

# Protecting Peer Review to Protect Patients

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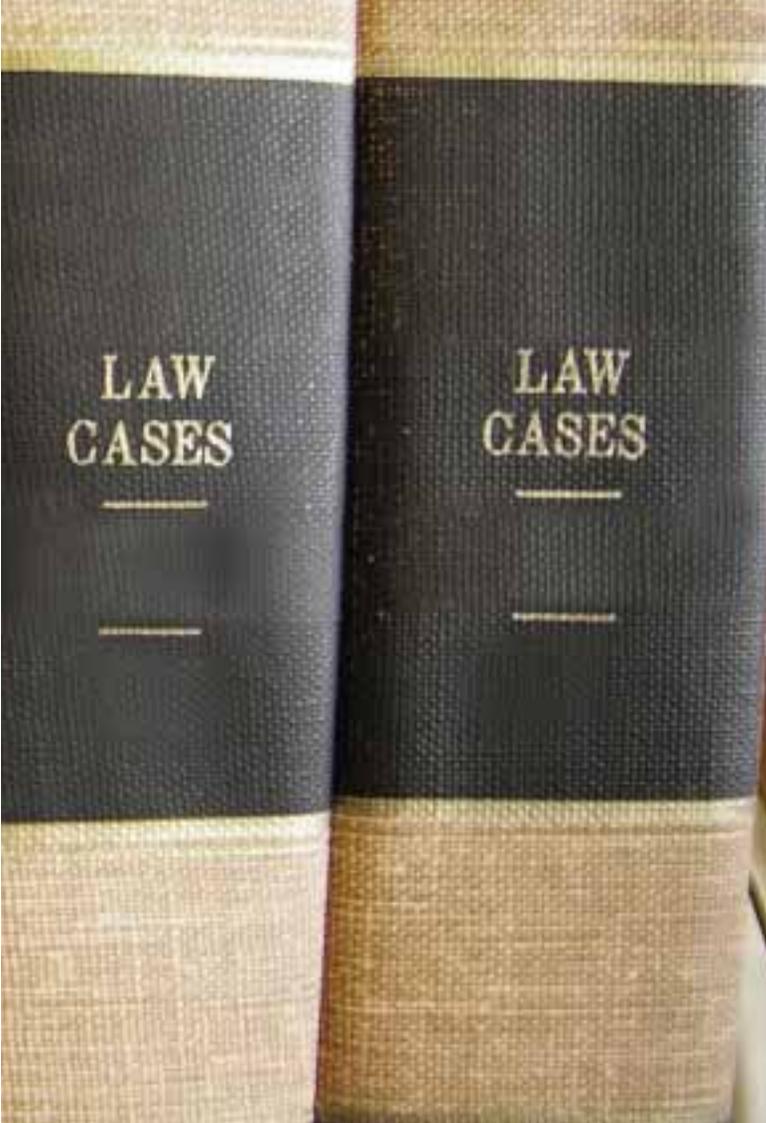
## Introduction

For better or worse, American physicians who practice in hospitals or large medical groups are responsible for policing their peers' professional conduct. Even if the states were not facing the most daunting fiscal challenges in decades, state medical boards lack the resources and access necessary to monitor licensees continuously, so doctors must evaluate their colleagues themselves. But many (if not most) physicians hesitate to perform this task for numerous reasons—it is time-consuming, generally unpaid, and puts them in the uncomfortable position of judging co-workers.

Not only do those burdens constitute a substantial disincentive to conduct peer review, but many physicians also fear

they will be sued for their trouble—and could face multi-million-dollar damages liability. Recent activities in the legal arena—e.g., the Texas *Poliner* case, the California *Kibler* and *O'Meara* cases, and California's new medical staff whistleblower law—have fueled physicians' fears of peer review participation.

A doctor who is reviewed may react with hostility and resort to legal action. Problem physicians often characterize themselves as victims of anti-competitive or retaliatory conduct, which makes it harder for hospitals and peer reviewing physicians to defend such suits even where they have acted with the best of intentions. Although the federal government and most states provide legal protections for peer



reviewers, physicians adversely affected by peer review have won some cases—and occasionally large monetary awards. Even if a wrongful peer review lawsuit ultimately fails, it may drag on for years at great expense to the litigants.

Effective peer review is essential to protect patients from doctors who lack the clinical or interpersonal skills necessary to ensure that patients receive appropriate care. Thus, it is equally essential for medical staffs, healthcare entities, courts, and legislatures to ensure that protection of individual physician rights does not vitiate patient protection by discouraging peer review participation and stifling candor.

### **Background: How We Got Today's Medical Peer Review Process**

Physician peer review dates back more than a millennium. The ancient Greeks used peer review for professional evaluation. *Medical* peer review was first documented by a Syrian physician who lived from 854-931 A.D. He articulated a physician's obligation to make notes of each patient's condition on every visit, and described how a medical counsel of local physicians

would review the physician's notes after a patient was cured or died, to determine whether the care met accepted standards. If the evaluations were negative, the physician could be sued.<sup>1</sup>

The American medical peer review process began in the colonies, which established "boards of medical examiners to evaluate and license individuals they found qualified to practice medicine."<sup>2</sup> Later, medical professional societies developed standards.<sup>3</sup> The American College of Surgeons (ACS), formed early in the 20th century to address concerns about poor quality of care, reviewed 100 surgical cases of each applicant for fellowship. To ensure that records would be available (since hospital record-keeping was inconsistent), ACS developed standards requiring hospital medical staffs to organize, supervise the professional work performed in their institutions, and conduct clinical review conferences.<sup>4</sup>

