

REPRESENTING PHYSICIANS IN FAIR HEARING PROCEEDINGS

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I. Introduction

A physician walks into your office. The hospital where the doctor is employed or has staff privileges notified the physician that the hospital is conducting an investigation regarding an incident that occurred at the hospital several months ago. The physician is looking to you for assistance and representation.

From the very first meeting with the physician-client, there are questions to ask, facts to gather, and documents to review. This white paper is intended to serve as a step-by-step guide through the process of a fair hearing proceeding, beginning with the initial client meeting and ending with considerations following the hearing.

The paper begins with a brief overview of the federal and Michigan peer review statutes. It then discusses when a physician's right to a fair hearing proceeding is triggered. Once such a right has been triggered, attorneys should know the next steps to take in order to represent a client at a peer review proceeding. As detailed below, the attorney will first need to obtain a complete statement of the background facts from the physician-client. Second, the attorney should perform an independent background check to confirm the information provided by the physician-client. Next, the attorney must request and review relevant records from the hospital relating to the peer review proceeding. Then, the attorney should send notice to the hospital regarding representation of the physician.

Once representation has been established, the attorney should consider the possibility of settlement with the hospital. If settlement is not an option or proves unsuccessful, the attorney and physician should prepare for the peer review proceeding. This paper discusses each of these steps in detail. The paper also discusses the hearing itself, steps to take post-hearing, strategies for reviewing the final decision, and considerations following the final decision.

While there is no doubt that a fair hearing proceeding can be a complicated matter, if taken step-by-step, as discussed below, it can lead to an effective and successful representation and outcome for the client.

II. Overview of Federal and Michigan Peer Review Statutes

A. Federal Law

The Health Care Quality Improvement Act of 1986, 42 USC 11101 *et seq.* ("HCQIA") is the federal peer review statute. HCQIA provides for mandatory reporting by health care entities under certain circumstances, as discussed below.

1. Mandatory Reporting. Federal reporting requirements codified in HCQIA require health care entities to report certain “reportable events” to the applicable state Board of Medical Examiners. These events include:

- (1) a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days;
- (2) the surrender of clinical privileges of a physician
 - (i) while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or
 - (ii) in return for not conducting such an investigation or proceeding; or
- (3) in the case of a professional society, a professional review action by the professional society which adversely affects the membership of a physician in the society.

2. National Practitioner Data Bank. HCQIA created the National Practitioner Data Bank (“NPDB”). The NPDB receives and maintains records of adverse actions taken by health care entities against physicians and makes these reports available to all health care entities across the country for background checks and credentialing. The NPDB enables hospitals and health care entities to obtain information about physicians across state lines.

3. Immunity. HCQIA provides that hospitals and other participants are immune from claims for damages in connection with a peer review if the action was taken: (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures; and (4) in the reasonable belief that the action was warranted by the facts.¹ HCQIA immunity applies only to claims for monetary damages; other relief, such as a request for injunctive relief, is not covered by HCQIA immunity.

B. State Law

The Michigan peer review statute can be found at MCL §331.531. Michigan’s peer review statute provides for both voluntary and mandatory reporting.

1. Voluntary Reporting. Michigan’s voluntary reporting provision can be found at MCL §331.531(1). This provision states that “a person, organization, or entity **may** provide to a review entity information or data relating to the physical or psychological condition of a person, the necessity, appropriateness, or quality of health care rendered to a person, or the qualifications, competence, or performance of a health care provider.”²

2. Review Entity Defined. A “review entity” includes:

- a duly appointed peer review committee consisting of 1 of the following: the state; a state or county association of health care professionals; a health facility or agency licensed under article 17 of the public health code; a health care association; a health care network, a health care organization, or a health care delivery system composed of health professionals licensed under article 15 of the public health code, or composed of health facilities licensed under article 17 of the public health code, or both; or a health plan qualified under the program for medical assistance administered by the department of human services under the social welfare act.
- a professional standards review organization qualified under federal or state law.
- a foundation or organization acting pursuant to the approval of a state or county association of health care professionals.
- a state department or agency whose jurisdiction encompasses the information described in subsection (1) of [MCL §331.531].
- an organization established by a state association of hospitals or physicians, or both, that collects and verifies the authenticity of documents and other data concerning the qualifications, competence, or performance of licensed health care professionals and that acts as a health facility's agent pursuant to the health care quality improvement act of 1986.
- a professional corporation, limited liability partnership, or partnership consisting of 10 or more allopathic physicians, osteopathic physicians, or podiatric physicians and surgeons licensed under article 15 of the public health code, who regularly practice peer review consistent with the requirements of article 17 of the public health code.
- an organization established by a state association of pharmacists, that collects and verifies the authenticity of documents and other data concerning the qualifications, competence, or performance of licensed pharmacists and pharmacies.
- a qualified hospital patient safety organization that collects data on serious adverse events under section 4 of [MCL §331.531].³

3. Mandatory Reporting. While the statute contemplates voluntary reporting for certain issues (detailed above), there are also mandatory reporting requirements. MCL §331.531(5) mandates that “an entity described in subsection (2)(a)(v) or (vi) that employs, contracts with, or grants privileges to a health professional licensed or registered under article 15 of the public health code **shall** report each of the following to the department of community health not more than 30 days after it occurs:”

(a) Disciplinary action taken by the entity against a health professional licensed or registered under article 15 of the public health code, 1978 PA 368, MCL 333.16101 to 333.18838, based on the health professional's professional competence, disciplinary action that results in a change of the health professional's employment status, or disciplinary action based on conduct that adversely affects the health professional's clinical privileges for a period of more than 15 days. As used in this subdivision, "adversely affects" means the reduction, restriction, suspension, revocation, denial, or failure to renew the clinical privileges of a health professional by an entity described in subsection (2)(a)(v) or (vi).

(b) Restriction or acceptance of the surrender of the clinical privileges of a health professional under either of the following circumstances:

(i) The health professional is under investigation by the entity.

(ii) There is an agreement in which the entity agrees not to conduct an investigation into the health professional's alleged professional incompetence or improper professional conduct.

