

Credentialing and Peer Review of Health Care Providers: The Process and Protections

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INTRODUCTION

In his recent novel *Monday Mornings*, renowned neurosurgeon and national medical celebrity Dr. Sanjay Gupta brings healthcare peer review into the public eye. *Monday Mornings* provides a look inside the morbidity and mortality conferences of a group of surgeons at Chelsea General Hospital in southwest Michigan. These peer discussions depict groups of surgeons openly talking about their errors and, occasionally, their personal failings. *Monday Mornings* is fictional, but Dr. Gupta based the book on ten years of real-life experience attending similar meetings and hearing about the mistakes made by even the most talented surgeons, some of which had tragic consequences.¹ The book does not have a clear message about the effectiveness of peer review – after all, it had to be salacious enough to get picked up as a soon-to-be-aired David E. Kelley television series. Dr. Gupta, however, has used the book as a springboard to talk about the importance of frank and honest discussion about medical error as a tool for increasing patient safety.

According to some estimates, there are as many as 100,000 deaths attributable to medical error in the United States each year. While subject to its share of criticism, peer review is viewed as an essential tool in combating medical error and preventing injury and death. Every hospital administrator and lawyer practicing in a hospital setting should be aware of the beneficial uses of peer review, as well as the litigation dilemmas it sometimes creates. This paper describes the peer review process, the framework of legal protections meant to strengthen that peer review process, and some of the issues that arise in related litigation. Because laws regulating the peer review process are a mix of federal and state regulations, this paper cannot comprehensively address every issue. Rather, it is meant to provide an overview of some frequently occurring issues, as well as to look at some important case law, with an inevitable focus on the jurisdictions where the authors practice.

THE PHYSICIAN CREDENTIALING AND PEER REVIEW PROCESSES: HISTORY, PROCEDURE, AND PURPOSE

Professions, by their nature, are composed of individuals with extensive specialized education, training, and knowledge. This specialization creates a knowledge disparity that makes it difficult for a generalist legislature or other regulatory body to regulate the specifics of professional practice. It also makes regulation especially important, as the customers of a

¹ See, e.g., *Dr. Sanjay Gupta on Combating Medical Errors*, CBS News: Good Morning America (March 11, 2012) http://www.cbsnews.com/8301-3445_162-57395032/dr-sanjay-gupta-on-combating-medical-errors/?tag=contentMain;contentBody

professional are typically unable to evaluate the quality of services rendered by that professional. This knowledge disparity is especially prevalent in the medical profession, where constant changes in technology and advancements in procedure render it particularly difficult to regulate. Thus, self-evaluation of the medical profession is necessary and inevitable.² One element of medical profession self-regulation is the establishment of state licensing boards made up primarily or exclusively of physicians. A second important component—the focus of this paper—is the peer review processes that take place in hospitals, whereby physicians evaluate the qualifications and quality-of-care of colleagues.

Peer evaluation among physicians has occurred for hundreds of years, mostly as an informal and voluntary process. Over time, credentialing and participation in peer review processes spread and became both more heavily regulated and essentially mandatory for physicians who practice in hospital settings. Currently, establishing a peer review committee is a requirement for a hospital to participate in the Medicaid and Medicare programs, and many states require hospitals to use a peer review committee as a requirement for licensure.³

Medical peer-evaluation happens at two stages: The credentialing stage and the review of care stage. The credentialing stage is the process by which a hospital evaluates whether a particular physician is qualified to practice or continue to practice at that hospital. This determination is made when a physician initially applies for privileges at a hospital and when the physician is up for “re-privileging” or “re-credentialing,” typically once every two years. The review of care stage involves hospital investigations into questionable professional conduct by a physician, including conduct that may result in a medical malpractice lawsuit. Typically, both credentialing stage peer review and review of care stage peer review would be initiated through a standing committee of the hospital. However, if the standing committee or any subsequently involved decision-making body of the hospital makes an adverse recommendation that would trigger a right of appeal by the affected physician, an *ad hoc* committee would usually be appointed to hear the appeal. Review of care evaluation can lead to the implementation of a corrective action, including a restriction, suspension, or elimination of privileges. Neither the credentialing nor the review of care committee makes the final decision about a physician’s privileges, but committee recommendations form the basis upon which the hospital’s governing body makes its decision.⁴

At both stages, the peer review process is intended to foster frank discussion about medical care by those who are qualified to discuss it, with an overall goal of improving healthcare and promoting patient safety. The idea is that that exacting a critical analysis of the

² George E. Newton II, *Maintaining the Balance: Reconciling the Social and Judicial Costs of Medical Peer Review Protection*, 52 ALA. L. REV. 729 (2001).

³ Eleanor D. Kinney, *Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?*, 13 MICH. ST. U. J. MED. & L. 57, 60 (2009).

⁴ Charles R. Koepke, *Physician Peer Review Immunity: Time to Euthanize a Fatally Flawed Policy*, 22 J.L. & HEALTH 1, 8 (2009).

competence and performance of physicians and other healthcare providers by their peers will result in better medical care. At the credentialing stage, peer evaluation and its accompanying protections are thought to be necessary for the all-important job of selecting and maintaining a well-qualified medical staff. Ongoing peer review, in response to complaints, mistakes, or general concerns about care, is intended to foster discussion and systemic improvement initiatives, as opposed to litigation, which encourages the concealment of mistakes and inadequacies.

