (1987); ARIZ. REV. STAT. ANN. § 36-441 (2002); ARK. CODE ANN. § 16-46-105 (2013); COLO. REV. STAT. § 12-30-204(11) (2020); GA. CODE ANN. § 31-7-133(a) (2012); IND. CODE § 34-30-15-4 (1998); IOWA CODE § 147.135 (2009); KAN. STAT. ANN. § 65-4915 (2019); ME. STAT. tit. 24, § 2510-B (1997); MD. CODE ANN., HEALTH OCC. § 1-401 (LexisNexis 2021); MISS. CODE ANN. § 41-63-1 (2006), MISS. CODE ANN. § 41-63-9 (1994); OR. REV. STAT. § 41.675 (1997); 5 R.I. GEN. LAWS § 5-37-1 (2012); TEX. OCC. CODE ANN. § 160.007 (West 1999); WASH. REV. CODE § 4.24.250 (2005).

malpractice claims against the physician in question; or negligence, negligent credentialing, or vicarious liability claims against the hospital.

From a preemption perspective, peer review immunity laws and peer review privilege laws are treated differently. While state immunity laws overlap significantly with the immunity provisions of the HCQIA and therefore may be subject to preemption, there is no analogous federal law establishing a peer review privilege.

The text of the HCQIA provides that the law shall not be construed as “preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter.”⁷¹ In other words, state laws that provide lesser peer review protections, or that have more stringent requirements for immunity, are expressly preempted by the HCQIA.⁷² By way of example, a state peer review law that grants immunity only in cases where the peer review is conducted “without malice” would be preempted by the HCQIA, which imposes no such requirement.⁷³ In contrast, a state law that establishes immunity from equitable relief, in addition to the immunity from damages established by the HCQIA, would not be preempted.⁷⁴ That said, in many cases where defendants claim immunity under peer review state laws, courts sidestep the question of HCQIA preemption.⁷⁵

71. 42 U.S.C. § 11115(a).

72. *Patrick v. Burget*, 486 U.S. 94, 105, n.8 (1988) (“The Act expressly provides that it does not change other ‘immunities under law,’ § 11115(a), including the state-action immunity, thus allowing States to immunize peer-review action that does not meet the federal standard.”); *Wood v. Archbold Med. Ctr., Inc.*, No. 6:05 CV 53(HL), 2006 WL 1805729, at *3 (M.D. Ga. June 29, 2006) (“Georgia Law generally provides immunity from criminal and civil liability unless the health care provider was motivated by malice. Georgia courts have consistently held, however, that ‘to the extent that peer review immunity ... is conditional upon the absence of motivating malice, it is preempted by the HCQIA.’”); *Goodwich v. Sinai Hosp. of Balt., Inc.*, 653 A.2d 541, 548 (Md. Ct. Spec. App. 1995) (holding that Maryland peer review immunity statute “is preempted by [HCQIA] only to the extent that it provides less immunity than [HCQIA].”).

73. Surprisingly, thirty-one jurisdictions grant peer review immunity only on the condition that peer review be conducted “without malice.” Only one jurisdiction, however, has explicitly acknowledged that this condition is preempted by HCQIA. *Wood*, 2006 WL 1805729, at *3 (“Georgia Law generally provides immunity from criminal and civil liability unless the health care provider was motivated by malice. Georgia courts have consistently held, however, that ‘to the extent that peer review immunity ... is conditional upon the absence of motivating malice, it is preempted by the HCQIA.’”).

74. *See, e.g., DeKalb Med. Ctr., Inc. v. Obekpa*, 728 S.E.2d 265, 267 (Ga. App. 2012) (finding that HCQIA does not preempt “Georgia’s peer review statute [covering] claims for equitable relief”); *Hoffman v. Spring Valley Hosp. & Med. Ctr.*, No. 52813, 2010 WL 3341802, at *2 (Nev. 2010) (finding that HCQIA does not preempt a cause of action for rescission); *Fahlen v. Sutter Cent. Valley Hosps.*, 318 P.3d 883, 852 (Cal. 2014) (noting “that, at a minimum, HCQIA does not preclude such remedies as reinstatement and injunctive relief.”).