(c) A case in which a health professional resigns or terminates a contract or whose contract is not renewed instead of the entity taking disciplinary action against the health professional.⁴

4. Required Information. For mandatory reporting, the following information is required: the name of the health professional against whom disciplinary action has been taken; a description of the disciplinary action taken; the specific grounds for the disciplinary action taken; and the date of the incident that is the basis for the disciplinary action.

5. Immunity. The statute provides civil and criminal immunity to individuals providing information thereunder. Immunity is also granted for an act or communication by an organization or entity that acts within the scope of the review entity. Immunity is further granted for releasing or publishing a record of the proceedings.⁵ Immunity is not granted if the person, organization, or entity acted with malice.⁶

III. When are Fair Hearing Rights Triggered?

By way of background, a hospital, health care entity, or peer review body will obtain immunity from claims for damages arising from the peer review process if the physician is afforded certain due process protections, as required by HCQIA. Under HCQIA, the physician is entitled to notice of a hearing.⁷ This statute also provides the physicians the following rights, should they avail themselves of them: (1) representation by an attorney; (2) a record of the proceedings; (3) the ability to call, examine, and cross-examine witnesses; (4) the right to present relevant evidence regardless of its admissibility in a court of law; and (5) the ability to submit a written statement at the close of the hearing.⁸ Generally, a physician's due process rights will be further outlined and detailed in a hospital's bylaws.

The question that typically arises under HCQIA analysis is: **when are these due process rights triggered?** The protections found in 42 USC 11112(b) are triggered if the hospital or health care entity engages in a professional review *action*. A professional review action is distinguished by a professional review *activity*. This distinction was discussed in *Reid v KentuckyOne Health, Inc.*⁹ where the Court considered whether a hospital had immunity under HCQIA. The court explained that there is a “presumption of immunity,” and that physicians seeking to overcome that immunity must show that the review process itself was not reasonable. However, before reaching the question of immunity, the court had to determine whether any professional review action was taken, or if the hospital had engaged in professional review activities.

In *Reid*, the court distinguished between a professional review action and a professional review activity, by looking at the language of the statute. A professional review *action* is defined as “an action or recommendation of a professional review body which is taken or made in the context of professional review activity, which affects or may affect adversely the clinical privileges of a physician.”

On the other hand, a professional review *activity* is defined as an activity of a health care entity with respect to a physician to determine whether the physician may have clinical privileges; to determine the scope of such privileges; or to change such privileges.

The hospital, in *Reid*, sent the physician a letter stating that all of his cases would be subject to a focus review, and then informed him that he could no longer perform surgical procedures unless accompanied by a certified surgeon. The court held that a professional review *action* was taken, because it effectively prevented the physician from performing surgeries at the hospital unless he could find another willing and qualified surgeon to assist him. This was a sufficient restraint on the physician’s employment to be considered an “action,” thus triggering the due process rights under HCQIA.

As such, the first step in assessing whether the right to a fair hearing proceeding has been triggered is to determine whether a professional review *action* has been taken. When communicating with or reviewing correspondence from a hospital, it is important for physicians and their attorneys to determine if language has been used demonstrating that a professional review action is underway. If so, the physician obtains the above-discussed rights under the statute, such as the right to a hearing, an attorney, cross-examination, and others.

IV. Preparing for Physician Fair Hearing Proceedings

Once a physician’s right to a fair hearing has been triggered, a number of steps should be taken to adequately represent physician clients. Below is a list of such steps, beginning with the initial client meeting, and ending with post-proceeding considerations.

A. Step 1: First Meeting with Client

The first meeting with a physician-client is critical. This is the time to gather a complete statement of the background facts, not only surrounding the situation that prompted the client to seek legal representation, but also the client's educational and employment background. Below are some important topics to cover with a physician-client, and which are vital to an effective representation of the physician.

1. Educational and Employment Qualifications. During the initial client meeting, it is important to review the client's educational and employment background. Where did the physician earn his or her undergraduate degree? Where did the physician attend medical school? Where did the physician perform his or her residency? What does the physician's career trajectory look like? Is the physician a member of any professional organizations? This information will not only help you become acquainted with the more intimate aspects of your client's life, but will also provide you with important background material to use in preparing for the fair hearing proceedings.

2. Prior Peer Review Proceedings. Has your client been subject to a peer review proceeding before? If so, ascertain the nature and background of the situation. What led to this previous peer review proceeding or action? Obtain all relevant facts. Was the client represented by an attorney? If so, who was that attorney? Did the peer review dispute settle before the hearing? What was the resolution? Was a report made to the National Practitioner Data Bank ("NPDB")?

3. Convictions Including Misdemeanors and Traffic Violations. Misdemeanor convictions or traffic violations may seem innocuous, but they can lead to peer review proceedings. This may come as a surprise to physicians, but the Michigan Department of Licensing and Regulatory Affairs ("LARA") may file an administrative complaint against any physician who fails to self-report a criminal conviction or the imposition of professional discipline imposed elsewhere. Indeed, pursuant to the Michigan Public Health Code, a licensee **shall** notify LARA of any criminal conviction within 30 days after the date of the conviction or adverse action.¹⁰ As such, it is important to ascertain whether the client has any criminal convictions, and if so, whether each has been accurately reported.

4. Events Leading Up to Peer Review. At this point in the initial meeting, the client should provide a detailed account of the events leading up to, and causing, the peer review activities or actions. It is important for the client to provide as much information and detail as possible regarding the events and conversations that are material to the situation. The client should try to recall each potential witness who may have vital information. This information is critical and will help determine whether rights to a fair hearing proceeding have been triggered.

5. All Communications with Hospital and Staff. Next, discuss with the client all communications that he or she has had with the hospital and hospital staff. Have the client bring in all letters, emails, voicemail messages, or other communications with members of the hospital. The client should also explain, in detail, all in-person or telephone conversations with hospital staff. These communications will provide key insight into whether a fair hearing proceeding has been triggered.

