

THE DUE PROCESS CONUNDRUM: USING MATHEWS V. ELDRIDGE AS A STANDARD FOR PRIVATE HOSPITALS UNDER THE HEALTH CARE QUALITY IMPROVEMENT ACT

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I. THE HEALTH CARE QUALITY IMPROVEMENT ACT

Medical malpractice litigation had exploded in the United States by the mid-1980s.¹ This increase in malpractice suits was partially caused by a shift in public opinion—what once was an unconditional trust of doctors shifted to a more searching inquiry into the motivations and behaviors of health care professionals.² As the number of cases increased over time, so too did the amounts awarded by juries in terms of damages, averaging in excess of \$100,000, and often exceeding \$1 million.³ Patients who had been wronged by their physicians also became more willing to file suit because of these increased jury awards. These jury awards were often crippling to private hospitals, which in turn would take responsive or sometimes preemptive action against these suits by terminating their

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1. 132 CONG. REC. 17,247 (1986) (statement of Sen. Al Gore) (“Medical malpractice poses a serious threat to America’s health care system. . . . The malpractice crisis has escalated throughout this past decade.”); *Manion v. Evans*, 986 F.2d 1036, 1037 (6th Cir. 1993) (“The early 1980s witnessed a new trend in health care litigation as states and health care accrediting bodies stepped up their promotion of peer review As this process gathered force, physicians aggrieved by the results of peer review increasingly appeared in federal court”).

2. *Health Care Quality Improvement Act of 1986: Hearings on H.R. 5540 Before the Subcomm. on Civil and Constitutional Rights of the H. Comm. on the Judiciary*, 99th Cong. 37 (1986) [hereinafter *Subcomm. Hearings*] (statement of Richard Kusserow, Inspector General, Dep’t of Health and Human Servs.); 132 CONG. REC. 17,247 (1986); *Subcomm. Hearings* at 135 (statement of Dr. William Mixon, former president, American College of Obstetricians and Gynecologists) (“The ACOG acknowledges that there is a problem of a lack of public confidence in the mechanisms employed to protect the public from poor practitioners.”); *Medical Practice: Hearings on H.R. 5110 Before the Subcomm. on Health and the Env’t of the H. Comm. of Energy and Commerce*, 99th Cong. 1 (1986) (statement of Rep. Henry Waxman, Chairman, Subcomm. on Health and the Env’t) (“Both doctors and their patients complain that their relationship is increasingly adversarial.”).

3. 132 CONG. REC. 17,247 (1986) (statement of Sen. Al Gore).

relationship with the offending physician.⁴ However, contemporaneous studies showed that for every 242 times a patient was killed or injured as a result of doctor negligence, only one serious internal disciplinary action was taken against the doctor.⁵ Thus even as external action in the form of litigation was increasing, internal action was stagnant or nonexistent as hospitals seemed to refuse to punish doctors for incompetent behavior.

During this time period only a few hospitals began to take proactive steps to stem the tide of litigation, revoking a doctor's privileges to practice at a hospital if the doctor was incompetent or unprofessional.⁶ The process used by hospitals to revoke a physician's privileges usually included a peer review process comprised of other doctors from the same hospital.⁷ However, the doctor whose privileges had been revoked could in turn sue the hospital for numerous state law violations such as breach of contract or defamation.⁸ This backlash litigation against the hospital meant that peer review and removal of offending doctors did not protect it from litigation as the hospital had initially theorized that it would.⁹

Aside from strategic use of litigation, some doctors under investigation by state boards would voluntarily surrender their licenses in one state before a formal hearing could take place so that they could continue to practice medicine in a different state where they maintained a license.¹⁰ This tactic would become part of a plea bargain where hospital boards could avoid costly due process hearings and physicians could continue to practice medicine.¹¹ In essence, the hospital would agree to take no action against the physician if he or she would simply leave town and practice incompetent medicine somewhere else. Sometimes these deals

4. *Id.* ("Meanwhile the skyrocketing cost of malpractice insurance has led many doctors to quit the business, and made health care more expensive for everybody."); H.R. REP. NO. 99-903, pt. 1, at 3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6385 ("One [problem] is that hospitals too often accept "voluntary" resignations of incompetent doctors in return for the hospital's silence about the reasons for the resignations. Hospitals make these agreements in order to avoid lengthy and unpredictable litigation. The other is that there is no comprehensive national reporting system to follow bad doctors from place to place.").

5. *Subcomm. Hearings, supra* note 2, at 54 (statement of Dr. Sidney Wolfe, Director, Public Citizen Health Research Group).

6. H.R. REP. NO. 99-903, at 2 ("Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so. Even when such bodies do act against bad physicians, these physicians find it easy to move to different hospitals or states and continue their practices in these new locations.").

7. *Subcomm. Hearings, supra* note 2, at 96 (statement of David H. Weinstein et al.).

8. 132 CONG. REC. 17,247 (1986) (statement of Sen. Al Gore) ("[D]octors and health care personnel will never be able to police their own ranks until Federal laws are changed to protect peer review. Under current law, a doctor who testifies against a colleague can be sued for slander or restraint of trade.").

9. *Subcomm. Hearings, supra* note 2, at 50 (testimony of Hon. Thomas J. Tauke).

10. *Id.* at 34 (statement of Richard Kusserow, Inspector General, Dep't of Health and Human Servs.).

11. *Id.*

would even include carrying *good references* from the hospital in exchange for leaving town and not suing the hospital.¹² The threat of being sued thus had an obvious chilling effect on the reporting of incompetence.¹³ Even in cases where payments were made to patients, part of the settlement agreement would sometimes include a promise not to report the information about the doctor to the state licensing board.¹⁴

Other doctors are considered the “first line of defense” against malpractice because they observe it happening around them.¹⁵ However, reporting or whistleblowing about another doctor’s incompetence, without any protection, can discourage doctors from coming forward with these claims to even start the peer review process.¹⁶ This meant that some hospitals simply did not engage sufficiently in peer review.¹⁷

A. The History of the Health Care Quality Improvement Act

In order to protect hospitals that did engage in peer review from any backlash litigation from unhappy physicians, state legislatures had begun to pass provisions to provide legal immunity for these hospitals.¹⁸

12. *Id.* at 48 (statement of Rep. Henry Waxman, Chairman, Subcomm. on Health and the Env’t).

13. *Id.* at 44 (statement of Richard Kusserow, Inspector General, Dep’t of Health and Human Servs.).

14. *Subcomm. Hearings, supra* note 2, at 55 (statement of Dr. Sidney Wolfe, Director, Public Citizen Health Research Group) (“Based on data from the American Medical Association, we have estimated that in 1984 patients were awarded damages 16,400 times in medical malpractice cases, usually by out-of-court settlements. In a large proportion of cases, part of the settlement agreement involves a promise not to report the information about the doctor to the State Licensing Board.”).

15. *Id.* at 52 (statement of Rep. Ron Wyden).

16. 132 CONG. REC. 17,247 (1986) (statement of Sen. Al Gore) (“In the long run, doctors themselves are in the best position to put an end to malpractice. As some of the most highly trained individuals in our society, physicians are ideally qualified to hold their profession to the highest standard. But doctors and other health care personnel will never be able to police their own ranks until Federal laws are changed to protect peer review.”); *Subcomm. Hearings, supra* note 2, at 66 (statement of Dr. Sidney Wolfe, Director, Public Citizen Health Research Group) (“Every physician I know in the country who is practicing medicine tells me that there are one or more physicians at his or her hospital who are incompetent and when I say why are they still there, they say we are afraid to bring an action against them because they will retaliate and so forth.”); H.R. REP. NO. 99-903, pt. 1, at 3 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6385 (“Doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review.”).

17. H.R. REP. NO. 99-903, pt. 1, at 2 (1986) (“Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent or unprofessional doctors often do not do so.”).

18. See Susan O. Scheutzow, *State Medical Peer Review: High Cost But No Benefit—Is It Time For A Change?*, 25 AM. J. L & MED. 7, 59 (1999). Congressional legislative history also shows that this was a federal problem. *Subcomm. Hearings, supra* note 2, at 131 (statement of Dr. William Nixon, former president, American College of Obstetricians and Gynecologists) (“The immunity granted in the bill would overcome . . . shortcomings in state law and the absence of protection for peer review in federal law.”).

While a majority of states already had legislation to protect both professional review and dismissal of physicians by the time Congress passed the Health Care Quality Improvement Act, the terminated physicians could work around these state immunity laws by filing actions in federal court.¹⁹ Usually the federal claims were grounded in federal antitrust law. An example of this type of litigation, and something that Congress noted as “a primary impetus for . . . immunity” in the form of the Health Care Quality Improvement Act,²⁰ was the case of *Patrick v. Burget*.²¹

Dr. Patrick had worked for the Astoria Clinic and Columbia Memorial Hospital in Astoria, Oregon as a general and vascular surgeon.²² He was invited by the partners of the Astoria Clinic to join them as a partner, but he declined and instead opened up his own, independent clinic that competed with the Astoria Clinic.²³ As a result, the doctors at the Astoria Clinic cut ties with Dr. Patrick and refused to give him referrals.²⁴ Ultimately, they initiated a peer review process at Columbia Memorial Hospital and Dr. Patrick resigned before the hospital could revoke his privileges.²⁵ He filed suit in the United States District Court for the District of Oregon claiming violations of the Sherman Act because the peer review had been conducted in order to reduce competition as opposed to improve patient care.²⁶ The jury returned an award of \$650,000 on the antitrust claims.²⁷ As required by law, the District Court trebled the damages.²⁸

The Court of Appeals for the Ninth Circuit reversed, holding that peer review proceedings were immune from antitrust scrutiny under the state-action exemption from antitrust liability.²⁹ As explained by the Ninth Circuit, “[t]he doctrine exempts from the antitrust laws actions by the state such as passage of laws by the legislature or promulgation of rules by the state Supreme Court acting in its legislative capacity.”³⁰ If the action is not directly undertaken by the state legislature or the state Supreme Court, it must be “taken pursuant to a clearly articulated and affirmatively expressed state policy and must be subject to active supervision by the state.”³¹ In this

19. Scheutzow, *supra* note 18, at 58.

20. *Subcomm. Hearings, supra* note 2, at 27 (statement of Rep. Don Edwards, Chairman, Subcomm. on Civil and Constitutional Rights) (Note that Edwards refers to this case as *Patrick v. Astoria Clinic* in the legislative history.).