In 1952, the ACS, American Medical Association, American Hospital Association, and American College of Physicians established the Joint Commission on the Accreditation of Hospitals (later called the Joint Commission on the Accreditation of Healthcare Organizations, and now simply The Joint Commission), which promulgated detailed requirements for both medical staff peer review, and hospital governing board oversight to ensure that medical staff processes work to identify and resolve problems. The federal government developed medical staff conditions of participation for Medicare-participating hospitals,<sup>5</sup> and the states enacted laws mandating and governing medical staff peer review.<sup>6</sup>

Physicians subject to peer criticism rarely welcome it. Once medical staff peer review became widespread, some physicians inevitably began to challenge the adverse actions against them legally—and some such actions have been successful.<sup>7</sup> By the mid-1980s, Congress had become concerned that physicians disciplined in one location could easily move elsewhere, and also that lawsuits by disciplined physicians threatened to chill the peer review process. The result of those concerns was the Health Care Quality Improvement Act of 1986 (HCQIA).<sup>8</sup> The new law mandated reporting of certain information about problem doctors,<sup>9</sup> and authorized creation of the National Practitioner Data Bank (NPDB) to track them.<sup>10</sup> HCQIA also established federal immunity from monetary liability for peer review activities and actions that substantially comply with HCQIA's procedural requirements.<sup>11</sup>

HCQIA also includes a rebuttable presumption of immunity for peer review activities and actions that meet HCQIA's standards.<sup>12</sup> This allows for resolution of some lawsuits via summary judgements on immunity grounds, because "the plaintiff bears the burden of proving that the professional review process was not reasonable."<sup>13</sup> While many such lawsuits have been dismissed,<sup>14</sup> HCQIA's protections are threatened by the chilling effect of highly publicized cases where physicians receive large damages awards or obtain broad discovery of peer review documents,<sup>15</sup> and by legislation that purports to supplant peer review privileges and immunities.

## Peer Review Under Attack: Recent Illustrations of the Tension Between Peer Review and Individual Physician Rights

### Cases

#### **\$ 366 Million Jury Verdict in *Poliner v. Presbyterian Hospital of Dallas* Strikes Fear in the Hearts of Peer Reviewers and Hospital Administrators Nationwide**

In August 2004, a Texas federal jury awarded Dr. Lawrence Poliner over \$366 million in a verdict against Presbyterian Hospital of Dallas (PHD) and three physician defendants, for what the jury considered “sham” peer review of Poliner’s cardiac catheterization (cath) privileges. Nearly four years later (after the district court had reduced the award to \$22.5 million), and after two defendant physicians settled with Poliner, the hospital and the remaining doctor defendant prevailed in the Fifth Circuit. Poliner petitioned the U.S. Supreme Court for *certiorari*, which was denied in March 2009.

#### **Facts of Poliner**

PHD’s Internal Medicine Advisory Committee (IMAC) was reviewing several complaints about Poliner’s cath lab practice when he misread a patient’s tests and failed to operate on a completely blocked artery during an angioplasty in May 1998. Poliner also failed to monitor the patient adequately afterward and recognize severe hemorrhaging, requiring a critical care specialist to intervene. The director of the Cath Lab and the Cardiology chief reviewed the procedure and reported their findings to the Internal Medicine chair.

The Internal Medicine chair proposed to Poliner what an “abeyance” (in PHD Medical Staff Bylaws parlance) of his cath lab privileges pending review of his cases, with the alternative being suspension of all his privileges. To accept the abeyance, Poliner was told to sign and return a letter by 5:00 PM the same afternoon he received it. He did so, and retained his admitting and consulting privileges. He was not permitted to consult counsel first.

A six-cardiologist *ad hoc* committee (AHC) reviewed 44 of Poliner’s cases and determined his care in 29 cases was substandard. Poliner agreed to a two-week abeyance extension when told again the alternative was suspension. Poliner was notified of an IMAC meeting where particular cases, which were listed along with reviewers’ comments, would be considered. He had three days to prepare (his request for more time was denied) and an hour to present his responses, which he did.

Afterward, the IMAC voted unanimously to recommend suspension of Poliner’s cath and echocardiography privileges based on poor clinical judgment, inadequate angiocardiology and echocardiography skills, unsatisfactory medical record documentation, and substandard care. Following a three-session hearing, the Hearing Committee unanimously concluded the summary suspension was justified by the evidence available at the time, but recommended restoring Poliner’s privileges with consultation conditions. PHD’s Medical Board accepted this report, the Committee on

Professional Affairs found Poliner had been afforded due process, and PHD’s Board of Trustees upheld the Medical Board’s decision in June 1999.

#### **District Court Proceedings**

Poliner sued PHD and numerous medical staff physicians including IMAC and AHC members in May 2000, for the allegedly improper suspension. His claims included state and federal antitrust allegations and state law claims for breach of contract, defamation, assorted business torts, and intentional infliction of emotional distress. The defendants moved for summary judgment and dismissal based on (*inter alia*) HCQIA immunity.

The court held the suspension was subject to HCQIA immunity, and granted relief on the claims arising from it, but concluded the original abeyance was a separate peer review action that raised factual issues precluding summary judgment—because the “threat” to suspend Poliner may have rendered the abeyance involuntary and the surrounding circumstances inconsistent with HCQIA standards. Poliner amended his complaint accordingly, asserting the abeyance was “forced,” and really a summary suspension for which he was not afforded the required procedures. The trial court later determined the initial abeyance and extension constituted two distinct peer review actions. The jury found for Poliner on all remaining claims, and awarded him \$366 million for mental anguish, career injury, and punitive damages.