6. Status of Investigation. HCQIA requires hospitals and health care entities to report to the Secretary of Health and Human Services (the “Secretary”) if a physician surrenders clinical privileges while under an “investigation” for incompetence or improper professional conduct. As such, discuss the status of the events with the client. Has an investigation occurred? Has the client surrendered his or her privileges?

While the term “investigation” is not defined in the statute or the regulations implementing the statute, courts that have examined what constitutes an “investigation” have found that an “investigation” ends “only when a health care entity’s decision-making authority either takes a final action or formally closed the investigation.”¹¹ Steps in an investigation may include: accepting a complaint, deciding to investigate, appointing an investigating committee, conducting fact-gathering, preparing to report, and so on, until the point at which a professional review action is taken.¹²

In *Doe v Rogers*,¹³ the Court further considered the definition of “investigation.” The *Rogers* court concluded that because the statute does not define the term, the Court “must presume that Congress intended to give the term its ordinary meaning.”¹⁴ The Court determined that the term “investigation” is ordinarily understood to mean “a systematic examination.”¹⁵ Applying its definition, the Court held that an investigation was ongoing where the hospital had gathered relevant documents, conferred with executive officials about the incident, met with physicians who were involved, reported the incident to the state health department, and formed a team to conduct a root cause analysis.

7. Notice and Written Communications. Attorneys should also determine whether proper notice has been provided to their physician clients. Specifically, HCQIA’s rules governing fair hearings require the hospital to provide notice to the physician of any proposed action.¹⁶ This notice must state that a professional review action has been proposed to be taken against the physician; the reasons for the proposed action; that the physician has the right to request a hearing on the proposed action; any time limit within which to request such a hearing; and a summary of the physician’s rights during the hearing.¹⁷

8. Licensing Complaints or Consent Orders. LARA may also file a separate administrative complaint against physicians in a number of situations detailed in MCL 333.16221.¹⁸ These include a violation of general duty consisting of negligence or failure to exercise due care; incompetence; substance use disorder; and a final adverse administrative action by a licensure, registration, disciplinary, or certification board involving the holder of, or an applicant for, a license or registration regulated by another state or a territory of the United States, by the United States military, by the federal government, or by another country.

The statute covers a wide range of actions, and it is therefore important to determine whether a complaint has been filed against the client for prior activity, or for the activity at issue in the peer review proceeding. A state administrative proceeding may proceed separately from a peer review proceeding.

9. Malpractice Claims. As discussed, actions resulting in peer review proceedings may also result in other disciplinary proceedings, such as a licensing complaint filed by LARA.

Depending on the physician's actions that resulted in the peer review proceedings, these actions may also result in a malpractice claim. Therefore, it is critical to request information from the client regarding any malpractice suits that were filed, or notices of intent to sue that he or she has received, related to the peer review proceedings.

10. Upcoming Deadlines. During the midst of the peer review process, it may come time for the physician to renew his or her privileges at the hospital. Some physicians, while undergoing the peer review process, may decide not to renew those privileges. This may be because the physician no longer wishes to continue a relationship with the health care entity, or because the physician is overwhelmed with the process and does not want to undergo the added stress of re-applying for privileges. However, as discussed herein, surrender of privileges while under investigation is a reportable event under both federal and state law. As such, make sure to ask the physician-client when his or her privileges are up for renewal. Calendar this date, and discuss the options with your client well in advance. Ensure that the physician-client is aware of the consequences of surrendering privileges during an investigation.

11. Additional Questions. The client will likely have additional questions regarding how the process works, and what to expect over the coming months. You should outline the fair hearing process for the client, and answer any questions the physician may have. This will set the client's mind at ease and give the physician an overview of what to expect from your representation. Furthermore, it is important to advise the client that, once representation begins, he or she should speak only to you about the peer review proceeding.

B. Step 2: Independent Background Check.

After the initial meeting, it is important to conduct independent research, to verify the information obtained at the first client meeting, to search for any additional information that may have been forgotten during the initial meeting, and to provide support to the facts discussed at the meeting.

First, perform an internet search of the client's name and practice to locate potential credentialing issues or malpractice suits. Next, verify the client's licensing status through LARA. Attorneys should also search for the client using a Westlaw or Lexis public records search, which may bring up past or current litigation history. Lastly, be sure to search for any patient complaints, formal or informal, that may be available through LARA.

C. Step 3: Obtaining Relevant Records.

The next step in the peer review procedure process is to obtain important and relevant records from the hospital. The physician may have already received certain records prior to retaining legal services, but it is essential to ensure all relevant records have been received. Review the hospital's rules and regulations to determine if there is a specific method for obtaining these records during the peer review process. The precise records to be obtained will vary depending on the facts, but the following list of recommended records is a good starting place:

1. **Hospital Bylaws.** Obtain bylaws for the hospital or health care entity that are applicable to the relevant timeframe. The bylaws may set forth specific and detailed peer review proceedings procedures and steps. It is important to be familiar with these requirements and follow any mandatory steps.

It is also important to be familiar with the hospital's bylaws because a violation of the bylaws may result in a peer review reportable event. *See e.g., Murphy v Goss*, 103 F Supp 3d 1234 (ED Or 2015) (holding that the Oregon Medical Board was entitled to absolute immunity under HCQIA where the Board found that a physician consuming wine while on cardiac call was a violation of the hospital's bylaws and state law). As such, determine whether the peer review action was taken pursuant to the health care entity's bylaws, state statute, federal statute, or some other regulation or ordinance.

2. **Credentialing and Privilege Policies Relevant to Peer Review.** Similar to a hospital's bylaws, it is important to obtain the hospital's credentialing and privilege policies, if in existence. This will provide guidance on what impact a peer review proceeding will have on the physician's employment, credentials or staff privileges at the hospital. Could an adverse decision prevent the physician from maintaining his or her credentials at the hospital? What if the final decision is favorable to the physician? In order to answer these questions, and others, it is critical to obtain these policies.

3. **All Policies or Addendums Referenced in Bylaws Related to Peer Review Proceedings.** The hospital's bylaws may not explicitly set forth information and requirements for the peer review proceeding. As such, it is important to ask for any policies or addendums either referenced in the bylaws, or otherwise, to ascertain the existence of such requirements.