21. 800 F.2d 1498 (9th Cir. 1986), *rev'd*, 486 U.S. 94 (1988).

22. *Patrick*, 486 U.S. at 95–96.

23. *Id.*

24. *Id.*

25. *Id.* at 97.

26. *Id.* at 97–98.

27. *Patrick*, 486 U.S. at 98.

28. *Id.*

29. *Id.*

30. *Patrick v. Burget*, 800 F.2d 1498, 1505 (9th Cir. 1986) (citing *Hoover v. Ronwin*, 466 U.S. 558, 567–68 (1984)).

31. *Id.* (citing *S. Motor Carriers Rate Conference, Inc. v. United States*, 471 U.S. 48 (1985)).

case, because Oregon required licensing of its health care facilities and also required that procedures existed for granting or restricting privileges of medical staff employed by those facilities, Oregon was compelling physicians to review their competitors and had “affirmatively . . . expressed a policy to replace pure competition with some regulation.”³²

The Supreme Court ultimately held, reversing the Ninth Circuit, that the state-action exemption did not immunize the hospital and federal antitrust law would apply.³³ The Court found that Oregon did not satisfy the active supervision part of the required test and thus did not “exercise ultimate control over the challenged anticompetitive conduct.”³⁴ None of the state actors mentioned by the Ninth Circuit or argued by the respondents, “[had] succeeded in showing that any of these actors reviews—or even could review—private decisions regarding hospital privileges to determine whether such decisions comport with state regulatory policy and to correct abuses.”³⁵

However, the Court noted that it was responsive to policy arguments articulated in *amici* briefs that “effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability [would] prevent physicians from participating openly and actively in peer-review proceedings.”³⁶ The Court responded that this argument was essentially about whether antitrust law should be applied in the area of medical care, a question properly addressed to the legislative branch.³⁷ This question had already been answered, in part, with the passage of the Health Care Quality Improvement Act.³⁸ Thus, the Court would not erect a barrier to federal court for physicians wishing to use antitrust law against hospitals.

The Supreme Court would also later interpret the jurisdictional requirement of the Sherman Act broadly, allowing even more cases to be brought into federal court against hospitals under federal antitrust law.³⁹ The Court recognized a federal cause of action by a physician who had lost medical privileges (or been denied those privileges) against the hospital or peer review committee if the physician alleged that the decision of that hospital or committee violated the Sherman Act.⁴⁰ In the case of *Summit Health v. Pinhas*, the Court concluded that even though a hospital’s main

32. *Id.* at 1505–06.

33. *Patrick*, 486 U.S. at 105.

34. *Id.* at 101 (“The active supervision prong of the . . . test requires that state officials have and exercise power to review particular anticompetitive acts of private parties and disapprove those that fail to accord with state policy. Absent such a program of supervision, there is no realistic assurance that a private party’s anticompetitive conduct promotes state policy, rather than merely the party’s individual interests.”).

35. *Id.*

36. *Id.*

37. *Id.*

38. *Id.* at 105 n.8.

39. *See, e.g., Summit Health, Ltd. v. Pinhas*, 500 U.S. 322, 328–33 (1991).

40. *Id.* at 332–33.

activity was providing health care services to a local market, it also engaged in interstate commerce.⁴¹ Therefore to initiate an action under antitrust law, there was no requirement of a manifest intent to actually restrain interstate commerce but rather any attempt to prevent the hospital from expanding would be covered by the Sherman Act.⁴² Merely the purchase of out-of-state medicines and supplies as well as revenues from out-of-state insurance companies would establish the appropriate interstate nexus.⁴³ Thus, a conspiracy on the part of the hospital (or a peer review panel) to terminate a doctor's privileges at a hospital would frustrate interstate commerce in the giving of medical services and potentially violate the Sherman Act.⁴⁴ Congress accordingly had the power to regulate the peer review process.⁴⁵ This power to regulate extended also to reporting on the results of peer review as "reports concerning peer review proceedings are routinely distributed across state lines and affect doctors' employment opportunities throughout the Nation."⁴⁶ Therefore, overall there could be "no doubt concerning the power of Congress to regulate [the] peer review process."⁴⁷

Congress had intervened amidst antitrust litigation and medical malpractice suits and passed the Health Care Quality Improvement Act, "[t]o encourage good faith professional review activities of health care entities, to require collection and dissemination to hospitals and other health care providers of information concerning certain payments in medical malpractice claims and certain adverse decisions, and for other purposes."⁴⁸ Congress was worried about "the chilling effect which treble damages in an antitrust claim can have on effective peer review,"⁴⁹ and these federal damage awards and claims were, of course, outside of the reach of state-based immunity laws. However, the immunity provided in the federal statute was much broader than any individual state law in that it insulated health care entities not only from antitrust lawsuits, but extended to "any

41. *Id.* at 329.

42. *Id.*

43. *Id.*

44. *See Id.* at 330 ("A violation [of the Sherman Act] may still be found . . . liability may be established by proof of *either* an unlawful purpose or an anticompetitive effect." (quoting *McLain v. Real Estate Bd. of New Orleans, Inc.*, 444 U.S. 232 (1980))).

45. *Summit Health*, 500 U.S. at 332–33 ("We have no doubt concerning the power of Congress to regulate a peer review process controlling access to the market for ophthalmological surgery in Los Angeles. Thus, respondent's claim that members of the peer review committee conspired with others to abuse that process and thereby deny respondent access to the market for ophthalmological services provided by general hospitals in Los Angeles has a sufficient nexus with interstate commerce to support federal jurisdiction.").

46. *Id.* at 327–28.

47. *Id.* at 332.

48. Health Care Quality Improvement Act of 1986, H.R. 5540, 99th Cong. (as reported by the Subcomm. on Civil and Constitutional Rights, Sept. 17, 1986).

49. *Subcomm. Hearings, supra* note 2, at 27 (statement of Rep. Don Edwards, Chairman, Subcomm. on Civil and Constitutional Rights).

law of the United States or of any State.”⁵⁰ In reviewing the bill before its passage, the task of the Committee on the Judiciary was partially to “consider the implications of such a broad immunity, and to explore the balance between encouraging peer review on the one hand and preserving important rights and remedies on the other.”⁵¹

The Committee on Energy and Commerce reported “the purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.”⁵² However, “it [was] the Committee’s intent that physicians receive fair and unbiased review to protect their reputations and medical practices.”⁵³ Part of this protection for physicians included the “due process and other standards provided in the bill.”⁵⁴

As described by the Eleventh Circuit in interpreting the statute:

Congress enacted the HCQIA to address the rising problem of medical malpractice and the ability of incompetent doctors to move between states without having their prior practice records follow them . . . We conclude that the intent of . . . the federal . . . statute [], therefore, is “to facilitate the frank exchange of information among professionals conducting peer review inquiries without the fear of reprisals in *civil lawsuits*.”⁵⁵

This balancing of interests is important. As noted by Richard Kusserow, the Inspector General for the Department of Health and Human Services at the time HCQIA was passed, public perception about the adequacy of hospital board discipline had shifted.⁵⁶ The public had become increasingly frustrated with boards not protecting patients but was also dissatisfied with the time it took to conduct a proper hearing.⁵⁷ He remarked, “the public perceives that bad doctors should not be practicing medicine, but we must give these doctors due process. Not everyone understands this.”⁵⁸

50. 42 U.S.C. § 11111(a)(1) (2013).

51. *Subcomm. Hearings, supra* note 2, at 27 (statement of Rep. Don Edwards).

52. H.R. REP. NO. 99-903, pt. 1, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6385.

53. *Id.* at 11.

54. *Id.* at 2.

55. *Ming Wei Liu v. Bd. of Trs. of the Univ. of Ala.*, 330 F. App’x 775, 779 (11th Cir. 2009) (quoting *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1322 (11th Cir. 1994)).

56. *Subcomm. Hearings, supra* note 2, at 37.

57. *Id.*

58. *Id.*

B. Structure of the Health Care Quality Improvement Act

HCQIA provides immunity from monetary damages to a hospital and the individual members of a peer review committee for the termination or suspension of a physician's privileges if those actions comport with the proper statutory requirements.⁵⁹ The statute also mandates a reporting system, implemented by the Secretary of Health and Human Services into a national registry and data bank. "Under the national reporting system, insurance companies are required to report medical malpractice payments . . . ; boards of medical examiners are required to report sanctions imposed against physicians . . . ; and health care entities are required to report adverse professional review information."⁶⁰ Hospitals are also under a duty to request information from the Secretary in order to grant privileges to a physician or licensed health care professional.⁶¹ Once privileges are granted, hospitals must renew their request every two years and update that information.⁶²

The Data Bank created by the Secretary under authority from the statute thus prevents a physician who applies for privileges at a hospital from being able to conceal disciplinary actions that have been taken against him or her.⁶³ The Data Bank information reports not only the hospital's findings but also the physician's response.⁶⁴ However, the hiring hospital is under no obligation to turn away a physician due to the information supplied by the previous hospital or the Data Bank. As the Eleventh Circuit explained:

What the requesting hospital does with the information it obtains from the Data Bank is entirely up to that hospital. It could completely discount the information, or it could back off from any professional relationship with the physician, or it could make further inquiries to determine what had actually happened.⁶⁵

If a hospital or health care entity does not participate in the national reporting system, the Secretary may publish the entity's name in the Federal

59. 42 U.S.C. §§ 11111(a), 11112(a) (2013).

60. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1028 (4th Cir. 1994) (citing §§ 11131–11133 (2013)).

61. § 11137(a).

62. *Id.* § 11135(a).

63. *See, e.g., Leal v. Sec'y, U.S. Dep't of Health and Human Servs.*, 620 F.3d 1280, 1283 (11th Cir. 2010).

64. *Id.* at 1284.

65. *Id.*

Register.⁶⁶ If an entity's name is published, it may not receive the immunity provided by the statute for a three-year period.⁶⁷

However, in order to receive immunity initially, the statute requires a professional review action to be taken in accordance with certain requirements found in § 11112(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).⁶⁸

It is clear from the legislative history surrounding the creation of these factors that they were established to ensure that physicians being reviewed by private hospitals were provided something akin to adequate due process.⁶⁹ Congress patently provided for due process in §§ 11112(b) and 11112(c), expanding on the nature of the “adequate notice and hearing procedures” required in § 11112(a)(3).

66. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1028 (4th Cir. 1994).

67. *Id.* (citing 42 U.S.C. § 11111(b) (2013)).