Two physicians settled, but PHD and the other doctor moved for a new trial. The court denied the motion but reduced the judgment against the remaining defendants to \$22.5 million (plus interest)—a fraction of the enormous original award, but still more than enough to intimidate most doctors and hospitals. The remaining defendants appealed to the Fifth Circuit in 2007 and eventually were vindicated.

#### **Fifth Circuit Reversal**

The Fifth Circuit held Poliner failed to rebut HCQIA’s presumption that the peer review actions complied with HCQIA.<sup>16</sup> Additionally, the abeyances met the four HCQIA standards.<sup>17</sup> The Fifth Circuit noted HCQIA “does not require that the professional review result in actual improvement of the quality of health care,” and it “bears emphasizing that the good or bad faith of the reviewers is irrelevant” because the inquiry is an objective one.<sup>18</sup> The appellate court reversed and rendered judgment for defendants—but not until after more than eight years of litigation, and settlement by two physician defendants.

Had the district court’s decision survived, it would have set a terrible precedent. Peer reviewed physicians, peer reviewers, and hospitals all benefit substantially from the alternative of protecting patients by allowing a physician to relinquish privileges voluntarily during an investigation—rather than imposing a suspension. A hospital may be required to report a suspension to its state medical board sooner than alternative actions.<sup>19</sup> Also, summary suspension may be considered the most drastic remedy in the corrective action arsenal, and carry a greater stigma when reported or self-disclosed (e.g., on an

application); this raises the stakes for everyone. During an “abeyance” period, peer reviewers may find the physician’s conduct was within accepted standards and should not warrant any corrective action. Offering this option should be viewed favorably and should not result in loss of immunity.

The Fifth Circuit in *Poliner* reiterated that peer reviewers cannot be deprived of HCQIA protection based upon their motivations or subjective feelings toward the affected physician, or a post hoc conclusion that their initial assessment of the situation was wrong.<sup>20</sup> The standards for immunity are objective because a medical staff cannot be precluded from taking action against a physician whose conduct raises serious concerns merely because the doctor also is widely disliked or has numerous competitors. Congress also understood that while peer review may not be perfect, those who perform it should be shielded for making appropriate efforts to protect patients—even if they sometimes err on the side of caution, and upon further review the doctor’s practice is found to be acceptable. Although these rules are well-settled, some courts may still get them wrong, and threaten the ability of the peer review process to function effectively.

### ***Kibler and O’Meara—Two California Cases Go Up to the California Supreme Court on the Issue of Anti-SLAPP Protection for Peer Review***

In California, a hospital and physician peer reviewers took action against a disruptive physician who (among other things) brought a gun into the facility. Although the physician signed a written settlement agreement, he sued them anyway in a lawsuit that went all the way to the California Supreme Court. In a companion case that also was granted review by the state’s high court on the same peer review protection issue, the hospital and its peer reviewers have been subject to protracted litigation even though the physician was simply placed on probation.

#### ***Facts of Kibler***

Dr. George Kibler had been on staff at northern Inyo County’s public “district” hospital (NIDH) for more than 20 years when the hospital sued him in December 2001 seeking an injunction against workplace violence, after he engaged in a series of hostile encounters with hospital personnel. The following day, a peer review committee summarily suspended Kibler due to his “continuing and recently escalating unprofessional conduct of extremely hostile and threatening verbal assaults, threats of physical violence, including assault with a gun, and related erratic actions of a hostile nature toward nursing and administrative personnel . . . .”<sup>21</sup>

Approximately two weeks later, NIDH entered into a written settlement agreement with Kibler and reinstated his privileges. The agreement required Kibler to refrain from hostile, violent, intimidating, or demeaning conduct, and from



keeping or carrying a firearm on hospital premises. It included a general release by Kibler of “all damages of any and all kind and nature” arising out of the summary suspension. Based on a stipulation between the parties, the trial court entered a permanent injunction requiring Kibler to attend anger-management classes and refrain from bringing any firearm to the hospital.<sup>22</sup>

#### ***Superior and Appellate Courts in Kibler Grant the Hospital Anti-SLAPP Protection***

Despite the settlement and release, Kibler sued NIDH and various doctors and nurses less than a year later. His claims included defamation, abuse of process, and interference with the practice of medicine. NIDH moved to strike Kibler’s complaint under California Code of Civil Procedure Section 425.16 as a “SLAPP” suit,<sup>23</sup> arguing that Kibler brought the suit solely to harass the defendants. The trial court agreed that Kibler’s lawsuit arose out of the peer review proceeding, which was an “official proceeding” that qualified for a motion to strike under the anti-SLAPP statute. The trial court granted the hospital’s motion and dismissed the lawsuit. Kibler appealed.

#### ***Appellate Courts Split on the Anti-SLAPP Issue***

While Kibler was pending before Division Two of California’s Fourth District Court of Appeal, another case, *O’Meara v. Palomar-Pomerado Health System*, was on appeal in another division of the same appellate district. Both cases presented the first-impression issue of whether the anti-SLAPP statute

applied to medical peer review. The *O'Meara* court held that the anti-SLAPP statute did not apply; less than two weeks later, the *Kibler* court published its decision reaching the opposite conclusion and acknowledging the conflict with *O'Meara*.