PROTECTIONS FOR PEER REVIEW

Despite the above-described benefits, many hospitals and physicians have been reluctant to participate in peer evaluation because of the risk of potential liability and the fear of other personal and professional consequences that candid evaluation of a colleague may create. The hospital's concern is two-fold: (1) that a negative decision may expose the reviewers to a lawsuit by the physician who is denied privileges or disciplined, or (2) that an affirmative decision may expose the committee or its members to liability if the privileged physician later makes a mistake.

To alleviate these concerns and realize the potential of peer review, Congress and every state has adopted a peer review statute to protect the interests of participants. The two main features of the peer review-protection legal framework are: (1) limited immunity from liability for peer review participants, and (2) confidentiality and/or privilege of peer review proceedings and documents. A third component of the peer review legal framework is the requirement that peer review committees report adverse actions to a state licensing agency, the National Practitioner Data Bank and other regulatory bodies, thereby increasing the effectiveness of the goal of protecting patient safety by preventing physicians from escaping a bad patient-care record through crossing state lines. The affected physicians are also required to report adverse actions to credentialing bodies, including the hospitals where they have or are requesting privileges.

Immunity

One important piece of the peer review protection framework is immunity from liability for peer review participants. Unlike the peer review confidentiality and privilege protections discussed below, which are primarily grounded in state law, the source for peer review immunity is federal law. In response to an explosion of medical malpractice litigation and the erosion of judicially granted antitrust immunity for peer review committees in the 1980s, Congress enacted the Healthcare Quality and Improvement Act ("HCQIA").⁵

HCQIA provides immunity for those involved in credentialing activities from a lawsuit, provided that the professional action was taken (1) in the reasonable belief that the action was in

⁵ 42 U.S.C. §11101 *et seq.* (1999).

the furtherance of quality healthcare (2) after a reasonable effort to obtain the facts of the matter (3) after adequate notice and hearing procedures were afforded to the physician involved or after such other procedures as were 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 procedural requirements listed above.⁶ A professional review action is presumed to have met the preceding standards for protection unless the presumption is rebutted by a preponderance of the evidence.⁷

A plaintiff trying to overcome this immunity has the burden of proof to show by a preponderance of evidence that the HCIA requirements were not met.⁸ Notably, most courts have interpreted the requirements of HCIA as *objective* requirements.⁹ Thus, although a plaintiff essentially must establish malice to overcome peer review immunity, evidence of subjective bad faith on the part of peer review participants is insufficient to overcome immunity, as long as the HCIA requirements are satisfied. The immunity afforded by the HCIA applies to actions for damages under both federal and state law. However, it is not a grant of general immunity and does not provide immunity against injunctive relief. Although courts often decide that HCIA applies at the summary-judgment stage, in some cases it may be deferred until the time of trial.

To safeguard the peer review participant immunity, detailed ground rules should be set out for how each physician is to be credentialed, re-credentialed, and evaluated in the case of quality-of-care concerns. The governing document for physician credentialing and standard-of-care review will usually be the hospital's medical staff bylaws, and hospitals should ensure their bylaws track the requirements of the HCIA.¹⁰ Moreover, adherence to HCIA and internal procedures may allow a healthcare provider (including a hospital, physician, or anyone else) sued for involvement in a credentialing activity to recover costs and attorneys' fees. If the healthcare provider meets the standards set forth by HCIA and as reflected in the medical staff bylaws, and the healthcare provider substantially prevails in the litigation, the court *shall* award costs of suit, including attorneys' fees, if it is also shown that the plaintiff's claim or conduct during the litigation was frivolous, unreasonable, without foundation, or in bad faith.¹²

In addition to the immunity provided by the HCIA, at least 48 states have adopted peer review statutes, most of which grant immunity to peer review participants.¹³ Texas law, for

⁶ *Id.* at §§ 1111(a), 1112(a)

⁷ *Id.* at § 1112(a).

⁸ *Ahi v. Charleston Area Medical Center, Inc.*, 562 F.3d 599 (4th Cir. 2009).

⁹ *Fo v. Parma Community Gen. Hosp.*, 160 Ohio App.3d 409 (2005); *Sugaraker v. SSM Healthcare*, 190 F.3d 905, 914 (8th Cir. 1999) ("The subjective bias or bad faith motives of the peer reviewers is irrelevant").

¹⁰ 42 U.S.C. § 11101.

¹¹ Notably, despite this mandatory language, at least a few courts have found that damages under HCIA are discretionary.

¹² *Id.* at § 1113.