68. § 11112. The statute was amended in § 11111 to clarify that all of the standards must be met in order to receive immunity. *See* § 11111; 132 CONG. REC. 30,766 (1986).

69. *See, e.g., Subcomm. Hearings, supra* note 2, at 52 (statement of Rep. Ron Wyden) (“[W]e have given physicians under review **full due process** rights with notice and representation.”) (emphasis added); H.R. REP. NO. 99-903, pt. 1, at 2 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6385 (“The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior. . . . [P]eer review will be protected . . . provided the peer review actions meet the **due process** and other standards provided in the bill.”) (emphasis added); 132 CONG. REC. 30,767 (1986) (“These provisions are now referred to in the amendment as “notice and hearing requirements.” The substantive provisions remain unchanged. This change in terminology is intended to preclude the implication that the bill defines “due process” for any purpose beyond the purview of the bill.”).

Section 11112(b) provides a list of “safe harbor” provisions, which if met by the hospital or peer review committee, can be used to satisfy § 11112(a)(3).⁷⁰ These safe harbor provisions provide:

[§ 11112](b): Adequate notice and hearing[:] A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action[.] The physician has been given notice stating—

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing[.] If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice[.] If a hearing is requested on a timely basis under paragraph (1)(B)—

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—

70. § 11112(b).

- (i) before an arbitrator mutually acceptable to the physician and the health care entity,
 - (ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
 - (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
- (B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
- (C) in the hearing the physician involved has the right—
 - (i) to representation by an attorney or other person of the physician's choice,
 - (ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
 - (iii) to call, examine, and cross-examine witnesses,
 - (iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
 - (v) to submit a written statement at the close of the hearing; and
- (D) upon completion of the hearing, the physician involved has the right—
 - (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.⁷¹

Clearly this is a robust list of provisions intended to give hospitals and other health care entities an idea of what an “adequate notice and hearing” in this context ought to contain.⁷² The Committee on Energy and Commerce explains, “[t]he due process requirement can always be met by the procedures specified in [§ 11112](b). . . . If other procedures are followed, but are not precisely of the character spelled out in [§ 11112](b), the test of ‘adequacy’ may still be met under other prevailing law.”⁷³ The Committee does not specify what kind of test will apply to adequacy in these other cases.⁷⁴ However the Committee notes that some courts have requirements for review activities and actions that might require fewer or different due process rights than the one specified in the statute and that these requirements should be taken into account for a proper analysis of whether a hearing is adequate under the statute.⁷⁵

Importantly, the language ending this subsection states that: “[a] professional review body’s failure to meet the conditions described in this subsection *shall not*, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.”⁷⁶ Therefore, if the safe harbor provisions of the statute are not met, that does not mean that the hearing is inadequate under the statute. The safe harbor provisions are mere guidelines, not requirements. There is consequently a gap between what the statute

71. *Id.*

72. However, there were even some concerns in the legislative history that the lengthy due process provisions contained in the listed portion of the statute were insufficient. *See, e.g.*, 132 CONG. REC. 30,770 (1986) (statement of Rep. Don Edwards, Chairman, Subcomm. on Civil and Constitutional Rights) (“In a host of ways, the due process procedures set forth in the bill, fail to provide adequate safeguards to health care providers improperly before peer review committees. Notice is inadequate; there appear to be no mechanisms for compelling testimony or for providing the physician, in advance, with the evidence supporting the peer review action; and, in the end, the ‘due process’ provisions of the bill are merely advisory, not obligatory.”); *Subcomm. Hearings, supra* note 2, at 81–82 (statement of Victor M. Glasberg) (“If the Federal Government is going to—if it is going to permit some kind of immunity arising out of adherence to due process, that there should be a requirement of full and reasonable notice, and I submit that vague and nonspecific reasons for the proposed actions won’t make it. Doctors are going to get letters saying, ‘We have a problem with these charts. . . .’ [T]he hospital will load it on. They will have culled the record, they will have gone through everything, and the doctor in question will be made to respond to a whole raft of allegations, within a period of time very short normally one or two weeks. . . . I submit that there should [also] be a provision for access to records and copying of records, as required for the fair defense of the case.”).

73. H.R. REP. NO. 99-903, pt.1, at 10 (1986).

74. *Id.*

75. *Id.* at 10–11. Again, there is no illumination about what kind of tests these are or what other tests for adequacy might contain.

76. § 11112(b) (emphasis added).

requires under these provisions and what kind of process a peer review committee needs to provide to meet the floor of adequacy.⁷⁷ However, the statute itself gives no particular insight into what satisfies for adequate notice and hearing outside of the safe harbor requirements.

The third point under this section in the statute, § 11112(c), provides certain conditions under which adequate notice and hearing process may be suspended or satisfied due to several emergency situations:

[§ 11112](c) Adequate procedures in investigations or health emergencies[:] For purposes of section 11111(a) of this title, nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3) of this section—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.⁷⁸

Thus if no professional review action is taken, as defined elsewhere in the statute, or there is a relatively short time period or danger involved in taking the time for more process, then the bar for adequacy of process may be moved lower.⁷⁹ The Committee on Energy and Commerce also notes that “due process can be different in health emergencies”⁸⁰

77. This statement seems to undermine the entire section. *Subcomm. Hearings, supra* note 2, at 80 (statement of Victor M. Glasberg) (“The immunity is predicated on the due process being provided and then at the end of the provision they say, oh, by the way, with regard to that due process, if you didn’t provide it, it doesn’t matter. That is not right.”).

78. § 11112(c).

79. *Id.*

80. H.R. REP. NO. 99-903, at 6.

II. CIRCUIT COURTS' INTERPRETATION OF THE HEALTH CARE QUALITY IMPROVEMENT ACT

Since the passage of the Health Care Quality Improvement Act in 1986, circuit-level courts have interpreted it or considered its provisions only seventy-two times.⁸¹ Only twenty-six of these cases dealt specifically with § 11112(a)(3) of HCQIA, which invokes the requirement that the peer review action at issue provide adequate notice and hearing procedures.⁸² If it is so imperative that doctors be protected during the peer review process, even as the occurrence and reporting of that process is being incentivized, then why is there not more litigation on this issue in the more than twenty-five years since the statute has been in existence? Courts have skirted the application of § 11112(a)(3) through finding a lack of an independent cause of action in the statute, waiver of the part of physicians, or the use of summary judgment to solve the problem as a pure legal question where the presumption lands against the physician.

A. Presentation of Statutory Due Process Argument before Circuit Courts

Initially, an obstacle to analyzing due process requirements under the statute stems from the fact that HCQIA itself provides no independent cause of action for a physician against a hospital.⁸³ There is nothing in the text of the statute itself to support a cause of action where a physician could sue a hospital for lack of due process in this area, but the Supreme Court has said in some cases statutory causes of action may be implied.⁸⁴ In order to determine whether an implied cause of action exists, four factors must be considered:

First, is the plaintiff 'one of the class for whose especial benefit the statute was enacted,' that is, does the statute create a federal right in favor of the plaintiff? *Second*, is there any indication of legislative intent, explicit or implicit, either to create such a remedy or to deny one?

81. This number was derived from performing a Westlaw search for "HCQIA" in the federal circuit courts. Those cases were then reviewed for relevance and are available in list format in a chart on file with the author [hereinafter "Chart"].

82. Chart, *supra* note 81.

83. Three separate circuit courts have ruled specifically on this issue. *Wayne v. Genesis Med. Ctr.*, 140 F.3d 1145, 1148 (8th Cir. 1998); *Bok v. Mut. Assurance, Inc.*, 119 F.3d 927, 928 (11th Cir. 1997); *Hancock v. Blue Cross-Blue Shield of Kan.*, 21 F.3d 373, 374-75 (10th Cir. 1994).

84. *Bok*, 119 F.3d at 928 ("When legislation does not provide expressly for a cause of action for individual plaintiffs, the legislation must provide an implied cause of action in order for individual plaintiffs to be able to sue under the legislation." (citing *Cort v. Ash*, 422 U.S. 66, 78 (1975))).

Third, is it consistent with the underlying purposes of the legislative scheme to imply such a remedy for the plaintiff? And *finally*, is the cause of action one traditionally relegated to state law, in an area basically the concern of the States, so that it would be inappropriate to infer a cause of action based solely on federal law?⁸⁵

The lower courts that have analyzed the issue of an implied cause of action in HCQIA have uniformly rejected an implied cause of action in the statute.⁸⁶ Instead, these courts have concluded that Congress did not enact the statute for the purpose of benefitting physicians but rather to encourage peer review against physicians.⁸⁷ This means that even if a hospital did not provide adequate notice and a hearing, a physician may not sue a hospital on that basis.

There is a possible cause of action for physicians that are reviewed by *public* hospitals, as their actions would potentially be governed by constitutional due process protections. State actors are not permitted to infringe on certain protected interests without providing proper due process of law.⁸⁸ However, public hospitals comprise less than twenty-five percent of all hospitals in the United States, so it is much less common for issues to arise from the peer review process.⁸⁹ Moreover, private health care entities do not have a parallel restriction unless one can be mined from the language or purposes of HCQIA. Any statutory protection for due process, however,

85. *Cort*, 422 U.S. at 78 (emphasis added).

86. *Wayne*, 140 F.3d at 1148 (“HCQIA does not explicitly or implicitly afford aggrieved physicians a cause of action when a hospital fails to follow the HCQIA’s prescribed peer review procedures.”); *Bok*, 119 F.3d at 929 (“Concluding that the HCQIA does not provide for a private cause of action”); *Hancock*, 21 F.3d at 374 (“However, the HCQIA does not expressly create a cause of action in favor of a physician against a professional peer review group that has violated its due process requirements.” (citing and accepting the trial court’s opinion)).

87. *Wayne*, 140 F.3d at 1148 (“The HCQIA’s grant of immunity to review boards strongly suggests that the Act was not enacted to benefit the physician undergoing peer review.”); *Bok*, 119 F.3d at 929 (“We agree . . . that Congress did not pass the HCQIA with the intent of benefitting physicians”); *Hancock*, 21 F.3d at 374 (“ . . . HCQIA was not enacted to benefit physicians subject to peer review”). These courts have also agreed that an overall weighing of the *Cort* factors also does not favor finding an implied cause of action. *Wayne*, 140 F.3d at 1148 (“We conclude that none of these relevant factors weighs in favor of an implied cause of action.”); *Bok*, 119 F.3d at 929 (“More importantly, a weighing of the *Cort* factors also argues against finding an implied cause of action in the HCQIA.”); *Hancock*, 21 F.3d at 374 (“A weighing of the factors outlined in *Cort v. Ash* leads the court to conclude that Congress did not intend to create a cause of action for the benefit of physicians to enforce provisions of the HCQIA.” (citing and accepting the trial court’s opinion)).

