A Physician's Last Chance

By Michael J. Jordan and John E. Schiller

For those who do not practice health law, we offer some context. Physicians practice at hospitals through a process known as privileging. The privilege to practice at a hospital is not tenure; privileges must be granted by a hospital and are conditioned in certain ways. They are subject to renewal every few years, and can be suspended or revoked "for cause", as defined by a hospital in its by-laws. Hospital by-laws provide a procedure that governs actions on privileges and allow for an internal hospital appeal process.

Under many circumstances, federal law requires the hospital to report a reduction or revocation of a physician's medical staff privileges to the National Practitioner Data Bank (NPDP). The NPDP was created two decades ago, when Congress enacted the Health Care Quality Improvement Act of 1986 (HCQIA). It was intended, inter alia, to ensure that a physician with a bad record could not escape detection by moving from state to state.[1] A report to the NPDB can, for all intents and purposes, end a physician's career, because without hospital privileges, most physicians have substantially reduced earning capacity. The last hope for a physician who faces the loss of privileges is an action in court. In contesting a loss of privileges in state or federal court a physician immediately faces a hospital's claim of protection under HCQIA. This protection comes in the form of a limited review of the hospital's conduct, designed to encourage open and candid self-policing by hospital physicians who serve on peer review committees.

At the risk of oversimplification, for a hospital to enjoy what is the qualified immunity HCQIA affords, it must show that it acted: (1) in the reasonable belief that it was doing so in the furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures have been afforded the physician involved, or after such other procedures as are fair to the physician under the circumstances; and (4) with a reasonable belief that the action was warranted by the facts known after a reasonable effort to obtain the facts after meeting the requirements of paragraph (3).[2] The predominant view of HCQIA is that the "reasonableness" requirements create an objective standard of performance on the part of a hospital and not a subjective good faith standard.[3] Some have argued that the standard for obtaining qualified immunity is so easily attainable that hospitals could engage in 'sham' peer review.[4]

As practitioners who represent both hospitals and physicians in peer review proceedings, we were skeptical of that viewpoint. We recently encountered a case, however, that highlighted the risks a physician encounters in challenging a peer review decision and shows why a court needs to carefully evaluate whether a hospital has satisfied the HCQIA standards. Our client was (and thankfully remains) a highly sought after specialist who had relocated from another country to practice medicine in the United States as a department head at Hospital A.[5] He soon found himself the subject of several claims of substandard care and came to us when Hospital A had scheduled a hearing on the sole issue of whether the non-renewal of his privileges would be reported to the NPDB. Because he was not a U.S. citizen, Hospital A contended he had no due process rights and could not challenge the revocation of his privileges, only whether such revocation would be reported. As noted above, a report to the NPDB about his loss of privileges would have made it extremely difficult, at the very least, for him to practice medicine in the United States.

The grounds for the non-renewal of his privileges consisted of allegations of substandard medical care involving fourteen patients. Our client was adamant that the care he had provided had been appropriate. He insisted that he was the victim of office politics since he had been selected to serve as department head over a physician who had been in the department many years. In support of his position our client had obtained an independent review of the cases at issue from a highly regarded specialist.

Simply resigning from the medical staff was not an option because a hospital must make a report to the NPDB if a physician resigns while under investigation. Consequently, our only option was to try to force the hospital to give our client a fair hearing on the issue of patient care; a hearing before independent panel members who would understand the medical issues involved. We filed an action in federal court seeking to compel the hospital to conduct a hearing on the issue of revocation. The hospital ultimately voluntarily agreed to do so.[6]

The panel formed by the hospital to hear the case consisted of three physicians who worked at the hospital. None practiced in our client's area of specialty. We challenged the composition of the panel on the day of the hearing based upon language in the bylaws that required that two members of the panel practice in the same specialty as our client. When we threatened to seek a temporary restraining order, the hospital conceded that our position was correct. The hearing was postponed pending the composition of a new panel.

We received notice of a new hearing date that afforded us only six days to prepare. In that notice we were informed that the hearing would address only three alleged cases of substandard care, not the original fourteen that had been used by the hospital to justify the non-renewal of our client's privileges. We will never forget the hearing because we saw what the process is supposed to be all about—justice. The two appointed specialists did not work at Hospital A, but practiced at affiliated hospitals. The third panel member practiced at Hospital A. The two specialists who practiced elsewhere deftly dissected the "allegations" of substandard care brought by the hospital and revealed the charges to be wholly without merit. Although obviously not trial lawyers, they so effectively cross-examined the hospital witnesses that our questioning was unnecessary. Moreover, they raised serious questions about the process that led to the hearing, even asking our client, "[w]hy did they do this to you?"