75. *See, e.g., Fahlen*, 318 P.3d at 852 (recognizing but not addressing the HCQIA preemption question, because it had not been raised by the parties prior to appeal).

State peer review privilege laws, on the other hand, are generally not preempted by the HCQIA, because the HCQIA only establishes review immunity and not an evidentiary privilege.⁷⁶ The only federal law that establishes evidentiary privileges in somewhat similar contexts is the 2005 Patient Safety and Quality Improvement Act (PSQIA).⁷⁷ However, the PSQIA has only a limited preemptive effect. Aimed at addressing systemic issues of health care quality, reducing medical errors, and promoting a culture of patient safety, the PSQIA establishes “broad confidentiality and legal protections of information collected and reported voluntarily for the purposes of improving the quality of medical care and patient safety.”⁷⁸ While the HCQIA is aimed at investigation of individual physicians, the PSQIA addresses investigation of systemic errors for the purposes of reporting to a Patient Safety Organization (PSO).⁷⁹ However, the narrow definition of “patient safety work product,”⁸⁰ the fact that not every hospital is a member of a PSO, and the fact that reporting to PSOs is voluntary means that the PSQIA privilege is much narrower than state peer review privileges. As noted by Professor Alan Williams, “Nowhere in the PSQIA does the term ‘peer review privilege,’ or even the term ‘peer review,’ appear.”⁸¹ The law was intended to be “separate from, and parallel to, complementary State, Federal, and local laws and regulations designed to ensure accountability” in health care.⁸² Consequently, the circumstances in which the PSQIA would preempt a comprehensive state peer review law are very limited.⁸³

76. See *KD ex rel. Dieffenbach v. United States*, 715 F. Supp. 2d 587, 594 (D. Del. 2010) (discussing HCQIA and describing the prevailing view that “federal policy is hostile to a medical peer review privilege”); *Teasdale v. Marin Gen. Hosp.*, 138 F.R.D. 691, 694 (N.D. Cal. 1991) (“Congress spoke loudly with its silence in *not* including a privilege against discovery of peer review materials in the HCQIA.”); *Gargiulo v. Baystate Health, Inc.*, 826 F. Supp. 2d 323, 327 (D. Mass. 2011) (noting that HCQIA established peer review immunity, but that “Congress declined . . . to create a federal evidentiary privilege for most documents produced during such reviews”), *objections overruled* by 279 F.R.D. 62 (D. Mass. 2012).

77. Patient Safety Quality and Improvement Act of 2005, 42 U.S.C. § 299b-22.

78. S. REP. NO. 108-196, at 4 (2003); see also *KD ex rel. Dieffenbach*, 715 F. Supp. 2d at 595 (discussing origins of the PSQIA).

79. See *KD ex rel. Dieffenbach*, 715 F. Supp. 2d at 595–96.

80. The PSQIA defines “patient safety work product” as “any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements . . . which . . . are assembled or developed by a provider for reporting to a patient safety organization and are reported to a patient safety organization.” 42 U.S.C. § 299b-21(7)(A).

81. Alan G. Williams, *Save Thousands of Lives Every Year: Resuscitate the Peer Review Privilege*, 29 J.L. & HEALTH 221, 241 (2016).