¹³ Susan O. Scheutow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?*, 25 AM. J.L. & MED. 7, 15 (1999).

example, largely follows the HCIA, providing immunity from any civil action brought against any individual who serves on a committee which makes decisions regarding the credentialing of physicians if such individual acted without malice.¹⁴ Moreover, anyone who in *good faith* reports or furnishes information to such a committee is also immune from civil liability.¹⁵ As with HCIA, a presumption of absence of malice applies to medical committee actions.¹⁶

Similarly, in Ohio, an individual serving on a peer review committee is immune from civil liability for any conduct within the scope of the functions of the committee.¹⁷ The health care entity itself also enjoys this same immunity with regard to peer review committee conduct.¹⁸ An individual who provides information to a peer review committee in the reasonable belief that such report is warranted is also immune.¹⁹ As for credentialing, a hospital is rebuttably presumed not to be negligent if the hospital itself was properly accredited.²⁰

Privileges

Although, as discussed below, some commentators and litigants have argued that recent Congressional actions created a federal peer review privilege, the current state of the law is that privilege is a state matter. The HCIA does not create a privilege and federal courts have been reluctant to find a common law federal peer review privilege.²¹

In the absence of a federal privilege, all 50 states adopted a statute privileging peer review information.²² Notably, Florida recently repealed its statute, which may signal a growing recognition of the criticism of peer review, discussed *infra*. However, in most states a robust protection of peer review information is the norm. One question that arises is how to establish peer review privilege. In most jurisdictions, the primary method for establishing privilege is

¹⁴ TE. OCC. CODE ANN. §60.010 (Vernon Pamph. 2002).

¹⁵ *Id.*

¹⁶ *Maewal v Adventist Health System*, 868 S.W.2d 886, 893 (Tex. App. Court North 1993, writ denied).

¹⁷ OHIO REV. CODE §2305.251(A).

¹⁸ *Id.*

¹⁹ OHIO REV. CODE §2305.251(D).

²⁰ OHIO REV. CODE §2305.251(C)(1).

²¹ *eMasters v Christ Hospital*, 791 F. Supp. 188, 191-92 (S.D. Ohio 1991) (holding in Title VII sex discrimination lawsuit that HCIA did not prevent plaintiff physician, who claimed that hospital terminated her employment for participating in EEOC proceedings against hospital, from discovering peer review materials); *Johnson v York Hospital*, 169 F.R.D. 550, 560-62 (S.D.N.Y. 1996) (holding in Title VII race discrimination lawsuit that HCIA did not provide privilege preventing defendant hospital from discovering peer review materials from other non-defendant hospitals to help rebut plaintiff's claims that his medical performance record was unblemished and to support hospital's defense that the physician was denied privileges because of his failure to establish clinical competence); *Syposs v United States*, 179 F.R.D. 406, 408-12 (S.D.N.Y. 1998) (holding in medical malpractice lawsuit against veterans' hospital under the Federal Tort Claims Act that HCIA did not establish privilege protecting peer review materials of non-party hospitals from discovery subpoenas of plaintiff).

²² *ee Medical, Inc v Beecher*, 312 S.W.3d 515 (Tenn. 2010).

some combination of affidavits and deposition testimony. In camera review is also used, but disfavored by some courts.²³

The scope of materials protected under the privilege varies considerably from state to state, and, in many jurisdictions, remains unsettled around the outer limits. Some states employ narrow statutes that limit the information protected by the peer review privilege to only the peer review committee's formal proceedings and internal records.²⁴ Under this view, incident reports—created by staff members as part of their employment after observing an unusual event in a patient's care and subsequently used by a peer review committee—are not deemed privileged or protected from discovery. These jurisdictions do not protect incident reports because they want to avoid providing hospitals with a way to hide incriminating information by funneling it through peer review committees.²⁵

Some states limit the privilege further by restricting it to documents of proceedings that deal directly with physician quality of care issues. For example, in *See Medical v Beecher*, the Supreme Court of Tennessee recently decided that the peer review privilege did not apply to peer review committee discussion regarding the decision to terminate a vascular services contract because of quality-of-care issues.²⁶ The Tennessee court determined that peer review privilege is not designed to protect discussions about quality of care generally, but rather only about quality of care issues related to a particular physician. Some states also limit the peer review privilege by making an exception to confidentiality and privilege rules where a plaintiff demonstrates a particular need for the information in order to avoid an injustice.²⁷

Other jurisdictions have interpreted their peer review privilege statutes more broadly. For example, many states adopting a broader view have tended to conclude that incident reports fall within the scope of the privilege, reasoning that the reports are necessary to the development of patient-safety information that is the goal of the peer review process.²⁸ In *Carr v Howard*, the Massachusetts Supreme Court found that incident reports generated after a patient had a psychiatric episode were protected by the peer review privilege because “incident reports are a core component of peer review, they begin the peer review process, and they are necessary to a committee's work product.”²⁹ Further, these states tend not to adopt equitable exceptions for plaintiffs that “need” otherwise privileged information.

²³ See John P. Patton & J. Matthew Anderson, *The Medical Peer Review Privilege: Illustrative Cases of the Public Policy Supporting the Privilege and a Practical Approach to Presenting the Case for Protection*, 46 TORT TRIAL & INS. PRAC. L.J. 95 (2010).

²⁴ Melissa Chiang, *Promoting Patient Safety: Creating a Workable Reporting System*, 18 WALE J. ON REG. 383, 388 (2001).

²⁵ See, e.g., *May v Wood River Township Hosp.*, 629 N.E.2d 170, 174 (Ill. App. Ct. 1994).