4. **Employment Agreement and Employee Manual.** Obtain the physician's employment agreement with the hospital, if relevant, and obtain a copy of the hospital's employment manual or handbook if the physician is a hospital employee. These will provide details as to the physician's expected employment duties, and may shed light on what the hospital considers to be a violation of such duties.

5. **Credentialing and Privileges File.** Generally, hospitals will keep detailed files on the credentialing and privilege process of physicians. This file will likely include the physician's applications for appointment, reappointment, and requests for clinical privileges, along with the hospital's evaluation and approval of privileges. The applications will contain helpful factual information to assist in completing the background check, such as work history, peer references, claims status, contact information, and various forms. The file may also include information on the hospital's code of conduct, bylaws, and rules and regulations.

6. **Physician Employee File.** The physician employee file, if relevant, can be a helpful tool in determining background information. It may also contain patient complaints, incident reports, or peer review reports, which may have led to the pending peer review action.

7. **Physician's National Practitioner Data Bank Records.** It is important to obtain the physician's NPDB records. While NPDB reports are not accessible by the public, the health

care practitioner may request his own NPDB profile.¹⁹ The procedures for requesting information from the NPDB are detailed in 45 CFR 60.18(b); specifically, that: “Persons and entities may obtain information from the NPDB by submitting a request in such form and manner as the Secretary may prescribe. These requests are subject to fees as described in § 60.19 of this part.”

Importantly, the NPDB query will provide vital information on whether the physician has engaged in previous reportable conduct and the outcome of those proceedings. While NPDB reports are confidential, they are not privileged, so they may be introduced or discovered in court proceedings. For example, see 42 USC 111137(b)(1) (“[n]othing in this subsection shall prevent the disclosure of such information by a party which is otherwise authorized, under applicable State law, to make such disclosure.”); *Klaine v Southern Illinois Hospital Services*, 47 NE3d 966 (Ill 2016) (discussing difference between confidential and discoverable information).

8. Relevant Medical Records. If the peer review action stems from an alleged violation of patient care, it is critical to obtain all relevant medical records for the patient at issue. During the proceeding, the physician is permitted to cross-examine witnesses, so it will be important to understand the patient’s medical history, and review the medical actions that were during the event in question. The physician will also want his or her experts to review the relevant medical files. *See infra for discussion of retaining experts.*

9. Medical Executive Meeting Minutes Related to Investigation. It is essential to obtain all records relating to the investigation, the peer review action, the peer review activities, and any underlying acts that led to the investigation and action. One example of this can be found in meeting minutes for any hospital executive committee or board responsible for determining peer review actions or overseeing the investigation. These minutes, and any related documents, will provide key insight into the hospital’s decision-making process, and may provide important factual background.

10. All Notices, Correspondence, and Communications from Hospital. A physician’s HCQIA due process rights require that the hospital must provide the physician with notice and a hearing. As such, attorneys should obtain any and all notices or correspondence from the hospital. Not only does this demonstrate whether notice was adequately provided, it will also provide insight as to whether the hospital’s acts constitute “activities” which would not provide due process protection under HCQIA, or “actions” which *do* provide these protections.

D. Step 4: Notice to Hospital about Physician Representation

1. Notify Hospital. Simultaneously with Step 3, an attorney should notify the hospital via written correspondence that the physician is now represented by counsel. Send a letter to the hospital, notifying the hospital of the physician’s attorney representation.

2. Request Information. At this time, request that the hospital provide all information that forms the hospital’s basis in initiating peer review proceedings. This includes all supporting documentation.

3. Analyze and Challenge Notice. The physician must be given notice of any proposed action. *See* 42 USC 11112(b)(1). Attorneys should analyze the notice carefully, to ensure that the notice complies with all HCQIA requirements. If it does not, challenge the notice to require such compliance. Under HCQIA, 42 USC 11112(b)(1), notice of the proposed action must state:

- (A)(i) that a professional review action has been proposed to be taken against the physician,
- (ii) reasons for the proposed action,
- (B) (i) that the physician has the right to request a hearing on the proposed action,
- (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
- (C) a summary of the rights in the hearing under paragraph (3).

4. Request Governing Documents and Information. Further, attorneys should request that the hospital produce its bylaws, policies, and/or regulations governing the hospital's actions and decision to initiate peer review proceedings. Also, request the names and specialties of every person serving on the peer review panel.

5. Request Meeting with Chairman. Lastly, request a pre-hearing meeting with the Chairman to allow the physician to present his or her position. To prepare for this meeting, make sure to discuss with your client the details and timeline of the facts which led to the peer review proceeding.

E. Step 5: Consider and Discuss Settlement.

Early settlement of the dispute may be beneficial to your client. It will save both time and resources, and avoid a potentially long and difficult peer review proceeding. If you and your client determine that settlement is in the client's best interest, initiate negotiations with the hospital attorney. Next, use your discussions with the hospital attorney to determine if settlement is feasible. If so, recommend that the parties attend a mediation session to resolve the matter at an early stage.

During negotiations or following mediation, draft a written settlement proposal. During this process, it is important to remember a few key issues. First, a settlement does not mean that the hospital's reporting requirements to the NPDB or state and local health boards are eliminated. Thus, the parties to the settlement agreement cannot agree that the hospital will refrain from initiating a peer review proceeding or other disciplinary action against the physician. Due to a hospital's strict reporting requirements under federal and Michigan law, the hospital cannot contract away its duty to report. Not only would such provisions be unenforceable as illegal, but the hospital could also face significant penalties for failing to report.

However, the settlement agreement may include language demonstrating that peer review issues are not relevant to the dispute, and that therefore, there is simply no such event to report.

The agreement should provide enough detail so that an outsider reviewing the settlement agreement can determine why a potential reportable event was not relevant to the settled dispute. Additionally, if the hospital has reviewed the situation and determined that no disciplinary action will be taken against the physician, and that there is no reportable event, then the parties should expressly state this in the agreement. To avoid potential publicity, the Settlement Agreement should contain a confidentiality provision.