82. S. REP. NO. 108-196, at 3.

83. See *Quimbey v. Cmty. Health Sys. Pro. Servs. Corp.*, 222 F. Supp. 3d 1038, 1043 (D.N.M. 2016) (noting that the PSQIA privilege is limited to “patient safety work product,” and the PSQIA only preempts state peer review privilege laws that fail to protect patient safety work product); Janice Suchyta, *Beyond Quality and Safety: How Patient Safety Organizations Impact Business and Financial Outcomes*, AM. HEALTH L. ASS’N (Feb. 14, 2020), <https://www.americanhealthlaw>

Indeed, Williams notes that as of 2016, not a single reported medical malpractice case has granted the PSQIA privilege; rather, several have denied it because of the narrow definitions of “patient safety work product” and “patient safety organization.”⁸⁴

B. Linking State Reporting and Peer Review Immunity

Given that state peer review laws include immunity provisions similar to those in the HCQIA, state legislatures might consider amending their laws to condition a hospital’s immunity on its satisfaction of state reporting requirements. In doing so, states could independently address the concerns described in Part III, which limit the effectiveness of the HCQIA’s immunity-based reporting incentive.⁸⁵

For example, a state might wish to amend its laws to establish that a hospital can lose peer review immunity based on a single demonstrated instance of non-reporting. Compared to the HCQIA’s requirement that immunity be withdrawn based on “substantial” non-compliance with reporting requirements, as determined through investigation by HHS and identification by the Secretary,⁸⁶ this approach would set a lower bar for loss of immunity and hopefully improve reporting. Unfortunately, states do not have the flexibility to make this change. Recall that the HCQIA preempts state peer review laws that provide lesser protections or pose additional steps for securing peer review immunity. Since the text of the HCQIA withdraws immunity from an entity that “fails substantially” to comply with reporting, a state that withdrew immunity based on a single instance of non-reporting—or, indeed, anything less than the HCQIA model of substantial non-compliance, investigation, opportunity for correction, and publication—would have a steep burden to overcome in terms of preemption.

.org/content-library/publications/briefings/8d513bce-7607-4f72-b57a-2b672fb00695/beyond-quality-and-safety-how-patient-safety-organ (“The PSQIA offers a limited federal preemption of a state peer review privilege regarding [patient safety work product]. However, if the [patient safety work product] is created or reported for any other reason than solely for the purpose of reporting to a PSO, then the federal privilege does not apply, and the data must be reported.”).

84. Williams, *supra* note 81, at 243–45. *But see KD ex rel. Dieffenbach*, 715 F. Supp. 2d at 592, 596 (recognizing the privilege in an FTCA medical malpractice case in light of the fact that the documents at issue were provided to NIH review bodies, which, “[w]hether or not [they] meet the technical requirements for listing as PSOs, they clearly perform the same functions Congress intended the PSQIA to encourage”); *Francis v. United States*, No. 09 Civ. 4004(GBD)(KNF), 2011 WL 2224509, at *4–6 (S.D.N.Y. May 31, 2011) (recognizing the privilege in an FTCA dental malpractice case in light of the fact that the documents at issue were provided to an external entity, the New York State Department of Health, “which, although not listed as a PSO, meets many of the same qualifying criteria for PSOs and performs similar functions, which Congress clearly intended to encourage”).

85. *See supra* Part III.

86. Health Care Quality Improvement Act, 42 U.S.C. § 11111(b).

Another possibility is that a state could lessen the severity of the HCQIA penalty by rejecting the idea of a prospective three-year loss of immunity. It could, for example, find that when an instance of non-reporting occurs, immunity is lost retrospectively with respect to any litigation relating to the physician or incident that the hospital failed to report. This change would also address the fact that state boards, similar to HHS, have limited resources to investigate non-compliance with reporting requirements. Rather than state boards having to actively investigate non-compliance with reporting requirements, failures to report would be brought to light in private litigation as a way to defeat a hospital's claim of HCQIA immunity.⁸⁷ However, for the same reasons described above, permitting any loss of immunity based on a single instance of non-compliance would conflict with the requirements of the HCQIA.

