Credentialing and Staff Privileges at Hospitals

Physician’s Rights: Real or Imaginary?

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The credentialing and staff privileging process is vital to physicians who must admit patients at hospitals. When staff privileges are terminated, physicians may even find themselves unable to practice at all. An added consequence of denial may also include an adverse decision being reported to the National Practitioner Data Bank (NPDB) and Healthcare Integrity and Protection Data Bank (HIPDB), making it difficult for physicians to seek staff privileges at another facility.

Many times when physicians are confronted with a hospital decision to deny privileges, they decide to challenge the decision through the peer review process established under hospital bylaws. This decision to challenge an adverse peer review decision may confound physicians as they engage in the process. Physicians may believe that they do not have rights that protect them during the process or that the outcome is a foregone conclusion.

This article will discuss statutes that protect physicians’ rights during credentialing and staff privileging. The article will then focus on recent developments in case law concerning physician’s rights during peer review. Finally, the discussion will suggest ways for physicians to protect their rights during this process.

The Health Care Quality Improvement Act of 1986

The most important statute covering a physician’s rights during peer review is the Health Care Quality Improvement Act of 1986 ("HCQIA"). The Act was intended to protect the public from incompetent physicians by allowing those physicians on peer review committees to communicate in an open and honest environment and to protect them from claims for damages by physicians who are dissatisfied with negative decisions. Perhaps an unintended result of the Act has been to provide physicians with a means to challenge physicians on peer review committees who corrupt the process with improper or biased motives.

HCQIA provides that hospitals and other participants are immune from claims for damages during a peer review if the following requirements are met: (1) the reason for the peer review is patient care; (2) the peer review is based on a reasonable investigation; (3) the physician was given fair process during the peer review; and (4) the investigation justifies taking an adverse action against the physician. The burden of proof that the four requirements have not been met is on the physician subject to peer review. The physician must show by a preponderance of the evidence that HCQIA was violated in order for the
Poliner v. Texas Health Systems

A significant case decided in 2008 involving legal principles related to physicians’ rights during peer review is Poliner v. Texas Health Systems. Poliner involved a cardiologist who challenged the termination of his hospital staff privileges. Dr. Poliner was an interventional cardiologist who, when treating a patient with a blocked artery, failed to diagnose and correct another blocked artery resulting in complications and near death. Other patient-care mistakes of varying severity also led to the hospital reviewing a number of his cases and to the conclusion that his staff privileges had to be restricted pending the outcome of the review.

The legal issues associated with the case involved whether certain actions constituted “professional review actions” as it is defined by the HCQIA, and in particular, whether the actions taken to temporarily restrict Dr. Poliner’s privileges met due process protections under the HCQIA. When the hospital suspended Dr. Poliner for his professional conduct, Dr. Poliner filed a lawsuit against the hospital for violation of his rights during peer review. At the trial court level, Dr. Poliner made the case that HCQIA immunity did not apply and submitted the case to a jury—who awarded the physician a verdict in the amount of $33 million. On appeal, the Court reviewed the hospital’s actions in light of the four prongs of the HCQIA, and found immunity applied because the review actions involved issues associated with patient care and met the rudimentary standards of due process contained in the HCQIA—reversing the jury verdict. The appeals court held that the hospital did not violate the physician’s rights under the HCQIA and upheld the hospital’s decision to restrict the physician’s privileges.

With such a case in mind, physicians should carefully consider the various risks involved in the decision to challenge adverse peer review decisions within the judicial system. The expense of litigation must necessarily be considered. Litigation of peer review decisions is costly. Hospitals typically have in-house counsel to represent them. In contrast, physicians must separately engage attorneys to represent their interests. Few attorneys will take peer review cases on a contingency basis. Peer review disputes are typically dismissed before reaching a jury. Further, even if a physician obtains a jury verdict, these cases are generally reversed on appeal, as occurred in Poliner.

The road of litigation requires overcoming many legal hurdles before a physician succeeds in reversing an adverse peer review decision. Poliner and similar cases illustrate several theories pursued by physicians in peer review litigation. Although the Court in Poliner ruled in favor of the hospital, the decision in Poliner did demonstrate that courts will examine peer review decisions that had been exclusively decided by hospitals. Physicians have taken advantage of this window of opportunity to dispute credentialing/staff privileging decisions.