²⁶ 312 S.W.3d 515 (Tenn. 2010),

²⁷ *Gylen v Dalton*, 1 Mass. L. Rptr. 572 (Mass. Super. Ct. 1994); *Health Midwest Develop. v Daugherty*, 965 S.W.2d 841 (Mo. 1998).

²⁸ Cynthia J. Dollar, *Promoting Better Healthcare: Policy Arguments for Concurrent Quality Assurance and Attorney-Client Hospital Incident Report Privilege*, 3 HEALTH MATRI 259, 290 (1993).

²⁹ 894 N.E. 2d 827, 835 (Ill. App. Ct. 2008).

The Texas peer review privilege law is an example of a moderately broad statute. It provides, *inter alia*, “each proceeding or record of a medical peer review committee is confidential, and any communication made to a medical peer review committee is privileged.”³⁰ Similarly, the Texas Health and Safety Code provides in relevant part: “The records and proceedings of a medical committee are confidential and are not subject to court subpoena.”³¹ Medical peer review is defined as “the evaluation of medical and healthcare services, including evaluation of the qualifications of professional healthcare practitioners. . . .”³² There appears to be no equitable exception to the privilege rule. The Supreme Court of Texas has held that documents and communications relating to the proceedings of medical peer review committees are protected from discovery, even in a suit by a physician claiming that false information was supplied to the committees with malice.³³ Further, under Texas law, only the peer review committee possesses the privilege and only that committee—not any of its individual members—can waive the privilege. Further, the peer review privilege cannot be waived inadvertently and its waiver must be in writing.³⁴

Ohio’s peer review privilege protection is also fairly broad, but certain evidentiary criteria must be met for it to apply. A peer review committee is defined as one that conducts professional credentialing or quality review activities involving quality of care provided by health care providers.³⁵ Its proceedings and records are not discoverable in a civil action against a health care entity or health care provider arising out of matters that are the subject of evaluation and review by the committee.³⁶ No individual who serves on or provides information to a peer review committee is permitted to testify as to any matters presented during the proceedings or as to any other action of the committee.³⁷ Any incident report, which is a report involving injury or potential to a patient as a result of care provided by health care providers, prepared by or for the use of the committee with the scope of its functions is also not discoverable.³⁸ To apply the privilege, Ohio courts do require certain evidence showing that a peer review committee existed and investigated the case in question, and that the reports at issue were prepared by or for the use of the committee and made available to it.³⁹ No authority requires the court to order an *in camera* review every time a demonstration of such privilege is challenged. Once the privilege is

³⁰ TEX. OCC. CODE ANN. § 60.007(a) (Vernon Pamph. 2000).

³¹ TEX. HEALTH & SAFETY CODE ANN. § 61.032(a) (Vernon Supp. 2000).

³² TEX. OCC. CODE ANN. § 51.002(7) (Vernon Pamph. 2002).

³³ *Irving Healthcare System v. Brooks*, 927 S.W.2d 12, 14, 16 (Tex. 1996).

³⁴ TEX. OCC. CODE § 160.007(e). While anyone may assert the privilege, only certain members of the committee may waive it. *Id.* (The waiver must be “executed in writing by the chair, vice chair, or secretary of the affected medical peer review committee.”).

³⁵ OHIO REV. CODE § 2305.25(E)(1).

³⁶ OHIO REV. CODE § 2305.252.

³⁷ *Id.*

³⁸ OHIO REV. CODE § 2305.25(D).

³⁹ *Smith v. Manor Care of Canton Inc.*, 2006-Ohio-1182; *Hard v. Summa Health Sys.*, 2009-Ohio-4859.

determined to apply, it is applied broadly, even in the case of a physician alleging abuse of the peer-review process.⁴⁰

Of course, even under the broadest grants of the peer review privilege, hospitals cannot use the peer review privilege to immunize from discovery independently available information that would otherwise be subject to discovery. In Texas, and most jurisdictions, records maintained in the regular course of business of a hospital are not protected by the privilege.⁴¹ Therefore, medical records of a patient are not privileged, even though they may be protected by other statutes related to the confidentiality of medical records. Similarly, information collected by a credentialing committee does not become confidential by virtue of its submission to the credentialing committee—only the analysis of that material by committee members is privileged and confidential in most states.⁴² In Ohio, information or records otherwise available from original sources are not unavailable for discovery merely because they were presented to a peer review committee, but the information or records must be obtained from the original sources and not from the committee’s proceedings or records.⁴³ Similarly, an individual who testifies or serves before a peer review committee is not prevented from testifying as to matters within his or her personal knowledge, but he or she may not be asked about testimony before the committee, information provided to the committee, or any opinion he or she formed as a result of the committee’s activities.⁴⁴ Consistent with other privileges, one cannot protect a troublesome document by gratuitously submitting it to a peer review committee.

However, in the jurisdictions adopting the broadest version of the peer review privilege, there may be a way to push the limits of even this seemingly firm rule. At least one court has shown a willingness to protect otherwise available information submitted to a peer-review committee if the content of that information would provide information about the committee’s deliberative process. In *Anderson v. Rush-Copley Medical Center, Inc.*, 894 N.E.2d 827, 835 (Ill. App. Ct. 2008), the court held that medical journal articles that had been used by peer review committee were privileged even though they were not created by the peer review committee and even though they were publicly available. The court reasoned that the fact that the articles were specifically sought out by the committee would reveal the committee’s decision-making process, which is protected by the peer review privilege.