We timely learned that the panel had fully exonerated our client. Even the panel member from Hospital A voted in his favor. We were elated for two days. Our client then received a letter from the Medical Center Director at Hospital A stating that he had rejected the Report of the Peer Review Committee—an action he was technically allowed to take under the bylaws—and

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in the First Circuit, this issue demands Supreme Court review. As Judge Torruella suggests, "the time is ripe for the Supreme Court to intervene and set the circuits straight on this issue which is essential to the daily practice of litigators across the country." *Textron*, 577 F.3d at 43. (Textron's application for extension of time within which to file a petition for writ of certiorari was extended through Dec. 24, 2009, by the U.S. Supreme Court.) Until that happens, companies who may be involved in litigation in the First Circuit are well advised to reevaluate any documents that could fall outside the scope of the work product doctrine under the new standard. Until this issue is resolved, companies should take care before creating documents which may not be protected. The practical result of the *Textron* decision may drive businesses to rely on non-written communications, which could lead to less effective corporate decision-making and erode the lines of communication between both in-house and outside counsel and their clients. Yet the alternative is to open one's files and produce documents that would likely be protected in every other circuit.

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upholding the decision not to renew our client's privileges, and reporting him to the NPDB. We had one option left: return to court. We filed an amended complaint requesting injunctive relief to prevent, inter alia, the filing of a report with the NPDB. The hospital responded with a motion to dismiss on a variety of grounds, including lack of jurisdiction. It also attempted to prevent any discovery prior to the preliminary injunction hearing.

The judge acted quickly and decisively. He granted our motion to amend our complaint, set a hearing date within ten days, overruled the motions to quash subpoenas, and required various hospital employees to appear at the hearing. He also ordered the hospital not to take any action adverse to our client until he ruled on our motion for injunctive relief. The gravamen of our motion was that the hospital could not have acted 'reasonably' under HCQIA, because it disregarded the findings and conclusions of the peer review panel.

Prior to the hearing, Hospital A finally "got the message" and the case was resolved without any reporting, when the Medical Center Director reversed his position and accepted the findings of the Peer Review Committee. But justice was hardly perfect. Our client could not obtain compensation for his legal fees nor compensation for the enormous stress and hardship that the hospital had caused him and his family during the year-long legal struggle. We respect the need for HCQIA immunity as appropriate protection to encourage the important self-policing function that the peer review process entails. However, the case we describe illuminates the severity of the consequences of affording a hospital protection under HQCIA without a full understanding of the internal process that has given rise to the hospital's action.

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Endnotes

[1]The NPDB is a repository of reports concerning physicians in several categories, including those pertaining to malpractice payments made for the benefit of the practitioner, licensing actions taken by state medical boards, adverse professional review actions taken by medical entities, DEA actions and exclusions from Medicare and/or Medicaid programs. These reports are made available to hospitals that, as designated health care entities under the statute, are essentially required to inquire about the background of a physician when he or she applies for clinical privileges. Hospitals are also required to follow up with an inquiry every two years thereafter, as long as the individual remains on staff or retains privileges. Hospitals also have an obligation to make reports to the NPDB when problems arise concerning a staff physician. For example, information must be sent to the data bank whenever a person's clinical privileges have been adversely affected by a professional review action that extends beyond thirty days. They are also required to make a report whenever a physician surrenders privileges while under investigation concerning allegations of incompetent or unprofessional actions, or if the hospital foregoes an investigation on the condition that the doctor surrenders his or her privileges. Physicians have the right to add a personal statement to any report that is submitted to the NPDB by a medical institution and, in addition, may ask the Secretary of Health and Human Services to review a report for alleged inaccuracies. However, it is generally accepted that these reports are rarely reviewed by government officials.

[2]42 U.S.C. §11112(A).

[3]*Poliner v. Tex. Health Sys.*, 537 F.3d 368 (5th Cir. 2008), *cert. denied*, 129 S.Ct. 1002, 2009 U.S. LEXIS 763 (U.S. 2009).

[4]*See, for example*, The Center for Peer Review Justice, www.peerreview.org.

[5]We have modified certain facts in order not to disclose information that would allow the parties to be identified, although the matter is one of limited public record.

[6]Following this agreement, the court subsequently dismissed this lawsuit.