Physicians should realize that their conduct may be subject to peer review even if the conduct occurs outside the hospital. This principle was discussed in the 2009 case of Moore v. Williamsburg Regional Hospital. In Moore, the physician was a pediatrician and the Department of Family Services filed a complaint against him for sexual abuse of his minor adopted daughter. The Family Services eventually
decided to dismiss the complaint because of the trauma to the minor child in having to testify in the proceeding. The hospital became aware of the allegations of sexual abuse and began a peer review investigation of the physician.

The hospital terminated the physician’s staff privileges because of the potential risk to pediatric patients treated by the physician. The court upheld the hospital’s decision stating that “a physician’s competence can be implicated by conduct outside a health care facility if there is a clear nexus between the conduct and the ability to render patient care.” This ruling thus means that where a physician’s conduct may cause potential risk to patients, the hospital may use the physician’s conduct as grounds for peer review. Other illustrations may include situations where a physician has a substance abuse or alcohol abuse problem but the physician does not show any signs of impairment while on staff at the hospital. Obviously, conduct involving substance abuse or alcoholism may be subject to peer review, even if occurring on non-work hours because of the risk that such abuse passes to patients.

Sometimes, the privileging decisions appear to be based on retaliation for the exercise of legal rights. This issue was recently addressed in the 2009 case of Ritten v. Lapeer Regional Medical Center. In Ritten, the physician disagreed with the hospital president on whether his patient should be transferred to another hospital. The physician claimed that the patient was unstable for transfer. At the time of this incident, the physician was also seeking renewal of his staff privileges. The hospital denied reappointment to the staff on the grounds that the physician posed a risk to patients due to his high rate of vacuum deliveries. The physician challenged the denial of reappointment claiming that the hospital was retaliating against him for his exercise of his rights under the federal Emergency Medical Treatment and Active Labor Act (EMTALA).

The physician filed suit against the hospital for retaliation in the denial of his staff privileges. The court found an issue of fact as to whether the hospital terminated staff privileges because of its disagreement with him over EMTALA or based on furthering quality care. The court did not dismiss the physician’s lawsuit and stated that the case may be decided by a jury on whether there was sufficient evidence to conclude that the president and chief executive officer of the hospital terminated the physician’s staff privileges for patient care reasons or on “less appropriate-and indeed, legally impermissible grounds.” Thus, motive is relevant.

There is also another emerging category of peer review cases involving claims of disruptive behavior that has been the basis of peer review investigations. The Joint Commission (“JC”) views disruptive physician behavior as a serious patient care problem and has thus disseminated a new standard, LD.03.01.01, on how to discipline disruptive physicians. The standards generally require the hospital to have a code of conduct that defines “acceptable” and “unacceptable” physician conduct, as well as a dispute resolution system to deal with disruptive physicians. The JC emphasizes that hospitals must have standards to assure quality and to promote a culture of safety and must address the problem of behaviors that threaten the performance of the health care team.

Disruptive can mean the physician has: employed threatening or abusive language, directed at nurses, hospital personnel, or other physicians (e.g., belittling, berating, and/or threatening another individual); made degrading or demeaning comments regarding patients, families, nurses, physicians, hospital
personnel, or the hospital; used profanity or other grossly offensive language while in a professional setting; used threatening or intimidating physical contact; made public derogatory comments about the quality of care being provided by other physicians, nursing personnel, or the hospital; wrote inappropriate medical records entries concerning the quality of care being provided by the hospital or any other individual; or imposed idiosyncratic requirements on ancillary staff which have nothing to do with improved patient care, but serve only to burden staff with “special” techniques and procedures.9

Lessons from the current trends

In certain circumstances peer review can become an “adverse event” potentially reportable to state licensing agencies and the National Practitioner Data Bank. The following are a series of questions and answers that illustrate common circumstances, how they arose, and the proper responses to reduce or avoid exacerbating the physician’s peer review problems.

How did I get involved in the peer review process?