Emergence of a Federal Peer Review Privilege?

⁴⁰ *Wall v. Ohio Permanente Medical Group, Inc.*, 119 Ohio App.3d 654,

⁴¹ See TEX. HEALTH & SAFETY CODE ANN. §61.032(c) (Vernon 2001); *McFee v. Bruce Hospital System*, 439 S.E.2d 257, 260 (S.C. 1993) (information that is available from a source other than the committee does not become privileged simply by being acquired by the review committee); *Cruger v. Dove*, 599 So.2d 111, 114 (La. 1992) (if an applicant obtains a document from a source that is not within the scope of the privilege, the document is not privileged).

⁴² See John A. Atson & J. Matthew Anderson, *The Medical Peer Review Privilege: Illustrative Cases of the Public Policy Supporting the Privilege and a Practical Approach to Presenting the Case for Protection*, 46 TORT TRIAL & INS. PRAC. L.J. 95 (2010).

⁴³ OHIO REV. CODE §2305.252; *Hammonds v. Ruf*, 2004-Ohio-6273.

⁴⁴ OHIO REV. CODE §2305.252; §2305.253.

The majority position holds that there is no federal peer review privilege. This creates some difficulties when a lawsuit touching on peer review activities ends up in federal court. In state court, the matter is simple. State privilege law applies. In federal court, the applicable law that governs a federal court's analysis is determined by the court's jurisdiction—diversity or federal question. Under pure federal question jurisdiction, state privilege law does not apply. If there is a basis for federal question jurisdiction *and* a supplemental state claim, then the question is whether the state law privilege should apply. This happens more frequently than one might initially think: plaintiffs will sometimes join medical malpractice claims with Emergency Medical Treatment and Active Labor Act (“EMTALA”) claims in order to obtain federal question jurisdiction. Although there is some authority to the contrary, the majority position seems to be that state privilege law does not apply in a case with federal question jurisdiction and supplemental state claims.⁴⁵

So, can a defendant in federal court make a colorable argument that a federal peer review privilege indeed exists? Perhaps. It is clear that the HCQIA contains no privilege, and most federal courts have not recognized a common law peer review privilege.⁴⁶ However, Congress recently enacted a statute that may change the analysis and convince some courts to recognize at least a limited federal peer review privilege. In 2005, Congress enacted the Patient Safety and Quality Improvement Act (“PSQIA”) in response to an Institute of Medicine study reporting about the significant number of deaths attributable to medical error.⁴⁷ The PSQIA created privilege protections for a specific category information: Patient Safety Work Product (“PSWP”). PSWP is information that healthcare entities voluntarily submit to a “Patient Safety Organization.” By its terms, the PSQIA does not include typical peer review information. However, a number of commentators have argued that the PSQIA lays the groundwork for the emergence of a peer review privilege. This argument has been addressed in a few cases, with mixed results. In one case, a federal court in California found that the PSQIA created only a limited peer review privilege for PSWP as specifically defined by the statute, not “a broad federal peer review privilege.”⁴⁸ On the other hand, a Delaware court recently extended a federal peer review privilege to information that did not technically fit within the terms of the PSQIA, noting that the PSQIA “announces a more general approval of the medical peer review process and more sweeping evidentiary protections for materials used therein.”⁴⁹

⁴⁵ See, e.g., *Atteberry v. Longmont United Hosp.*, 221 P.3d 644, 646-47 (D. Colo. 2004) (“Federal law of privilege governs even where the evidence sought also may be relevant to pendent state law claims.”); *Burrows v. Redwood Cmty. Hosp. Dist.*, 187 P.3d 606, 609 (N.D. Cal. 1998) (applying federal law to pendent state law malpractice claims where state privilege was “inconsistent with the flexibility of federal privilege law.”).

⁴⁶ Lisa M. Niim, *Pitfalls of Peer Review: The Limited Protections of State and Federal Peer Review Law for Physicians*, 24 J. LEGAL MED. 541, 543 (2003).

⁴⁷ Note, *Just What the Doctor Ordered? How the Patient Safety and Quality Improvement Act May Cure Florida's Patients' Right to Know About Adverse Medical Incidents Amendment*, 64 FLA. L. REV. 513, 548 (2012).

⁴⁸ *Schlegel v. Kaiser Foundation Health Plan et al.*, 2008 WL 4570619, at *1 (E.D. Cal. Oct. 14, 2008).

⁴⁹ *Dieffenbach v. US*, 715 F. Supp. 2d 587 (D. Del. 2010).

Reporting Requirements

A third part of the legal framework designed to increase the effectiveness of medical peer evaluation is the requirement that peer review and credentialing committees report adverse decisions to the National Practitioner Data Bank (“Data Bank”), a nationwide system that hospitals are required to query before granting privileges to any physician and that also contains records of medical malpractice judgments against a physician. The HCQIA requires a hospital to report any adverse action that affects a physician’s privileges for more than 30 days. HCQIA also prevents physicians from circumventing this nationwide record keeping system. It requires them to report when they accept a surrender of clinical privileges from a physician who is under investigation or threat of investigation. Failure to comply with these reporting may result in a loss of HCQIA immunity.