In the event the hospital determines that a reportable event has occurred, the settlement agreement may allow the parties to jointly draft the language used by the hospital in a report to the NPDB. This allows the physician to have input in the process, and be aware of the report's contents before it is submitted to the NPDB.

If the physician will be continuing employment or staff privileges at the hospital, the settlement agreement may include proposed remedial measures, such as monitoring of the physician or continuing education. This can help minimize conflicts arising from the physician's continued presence at the hospital, and provides assurances that the physician will take due care to remedy the hospital's concerns.

If the physician does not return to the hospital, but instead opts to resign, attorneys should discuss with your physician-client the potential employment risks or risks to the physician's staff privileges that may result. What will the hospital include in the physician's employee file? Will the hospital be required to report the resignation to the NPDB? As discussed above, pursuant to HCQIA, the hospital must report if the physician surrenders clinical privileges while under an investigation or in return for not conducting such an investigation. Again, this should all be considered when drafting the settlement agreement. *See Addendum B* for an example of language to include in a settlement agreement.

F. Step 6: Prepare for the Peer Review Proceeding

If mediation proves unsuccessful, it is time to prepare for the peer review proceeding. As discussed in detail below, it is important to be familiar with the hospital's fair hearing rules and regulations. These may be located in the bylaws, a separate rules and regulations document, or in a separate "Plan." For example, the University of Michigan Hospitals and Health Centers publishes its guidelines for a fair hearing in a "Fair Hearing Plan." The Plan details the rights of a physician to a fair hearing, tracks the HCQIA language for adequate procedural protections, and provides information on any additional rights granted to the physician. *See University of Michigan Hospitals and Health Centers Medical Staff Rules and Regulation*, 2011 (hereafter referred to as "U of M Fair Hearing Plan").²⁰ The U-M Fair Hearing Plan provides for a pre-hearing conference to discuss procedural questions, an explanation on the burden of proof, and discusses admissibility issues. *Id.*

1. Examine Notice of Hearing. First, examine whether the Notice of Hearing complies with HCQIA. If not, challenge the notice. Pursuant to HCQIA, 42 USC 11112(b)(2), if a hearing is requested by the physician, the physician involved must be given notice stating: (A) the place, time, and date of the hearing, which date shall not be less than 30 days after the date of

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

2. HCQIA Protections. Once the physician requests a hearing on a timely basis, then a hearing *shall* be held (as determined by the health care entity), before: (1) an arbitrator mutually acceptable to the physician and health care entity; (2) a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician; or (3) a panel of individuals who are appointed by the entity are not in direct competition with the physician involved.²¹

HCQIA provides that, during the hearing, the physician has the following rights: (1) representation by an attorney; (2) a record of the proceedings; (3) the ability to call, examine, and cross-examine witnesses; (4) the right to present relevant evidence regardless of its admissibility in a court of law; and (5) the ability to submit a written statement at the close of the hearing.²² While preparing for the hearing, make sure that your client is provided with all of these protections.

It is important for attorneys representing physician-clients to be familiar with HCQIA, and the protections provided to physicians under the statute. Attorneys should also be familiar with whether HCQIA provides any additional protections to physicians; whether a physician can waive his or her HCQIA protections; and whether hospital bylaws are a “safe harbor.” These issues are discussed below.

- a. **Does HCQIA provide any additional protections?** This element of the statute has been litigated many times. The Sixth Circuit has held that complying with the requirements in 42 USCA § 11112(b)(3)(C) provides a hospital with a “safe harbor,” and that the notice and hearing requirements will be considered met if these elements are satisfied.²³ The Sixth Circuit also noted that “§ 11112(b) also provides that a failure to meet the ‘safe harbor’ provisions outlined above does ‘not, in itself, constitute failure to meet the [adequate notice and hearing] standards of subsection (a)(3) of this section.’”²⁴ As such, according to the *Meyers* Court, a hospital is not required to provide any additional protections under HCQIA.
- b. **Can a physician waive his or her HCQIA protections?** Any waiver of HCQIA rights must be *knowing and voluntary*. HCQIA expressly requires that any waiver be made “voluntarily by the physician.”²⁵ As such, some courts considering the issue have found that “any agreement to be bound by hospital bylaws [is] legally insufficient to waive statutory due process rights under the third HCQIA standard.”²⁶
- c. **Are hospital bylaws a “safe harbor”?** Courts have distinguished between hospital bylaws and rights granted under HCQIA. Several courts have held that a hospital’s failure to comply with the procedures set forth in its own bylaws does not defeat HCQIA immunity. See, e.g. *Poliner v Texas Health Sys*, 537 F3d 368, 380-81 (CA 5 2008) (“HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws,” so “a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages”); *Meyers v*

Columbia/HCA Healthcare Corp, 341 F3d 461, 469–70 (CA 6 2003) (hospital entitled to HCQIA immunity “even assuming [it] did violate the bylaws, [because] the notice and procedures provided complied with the HCQIA's statutory ‘safe harbor’”); *Bakare v Pinnacle Health Hospitals, Inc*, 469 FSupp2d 272, 290 n. 33 (MD Pa2006) (“HCQIA immunity attaches when the reviewing body satisfies the requirements under HCQIA, regardless of its own policies and procedures.”).

Indeed, “just as noncompliance with hospital bylaws does not show noncompliance with the HCQIA, compliance with hospital bylaws does not show compliance with the HCQIA.”²⁷ “This is because a peer review disciplinary action does more than terminate one physician-hospital relationship. Indeed, Congress intended the HCQIA to address a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance. To that end, it *required* hospitals taking adverse peer review actions against physicians to report the actions to the state medical board and to a national data bank.”²⁸

3. Request Court Reporter. Pursuant to the physician’s rights under HCQIA, attorneys should request the peer review proceedings be transcribed by a court reporter. This ensures the physician has a record of the proceedings. However, make sure to first review the hospital’s fair hearing rules and regulations to determine if there is a prescribed manner for recording the proceedings. *See, e.g.*, U of M Fair Hearing Plan (mandating that the hearing officer “shall determine the nature of the record including whether the hearing will be transcribed. Copies of the record may be obtained by the Member or Applicant upon payment of any reasonable charges associated with the preparation thereof.”).