88. U.S. CONST. amend. XIV, § 2.

89. TARESSA FRAZE ET AL., HEALTHCARE COST AND UTILIZATION PROJECT, STATISTICAL BRIEF #95: PUBLIC HOSPITALS IN THE UNITED STATES 2008 (2010), available at <http://www.hcup-us.ahrq.gov/reports/statbriefs/sb95.pdf>.

would still not provide an independent cause of action for this type of violation.

If an argument about the adequacy of procedures is raised to a court, it is raised only to mitigate the immunity that a hospital is already using as a shield. Therefore, a physician would sue for an independent claim such as defamation or antitrust and the hospital would assert HCQIA immunity against such a claim.⁹⁰ In order to overcome this immunity defense, a physician would *then raise* the issue about adequacy of proceedings to defeat that immunity. Inadequate procedures are never enough under HCQIA to initiate the physician's claim—no matter how severe the violation.

Courts have tried to soften this analysis with the understanding that HCQIA only provides immunity for monetary damages and does not prevent declaratory or injunctive relief.⁹¹ For example, the Fifth Circuit in *Polinar v. Texas Health Systems* explained:

It bears emphasizing that . . . hospitals and peer review committees that comply with the HCQIA's requirements are [not] free to violate the applicable bylaws and state law. The HCQIA does not gainsay the potential for abuse of the peer review process. To the contrary, Congress limited the reach of immunity to money damages. The doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive or declaratory relief in response to such treatment. The immunity from money damages may work harsh outcomes in certain circumstances, but that results from Congress' decision that the system-wide benefit of robust peer review in rooting out incompetent physicians, protecting patients, and preventing malpractice outweighs those occasional harsh results; that giving physicians access to the courts to assure procedural protections while denying a remedy of money damages strikes the balance of remedies essential to Congress' objective of vigorous peer review. The doctor may not recover money damages, but can access the court for other relief preventive of an abusive peer review.⁹²

However, none of the cases before courts of appeals argued or raised the issue of declaratory or injunctive relief. This is partially because HCQIA

90. It is true that HCQIA only immunizes for monetary damages, and injunctive or declaratory relief is still available. 42 U.S.C. § 11111(a) (2013).

91. *See, e.g., Polinar v. Tex. Health Sys.*, 537 F.3d 368, 381 (5th Cir. 2008); *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 211 (4th Cir. 2002).

92. *Polinar*, 537 F.3d at 381.

does not provide a cause of action to remedy lack of procedure but only provides immunity. It may also be that monetary damages are the desired remedy to deter problematic peer review. The converse of this is also unfortunately true, if a hospital violates its bylaws or state laws in providing procedure to a physician, HCQIA offers no protection. As the Fourth Circuit notes, “[n]othing in HCQIA makes immunity depend on adherence to bylaws.”⁹³

There are also times where a physician will either intentionally or unintentionally waive his or her ability to raise a procedural claim.⁹⁴ For example, in the Fourth Circuit a plaintiff physician waived his right to object before the court because he did not object to the composition of a hearing panel at the time it was convened.⁹⁵ To be fair, the statute does explicitly state in § 11112(b) that the requirements of subsection (a)(3) will be met if they are “waived voluntarily by the physician.”⁹⁶ However, if the requirements under the safe harbor provision are not requirements at all but mere guidelines, how confident can a court be that a physician has properly waived them or even understands what pieces of process are necessary to induce fairness at the time of the hearing? Without a rubric or a firm list of requirements, waiver seems at best to be illusory.

Even when claims about proper procedural process are raised, the larger claim about HCQIA immunity is usually settled at the summary judgment stage. Courts have broadly viewed the presence of immunity as a “question of law for the court to decide . . . [that] may be resolved whenever the record in a particular case becomes sufficiently developed.”⁹⁷ The Eleventh Circuit pointed out in *Bryan v. James E. Holmes Regional Medical Center* that the House Committee intended for the provisions of HCQIA to allow defendants to resolve the issue of immunity in as expeditious a manner as possible and intended for a court to determine immunity even though other issues remained to be resolved.⁹⁸ The court noted, “[t]he substantive standards under HCQIA remain the same regardless of the point at which the immunity determination occurs.”⁹⁹ The court then compared HCQIA immunity with immunity under 42 U.S.C. § 1983 and held that qualified immunity in either case should not become a part of the jury instructions once the defense has been denied on a motion for summary judgment.¹⁰⁰ While not making this same direct comparison,

93. *Wieters v. Roper Hosp., Inc.*, 58 Fed.Appx. 40, 46 (4th Cir. 2003).

94. *See e.g.*, *Moore v. Williamsburg Reg'l Hosp.*, 560 F.3d 166, 176 (4th Cir. 2009); *Meyers v. Columbia/HCA Health Corp.*, 341 F.3d 461, 470 (6th Cir. 2003); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 915 (8th Cir. 1999); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1336 (11th Cir. 1994).

95. *Moore*, 560 F.3d at 176.

96. 42 U.S.C. § 11112(b) (2013).

97. *Bryan*, 33 F.3d at 1332.

98. *Id.* at 1332 and n.24.

99. *Id.* at 1332.

100. *Id.* at 1332–33.

other courts have similarly concluded that the issue of immunity is a legal question.¹⁰¹

Contrariwise, the First Circuit in *Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*, would draw a line between immunity under HCQIA with immunity under 42 U.S.C. § 1983 because “[q]ualified immunity determinations under § 1983 are ‘question[s] of law, subject to resolution by the judge and not the jury,’ while HCQIA immunity determinations may be resolved by a jury if they cannot be resolved at the summary judgment stage.”¹⁰² Making this division would make HCQIA immunity, especially questions involving adequate process, a fact-based question that could be answered by either a judge or a jury as opposed to a pure legal question. The court found this distinction appropriate because qualified immunity analysis for § 1983 involves a “quintessential legal question: whether the rights at issue are clearly established.”¹⁰³ HCQIA immunity does not involve such a clear legal question, although the court did concede that “determinations under the HCQIA may often become legal determinations appropriate for resolution by the judge at summary judgment.”¹⁰⁴ A further distinction was drawn between the two types of immunity because qualified immunity under § 1983 is an immunity from suit that is effectively lost if a case is erroneously permitted to go to trial while HCQIA is a mere defense to liability for monetary damages only.¹⁰⁵ If a suit is improperly allowed to continue when § 1983 immunity is present, the harm is partially in merely allowing the suit to continue. However, under HCQIA, if money damages are not awarded, litigating over whether they should be does not violate the immunity in and of itself.¹⁰⁶

The First Circuit further argues that there is no reason to insulate the determination of proper peer review actions from jurors, because while peer review actions may not be “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.”¹⁰⁷ If jurors are asked to conclude about the quality of medical care in medical malpractice cases, there is no reason to exclude them from decisions about immunity determinations under the statute.¹⁰⁸

101. *See, e.g.*, *Doe v. La. Psychiatric Med. Ass’n*, No. 96-30232, 1996 WL 670414, at *2 (5th Cir. Oct. 28, 1996) (“[T]he issue of immunity is a legal question for the court to decide.”); *Parsons v. Sanchez*, No. 93-55656, 1995 WL 21695, at *4 (9th Cir. Jan. 19, 1995) (“Congress intended for the court to address the immunity issue well before trial.”).

102. 308 F.3d 25, 34–35 (1st Cir. 2002) (citations omitted).

103. *Id.* at 35.

104. *Id.* at 36.

105. *Id.* at 35.

106. *Id.* *See also* *Decker v. IHC Hosps., Inc.*, 982 F.2d 433, 436 (10th Cir. 1992) (holding that HCQIA immunity is “immunity from liability only,” not an immunity from suit).

107. *Singh*, 308 F.3d at 35.

108. *Id.*

While some courts debate about whether the issue of immunity should ever be given to a jury, other courts avoid the issue by simply resolving immunity determinations under HCQIA at the summary judgment stage. However, summary judgment determinations about immunity in this context are described by most courts to be “unusual” because of a presumption provision contained in the statute.¹⁰⁹ The statute states, after laying out the requirements necessary for a health care entity to receive immunity, that “[a] professional review action shall be *presumed* to have met the preceding standards necessary for the protection set out in section 1111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.”¹¹⁰ This presumption language creates a standard for summary judgment that asks, irrespective of the party moving for summary judgment, “[m]ight a reasonable jury, viewing the facts in the best light for [the plaintiff physician] conclude that [he/she] has shown, by a preponderance of the evidence, that the [defendant hospital’s or defendant physicians’] actions are outside the scope of § 1112(a)?”¹¹¹ This means that “the *plaintiff* bears the burden of proving that the peer review process was *not* reasonable.”¹¹² Courts have understood this statutory language to “place[] a high burden on physicians to demonstrate that a professional review action should not be afforded immunity.”¹¹³ A lack of a cause of action contained in HCQIA combined with inappropriate waiver and a presumption that health care entities should receive immunity explains why this issue rarely presents itself before federal courts, and why so few physicians have been able to overcome these obstacles.

B. Analysis of Statutory Due Process before Circuit Courts

Circuit courts attempted to interpret or apply HCQIA seventy-two times since the statute was enacted, but only dealt with the issue of whether adequate notice and hearing was provided twenty-six times.¹¹⁴ Of those twenty-six cases, four were summary affirmations—the courts indicated that the physician had not provided by a preponderance of the evidence that

109. *See, e.g.*, *Moore v. John Deere Health Care Plan, Inc.*, 492 F. App’x 632, 636 (6th Cir. 2012); *Wahi v. Charleston Area Med. Ctr., Inc.*, 562 F.3d 599, 607 (4th Cir. 2009) (calling it an “unconventional standard”); *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 202 (3d Cir. 2005); *Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1070 (8th Cir. 2005) (“The statutory presumption . . . adds a rather unconventional twist to the burden of proof in our summary judgment standard of review.”); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468 (6th Cir. 2003); *Singh*, 308 F.3d at 33–34; *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir. 1994); *Austin v. McNamara*, 979 F.2d 728, 733–34 (9th Cir. 1992).

110. 42 U.S.C. § 1112(a) (2013) (emphasis added).