Hospitals and healthcare lawyers should be aware that, in addition to this duty to report adverse actions to the Data Bank, hospitals and other healthcare providers *may* have a special duty to provide a candid evaluation of physicians to other credentialing bodies. A district court in Louisiana held that there is a “duty to disclose information related to a physician’s adverse employment history that risks death or bodily injury to future patients,” and found a hospital liable for not affirmatively disclosing a former physician-employee’s substance-abuse problems to a new employer.⁵⁰ The decision was ultimately reversed in relevant part by the Fifth Circuit, but highlights a potential area for future litigation.⁵¹

I. PEER REVIEW PROTECTIONS AND ORGANIZATIONAL STRUCTURE

Despite its deep roots and its expanding network of protections, the current peer review system has been the subject of criticism from a number of different sources and angles. The criticism most relevant to this paper is the claim that the current framework of peer review protections interferes with important types of litigation. This criticism has three major components: (1) the current system of peer review interferes with medical malpractice litigation, which is necessary for the promotion of patient safety;(2) the current system of protections for credentialing and peer review is inappropriate because it leaves good physicians who were the subject of “sham” peer review without a meaningful remedy;and (3) the current system is inappropriate because it interferes with the right of patients to recover against a hospital for its improper credentialing decisions.

Peer review and medical malpractice litigation

Medical malpractice claimants frequently argue that the peer review privilege undermines malpractice litigation because it prevents a plaintiff from discovering information highly relevant

⁵⁰ *Adlec Medical Center v. Wakeview Anesthesia Services*, No. Civ.A 04-0997, 2005 WL 1309153, at 7 (E.D. La. May 19, 2005), *aff’d in part, rev’d in part, remanded*, 527 F.3d 412 (5th Cir. 2008),

⁵¹ Note, *Candor After Kadlec: Why, Despite the Fifth Circuit’s Decision, Hospitals Should Anticipate an Expanded Litigation to Disclose Risky Physician Behavior*, 1 DREBEL L. REV. 383, 438 (2009).

to his claim. This use of the privilege is somewhat akin to Federal Rule of Evidence 407, which bars the admissibility of subsequent remedial measures to prove negligent conduct. Of course, a key distinction is that the peer review privilege on its face bars discovery, not just admissibility.

Healthcare provider defendants reply that the that the peer review protections are important to improving patient care and argue that concerns about hampering legitimate medical malpractice claims are overblown. Typically, the discovery process in a medical malpractice lawsuit will eventually uncover the pertinent facts. Once the facts related to a specific case are discovered, the injured plaintiff is typically required to retain one or more expert witnesses who will testify about the relevant standard of care, the breach of this standard, and the causal connection between the breach and the injury.

Discovery and review of a physician's credential file relating to the investigation of an incident or relating to other particulars of the defendant physician's background may add very little to evaluating the specific case, but claimants hope to find evidence of an admission or continued negligent practice, perhaps in hopes of obviating the need to hire an expert. Some jurisdictions like Florida and North Carolina have a very restrictive view of discovery in this litigation context,⁵² while other jurisdictions like Illinois and Rhode Island permit more liberal discovery.⁵³

In any case, even if it can be argued that the protections provided by peer review might hamper the use of litigation to promote patient safety, there are alternate non-litigation mechanisms, such as disciplinary action from the state licensing boards that can utilize otherwise peer review-protected information to protect patients. At least in Texas, the privileges that preclude discovery by a patient litigant or physician unhappy with the credentialing process do not bar the Texas Medical Board from reviewing peer review materials nor obtaining sworn testimony on the subject.⁵⁴ A medical licensing board is simply not burdened with the discovery impediments that civil litigants must negotiate.⁵⁵ Medical licensing boards take disciplinary actions based on different criteria than hospitals, but these boards are likely more qualified to analyze professional practice problems and select appropriate corrective measures than plaintiffs'

⁵² See *Munroe Regional Medical Center v Rountree*, 721 So.2d, 1220, 1222-23 (Fla. Dist. Ct. App. 1998) (holding that hospital peer review privilege protected physician accused of malpractice during surgical operation from being compelled to testify about whether suspension of his staff privileges was related to the alleged malpractice or even if suspension had anything to do with his surgical practice) *Shelton v Morehead Memorial Hospital*, 347 S.E.2d 824, 827-29 (N.C. 1986) (stating that legislature created privilege after deciding to embrace "medical staff candor at the cost of impairing plaintiff's access to evidence").

⁵³ *Menoski v Shih*, 612 N.E.2d 834, 836, 838 (Ill. App. Ct. 1993) (stating that privilege does not apply to any documents generated before peer review process, such as applications for privilege, or actions "taken as a result of the process," such as the nature and extent of restrictions placed on physician) *Moretti v Lowe*, 592 A.2d 855, 857-58 (R.I. 1991) (holding that privilege must be strictly construed and forcing healthcare provider to supply more information about revocation of privileges).