4. Challenge Hearing Officer or Panel Members. HCQIA provides that once the physician requests a hearing, then a hearing *shall* be held: before an arbitrator mutually acceptable to the physician and health care entity; before a hearing officer who is appointed by the entity and ***who is not in direct economic competition with the physician***; or before a panel of individuals who are appointed by the entity are ***not in direct competition with the physician involved***.²⁹ As such, examine whether the hearing officer or panel members are or may be considered in direct economic competition with the physician. If you conclude that the officer or members are in competition, make sure to challenge those members for bias under the statute.

What does it mean to be in “direct economic competition” with the physician? Courts reviewing the issue have considered the following: whether the physicians are employed by the same hospital;³⁰ whether the physicians compete for the same patients;³¹ whether the physicians are both in private practice;³² whether the geographical region could support multiple physicians in the same specialty,³³ and whether the region was understaffed in that specialty.³⁴

It is important to note that the prohibition of those in direct economic competition with the physician applies only to the hearing officer and the hearing panel. It does not necessarily apply to members of ad hoc committees participating in the peer review process prior to a hearing, or to other individuals engaging in the peer review process.³⁵

As such, the mere participation in the peer review process by individuals in direct competition with the physician will not be enough to strip the health care entity of its immunity. For example, in *Mathews v Lancaster Gen Hosp*,³⁶ the physician alleged that because certain individuals engaging in the peer review process were in direct competition with him, this demonstrated bad faith on behalf of the health care entity. The Court explained that, “although the Act suggests that a hearing officer or individuals sitting on a hearing panel should not be in direct competition with the physician who is the subject of the hearing, see § 11112(b)(3)(A)(ii) & (iii), it imposes no such requirement on participants in other phases of the peer review process.”³⁷ The focus, for purposes of immunity, is not whether individuals engaging in the process were in direct economic competition with the physician, but whether the professional review action was taken in the reasonable belief that the action was in the furtherance of quality health care.³⁸ This is an objective standard.³⁹

Review the hospital’s fair hearing rules and regulations to determine if there is a required process for challenging the hearing officer or panel members. For example, the U of M Fair Hearing Plan details how to object to the hearing panel and officer. Specifically, pursuant to the U of M Fair Hearing Plan:

Any objections to any member of the Hearing Panel, or the Hearing Officer or Presiding Officer, shall be made in writing, within ten (10) days of receipt of notice, to the CEO. A copy of such written objections must be provided to the COS [Chief of Staff] and must include the basis for the objections. The COS shall be given a reasonable opportunity to comment. The CEO shall rule on the objections and give notice to the parties. The CEO may request that the Hearing Officer make a recommendation as to the validity of the objections.

Any objections to the officer or members based on direct economic competition should be made as soon as possible. Otherwise, the physician may be seen as waiving this objection.⁴⁰

5. Retain an Expert. Next, you will need to retain an expert. This expert will review the relevant medical records and provide an opinion regarding the physician’s actions. The expert will also review any outside reviewer’s report (if the health care entity retains an outside reviewer), and render an opinion on that report. It is important to retain an expert who is experienced in the specialty and is well-respected. The physician should, if he or she is able, retain the most experienced expert in the subject area, and do so as soon as possible.

In 2011, the American College of Surgeons published a “Statement on the Physician Acting as an Expert Witness.”⁴¹ This statement provides for recommended qualifications for physicians acting as expert witnesses. An attorney or physician retaining an expert witness may wish to consider the following recommendations when deciding which expert to retain. These recommended qualifications include the following:

- (1) a current, valid, and unrestricted state license to practice medicine at the time of the alleged occurrence;

(2) the physician expert witness should have been a diplomate of a specialty board recognized by the American Board of Medical Specialties at the time of the alleged occurrence and should be qualified by experience or demonstrated competence in the subject of the case;

(3) the specialty of the physician expert witness should be appropriate to the subject matter in the case;

(4) the physician expert witness should have held, at the time of the alleged occurrence, privileges to perform the same or similar procedures in a hospital accredited by The Joint Commission or the American Osteopathic Association;

(5) the physician expert witness should be familiar with the standard of care provided at the time of the alleged occurrence and should have been actively involved in the clinical practice of the specialty or the subject matter of the case at the time of the alleged occurrence;

(6) the physician expert witness should be able to demonstrate evidence of continuing medical education relevant to the specialty or the subject matter of the case; and

(7) the physician expert witness should be prepared to document the percentage of time that is involved in serving as an expert witness. In addition, the physician expert witness should be willing to disclose the amount of fees or compensation obtained for such activities and the total number of times he or she has testified for the plaintiff or defendant.

6. Request Records. As discussed above, it is important to request and obtain all records relevant to the proceeding. Additionally, request any other records (as detailed above) which are pertinent to the peer review action, including notes of the investigation, incident reports, and meeting minutes. Provide these records to your expert to review as soon as possible.

7. Comply with Health Care Privacy Laws. Be sure to comply with all health care privacy laws, including the Health Insurance Portability and Accountability Act of 1996 (“HIPAA”), 42 USC 1320a-7e(b). HIPAA may become a concern because a physician accused of not following accurate standards of care or hospital regulations may wish to produce the records of other physicians’ patients to prove that his own level of care was not substandard. If this is the case, it is important to be familiar with HIPAA requirements, and maintain a robust compliance system to ensure that helpful information can be provided during the peer review proceedings, while also protecting patient privacy, and ensuring compliance with HIPAA.

Review the hospital’s fair hearing rules and regulations to determine if there is a required process for complying with health care privacy laws. For example, the U of M Fair Hearing Plan mandates that, prior to receiving any confidential documents, the physician shall agree that all documents and information will be maintained as confidential and will not be disclosed or used for any purpose outside of the hearing. Additionally, the physician “must also provide a written representation that his/her representative and any expert(s) have executed business associate agreements compliant with [HIPAA], implementing privacy and security regulations, and

applicable state law in connection with any identifiable patient information contained in any documents provided.” See U of M Fair Hearing Plan, Section 1.9.