111. *Austin*, 979 F.2d at 733–34.

112. *Bryan*, 33 F.3d at 1333.

113. *See, e.g.*, *Gordon*, 423 F.3d at 202.

114. Chart, *supra* note 81.

the process was inadequate with absolutely no explanation or reasoning.¹¹⁵ Only twice did the physician prevail in while claiming an issue of inadequate hearing or notice (and only three times total out of seventy-two cases did the physician prevail in any capacity) and the courts found in those cases that the district courts simply did not consider the issue of HCQIA or whether the presumption was overcome and instructed them to do so.¹¹⁶ However, in both of those cases, the physician was ultimately denied any relief from HCQIA immunity.¹¹⁷

Initially, it is important to note, that the courts, like Congress, believe strongly that § 11112(a)(3) provides a due process component.¹¹⁸

115. Three of these summary affirmations occurred in the Fifth Circuit and one in the Third Circuit. *Angelico v. Lehigh Valley Hosp., Inc.*, 85 F. App'x 308 (3d Cir. 2004); *Van v. Anderson*, 66 F. App'x 524 (5th Cir. 2003); *Payne v. Harris Methodist HEB*, 44 F. App'x 652 (5th Cir. 2002); *Pickett v. HCA Hosp. Corp.*, 199 F.3d 440 (5th Cir. 1999).

116. *Bundren v. Parriott*, 245 F. App'x 822, 826 (10th Cir. 2007) ("Dr. Bundren . . . attacked the fairness of the . . . proceeding Given these attacks on the . . . proceeding, the district court should have determined whether Dr. Bundren had overcome the presumption that the § 11112(a) factors were met. It did not do so."); *Brader v. Allegheny Gen. Hosp.*, 64 F.3d 869, 879 (3d Cir. 1995) ("If Brader's allegations, such as the alleged failure to provide Brader with fair hearing procedures, are true, the defendants would not be entitled to HCQIA immunity. We therefore decline to affirm the district court's dismissal of Brader's claims on the alternative grounds of HCQIA immunity."). The third case of a doctor prevailing under HCQIA was *Brown v. Presbyterian Healthcare Services*, but it did not have to do with adequate notice and hearing. 101 F.3d 1324, 1333 (10th Cir. 1996) ("At trial, Dr. Brown presented sufficient evidence for a reasonable jury to find, by a preponderance of the evidence, the peer review action was not taken after a 'reasonable effort to obtain the facts of the matter.'").

117. The Tenth Circuit affirmed the summary judgment against the physician on the merits of his original claims without regard to the claims of HCQIA immunity. *Bundren*, 245 F. App'x at 826–27. The Third Circuit later found that the hospital had met the requirements under HCQIA for immunity. *Brader*, 167 F.3d at 832.

118. *See, e.g.*, *Johnson v. Spohn*, 334 F. App'x 673, 682 (5th Cir. 2009) ("[A]ppellees were required to grant Dr. Johnson *due process* protections at some point prior to the final revocation of his medical staff membership and clinical privileges.") (emphasis added); *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 211 (4th Cir. 2002) ("For HCQIA immunity to attach, however, the peer review action must comport with *due process*." (emphasis added)); *Sugarbaker v. SSM Healthcare*, 190 F.3d 905, 915 (8th Cir. 1999) ("The failure to provide a physician with adequate notice and fair procedures precludes immunity under the HCQIA. Dr. Sugarbaker asserts that evidence . . . rebut[s] the presumption that St. Mary's provided adequate notice and *due process* in this case.") (emphasis added); *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 632 (3d Cir. 1996) ("The standards that a professional review action must satisfy in order to entitle participants in the review process to immunity . . . include certain fairness and *due process* requirements.") (emphasis added); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1321–22 (11th Cir. 1994) ("Accordingly, HCQIA provides that, if a 'professional review action' (as defined in the statute) meets certain *due process* and fairness requirements, then those participating in such a review process shall not be liable . . .") (emphasis added); *Hancock v. Blue Cross-Blue Shield of Kan., Inc.*, 21 F.3d 373, 374 (10th Cir. 1994) ("The HCQIA's granting of professional peer review immunity, however, is conditioned by two factors. First, a professional peer review group must provide adequate *due process* protection to the physician subjected to review.") (emphasis added); *Austin v. McNamara*, 979 F.2d 728, 733 (9th Cir. 1992) ("HCQIA provides that if a 'professional review action' (as defined in

The immunity contained in the statute is conditioned partially upon a provision of “adequate due process protection to the physician subjected to the review.”¹¹⁹ However, the real problem is that courts have no way to analyze whether due process protections in any given situation are “adequate” besides holding them up to the safe harbor provisions of the statute, or in some cases a hospital’s bylaws. Even when a hospital violates its own bylaws or does not provide what is required under § 11112(b), a court will point out that the statute does not require full compliance with those listed procedures.¹²⁰ There is no rubric for adequacy given in the statute and courts have uniformly declined to adopt one. For example, the Tenth Circuit in *Hancock v. Blue Cross-Blue Shield of Kansas* notes that a professional peer review group must provide adequate due process protection, but further states, “HCQIA details a number of procedures which Congress deemed to be adequate due process, and creates a rebuttable presumption that the professional peer review group met the due process requirements *even if* it did not follow the HCQIA’s procedures.”¹²¹ Therefore there is no way inside the language of the statute for a court to tell whether a health care entity has provided adequate notice and hearing procedures but merely a requirement that these things exist. This line of thinking renders the safe harbor provisions in § 11112(b) virtually meaningless and does not help to provide physicians with any procedural protection.

Courts have sometimes at least recognized that, at base, the due process requirements in HCQIA must imply there is some kind of notice to the physician and an opportunity for him or her to be heard (just like the base requirement of constitutional due process).¹²² However, some courts seem to be confusing the safe harbor provisions that *can* satisfy the adequacy requirement as the only list against which violations may be

HCQIA) meets certain *due process* and fairness requirements, then those participating in the review ‘shall not be liable in damages’”) (emphasis added).

119. *Hancock*, 21 F.3d at 374.

120. *See, e.g.*, *Wieters v. Roper Hosp., Inc.*, 58 F. App’x 40, 46 (4th Cir. 2003) (“Although Dr. Wieters has pointed out parts of the process that did not hew strictly to the bylaws and the safe harbor provisions, he has presented nothing that would lead a reasonable jury to find by a preponderance of the evidence that the hospital treated him unfairly under the circumstances.”); *Meyers v. Columbia/HCA Health Corp.*, 341 F.3d 461, 469–70 (6th Cir. 2003) (“[Doctor] argues that a reasonable jury could conclude that LMH did not provide adequate notice and procedures because it did not comply with its own bylaws. . . . [E]ven assuming LMH did violate the bylaws, the notice and procedures provided complied with the HCQIA’s statutory ‘safe harbor’”).

121. *Hancock*, 21 F.3d at 374 (emphasis added).

122. *See, e.g.*, *Soriano v. Neshoba Cnty. Gen. Hosp. Bd. of Trs.*, 486 F. App’x 444, 446 (5th Cir. 2012) (“His procedural due process rights were not violated. . . . ‘The essential requirements of procedural due process under the Constitution are notice and an opportunity to respond.’”) (citation omitted); *Lee v. Trinity Lutheran Hosp.*, 408 F.3d 1064, 1072 (8th Cir. 2005) (“We also reject Dr. Lee’s argument that the hospital did not afford her ‘adequate notice and hearing procedures,’ as required by § 11112(a)(3) Dr. Lee had ample notice and an opportunity to be heard.”).

measured. In other words, these courts have held that if a piece of process is not listed in the statute it is *never* required in order to have an adequate process. For example, the Ninth Circuit in *Smith v. Ricks* involved a challenge from Dr. Smith concerning his removal from Good Samaritan Hospital.¹²³ The court concluded that the allegation of defects in the procedure was an attempt by Dr. Smith to convert “peer review proceedings to look like regular trials in a court of law.”¹²⁴ However, “nothing in the statute requires such formalities.”¹²⁵ This was held to be true even though “[t]he statute expressly provides that hospitals need not meet all of the § 11112(b) requirements. The ultimate inquiry is whether the notice and hearing procedures were *adequate*.”¹²⁶ The court never identifies which formalities suffice for adequacy and which are those that the statute does not require. Ultimately the court does conclude that either the procedures undertaken by the hospital satisfy § 11112(b) safe harbor provisions or they are “so close to the ‘safe harbor’ that no reasonable jury could find Dr. Smith rebutted the presumption that the procedures were adequate.”¹²⁷ No indication was given by the court as to how wide the margin of error was for procedures to be “so close” to the safe harbor provisions as to still be adequate.

Similarly, in the Fourth Circuit case of *Freilich v. Upper Chesapeake Health, Inc.*, the court concluded that Dr. Freilich’s seventeen alleged procedural defects, including permitting hearsay and denying hospital privileges when no incompetence had been found, were insufficient to deny HCQIA immunity.¹²⁸ Her allegations were interpreted by the court that “she would like this court to rewrite the HCQIA. . . . [W]e cannot substitute our judgment, or that of Dr. Freilich, for Congress’s rationally based belief that the HCQIA is an effective means to achieve its goal.”¹²⁹ Merely alleging that certain procedures were necessary to be “fair under her circumstances” was tantamount to the court to a claim to rewrite the statute to mandate them in all cases.

The First Circuit has also held that “the HCQIA procedural standard does not require . . . such a procedural safeguard [as claimed by the plaintiff]. Nothing in the Act *requires* that a physician be permitted to participate in the review of his care.”¹³⁰ Apparently, the fear is that in imposing *any* additional requirements or of merely requiring some of the requirements in the safe harbor provision would “force every informal review activity of a doctor or a department into time-consuming and

123. 31 F.3d 1478, 1481 (9th Cir. 1994).

124. *Id.* at 1487.

125. *Id.*

126. *Id.* at 1486. (emphasis added).

127. *Id.* at 1487.

128. 313 F.3d 205, 212 (4th Cir. 2002).

129. *Id.*

130. *Singh v. Blue Cross-Blue Shield of Mass., Inc.*, 308 F.3d 25, 40 (1st Cir. 2002) (emphasis added) (internal quotation marks omitted).