⁵⁴ TEX. OCC. CODE ANN. §§ 53.007, 160.009 (2002).

⁵⁵ At least one Texas appellate court has rejected the argument of plaintiffs that they should be entitled to discovery of board documents. *Gustafson v Chambers*, 871 S.W.2d 938, 949 (Tex. App. Houston 1st Dist. 1994, no writ).

lawyers and juries. A well-considered restriction imposed by a medical licensing board should prove more effective in improving, limiting the practices of, or eventually getting rid of problem physicians. Moreover, in Texas, just about anyone can make a complaint about a physician with the Texas Medical Board without going through the filter of a hospital committee.

Physician Challenges to Credentialing or Peer Review Decisions

A more recent critique of the current peer review framework is that it insulates “sham” peer review, allowing largely unreviewable adverse actions against physicians based on reasons other than genuine concerns about their quality of care. There are two basic possible reasons that “sham” peer review might occur. One reason is that a treating physician’s competitors may make adverse peer review statements against a physician because they would benefit economically from less competition if the treating physician’s privileges were altered or terminated. Alternatively, some argue that the system can be abused by a critical peer review brought in retaliation against a physician who has raised concerns about the quality of care given by other physicians.⁵⁶

In recent years, a number of medical commentators have argued that disingenuous peer review is a serious problem for the medical profession.⁵⁷ Anecdotal evidence suggests that juries are willing to award significant damages to physicians who are thought to be victims of “sham” peer review, but peer review protections often make litigating such a lawsuit all but impossible. This is especially true in jurisdictions that have maintained a broad peer review privilege in even physician challenges to privileging decisions. Some states, however, have alleviated this difficulty by either limiting⁵⁸ or totally eliminating⁵⁹ the peer review privilege in cases where a physician is challenging the peer review action.

Notably, peer review immunity does not preclude actions based on demographic categories that are generally protected in the employment context. HCIA explicitly states that it does not apply to civil rights litigation, meaning that physicians who are not granted privileges or who have their privileges revoked based on race or national origin can bring suit against peer review participants.

Patient Challenges to Credentialing Decisions

⁵⁶ See Alissa Marie Passler, *Federal Law Should Keep Pace with States and Recognize a Medical Peer Review Privilege*, 39 IDAHO L. REV. 689, 690 (2003)

⁵⁷ See Eleanor D. Kinney, *Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?*, 13 MICH. ST. U. J. MED. & L. 57 (2009). (collecting medical sources).

⁵⁸ In *Eyring v. Fort Sanders Parkwest Med. Ctr.*, the Tennessee Supreme Court allowed a physician whose staff privileges had been revoked to take discovery “for the limited purpose of investigating the peer review committee members’ good faith, malice, and reasonable knowledge or belief, but prohibited any inquiry into the peer review process itself.” 991 S.W.2d 230, 239 (Tenn. 1999).

⁵⁹ *State ex rel. Health Midwest Development Group, Inc. v. Daugherty*, 965 S.W.2d 841 (Mo. 1998),

A third criticism is that peer review protections improperly allow hospitals to abdicate responsibility for their credentialing decisions that ultimately cause harm to patients. This appears to be a fairly powerful criticism as states have carved “negligent credentialing” actions out of peer review immunity. Texas, on the other hand, has adopted a broad view of peer review immunity that essentially eliminates the cause of action for negligent credentialing. The Supreme Court of Texas held that the state’s peer review law immunized a hospital from liability for negligence or gross negligence in credentialing a physician. *St. Luke’s Episcopal Hospital v. Gbor*, 952 S.W.2d 503 (Tex. 1997). Malice was required to escape immunity, even in a patient challenge to a hospital’s credentialing decisions. This decision may have expanded immunity too far.⁶⁰ However, it is not the only decision to reach this result. In *Mauntz v. HC Healthone, LLC*, a Colorado court of appeals reached a similar conclusion.⁶¹ At least one Ohio court of appeals also has protected peer review materials from discovery in negligent credentialing claims and affirmed that hospitals are statutorily protected from such suits once procedures are in place and followed.⁶² Indeed, even in jurisdictions where courts have not found negligent credentialing actions to be precluded by peer review immunity, relevant documents are often still covered by the peer review privilege.⁶³

NURSING PEER REVIEW

Although not the focus of this paper, some jurisdictions have adopted analogous peer review procedures and protections for nurses. Many of the same concerns that motivate the extensive network of peer review processes and procedures for physicians also arise in the case of nurses. The dominant view is that nursing peer review is not protected by the HCIA.⁶⁴ However, some states interpret their peer review privilege and immunity statutes to cover all healthcare providers, including nurses.⁶⁵ Texas has gone even further, explicitly adopting a nursing peer review statute.

In Texas, establishing a nursing peer review committee is mandatory for some employers. Any person or entity that regularly employs, hires, or contracts for the services of ten or more vocational or professional nurses, including at least five registered nurses, is required to form a peer review committee.⁶⁶ As opposed to physician peer review, where courts have been relatively deferential to the procedures used by hospitals, the nursing peer review statute has a number of fairly strict procedural requirements that are taken seriously by courts. For example,

⁶⁰ Scheutow, *State Medical Peer Review: High Cost But No Benefit—Is It Time for a Change?* 25 Am. J.L. & Med. 7, 8-9 (1999).