#### **Facts and Superior Court Procedural History of *O'Meara***

Dr. Patrick O'Meara, former Orthopedic Surgery chair at Palomar Medical Center (Palomar), had sued Palomar, related entities, individual members of an ad hoc committee, Palomar's chief operating officer (Palomar Defendants), and Graybill Medical Group, Inc. (Graybill)—which had a financial relationship with Palomar—after O'Meara was placed on probation in February 2000 (the probation was extended in April 2001). In 2002, the Palomar medical staff's Executive Committee (EC) voted to let the probation expire, but placed a letter of reprimand in O'Meara's file. Neither California law nor the Palomar medical staff bylaws entitled O'Meara to a hearing to challenge the probation or the reprimand letter.

O'Meara alleged the Palomar Defendants retaliated against him for complaining about Palomar or Graybill's disapproval of his decision to transfer a patient to another hospital for medically necessary surgery. The day after a Graybill case manager told O'Meara she would not approve the transfer and wanted a Graybill physician to assume responsibility for the patient's care, a Graybill physician performed the surgery at Palomar. Hospital personnel reported that while the patient was in surgery, O'Meara approached the patient's family in an emotional state and said the surgery had proceeded without his knowledge or consent. O'Meara also reportedly told the patient's family that the surgeon was "committing malpractice" and "treats his patients like cats and dogs." The procedure was unsuccessful and the patient eventually was transferred to a university hospital for another surgery. O'Meara then wrote to Palomar administration objecting to Graybill's conduct, asserting the refusal to approve the transfer was based on managed care financial considerations, and asking that action be taken against the Graybill surgeon.

Palomar's Chief of Staff and another member of the EC met with O'Meara to discuss his reported inappropriate statements to the surgical patient's family and another patient. O'Meara denied making such remarks and believed the matter was closed, but two weeks later he received a letter stating the EC

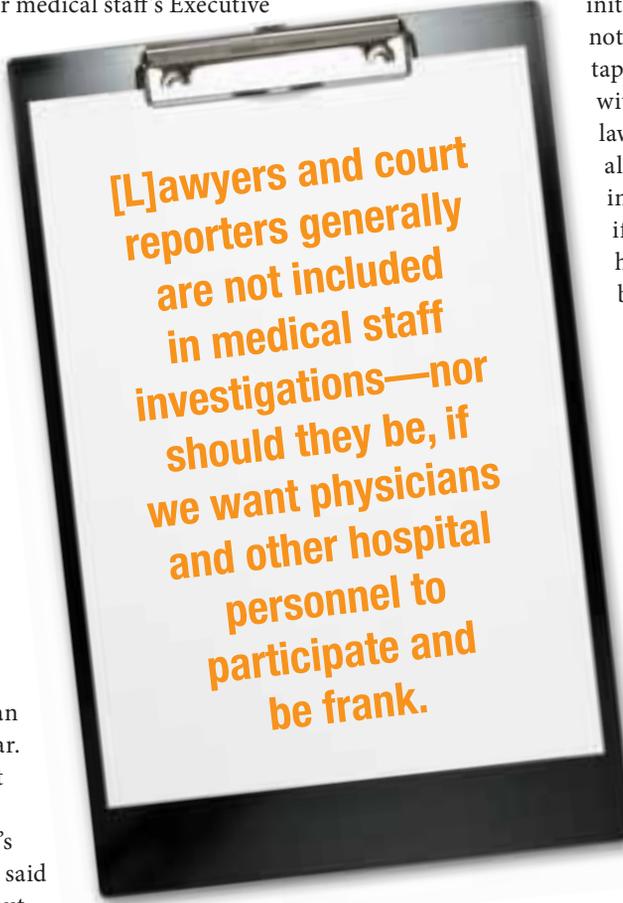
considered an investigation warranted, and asking that he step down as chairman-elect of Orthopedic Surgery/Rehabilitation during the investigation. An *ad hoc* committee conducted a six-week investigation and issued a report recommending that O'Meara be placed on probation, based upon evidence showing O'Meara had made inappropriate and unethical comments about the care of two patients.

The EC reviewed the report, placed O'Meara on probation for the remainder of his reappointment period, and required him to attend an anger-management course (February 2000 Probation). O'Meara's hearing request was denied. The reviewing courts later noted O'Meara was not given the *ad hoc* committee's report, his request for a shorthand reporter at the initial meeting was denied, and he was not permitted to bring an attorney or tape recorder to his second meeting with the *ad hoc* committee. However, lawyers and court reporters generally are not included in medical staff investigations—nor should they be, if we want physicians and other hospital personnel to participate and be frank.

O'Meara alleged that he was given no opportunity to present arguments or evidence. He claimed that neither the *ad hoc* committee nor the EC had ever questioned him about two of the issues that formed the basis for his probation: his conduct toward the patient who had been operated on by the Graybill surgeon, and his improper medical record entries.

O'Meara's September 2000 lawsuit claimed the probation was improper, alleging (1) violations of (a) California's statutory ban on retaliation against a physician for advocating for medically appropriate healthcare, (b) constitutional free speech rights, and (c) the common law right to fair procedure; (2) interference with his exercise of civil rights; (3) defamation; (4) conspiracy; and (5) common-law torts such as (a) negligence, (b) intentional interference, and (c) infliction of emotional distress. The defendants sought dismissal based on O'Meara's failure to challenge the February 2000 Probation through a mandate proceeding. The trial court agreed O'Meara's claims were barred under the exhaustion of judicial remedies doctrine.

Two weeks later, Palomar extended the probation for a year (April 2001 Extension) based on new EC findings that O'Meara had: (1) engaged in continued disruptive behavior; (2) filed his lawsuit before any punishment was imposed and before he had exhausted internal remedies; (3) disclosed peer review documents in the lawsuit; and (4) failed to recuse himself when



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he had a conflict of interest based on the lawsuit. O'Meara's request for a hearing to challenge the April 2001 Extension was denied. After a year, the EC allowed the probation to expire, but placed a letter criticizing O'Meara in his file.