(depending on the outcome of the informal review) possibly unnecessary formalized proceedings.”¹³¹

In some extreme cases, procedures that are “fair to the physician under the circumstances” might even result in a complete lack of a hearing. The Fourth Circuit in *Wahi v. Charleston Area Medical Center, Inc.* concluded that not providing a hearing did not necessarily violate HCQIA’s statutory requirements.¹³² The court interpreted the statute to provide immunity in two capacities under § 11112(a)(3) because “[s]tated in the disjunctive, the statute contemplates two independent avenues by which the subsection (a) immunity prong may be obtained.”¹³³ Either immunity can be achieved by providing “adequate notice and hearing procedures” or it may be obtained by using “other procedures as are fair to the physician under the circumstances.”¹³⁴ It is completely unclear why inadequate notice and hearing procedures would ever be fair unless relying on the emergency valve of § 11112(c) that is already provided. Even though the legislative history notes a concerted effort to protect the doctor in the process of peer review,¹³⁵ the Fourth Circuit contends, “[n]othing in this legislative history alters the conclusion that a health care entity can satisfy subsection (a)(3) without providing a formal hearing, as contemplated in the safe harbor provisions, depending on the circumstances of a particular case.”¹³⁶ In other words, sometimes it is fair to the physician under the circumstances to provide no hearing at all.

There is no more of a rubric for “fairness” than there is for “adequacy of proceedings,” should proceedings occur at all. Another example of a hospital offering no hearing whatsoever is in the Ninth Circuit case of *Fox v. Good Samaritan Hospital*, where:

[a]lthough Good Samaritan did not offer Fox a formal administrative hearing, such a hearing was not necessary under the unique circumstances of Fox’s case A formal hearing geared toward resolving factual disputes would therefore have done nothing to help Fox’s case or aid Good Samaritan’s decision-making.¹³⁷

Factual disputes are also necessary to lodge a constitutional procedural due process claim,¹³⁸ however, as physicians are unable to challenge the abuse

131. See *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 842 (3d Cir. 1999).

132. 562 F.3d 599, 606 (4th Cir. 2009).

133. *Id.* at 608.

134. *Id.*

135. See *Subcomm. Hearings*, *supra* note 2, at 52.

136. *Wahi*, 562 F.3d at 609.

137. 467 F. App’x 731, 735 (9th Cir. 2012).

138. *Codd v. Velger*, 429 U.S. 624, 627 (1977) (“But if the hearing mandated by the Due Process Clause is to serve any useful purpose, there must be some factual dispute between an employer and a discharged employee which has some significant bearing on the

of a lack of hearing directly and may inadvertently waive their right to a hearing, a complete lack of procedure seems inapposite to the purpose of the statute. Furthermore, without notice or an opportunity to respond, it may be impossible in some cases to determine whether there is indeed a factual dispute.

Even with some resistance on the part of some circuit courts to offer the overall question of HCQIA immunity to a jury,¹³⁹ other courts have concluded that summary judgment is appropriate because a reasonable jury could find that the treatment of the physician was fair under the circumstances.¹⁴⁰ This type of conclusion begins with the premise that the adequacy of process may be measured with an objective standard of reasonableness.

There has been some debate in the circuit courts over the use of the word “reasonable” in the other three standards that confer HCQIA immunity:¹⁴¹ “a professional review action must be taken . . . in the *reasonable* belief that the action was in the furtherance of quality health care . . . after a *reasonable* effort to obtain the facts of the matter . . . in the *reasonable* belief that the action was warranted by the facts known.”¹⁴² The Ninth Circuit contended that “the legislative history of HCQIA reveals that Congress rejected a subjective standard in favor of an objective . . . standard,” therefore, “the propriety of professional review actions *only* concern[] issues of objective reasonableness.”¹⁴³ This makes any claims of bad faith on the part of the reviewing panel irrelevant to the concern of whether it should receive immunity.¹⁴⁴ The Eleventh Circuit

employee’s reputation.”). However, adequate notice and an opportunity to refute the charges should there be some sort of factual dispute is still required.

139. *See, e.g., Parsons v. Sanchez*, No. 93-55656, 1995 WL 21695, at *4 (9th Cir. Jan. 19, 1995) (“Parsons contends that the immunity defense raises issues of subjective intent that cannot be resolved at the summary judgment stage. We reject this argument, because the propriety of professional review actions only concerns issues of objective reasonableness.”); *Bryan v. James E. Holmes Reg’l Med. Ctr.*, 33 F.3d 1318, 1322 (11th Cir. 1994).

140. *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 633 (3d Cir. 1996) (citing *Bryan*, 33 F.3d at 1333) (“We must examine the record in this case to determine whether [Dr. Mathews] satisfied his burden of producing evidence that would allow a reasonable jury to conclude that the Hospital’s peer review disciplinary process failed to meet the standards of the [Act].”).

141. *See, e.g., Parsons*, 1995 WL 21695; *Bryan*, 33 F.3d at 1335.

142. 42 U.S.C. § 11112(a) (2012) (emphasis added).

143. *Parsons*, 1995 WL 21695, at *4. This is partially borne out in the language of the Committee on Energy and Commerce Report. (“Initially, the Committee considered a ‘good faith’ standard for professional review actions. 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, the Committee changed to a more objective ‘reasonable belief’ standard. The Committee intends that this test will be satisfied if reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.”) H.R. REP. NO. 99-903, pt. 1, at 10 (1986), *reprinted in* 1986 U.S.C.C.A.N. 6392.

144. *Parsons*, 1995 WL 21695, at *4–5.

found immunity when a physician was terminated due to his hostile behavior towards his fellow staff members.¹⁴⁵ The hospital was found to have acted in the reasonable belief that its actions were to protect patients even though the physician claimed the action was a personal vendetta by the board members.¹⁴⁶ The court claimed that:

assertions of hostility do not support [the doctor's] position [that the Hospital is not entitled to the HCQIA's protections] because they are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial. The real issue is the sufficiency of the basis for the [Hospital's] actions.¹⁴⁷

This kind of judicial interpretation ignores any motivation on the part of the peer review committee or health care entity to abuse the peer review process for reasons incompatible with patient care. Essentially the courts are abdicating the oversight role given to them by the statute when insulating their “reasonableness” analysis from clear subjective malice in initiating the process of peer review or the conduction of procedures as a whole. It also removes consideration of whether or not the decisionmaker was neutral, which is a key consideration in constitutional procedural due process claims.¹⁴⁸

Courts also tend to read all of the requirements for immunity together, imputing this objective reasonableness standard into the adequacy component as well.¹⁴⁹ This leads to minimal analysis about the adequacy of

145. *Bryan*, 33 F.3d at 1335.

146. *Id.*

147. *Id.* (quoting *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)).

148. *Withrow v. Larkin*, 421 U.S. 35, 58 (1975) (“Clearly, if the initial view of the facts based on the evidence derived from nonadversarial processes as a practical or legal matter foreclosed fair and effective consideration at a subsequent adversary hearing leading to ultimate decision, a substantial due process question would be raised.”).

149. *See, e.g.*, *Moore v. John Deere Health Care Plan, Inc.*, 492 F. App'x 632, 638 (6th Cir. 2012) (“A professional review action is presumed to satisfy HCQIA’s four-factor reasonableness test for immunity unless rebutted by a preponderance of the evidence.”); *Cohlmi v. St. John Med. Ctr.*, 693 F.3d 1269, 1277 (10th Cir. 2012) (“The entity or persons that undertake the professional review are immune under HCQIA as long as they substantially comply with a list of objective standards set forth in the Act.”); *Wahi v. Charleston Area Med. Ctr.*, 562 F.3d 599, 607 (4th Cir. 2009) (“In determining whether a health care entity has met these four [immunity] requirements, the Court applies an objective test”); *Poliner v. Texas Health Sys.*, 537 F.3d 368, 377 (5th Cir. 2008) (“We agree with our sister circuits that the HCQIA’s reasonableness requirements were intended to create an objective standard of performance”) (internal quotation marks omitted); *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir. 2002) (“Adopting objective reasonable belief standards, the HCQIA advances the Congressional purpose of permitting a determination of immunity without extensive inquiry into the state of mind of peer reviewers. . . . Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards.”) (internal quotation marks omitted); *Smith v. Ricks*, 31 F.3d 1478,

any given proceeding and can even allow the immunity requirements to blend into one sliding scale of “reasonableness” rather than four independent, necessary requirements. Several circuits have relied on whether the court believes in the abstract that a reasonable jury could conclude that the process was unfair.¹⁵⁰

The Fourth Circuit has further imported this objectivity into an analytical framework that looks to the totality of the circumstances for whether HCQIA immunity is appropriate.¹⁵¹ Even when a hospital failed to follow its own bylaws and procedures manual or provide the doctor with a list of witnesses who would testify against him, the court said, “[T]hese failures by [Charleston Area Medical Center], when viewed in the *totality of the circumstances* against a measuring stick of *objective reasonableness*, do not show [Dr.] Wahi met his burden of proof to rebut the presumption of immunity under the HCQIA.”¹⁵² According to the court, if a physician can allege procedural deficiencies on behalf of the hospital or reviewing panel, it is determined from a jury’s perspective whether that renders the process unfair or objectively unreasonable.¹⁵³

In 2013, the Fourth Circuit again used this rubric in the case of Dr. Muniz, saying “[w]e do not believe that a reasonable jury could find that the procedural irregularities involving the hearing officer—unwise though some of them were—rendered Muniz’s peer review process unfair or objectively unreasonable.”¹⁵⁴ Rather than determine what procedures would be appropriate to satisfy the statutory requirement, the court concluded, “[a] reasonable jury could only conclude that it was ‘fair’ for the Board to terminate Muniz after giving her extensive opportunity in a lengthy hearing to explain her misrepresentations.”¹⁵⁵ This kind of analysis completely ignores the list of safe harbor provisions Congress provided in § 11112(b) as an example of a proceeding that would be adequate in favor of the most informal procedure possible. It reduces the floor to mere notice and an opportunity to be heard, with no real measuring calculus for either component.

1485 (9th Cir. 1994) (“Because the ‘reasonableness’ requirements of § 11112(a) were intended to create an objective standard . . .”).

150. See, e.g., *Moore*, 492 F. App’x at 641 (“The district court found that a reasonable jury could not find by a preponderance of evidence that the peer review action in this case was taken in the absence of adequate notice and hearing procedures . . . [T]he district court correctly found that Moore failed to meet his burden . . .”); *Smith*, 31 F.3d at 1487 (“Good Samaritan’s procedures either fit into the § 11112(b)(3) ‘safe harbor,’ or are so close to the ‘safe harbor’ that no reasonable jury could find Dr. Smith rebutted the presumption that the procedures were adequate.”).