⁶¹ 174 P.3d 813 (Colo. Ct. App. 2007)

⁶² *Huntsman v. Ultman Hosp.*, 2008-Ohio-2554; *Huntsman v. Ultman Hosp.*, 2011-Ohio-1208

⁶³ See, e.g., *Eparte Oureshi*, 768 So. 2d 374 (Ala. 2000).

⁶⁴ Joseph Mark Saponaro, Note, Determining the Immunity *Measuring Stick: The Impact of the Health Care Quality Improvement Act and Antitrust Laws on Immunity Aspects of Granting Privileges to Physician Assistants*, 47 Clev. St. L. Rev. 115, 127-32 (1999)

⁶⁵ *Adams v. St. Francis Reg'l Med. Ctr.*, 955 P.2d 1169 (Kan. 1998).

⁶⁶ Tex. Occ. Code §303.0015(a).

in one case, failure to comply with all the requirements of the nursing peer review statute resulted in the loss of the confidentiality privilege.⁶⁷

There is no peer review at the “credentialing” stage for nurses. However, there are two distinct types of nursing peer review: (1) incident based peer review, and (2) “safe harbor” peer review. Incident based peer review determines if a nurse’s actions or conduct should be reported to the Texas Board of Nursing, whereas safe harbor peer review protects a nurse when the nurse believes the conduct he/she is requested to perform violates a duty of care or other established rule.⁶⁸

Incident based nursing peer review is similar to review of care evaluation for physicians. Like its physician counterpart, incident based nursing peer review is supported by several protective features designed to encourage candid participation and to increase its ability to promote patient safety. Similar to the medical peer review statute, the nursing peer review statute provides immunity from civil liability for those persons and entities involved in the peer review process provided their acts were performed without actual malice. The statute provides: “a cause of action does not accrue for an act, statement, determination, or recommendation made, or act reported, without malice” in the course of a peer review.⁶⁹ This language may, in fact, be even broader than the liability in the physician peer review statute.⁷⁰ The nursing peer review statute also provides immunity from civil liability for more ancillary participants such as those who provide records, information, or assistance.

The confidentiality provisions are strict and protect information from various types of proceedings. Any information that is confidential: (1) is not subject to subpoena or discovery in any civil matter; (2) is not admissible as evidence in any judicial or administrative proceeding; and (3) may not be introduced into evidence in a nursing liability suit arising out of the provision of, or failure to provide, nursing services.⁷¹

Unlike most physician peer review statutes, the nursing peer review statute also provides protection against retaliation or discipline for requesting or engaging in the peer review process.⁷² Additionally, like physician peer review, incident based nurse peer review is subject to mandatory reporting requirements for certain adverse findings.⁷³

Safe harbor peer review is a unique feature of nursing peer review. It gives nurses the opportunity to institute peer review of their own actions in order to immunize themselves from

⁶⁷ *In re Living Ctrs. of Tex., Inc.*, 175 S.W.3d 253, 258 (Tex. 2005).

⁶⁸ See 22 Tex. Admin. Code §217.19(a)(7), (15) (2008)

⁶⁹ *Id.* at §303.010(b).

⁷⁰ Mary M. Meardon, *Neglecting the Nurses: Nursing Peer Review Remains an Untapped Resource*, 15 TEX. LA. 16 (Nov. 22, 1999).

⁷¹ Tex. Occ. Code §303.006(e).

⁷² See Thomas C. Riney & Christopher D. Colek, *Hippocrates Enters the New Millennium: Texas Medical Privileges in the Year 2000*, 41 S. TEX. L. REV. 315, 335-36 (Spring 2000).

⁷³ Tex. Occ. Code §301.401; 22 Tex. Admin. Code §217.19(4).

liability. Safe harbor peer review is a process a nurse may initiate when the nurse is asked to engage in an assignment or conduct the nurse believes, in good faith, would potentially result in a violation of the Nursing Practices Act or Texas Board of Nursing rules.⁷⁴ For example, the nurse may believe that patient harm may result from the conduct or that the conduct would be unprofessional or illegal. The main purpose of safe harbor peer review is to protect a nurse from licensure sanction by the Texas Board of Nursing.⁷⁵

CONCLUSION

Despite the differences among jurisdictions and some unsettled questions, peer review privileges and immunities are well-established and fairly robust. Therefore, the hurdles are very high for a plaintiff suing a hospital or committee member in connection with credentialing or review-of-care actions. Most, if not all, of the information provided and evidence relating to deliberations of the committee is protected from discovery and one must show not simply that the committee or committee members were negligent or wrong in their actions, but that they acted with malice. These additional legal protections are designed to facilitate candor and thoroughness in the credentialing of physicians. Physicians are often wary of serving on such committees and of making tough decisions concerning one of their peers. These statutory protections are designed to, and should, ensure the willingness of physicians to serve on such committees.

⁷⁴ 22 Tex. Admin. Code §217.20(a)(15).

⁷⁵ Tex. Occ. Code §303.005(c), (h).

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