Physicians often come to attorneys in the middle of the peer review process. When a physician first becomes aware of a peer review, the knee-jerk reaction of many physicians is denial: “I’ve treated every patient well, and medically appropriately,” and other similar statements. Often, though, the problem begins not necessarily directly with patient care, but through a tangentially related issue, like staff or nursing complaints about disruptive behavior (for example through the Joint Commissions new standards), or through the hospital’s own internal dispute system. Other physicians (likely competitors) may also game the system to remove a physician from the hospital and increase their own patient base. An unsatisfied patient may also trigger peer review events. At times, even conduct completely outside the hospital can lead to a problem, as in Moore.

Physicians forget that once they receive a notice of formal investigatory action, the hospital has likely already done substantial preliminary investigation pursuant to the hospital bylaws. This is not the time to send scathing letters denying improper conduct. Rude or argumentative letters can polarize or further polarize an investigatory committee which often has the ability to conclude the investigation or recommend further action. Once a physician receives the notice of peer review, a scathing letter will be of little help in resolving the dispute.

I have received the notice of investigation, what should I do?

The first thing is to review the notice carefully. Review should proceed on two fronts. First is the procedural front. Review the notice for important dates, deadlines, and requested submissions. The bylaws govern what must be contained in the notice, so comparing the bylaw requirements with the notice is important. Often, the medical staff fails to follow their own bylaws, which, in part may be grounds for eliminating immunity under HCQIA, and provides appealable issues apart from substance.

Calendar dates carefully. Missing such a deadline to appeal can result in a waiver of a physician’s rights to a peer review. Courts consistently hold that if the bylaws are followed with respect to deadlines, dates and notice, and the physician fails to adhere to these procedures, physicians waive their rights.10 Such a waiver can result in a physician losing their ability to challenge substance (the patient care issues). Once
procedural steps have been followed, physicians are then postured to challenge substantive issues during the process.

**When should physicians challenge the proper standard of care?**

Next is substance. Review the letter again, looking specifically for the substantive basis for the review. Determine what patients are concerned and the precise problem identified. Often the review is about a specific procedure or specific question that needs to be answered. Answer only the questions asked. Crisp and clear responsive answers can be more powerful than long, drawn out explanations.

In preparing the response, physicians will have the opportunity to discuss the questions the investigational committee requires in writing or in person, as the bylaws direct. There are numerous opportunities to address the substantive issues during a peer review. The first is at the investigation stage, where physicians may have to submit answers to questions and or meet with other medical staff physicians. If the case continues, there may be a hearing where physicians will be able to present the medical evidence in a conference room setting.

**Conclusion**

Physicians have begun to challenge credentialing and staff privileging decisions by hospitals, which have resulted in some surprising legal outcomes. Some courts have expanded the rights of hospitals, and some, the rights of physicians, depending on their interpretation of HCQIA and relevant case law. One predictable development is that more litigation over credentialing and staff privileging disputes is likely.

The peer review process should be managed and conducted competently, professionally, and fairly from the onset in relation to a number of key criteria and standards as detailed above. As widely recognized throughout the field, the assessment and evaluation of one’s peers should be objective, evidence-based, time sensitive, transparent, and equitably conducted in line with what the reviewer would expect for him or herself. If such is not the case in the peer review, HCQIA claims are likely to occur.

**Footnotes**

2. Wahi v. Charleston Area Medical Center, Inc., --- F.3d ----, 2009 WL 962310 *4 (4th Cir. 2009) ("licensed physician failed to rebut presumption that medical center afforded him fair procedures under the circumstances in suspending his medical privileges, as required for center to receive immunity under HCQIA in physician’s action challenging center’s suspension").
3. 537 F.3d 368 (5th Cir. 2008).
6. Id. at *4.
8. Id. at *15.
9. www.ncphp.org/code/inform/articles/drgnalc/drphyI.doc. See also www.4patientsafety.net. PreP 4 Patient Safety is a pilot project funded by a contract with the Health Resources and Services Administration (HRSA) which provides tools for state medical and nursing boards to work with hospitals and other health care organizations to identify, remediate and monitor health care practitioners (now limited to physicians and nurses) with deficiencies that do not rise to the level of disciplinary action.
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