8. Letters of Support. Obtain credible letters of support for the physician. These letters can be from hospital staff, administration, or fellow physicians.

9. Arbitrator. HCQIA provides that once the physician requests a hearing, then a hearing *shall* be held *before an arbitrator mutually acceptable to the physician and health care entity*; before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician; or before a panel of individuals who are appointed by the entity are not in direct competition with the physician involved.⁴² If the hospital chooses to hold the hearing before an arbitrator, then this is the time to suggest a mutually acceptable arbitrator before which to hold the hearing.

10. Witnesses and Exhibits. Next, prepare your witness list and expert witness list. Then exchange witness and expert lists with the hospital attorney. Review the hospital’s fair hearing rules and regulations to determine if there is a deadline for exchanging witness lists. For example, the U of M Fair Hearing Plan provides that at least fifteen days before the hearing date, the physician must send via certified mail to the CEO, a written list of the names of witnesses expected to offer testimony on his behalf, together with a brief summary of the anticipated testimony of each. *See* U of M Fair Hearing Plan, Section 1-4.3.

Furthermore, prepare and exchange exhibit binders with the hospital attorney. These binders should contain all exhibits you intend to introduce at the hearing. Again, be sure to review the hospital’s rules and regulations, to determine any evidentiary requirements or restrictions. *See id.*, Section 1.11, regarding Limiting Admissibility of Evidence: “The hearing will not be conducted according to rules of evidence. There shall be no right of discovery. Any relevant evidence will be admitted if it is the sort of evidence on which responsible persons are accustomed to rely in the conduct of serious affairs, regardless of the admissibility of the evidence in a court of law.”

Next, meet with your witnesses (both lay witnesses and expert witnesses) to prepare them for the hearing. This includes preparing your lay witnesses for direct examination and cross-examination, and preparing your expert witnesses for cross-examination. Then, prepare for the cross-examination of the hospital witnesses. Your own expert witnesses may be able to assist you in preparing for the cross-examination of hospital witnesses, by pointing out potential testimony, and how to refute that testimony.

G. Step 7: The Hearing.

1. Opening Statement. At the hearing, you will be permitted to make an opening statement to the hearing officer, panel, or arbitrator. As with any opening statement, always be aware of the audience is. Unlike a civil trial, there will be no jury at the proceeding; you will be speaking directly to the officer, panel, or arbitrator.

2. **Present Witnesses.** By this time in the process, you have already exchanged witness lists and prepared your witnesses. Pursuant to HCQIA, the physician then has the right to present witnesses.

3. **Track Exhibits.** During the proceeding, make sure to keep track of your exhibits. Identify the exhibit, mark it for entry, and admit the exhibit. Again, be sure to review the hospital's rules and regulations for fair hearing procedures, to determine what evidence is admissible. Exhibits should be properly marked as "peer review." However, use caution to not be overbroad. As discussed below, these exhibits will be privileged and undiscoverable in any subsequent litigation.

4. **Cross-Examination of Hospital Witnesses.** HCQIA provides that the physician is permitted to cross-examine the hospital's witnesses. As discussed above, it may be a good idea to discuss such cross-examination with your own witnesses and experts. The experts may be able to provide you with information or questions to use during cross-examination, or point out flaws or uncertainties in the testimony.

5. **Closing Argument.** As with the Opening Statement, be cognizant of your audience. Summarize your arguments and the evidence. Consider your strongest and most important points, and emphasize those points.

H. Step 8: Post-Hearing.

HCQIA provides that the physician may submit a written statement at the close of the hearing. This is an important step, as it provides the physician with an additional opportunity to detail his arguments and summarize the evidence and testimony. In the written statement, identify all exhibits and testimony in the record that support the positions taken in the statement. If you have obtained a transcript, you should consider attaching all or part of it to the post-hearing brief so that the arbitrator has the benefit of the written record. Additionally, you may wish to suggest a remedy based on the record and the hospital's bylaws. As discussed above in the settlement section, this may include recommendations for continued education.

I. Step 9: Final Decision.

Pursuant to HCQIA, "upon completion of the hearing, the physician involved has the right - (i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and (ii) to receive a written decision of the health care entity, including a statement of the basis for the decision."⁴³

As such, ensure that the hospital provides the physician with the arbitrator, officer, or panel's written recommendation. According to the statute, the recommendation must include a statement of the basis for the recommendation. Additionally, the hospital must provide a written decision to the physician, including a statement of the basis for the decision. Once the physician receives the recommendation and final decision, review them closely to confirm they are compliant

with 42 USCA § 11112(b)(3)(D). If either one is not compliant with HCQIA, challenge the decision and request revision.

Lastly, if the decision is averse to the physician, examine the hospital's bylaws or rules and regulations to determine if there is a review process available for the decision. For example, the U of M Fair Hearing Plan limits the grounds for appeal to the following: There was substantial failure to comply with this Fair Hearing Plan and/or the Bylaws of the Medical Staff during or prior to the hearing, so as to deny a fair hearing; or the recommendations were made arbitrarily or capriciously. *See* U of M Fair Hearing Plan, Section 1.16. The Fair Hearing Plan goes on to detail the time for appeal and the appeal process.

J. Step 10: Post-Decision Considerations.

After the fair hearing proceeding has concluded, along with a review of the final decision and any applicable appeals, there are potentially very important ramifications that may result from the proceedings. This section discusses those post-decision considerations.

1. Can the Physician Bring a Civil Lawsuit Against the Hospital?

Once a peer review of the physician's professional practices has occurred, along with disciplinary action, can the physician bring a lawsuit against the hospital? What hurdles will the physician face in doing so? Physicians may sometimes bring suit against the hospital arising from a peer review and corresponding disciplinary action. However, the physician will have to overcome Michigan's broad peer review immunity and peer review privilege statutes.

a. Peer Review Immunity.