After his superior court loss, O'Meara appealed. The appellate court reversed, requiring Palomar to set aside the April 2001 Extension, remove the reprimand letter from O'Meara's file, and afford him fair procedure before instituting further probation. O'Meara also filed a writ of mandate petition and won. The judge ruled that while no formal hearing had been required, Palomar's actions were still unlawful. Rather than appeal that ruling, the defendants moved to strike the complaint in the initial action under the anti-SLAPP statute. In opposition, O'Meara argued the anti-SLAPP statute did not apply because hospital peer review is not an "official proceeding" and no issue of "public interest" was involved. Alternatively, O'Meara argued the motion should be denied because he probably would prevail on the merits of his claims.

The trial court denied the anti-SLAPP motion, finding that although the anti-SLAPP statute applied to the complaint, O'Meara had met his burden to show a probability of prevailing on his claims.<sup>24</sup> On appeal, Division One of the Fourth Appellate District disagreed with the trial court's holding that the anti-SLAPP statute applied, and affirmed the superior court's order on that alternative basis. The California Supreme Court granted defendants' petition for review of that decision, then issued an order placing O'Meara on hold pending the decision in *Kibler*.<sup>25</sup> When O'Meara came back before the California Supreme Court in 2006 (after *Kibler* was decided), the high court transferred it back to the appellate court with directions to vacate its decision and reconsider the case in light of *Kibler*.<sup>26</sup>

In doing so, the appellate court acknowledged the anti-SLAPP statute governed O'Meara's claims, but reached the same outcome as before: the trial court properly denied the anti-SLAPP motion, as O'Meara showed a probability of prevailing on his claims. Because the Palomar Defendants had based their anti-SLAPP motion on the affirmative defense of failure to exhaust administrative or judicial remedies, the burden of proof shifted to them to establish the defense. Considering the two probations separately, the court held that the judicial exhaustion defense *did* apply to the February 2000 Probation claims (so O'Meara was required to exhaust his remedies before suing), because O'Meara had two opportunities to explain his version of the facts and identify witnesses, which the court considered the functional equivalent of a hearing.

Regarding the April 2001 Extension, however, the court held O'Meara was not required to exhaust his judicial remedies because he got no quasi-judicial hearing. The court focused on the circumstances existing when the anti-SLAPP motion came before the trial court, and rejected the defendants' argument that O'Meara had been required to utilize Palomar's internal review procedures, because there was no internal process to exhaust at that time. Since O'Meara's claims could be supported solely by the April 2001 Extension, the court held the trial court properly had denied the motion.

As this article goes to press, the *O'Meara* case remains ongoing, after further proceedings both at the hospital and in the superior court (where it is pending now<sup>27</sup>). Thus, the parties already have spent nine years litigating over a probation, and another appeal seems likely. How many doctors will express concerns about a colleague, much less take adverse action, if they are aware that such consequences may be their reward for participating in the process?

## Additional Cases Illustrating the Tensions Inherent in Peer Review

Other factors prevalent in our healthcare system, such as competition among providers, also can undermine protection for peer review activities. In *Smith v. Selma Community Hospital*, a failed business relationship between the plaintiff physician and the healthcare system that recently had acquired the defendant hospital caused the courts to mistrust the hospital's motives for excluding the doctor.<sup>28</sup> Among other things, the Medical Executive Committee (MEC) had attempted to settle with the doctor, which was perceived as evidence the medical staff and hospital cared more about money than patient care.<sup>29</sup> The appellate court, like the mandamus court below, refused to uphold the hospital's reliance on findings of misconduct and substandard care from two other hospitals—even though those findings had been fully adjudicated in hospital administrative proceedings, and had not been overturned via mandamus.<sup>30</sup>

Other court decisions also seem to make an already lengthy and difficult process even more complicated and daunting for physician peer reviewers. In *Mileikowsky v. West Hills Medical Center*, one division of the California Court of Appeal had disagreed with another and held that only physician peer reviewers—not a peer review hearing officer—can decide whether a doctor who requested a hearing has engaged in procedural misconduct warranting termination of the proceeding. The California Supreme Court upheld that decision,<sup>31</sup> so now California doctors serving on peer review hearing panels will have to make at least some procedural rulings in addition to deciding the medical merits of peer review cases.

Although HCQIA provides valuable protections to peer reviewers, battles over HCQIA immunity can be costly, and in rare instances hospitals and peer reviewers may lose. While the number of cases where courts have found HCQIA immunity far exceeds the number where immunity was denied, the cases where the disciplined physician prevailed may give pause to even the most dedicated and well-intentioned peer reviewers. Several recent federal and state court decisions illustrate how judicial focus on notice and hearing rights may result in loss of immunity even where hospitals and their reviewers were trying to protect patients.

For example, in *Chudacoff v. University Medical Center of Southern Nevada*,<sup>32</sup> the district court granted the physician's motion for partial summary judgment against the hospital for denying due process rights. After voicing concerns about the hospital's residency program, the physician had been suspended and reported to the NPDB for allegedly providing

substandard care—without prior notice of the issues giving rise to the suspension and NPDB report, or that the MEC was considering restricting his privileges.<sup>33</sup> In the notice of suspension (and a requirement to undergo drug testing and physical/mental examinations), he was advised of his hearing rights but not the allegations against him.