151. *Wahi*, 562 F.3d at 606.

152. *Id.* at 614.

153. *Id.* at 607.

154. *Hein-Muniz v. Aiken Reg’l Med. Ctrs.*, 532 F. App’x 342, 344 (4th Cir. 2013).

155. *Id.* at 345.

III. IMPORTING CONSTITUTIONAL DUE PROCESS ANALYSIS TO THE HEALTH CARE QUALITY IMPROVEMENT ACT

A. Constitutional Due Process

When making a constitutional procedural due process claim, it is necessary that the individual be subject to government action in an individualized hearing that infringes on a protected interest.¹⁵⁶ Once due process has been triggered, a court must determine what process is due in any given situation.¹⁵⁷ There is no set standard of what procedures due process may provide for in any particular adjudication, although case law has created a continuum for the kinds of process that may be required.¹⁵⁸

At the floor, due process requires merely that an individual be given notice and an opportunity to be heard.¹⁵⁹ At the ceiling, due process can demand much or all of the process of a full trial.¹⁶⁰ The Court in *Goldberg* required significant procedure, including:

[T]imely and adequate notice detailing the reasons for the proposed termination; an effective opportunity to defend by confronting and cross-examining adverse witnesses and by presenting his own arguments and evidence orally, although informal procedures would suffice; the right to be represented by counsel, although not the right to have counsel provided; a decision that rests solely on the evidence adduced at the hearing; an impartial decisionmaker; and a statement by the decisionmaker explaining his decision and the evidence relied upon, although the statement need not be a “full opinion” or contain “formal findings of fact and conclusions of law.”¹⁶¹

While requiring an exhaustive list of procedures, the Court in *Goldberg* noted that “[t]he opportunity to be heard must be tailored to the capacities

156. RONALD D. ROTUNDA & JOHN E. NOWAK, TREATISE ON CONSTITUTIONAL LAW—SUBSTANCE & PROCEDURE § 17.1 (2014).

157. *Id.* § 17.8(i).

158. *Id.* § 17.9(c)(i).

159. *Goss v. Lopez*, 419 U.S. 565, 581 (1975) (holding that a student in a public high school was entitled to due process, but it was satisfied by minimal procedures) (“[O]ral or written notice of the charges against him and, if he denies them, an explanation of the evidence the authorities have and an opportunity to present his side of the story. The Clause requires at least these rudimentary precautions against unfair or mistaken findings of misconduct and arbitrary exclusion from school.”).

160. *Goldberg v. Kelly*, 397 U.S. 254, 268–69 (1970).

161. WILLIAM F. FUNK, SIDNEY A. SHAPIRO & RUSSELL L. WEAVER, ADMIN. PROCEDURE AND PRACTICE: PROBLEMS AND CASES 259 (5th ed. 2014) (discussing requirements of *Goldberg*).

and circumstances of those who are to be heard.”¹⁶² Once this continuum has been established, due process might require any number of procedures ranging from informal to formal, and the critical question becomes, how does a court tell what measure of process is constitutionally required in a given case?

From an administrative law perspective, which seems appropriate given the involvement of Health and Human Services under HCQIA, most agencies have a choice of procedures when performing adjudications like a peer review. Formal adjudications are only required when invoked under §§ 554, 556, and 557 of the Administrative Procedure Act.¹⁶³ Section 554 of the Administrative Procedure Act says that it will apply and trigger a formal hearing “in every case of adjudication required by statute to be determined on the record after an opportunity for an agency hearing.”¹⁶⁴ While not the full protection of a trial, a “formal agency hearing” still has strict requirements about notice, burden of proof, ex parte communications, testimony and cross-examination, and the record established.¹⁶⁵ Agencies also frequently conduct informal hearings and while those proceedings are unregulated directly by the Administrative Procedure Act,¹⁶⁶ they are still subject to the procedural due process protections of the federal constitution.¹⁶⁷ Informal hearings occur frequently and can invoke a variety of potential processes to satisfy constitutional requirements.¹⁶⁸

As the Supreme Court noted in *Goss*, while reifying a minimum of procedures, “the interpretation and application of the Due Process Clause [is an] intensely practical matter[] and that ‘[t]he very nature of due process negates any concept of inflexible procedures universally applicable to every imaginable situation.’”¹⁶⁹ How does an agency, or a hospital peer review

162. 397 U.S. at 268–69.

163. 5 U.S.C. §§ 554, 556, 557 (2014).

164. *Id.* § 554.

165. *Id.*

166. Although these adjudications are still subject to the ancillary requirements of § 555. CHARLES H. KOCH, JR. & RICHARD MURPHY, ADMINISTRATIVE LAW AND PRACTICE § 2:33(2)(b) (2015).

167. *Id.*

168. WILLIAM J. RICH, MODERN CONSTITUTIONAL LAW § 22:1–22:16 (3d ed. 2011) (“These potential processes include: adequate notice, right to counsel, right to prompt hearing and disposition, judicial hearings, right to present evidence, right to confrontation, privilege against self-incrimination, right to an impartial tribunal, right to a jury, allocation of burden of proof, and right to appeal.”). *See generally* Bd. of Curators of the Univ. of Missouri v. Horowitz, 435 U.S. 78 (1978) (holding that merely informing the student and making a careful and deliberate decision is sufficient procedure to satisfy due process); *Gabrilowitz v. Newman*, 582 F.2d. 100 (1st Cir. 1978) (holding that assistance of counsel at a university disciplinary hearing was required to satisfy due process when the student was charged with a crime); *Withrow v. Larkin*, 421 U.S. 35 (1975) (holding that a neutral decision maker, separate from the investigating committee, was not required to satisfy due process when deciding whether to suspend a physician’s license to practice medicine).

169. *Goss v. Lopez*, 419 U.S. 565, 578 (1975) (quoting *Cafeteria Workers v. McElroy*, 367 U.S. 886, 895 (1961)).

committee, determine where along the due process continuum is appropriate in any given case? For constitutional due process, courts almost uniformly use the rubric from *Mathews v. Eldridge* to determine how much process is due.¹⁷⁰

At issue in *Mathews* was whether Mr. Eldridge was entitled, under the due process clause, to receive an evidentiary hearing before the termination of his Social Security disability benefits.¹⁷¹ The Social Security Act provided cash benefits to workers who were completely disabled.¹⁷² Mr. Eldridge began receiving benefits in 1968 but after a series of letters the state agency made a final determination that his disability had ceased in May of 1972 and he would no longer receive benefits.¹⁷³ This determination was accepted by the federal Social Security Administration.¹⁷⁴ Eldridge sued, relying on the logic of *Goldberg v. Kelly*, that there was a due process right to an evidentiary hearing before termination of benefits.¹⁷⁵

After concluding that the due process clause did apply to his case, the Court noted that it had “consistently . . . held that some form of hearing is required before an individual is finally deprived of a property interest.”¹⁷⁶ While, “[t]he fundamental requirement of due process is the opportunity to be heard at a meaningful time and in a meaningful manner,” what process is due in any given circumstance “generally requires a consideration of three distinct factors.”¹⁷⁷ These three factors include: first, the private interest that will be affected by the action; second, the government’s interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirements would require; and third, the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards.¹⁷⁸

As Eldridge’s benefits were not based on financial need as the welfare benefits were in *Goldberg*, the Court did not weigh his individual interest to be overly strong, and the weight on the administration for full evidentiary hearings was high.¹⁷⁹ Moreover, disability benefits usually turned upon “routine, standard, and unbiased medical reports by physician specialists” and “the potential value of an evidentiary hearing, or even oral presentation to the decisionmaker is substantially less in this context than in

170. ROTUNDA & NOWAK, *supra* note 156, at § 17.8(i).

171. *Mathews v. Eldridge*, 424 U.S. 319, 323 (1976).

172. *Id.*

173. *Id.* at 323–24.

174. *Id.* at 324.

175. *Id.* at 324–25.

176. *Mathews*, 424 U.S. at 333 (citing *Wolff v. McDonnell*, 418 U.S. 539, 557–58 (1974)).

177. *Id.* at 333, 335 (citations omitted).

178. *Id.* at 335.

179. *Id.* at 340–41, 349.

Goldberg.¹⁸⁰ Therefore, when weighing out the factors, Mr. Eldridge was not entitled to an evidentiary hearing as a matter of constitutional, procedural due process protections.¹⁸¹ However, the formula remains. The way the factors are structured, particularly the third factor concerning the value of a piece of process, requires the aggrieved party to identify a piece of process that was missing in the underlying proceeding and argue for the merits of its inclusion.

B. The Appropriateness of Using *Mathews v. Eldridge* to Analyze Statutory Due Process Required by the Healthcare Quality Improvement Act

If a hospital is public and thus a state actor, then taking away a doctor's liberty interest in pursuing his or her profession or a property right in his or her employment via an individualized decision making may trigger the due process protections of the federal constitution.¹⁸² However, relying on the use of "adequate notice and hearing" and even "fair under the circumstances" combined with a robust legislative history and court analysis, it is clear that HCQIA is trying to import a due process standard into the peer review process. For analysis of procedural due process, the statutory framework means that there is no need to consider whether or not due process has been "triggered" as is done in a constitutional analysis of what interests are being protected and who is acting and how they are acting. Rather, in recognition of Congress' intention for doctors to have due process protections under the statute, the analysis may start with what process is due. Once that obstacle is overcome, there is no reason to suffer the application of § 11112(a)(3) without a rubric as to adequacy, as due

180. *Id.* at 344–45 (citations omitted).

181. *Mathews*, 424 U.S. at 349.