C. *Linking State Reporting and Peer Review Privilege*

Federal preemption prohibits states from requiring compliance with state reporting requirements as a condition of peer review immunity. However, states have another tool at their disposal for incentivizing hospital reporting. As noted in Section IV-A, state peer review laws provide an evidentiary privilege that protects peer review materials from discovery in litigation.⁸⁸ The HCQIA, in contrast, does not. Because state peer review privilege laws “provide[] incentives, immunities, or protection for those engaged in a professional review action . . . in addition to or greater than” those provided by the HCQIA,⁸⁹ they are not preempted by federal law; accordingly, states have the leeway to modify their peer review privilege law without HCQIA preemption.⁹⁰ Furthermore, because the PSQIA's protection of “patient safety work product” is much narrower than the evidentiary privilege established by state peer review laws, and because there is no federal common law peer review privilege, amendments to peer review privilege laws would not be preempted except in the rarest of circumstances.⁹¹

87. In this sense, this model could be analogized to whistleblower and qui tam suits for health care fraud and abuse claims.

88. *See supra* Section IV.A.

89. 42 U.S.C. § 11115(a).

90. *Columbia Hosp. Corp. of S. Broward v. Fain*, 16 So. 3d 236, 242 (Fla. Dist. Ct. App. 2009) (“Nothing in the HCQIA requires the states to provide confidentiality for peer review materials.”).

91. *See KD ex rel. Dieffenbach v. United States*, 715 F. Supp. 2d 587, 592 (D. Del. 2010) (finding that “the balance of authority weighs against recognition” of a federal peer review privilege); *Krolikowski v. Univ. of Mass.*, 150 F. Supp. 2d 246, 248 (D. Mass. 2001) (“Federal courts have been reluctant to adopt a peer review privilege into federal common law.”); *Jenkins v. DeKalb Cnty.*, 242 F.R.D. 652, 659 (N.D. Ga. 2007) (“It appears that every United States Court of Appeals that has addressed the issue of whether there is a federal medical peer review privilege has rejected the claim.”).

Therefore, one approach state legislatures should consider is linking the peer review privilege with satisfaction of state reporting requirements. Thus, if a hospital were sued in connection with a physician's misconduct, the privilege against discovery of materials used in peer review would be lost if the hospital failed to satisfy its reporting requirements to the SMB in connection with that misconduct. Only by fully complying with the reporting requirements of the state medical practice act could the hospital ensure that it would receive the protection of the peer review privilege if a lawsuit arose in connection with the reportable physician misconduct.

This change would likely have an even greater impact than a change to peer review immunity laws, because HCQIA and peer review immunity claims are most often, though not exclusively, brought in suits by aggrieved physicians who have had adverse action taken against them. Withdrawing the evidentiary privilege, on the other hand, would primarily impact suits by injured patients for negligent credentialing, negligence, vicarious liability, and malpractice.⁹² Such suits are brought in state court and pose significant liability risks for hospitals, particularly given that the damages sought by injured patients are typically high. Accordingly, when hospitals are faced with a physician whose conduct is likely to harm patients, they would have a strong incentive not only to investigate the physician's conduct through peer review, but to report their concerns to state boards in an effort to secure the greatest protection in any future litigation. Hospitals engaging in the peer review process would arguably be more likely to report to boards if they knew that only by doing so would those documents be protected from discovery in subsequent litigation.

Another benefit of the state-level approach is that physicians may be less likely to oppose a proposal to strengthen reporting to SMBs as compared to reporting to the NPDB. The NPDB reporting requirements of the HCQIA have been widely criticized by physicians and some advocates as being unfairly disadvantageous to physicians. There is some evidence that "sham" peer review actions may be initiated with discriminatory or anti-competitive motives, and with the goal of revoking a provider's clinical privileges for reasons other than quality of care.⁹³ In such cases, an NPDB adverse action report regarding that

92. Note that the peer review privilege may not apply in the context of suits by aggrieved physicians. See *Hospital & Provider Regulation: Peer Review Protections*, *supra* note 65.