After he sued, fair hearings were held to consider alleged incidents of substandard care and disruptive behavior, and concerns about his alleged failure to disclose a past adverse action against him in his medical staff application. The court opined that the “defendants likely had a reasonable belief that their actions were taken in furtherance of quality health care,” but still denied HCQIA immunity because the physician was told “after the fact” that an adverse peer review action already had been taken against him, and thus he did not get reasonable notice and hearing procedures.<sup>34</sup>

In *Ritten v. Lapeer Regional Medical Center*,<sup>35</sup> a Michigan Ob/Gyn sued a hospital, its chief executive officer (CEO), and others over summary suspension of his clinical privileges. The court refused to grant immunity with respect to several claims.

The recredentialing process had revealed that the physician accounted for more than one-fifth of the total occurrence and incident reports filed during a five-year period about the entire medical staff of over 200 physicians, and his trauma rate during deliveries was more than twice that of other obstetricians at the hospital and around the country. An outside reviewer’s report questioned the trauma rate statistic, but disclosed a concern that the physician was performing too many vacuum deliveries. After the CEO and the outside reviewer discussed his preliminary findings, but before the review was completed three days later, the CEO sent the physician a summary suspension notice citing the physician’s frequent deviation from patient safety indicators and performance of unnecessary instrument-assisted deliveries.

Four days later, the MEC voted to rescind the summary suspension, appoint a preceptor to supervise the physician, and obtain a retrospective outside review of certain cases. The CEO then brought the matter before the Board of Trustees during a special meeting to which the physician was not invited. The Board heard testimony about the physician’s incident report rate, the outside review, the Chief of Staff’s observations as the physician’s peer and proctor, and the Chief Nursing Officer’s

summaries of past incidents. The Board then voted to reinstate the summary suspension. After a hearing, the physician’s privileges were suspended permanently a year later.

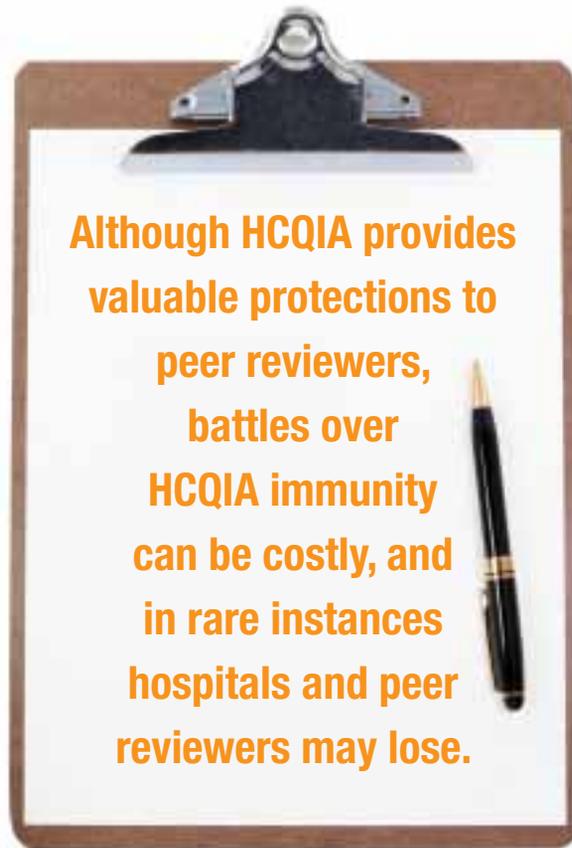
The *Ritten* court found remaining factual issues about whether the CEO suspended the physician in retaliation for his refusal to transfer a pregnant patient (who may have been in active labor) around the time of the incident report review, and also about whether the CEO and Board conducted reasonable fact-finding before acting. Summary judgment on claims relating to those issues was denied.<sup>36</sup>

Some state courts also have denied HCQIA or state-law immunity in recent cases.

In *Peper v. St. Mary’s Hospital & Medical Center*,<sup>37</sup> for a second time<sup>38</sup> the appellate court reversed the trial court’s grant of summary judgment to a hospital and three physician defendants based on HCQIA immunity. The hospital had revoked the plaintiff physician’s provisional privileges “effective immediately” and reported to the NPDB and state licensing board, after an external reviewer assessed some cardiothoracic surgery procedures and expressed concerns about the physician’s procedure times, blood usage, and complication rate. The review had occurred without the physician’s knowledge, allegedly after he told the hospital president he intended to establish a competing medical practice.

The defendants asserted that because the medical staff bylaws did not afford procedural rights for revocation of provisional privileges, the physician had waived any HCQIA hearing rights when he applied for provisional privileges and agreed to be bound by the bylaws.<sup>39</sup> The court disagreed, holding that “any waiver of HCQIA rights must be knowing and voluntary”<sup>40</sup> and “any agreement to be bound by hospital bylaws was legally insufficient to waive statutory due process rights under the third HCQIA standard,”<sup>41</sup> because “[t]here is a legally significant distinction between rights under a hospital’s or medical staff’s own bylaws and those under the HCQIA.”<sup>42</sup>

In *In re Peer Review Action*,<sup>43</sup> the Minnesota Court of Appeals upheld the lower court’s temporary injunction against a hospital, preventing it from imposing a suspension and five-year probation for a physician’s disruptive behavior. Citing numerous trial-court findings such as initiation of peer review outside normal channels; investigation in a manner contrary to existing policies; unfair reliance on old incidents;



disparate treatment of the physician; and abuse of power to “make a public statement . . . without first attempting a less-extreme intervention,”<sup>44</sup> the appellate court agreed that the hospital acted maliciously—so state law did not immunize it from injunctive relief.<sup>45</sup> In response to hospital *amici curiae*’s concerns about such a decision’s effect, the court stated, “Neither the ruling of the district court nor our decision here implicates the judgment of the peer reviewers on the merits. Rather, the focus of attention centers on Hospital’s wrongful acts without legal justification, in willful disregard of Physician’s procedural rights under Hospital’s own policies.”<sup>46</sup>