182. *See, e.g.,* *Schueller v. Goddard*, 631 F.3d 460, 462–63 (8th Cir. 2011) ("A protected property interest exists where a plaintiff has a 'legitimate claim of entitlement' to a benefit that is derived from a source such as state law" (quoting *Bd. of Regents v. Roth*, 408 U.S. 564, 577 (1972))). "To survive summary judgment on [his] property interest procedural due process claim, [Dr. Schueller] must provide evidence that [he] had a reasonable and legitimate expectation of continued employment" (quoting *Howard v. Columbia Pub. Sch. Dist.* 363 F.3d 797, 803 (8th Cir. 2004)); *Ming Wei Liu v. Bd. of Trs. of Univ. of Ala.*, 330 F. App'x 775, 780 (11th Cir. 2009) ("The Supreme Court has recognized that the liberty component of the Fourteenth Amendment's Due Process Clause includes the right to pursue a profession. . . . [However,] a claimant must present evidence suggesting that a governmental act effectively banned him or her from a profession."); *Osuagwu v. Gila Reg'l Med. Cen.*, 938 F. Supp. 2d 1142, 1159 (D.N.M. 2012) ("Gila Regional supplied Plaintiff with Bylaws that carefully restrict the termination or suspension of staff privileges and provide specific procedures to be followed in disciplinary or suspension actions. He has, therefore, established that he has a constitutionally-protected property right in his medical privileges.").

process jurisprudence has already provided one in the form of *Mathews v. Eldridge*.¹⁸³

Without this kind of procedural protection, it is as if, “[p]rivate hospitals, now largely supported by public moneys, [are not] required to govern their staff by accepted 20th Century democratic standards. Therefore, physicians . . . sacrifice[] their constitutional, civil, due process, 14th Amendment, and natural rights under peer review in private hospitals.”¹⁸⁴ Judicial interpretation of the statutory standard requiring adequate notice and hearing procedures has completely abandoned any desire to hold health care entities accountable to their bylaws, the safe harbor provisions, or any rubric for a proper hearing. The peer review process may be leveraged for abuse or induced for competitive reasons that have nothing to do with the furtherance of quality patient care. There is immunity for the process, but no oversight of the process itself.

Part of the problem with the application of the peer review process is that it has been used to oust physicians for reasons other than incompetence in the workplace. At times, the legal question has turned to whether the termination at issue was actually based on physician competence or rather based on other professional conduct or even private conduct that might impact the care of patients. For example, the Third Circuit in *Gordon v. Lewistown Hospital* extended HCQIA immunity to conduct that did not have a direct impact on any patients but still took place in a professional capacity.¹⁸⁵ Gordon, the physician, questioned whether the acts triggering the professional review action under HCQIA truly adversely affected patients.¹⁸⁶ Dr. Gordon was employing what he believed to be a better surgical technique than another physician at the hospital.¹⁸⁷ He ran ads in the newspaper advising potential patients to call the hospital to get more information about the two procedures and eventually went so far as to call the other physician’s patients to tell them disparaging information about the other physician.¹⁸⁸ The hospital initially only suspended Dr. Gordon for forty-five days and conditioned his return on not communicating with patients or others about the skills, competence, or procedures of other physicians at the hospital.¹⁸⁹ Dr. Gordon breached these obligations by placing a phone call to at least one patient and mailing

183. This would also stem resistance to the usage of procedural due process jurisprudence as a benchmark in cases that fall under both 42 U.S.C. § 1983 and HCQIA. See, e.g., *Osuagwu*, 938 F. Supp. 2d at 1158 (The hospital argued before the court that “because HCQIA immunity standards ‘are different’ from those establishing violation of procedural due process rights, the Court’s . . . due process analysis ‘is not determinative.’”).

184. *Subcomm. Hearings*, *supra* note 2, at 138 (statement of Dr. W. Michael Bird).

185. 423 F.3d 184, 206 (3d Cir. 2005).

186. *Id.* at 202.

187. *Id.* at 193.

188. *Id.*

189. *Id.* at 194.

information to over thirty others about his technique, at which point the hospital revoked his privileges.¹⁹⁰

Dr. Gordon claimed that the hospital was not entitled to immunity under HCQIA because his acts did not affect adversely the health or welfare of patients as required for a professional review action.¹⁹¹ The Third Circuit disagreed and determined that even though the physician's act did not directly threaten the *health* of the patients his acts harassed and intimidated patients.¹⁹² The court heavily relied on the language of the statute, more specifically "could" and "welfare."¹⁹³ The court determined that these terms allow for the inclusion of *any* conduct that *might* affect a patient's well-being in *any* capacity.¹⁹⁴ This is a common interpretation among the different circuits.¹⁹⁵ Courts have determined that any narrower interpretation would be counter to the congressional intent behind HCQIA.¹⁹⁶ As is common in agency interpretations of mandates, a court will refuse to substitute its own judgment with that of the hospital's as to whether the actions could adversely affect a patient.¹⁹⁷

Pretext in the peer review process for outside conduct may extend to other areas as well. When testifying before the Subcommittee on Civil and Constitutional Rights of the Committee of the Judiciary, Dr. W. Michael Byrd contended:

The hospital staff disciplinary process in this country is a national disgrace at the present time. Physicians are maliciously being deprived of their rights to practice medicine based on race, economics, social class, ethnicity and even their political views. This new climate of intolerance has permeated the peer review process to such an extent that often these proceedings have little to do with the quality of medicine offered the patient.¹⁹⁸

Additionally, before the House of Representatives, the lack of protection under the statute was specifically attacked, and Congressman Edwards

190. *Gordon*, 423 F.3d at 196–97.

191. *Id.* at 202.

192. *Id.* at 203.

193. *Id.*

194. *Id.* at 203–04 (emphasis added).

195. *Gordon*, 423 F.3d at 203–04 (citing *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir. 2003); *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 835 (3d Cir. 1999); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1324 (11th Cir. 1994); *Imperial v. Suburban Hosp. Ass'n*, 37 F.3d 1026 (4th Cir. 1994); *Morgan v. PeaceHealth, Inc.*, 14 P.3d 773, 782 (Wash. Ct. App. 2000)).

196. *Id.* at 203 (“[C]ompetence and professional conduct should be interpreted in a way that is sufficiently broad to protect legitimate actions based on matters that raise concerns for patients or patient care.” (quoting 132 CONG. REC. 30,768 (1986))).

197. *Id.* at 204.

198. *Subcomm. Hearings, supra* note 2, at 137.

noted, “[u]nder the scheme established by this proposed legislation, competent doctors, with limited financial resources, whose rights have been violated by illegal peer review actions will be driven from medical practice with no hope of redress from existing Federal and State laws which provide protections from such illegal acts.”¹⁹⁹ His argument was that there were simply not enough protections under the bill and that “the fundamental flaw of the bill in its present form continues to be that the immunities shield professional actions which are fair as well as actions which are illegal.”²⁰⁰

There are some specific procedural protections that may be of use in particular circumstances to physicians. With a *Mathews v. Eldridge* rubric a court could ask what is “fair under the circumstances” when the safe harbor provisions are not met, and determine whether another procedure is needed to ensure this fairness. As the legislative history points out:

[the statute] does not mandate access to all medical records and documents that may be used by the peer review committee. Since a physician subject to peer review is, in a real sense, in jeopardy of losing his professional standing, it is essential that he have available all pertinent documents and other written evidence relevant to the proceedings in order to rebut the charges.²⁰¹

Of course, these requirements are all the more important when “a presumption of validity attaches to peer review actions, as the [statute] also provides.”²⁰² *Mathews* provides for a weighing mechanism, a way to achieve the balance desired by Congress, between the resources and administrative and financial needs of the hospital or medical review panel and the individual interest of the physician at issue in the case.

IV. CONCLUSIONS

Mathews v. Eldridge analysis requires that a court evaluate each requested piece of process to see whether it is required in a given instance. This analysis does not mandate any particular kind of formal proceeding but looks, as the statute here requires, to see what is “adequate” or “fair under the circumstances.”²⁰³ When evaluating competing interests in a peer review proceeding, it is clear to see with a *Mathews* framework that a physician’s interest is strong. Even without reverting to the constitutional analysis requirement of a liberty or property interest, a doctor has invested

199. 132 CONG REC. 30,769 (1986).

200. *Id.*

201. 132 CONG REC. 30,773 (1986) (statement of Rep. Peter Rodino).

202. *Id.*

203. 42 U.S.C. § 11112(a)(3) (2013).

an enormous amount of time and money into his or her education and career.²⁰⁴ With the reporting system in place, a bad outcome from a peer review proceeding could easily cost a physician his or her career in every state. A hospital's interest *could* also be strong in furthering patient care and protecting patients from incompetent or unprofessional doctors. However, in order to test whether or not the health care entity actually has such an interest in the proceeding and is not using the proceeding as a mere pretext would aid the analysis. If pretext is found, that would weigh against the hospital. The cost, both of time and expense, of any additional procedures would also fall under this side of the interest analysis as a court seeks to balance the interests of the physician and the hospital.

However, perhaps the most important part of the rubric is the investigation of whether a certain piece of process is required. For example, the safe harbor provisions provide that a physician may be represented in the hearing by an attorney or other person of the physician's choice.²⁰⁵ Rather than looking at that as a mandate or something to be ignored entirely, a court should inquire, given the competing interests in this case, does the addition of representation add something to the proceeding? Does it reduce the possibility of error in a manner that is worth the cost of requiring the procedure in this instance? This is a fact intensive case by case determination. Certainly this asks more of a court than refusing to analyze the problem of procedure all together or sweeping it under a rug of opaque "reasonableness," but it satisfies the will of Congress with regard to the statute. Moreover, there is a body of jurisprudence in the area of constitutional procedural due process to apply *Mathews v. Eldridge* and to see when and why certain pieces of process are appropriate or required.²⁰⁶ Currently the scale is not set to balance interests but is weighted presumptively, again and again and in a myriad of ways, in favor of the health care entity in ways that may not improve the quality of health care for patients. This is an inexcusable interpretation of the statute given the accessibility of a procedural due process framework that does provide a

204. See "How Do I . . . Pay for Medical School?," ASS'N OF AM. MED. COLLS., <https://www.aamc.org/students/aspiring/paying/283080/pay-med-school.html> (last visited Mar. 25, 2014) (stating that the median debt for a graduating medical student was approximately \$175,000 in 2013). This figure does not include further training and specialization necessary for gainful employment.

205. § 11112(b)(3)(C)(i).

206. See, e.g., Jason Parkin, *Adaptable Due Process*, 160 U. PA. L. REV. 1309, 1325–26 (2012) ("*Mathews* had an impact far beyond the narrow question presented in that case. According to the Supreme Court, *Mathews* offers 'a general approach' for testing challenged procedures under a due process claim. The Court has subsequently applied *Mathews*'s three-factor analysis in a variety of contexts unrelated to public benefits terminations, including terminations of parental rights, involuntary civil commitments to mental hospitals, civil forfeitures, detention of citizens as enemy combatants, immigration deportation proceedings, and terminations of public employment. The Court has even used the *Mathews* balancing approach to analyze claims under the Constitution's Suspension Clause.") (citations omitted).

rubric for adequate notice and hearing procedures and a weighing mechanism for these important competing interests.