93. See, e.g., Lawrence R. Huntoon, *Sham Peer Review and the National Practitioner Data Bank*, 22 J. AM. PHYSICIANS & SURGEONS 66, 66 (2017) (noting that "[w]idespread abuse of the peer review process, sham peer review, is well-known," that improper motives for peer review may include "anti-competitive motives, retaliation against physician whistleblowers, and discrimination based on race, ethnicity, sex, and age"); Koepke, *supra* note 40, at 10, 13 (offering examples of "bad faith peer review," including economic credentialing); Benson et al., *supra* note 43, at 8-9 (describing "bad-faith" or "sham" peer review as a serious problem with the HCQIA model and offering examples).

peer review action would be misleading.⁹⁴ Many argue that physicians who have adverse actions listed on their NPDB reports are effectively “blacklisted” from the profession, and that overly aggressive peer review and reporting violates their due process interests.⁹⁵ In contrast, a hospital’s report of physician misconduct to the SMB does not automatically lead to censure on the physician’s record. Rather, a report triggers the SMB’s responsibility to investigate and determine whether any disciplinary action needs to be taken in a process that is governed both by state regulations and due process principles.⁹⁶ Because of the due process protections inherent in the process of SMB discipline, physicians are less likely to be unfairly disadvantaged when a hospital makes a board report rather than an NPDB report.⁹⁷ Thus, they might be less likely to oppose the proposal offered in this Article.

Linking state reporting requirements with the peer review privilege would be a relatively simple legislative fix. Both pieces are already codified in state law, and such an amendment would not impose any additional reporting burdens on hospitals beyond those with which they are already required to comply. SMBs, whose ability to respond to physician misconduct is stymied as a result of hospital non-reporting, would be in a strong position to petition state legislators to make this change.

V. CONCLUSION

Existing state and federal laws require hospitals to report information about physicians who engage in misconduct to government entities. It is reasonable to require hospitals to comply with these laws as a condition of securing important

94. Huntoon, *supra* note 93, at 66–67 (noting that sham peer review can lead to inaccurate reporting to the NPDB); Madison, *supra* note 12, at 75–76 (noting criticism of the NPDB); William M. Sage et al., *Bridging the Relational-Regulatory Gap: A Pragmatic Information Policy for Patient Safety and Medical Malpractice*, 59 VAND. L. REV. 1263, 1300 (2006) (noting that “NPDB information appears to be of limited utility for purposes of rating physician quality”).

95. Van Tassel, *supra* note 12, at 2058–62 (describing the “disastrous” consequences that can arise as a result of an NPDB report); Huntoon, *supra* note 93 (noting concerns during the time of HCQIA’s passage that its immunity provisions “would invite abuse of the peer review process and ruin or end the careers of physician whistleblowers and other physicians for purposes unrelated to professional competence or conduct”); Koepke, *supra* note 40, at 10 (noting that the “disadvantaged victim of bad faith peer review faces an almost insurmountable uphill battle”); Benson et al., *supra* note 43, at 9–10 (noting that an NPDB report often seriously damages a physician’s career); Guillermo A. Montero, *If Roth Were a Doctor: Physician Reputation Under the HCQIA*, 30 AM. J.L. & MED. 85, 85 (2004) (noting that NPDB reporting “is in fact designed to [] stigmatize the practitioner”).

96. See Paul K. Ho, *HCQIA Does Not Provide Adequate Due Process Protection, Improve Healthcare Quality and Is Outdated Under “Obama Care”*, 11 IND. HEALTH L. REV. 303, 313 (2014) (noting that medical boards’ “state [licensing] systems are public and provide due process to physician defendants prior to providing a negative report to the NPDB”).

97. *Id.* at 319–20.

protections in litigation. Although the HCQIA attempts to do this by linking NPDB reporting to peer review immunity, that approach has been unsuccessful. States, however, could effectively incentivize hospital reporting at the state level by drawing a similar linkage with the state-law evidentiary privilege against discovery of peer review materials. Hospitals seeking to protect their peer review materials from discovery in suits by injured patients would then be strongly motivated to report physician misconduct to state boards when that misconduct poses a litigation risk. SMBs, in turn, would have the information they need to investigate and discipline physicians whose conduct poses a risk to patients.