The court also rejected the hospital’s argument that the physician had agreed through a release not to challenge peer review decisions in court. Noting that a contract “cannot release a party from intentional or willful acts,” the court held the hospital’s malicious conduct precluded contractual immunity.<sup>47</sup>

These cases highlight the need to make a record in each peer review matter that demonstrates basic fairness to the physician at every stage, so the available legal protections for the hospital and its peer reviewers will not be lost. Courts may well be reluctant to second-guess doctors and hospital boards on the merits of medical standard-of-care issues, but judges are confident of their ability to determine what constitutes fair procedure—and what does not.

## Statutes

### California’s Physician Whistleblower Law

The California Legislature recently enacted a physician whistleblower statute that also could impede peer review significantly, depending on how the new provisions are interpreted in litigation—which appears likely because the law expressly provides a private right of action for damages, including lost income.

AB 632 amended California Health and Safety Code Section 1278.5, a whistleblower statute originally enacted to protect patients and healthcare facility employees, to include hospital medical staff members as another protected category. The amendments prohibit health facilities from discriminating or retaliating against any medical staff member who has either:

- >> presented a grievance, complaint, or report to the facility, the facility’s medical staff, an accrediting or evaluating entity or agency, or any other governmental entity; or
- >> initiated, participated in, or cooperated in an investigation or administrative proceeding by an accrediting or evaluating entity or agency or other government entity, related to the quality of care, services, or conditions at the facility.

The penalties can be severe: a civil penalty of up to \$25,000, reinstatement, reimbursement for lost income “caused by the acts of the facility,” legal costs of pursuing the case, and any other remedy deemed warranted by the court under statutory or common law.

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AB 632 also creates a rebuttable presumption that any adverse action against a medical staff member was discriminatory/retaliatory if it occurred within 120 days after the physician engaged in any of the protected conduct described above, and “if responsible staff at the facility or the entity that owns or operates the facility had knowledge of” the protected conduct.

How will the new physician whistleblower law and its private right of action affect existing procedural protections, such as the exhaustion of administrative remedies requirement and the anti-SLAPP law? Nothing in the statute addresses those issues. Many disciplined physicians claim the adverse actions against them were retaliation for complaints about hospital operations or other professionals, so peer review could be severely impeded if any physician who has lodged such a complaint within 120 days can sue while peer review is ongoing.

## Conclusion

Under the best circumstances, peer review’s burdens substantially limit the pool of medical staff leaders and peer reviewers. For the public to be protected through peer review—and we have no other practical way to monitor hospital and medical group physicians—peer review must work effectively. It cannot do so if peer reviewers and hospitals are intimidated and discouraged by the threat of protracted, expensive litigation and liability.

Courts repeatedly have recognized that “physicians’ due process rights are subordinate to the needs of public safety.”<sup>48</sup> The law provides sufficient mechanisms, such as injunction actions, for physicians to obtain relief in those rare instances where peer review goes seriously awry. To protect patients, statutory and common-law protections for peer reviewers and hospitals must be enforced, not weakened. **□**

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## Endnotes

- 1 Ray Spier, *The History of the Peer-Review Process*, 20 TRENDS IN BIOTECHNOLOGY 357 (2002).
- 2 JONATHAN P. TOMES, MEDICAL STAFF PRIVILEGES AND PEER REVIEW 10 (1994).
- 3 *Id.*
- 4 Jeanne Darricades, *Medical Peer Review: How Is It Protected by the Health Care Quality Improvement Act of 1986?*, 18 J. CONTEMP. L. 263, 265-270 (1992).
- 5 See 42 C.F.R. §§ 482.12(a), 482.22.
- 6 See, e.g., CAL. BUS. & PROF. CODE § 809 *et seq.* (mandating peer review fair hearing processes); FLA. STAT. § 395.0193 (describing peer review obligations, processes, protections, and penalties for violations of reporting requirements); GA. CODE ANN. § 31-7-15 (mandating professional practice review in hospitals and ambulatory surgery centers); MASS. GEN. LAWS ANN. CH. 111 § 203(a) and (b) (mandating that hospitals and medical staffs establish requirements for internal reporting of problem providers and suspension of privileges in the best interests of patient care); 22 CAL. CODE REGS. §§ 70701(a)(1)(B), (C), (D), (E), and (F) (enumerating a hospital governing body's duties relating to the medical staff), and 70703 (listing an organized hospital medical staff's responsibilities).
- 7 See, e.g., *Clark v. Columbia/HCA*, 25 P.3d 215 (Nev. 2001) (hospital improperly terminated physician for complaining about patient care to outside agencies); *Rosenblit v. Superior Ct. (Fountain Valley Reg'l Hosp. & Med. Ctr.)*, 231 Cal. App. 3d 1434 (1991) (hospital's peer review process had "a notable stench of unfairness").
- 8 42 U.S.C. § 11111 *et seq.*
- 9 See 42 U.S.C. §§ 11131-11133.
- 10 See 42 U.S.C. § 11134; 45 C. F. R. § 60.1.
- 11 42 U.S.C. §§ 11111(a)(1), 11112(a).
- 12 42 U.S.C. § 11112(a).
- 13 *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 202 (3d Cir. 2005); Bryan v. *James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir. 1994).
- 14 See AMERICAN HEALTH LAWYERS ASSOCIATION, PEER REVIEW GUIDEBOOK, Appendix D (3d ed. 2003).
- 15 See, e.g., *Cohlina v. Ardent Health Servs., LLC*, No. 05-CV-384-GKF-PJC (N.D. Okla. Nov. 14, 2008) (ordering production of, *inter alia*, complete unredacted peer review and credentialing files of all other cardiovascular surgeons, interventional radiologists, and cardiologists on the hospital system's medical staffs, going back 10 years).
- 16 42 U.S.C. § 11112(a).
- 17 To qualify for HCQIA immunity, a professional review action must have been taken (1) in the reasonable belief it was in furtherance of quality healthcare; (2) after a reasonable effort to obtain the facts; (3) after adequate notice and hearing or other procedures that were fair to the physician under the circumstances; and (4) in the reasonable belief it was warranted by the facts known after the reasonable effort to obtain them and after meeting the requirement to afford fair process. 42 U.S.C. § 11112(a), cited in *Poliner v. Texas Health Sys.*, 537 F.3d 368, 376-377 (5th Cir. 2008).
- 18 *Poliner*, 537 F.3d at 378.
- 19 See, e.g., CAL. BUS. & PROF. CODE § 805(e) (summary suspension must be reported within 15 days following imposition if it is in effect for more than 14 days, as opposed to a cumulative total of 30 days or more that triggers reporting for all other reportable actions).
- 20 *Poliner*, 537 F.3d at 379.
- 21 *Kibler v. Northern Inyo County Local Hosp. Dist.*, 39 Cal. 4th 192, 196 (2006).
- 22 *Id.*
- 23 "SLAPP" is an acronym for "strategic lawsuit against public participation"; the anti-SLAPP law provides for prompt striking of complaints that target the exercise of free speech and petition rights in certain contexts. *Kibler*, 39 Cal. 4th at 196 (2006).
- 24 Superior Court of San Diego County, No. 754197, Ronald L. Styn, Judge.
- 25 *O'Meara v. Palomar-Pomerado Health Sys.*, 2005 Cal. LEXIS 5397 (Cal. May 18, 2005).
- 26 *O'Meara v. Palomar-Pomerado Health Sys.*, 143 P.3d 657 (Cal. 2006).
- 27 Trial is scheduled to begin on August 7, 2009.
- 28 *Smith v. Selma Community Hosp.*, 164 Cal. App. 4th 1478, 1517 (2008).
- 29 *Id.* at 1511.
- 30 *Id.* at 1491-1493, 1503-1508, 1519-1520. The doctor's mandamus petition in the earlier case was still pending when the court of appeal decided the *Selma* case.
- 31 *Mileikowsky v. West Hills Hosp. and Med. Ctr.*, 45 Cal. 4th 1259; 203 P.3d 1113; 91 Cal. Rptr. 3d 516 (Apr. 6, 2009).
- 32 *Chudacoff v. University Med. Ctr. of S. Nev.*, No. 2:08-CV-863-ECR-RJJ (D. Nev. filed Apr. 8, 2009).
- 33 The doctor argued (apparently without contradiction) that he was not "summarily suspended," so the statutory provision allowing for a post-suspension hearing under limited circumstances (42 U.S.C. § 11112(c)(2)) did not apply, and thus his due process rights were violated. *Chudacoff* at 14, 15 n.2.
- 34 *Id.* at 22.
- 35 *Ritten v. Lapeer Reg'l Med. Ctr.*, No. 07-10265 (E.D. Mich. filed Mar. 11, 2009).
- 36 The court did summarily adjudicate the physician's claims about the hearing committee's ultimate decision to uphold the suspension (and some other claims), finding HCQIA immunity.
- 37 *Peper v. St. Mary's Hosp. and Med. Ctr.*, No. 07CA2491 (Colo. Ct. App. filed Dec. 11, 2008) (*Peper II*).
- 38 The first appellate decision was *Peper v. St. Mary's Hosp. and Med. Ctr.*, No. 05CA1099 (Colo. Ct. App. filed July 20, 2006) (*Peper I*).
- 39 The majority of the *Peper I* court concluded the defendants met the HCQIA standards regarding action in furtherance of quality healthcare, reasonable effort to obtain the facts, and reasonable belief the action was warranted, so the only remaining HCQIA immunity issue was whether the process was fair.
- 40 *Peper II* at 18.
- 41 *Id.* at 8.
- 42 *Peper II* at 19.
- 43 *In re Peer Review Action*, 749 N.W.2d 822 (Minn. Ct. App. 2008).
- 44 *Id.* at 828-829.
- 45 The court cited the rule that HCQIA does not afford immunity from suit for injunctive relief (*Sugarbaker v. SSM Health Care*, 190 F.3d 905, 911 (8th Cir. 1999)), and disposed of the defendants' HCQIA argument in a single paragraph. *In re Peer Review Action*, 749 N.W.2d at 827. Because only state-law protections were at issue, the defendants could be and were deprived of immunity based on their motives, which would not have been relevant under HCQIA.
- 46 *Id.* at 829.
- 47 *Id.*
- 48 *Medical Staff of Sharp Mem'l Hosp. v. Superior Ct.*, 121 Cal. App. 4th 173, 182 (2004), citing *Miller v. Eisenhower Med. Ctr.*, 27 Cal. 3d 614, 626-627 (1980); *Webman v. Little Co. of Mary Hosp.*, 39 Cal. App. 4th 592, 600-601 (1995); *Rhee v. El Camino Hosp. Dist.*, 201 Cal. App. 3d 477, 489 (1988).