In order to promote effective patient care in hospitals, the Michigan Legislature enacted MCL 331.531(3), commonly referred to as Michigan's peer review immunity statute.⁴⁴ Specifically, "[t]he purpose of statutory peer review immunity is to foster the free exchange of information in investigations of hospital practices and practitioners, and thereby reduce patient mortality and improve patient care within hospitals."⁴⁵

Michigan's peer review immunity statute protects a person, organization, or entity from civil and criminal liability when engaging in three types of protected tasks:

"First, immunity protects those that provide information or data to a review entity pursuant to MCL 331.531(1). Second, it protects specific "review entities," such as a duly appointed peer review committee of a hospital, for those acts or communications within its scope as a review entity. Finally, subject to MCL 331.53255 and MCL 331.533,56 immunity applies to those who release or publish a record of peer review proceedings, or the reports, findings, or conclusions of a review entity."⁴⁶

The peer review statute establishes qualified immunity from liability for peer review communication and participants who provide such communications to all who participate in peer review without "malice."⁴⁷ The Michigan Supreme Court has defined malice as when a "person

supplying information or data [to a peer review entity] does so with knowledge of its falsity or with reckless disregard of its truth or falsity. Similarly, a review entity is not immune from liability if it acts with knowledge of the falsity, or with reckless disregard of the truth or falsity, of information or data which it communicates or upon which it acts.”⁴⁸

In other words, “malice” is an exception to peer review immunity. Once a defendant (hospital) has stated facts sufficient to invoke peer review immunity, the plaintiff (physician) then has the burden of demonstrating malice.

b. Peer Review Privilege.

MCL 333.21515, MCL 333.20175(8), and MCL 331.533 provide that the records, data, and knowledge collected for or by peer review entities are confidential and not discoverable during litigation.⁴⁹ This privilege is broad, extending even to disclosure to the Attorney General when conducting a criminal investigation.⁵⁰

The Michigan Supreme Court broadened peer review privilege even further in *Krusac v Covenant Medical Center, Inc.*, 497 Mich 251; 865 NW2d 908 (2015). In *Krusac*, the Court considered whether Michigan’s peer review privilege statutes encompass objective facts contained in an otherwise privileged report. The Court held that the statutes do include objective facts, and therefore, these facts are subject to the peer review privilege. This decision overruled *Harrison v Munson Healthcare, Inc.*,⁵¹ which had held that the privilege does not extend to objective facts gathered contemporaneously with an event.

Krusac has therefore made it more difficult for litigants to obtain information surrounding peer review events. However, the Court explained: “while the peer review privilege may make it more difficult for a party to obtain evidence, the burden on a litigant is mitigated by the fact that he or she may still obtain relevant facts through eyewitness testimony, including from the author of a privileged incident report, and from the patient’s medical record.”⁵² This may not provide much comfort to litigants; however, “if a litigant remains unsatisfied with the statutory balance struck between disclosing information to patients and protecting peer review materials, any recalibration must be done by the Legislature.”⁵³

2. Can a Patient Bring Suit Against the Physician and Hospital?

Although peer review proceedings may have determined the hospital’s response to the physician’s actions, this does not mean that the physician’s troubles are over. If the peer review action was triggered by allegedly substandard patient care, the physician (and hospital) may face a medical malpractice suit from the patient. This raises important privacy concerns, especially if the physician seeks to discover or disclose information obtained or disclosed during the peer review proceedings. Similarly, the patient may seek to discover such information. As described above, MCL 333.21515, MCL 333.20175(8), and MCL 331.533 provide that the records, data, and knowledge collected for or by peer review entities are confidential and not discoverable during litigation. Michigan interprets these statutes broadly, and the Michigan Supreme Court has found that the privilege includes objective facts that are contained in a privileged report. As such, it will be difficult for physicians *and* patients to obtain this information.

3. Does the Hospital Still Have Reporting Requirements?

Once the dispute is either settled in mediation or concluded through the peer review fair hearing proceedings, the Hospital may still have reporting requirements under HCQIA. As described above, HCQIA requires health care entities to report certain “reportable events” to the Board of Medical Examiners. These events include a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days; the surrender of clinical privileges of a physician while the physician is under an investigation by the entity relating to possible incompetence or improper professional conduct, or in return for not conducting such an investigation or proceeding; or in the case of a professional society, a professional review action by the professional society which adversely affects the membership of a physician in the society.

As such, if the peer review fair hearing results in an action that adversely affects the clinical privileges of the physician for a period longer than 30 days, then the hospital must report that event to the NPDB.

Reports to the NPDB may have a substantial impact on a physician’s employment opportunities. Hospitals are not only permitted to review these reports, but they are **required** to request information from the NPDB concerning a health care practitioner at the time a health care practitioner applies for a position on its medical staff (courtesy or otherwise) or for clinical privileges at a hospital, *and* every 2 years for any health care practitioner who is on its medical staff (courtesy or otherwise) or has clinical privileges at the hospital.⁵⁴ Any hospital that does not request the information is presumed to have knowledge of any information reported to the NPDB concerning the health care practitioner.⁵⁵ Each hospital may rely upon the information provided by the NPDB to the hospital. A hospital shall not be held liable for this reliance unless the hospital has knowledge that the information provided was false.⁵⁶

Hospitals are not the only entities that may request information on a health care practitioner from the NPDB. In addition to hospitals and the physician himself, the following parties can also obtain information from the NPDB:⁵⁷

- a State Medical Board of Examiners or other state authority that licenses health care practitioners;
- a health care entity which has entered or may be entering into an employment or affiliation relationship with a health care practitioner, or to which the health care practitioner has applied for clinical privileges or appointment to the medical staff;
- an attorney, or individual representing himself or herself, who has filed a medical malpractice action or claim in a state or Federal court or other adjudicative body against a hospital, and who requests information regarding a specific health care practitioner who is also named in the action or claim;⁵⁸
- a health care entity with respect to professional review activity;
- agencies administering (including those providing payment for services) federal health care programs, including private entities administering such programs under contract;

- state licensing or certification agencies and federal agencies responsible for the licensing and certification of health care practitioners, providers, or suppliers;
- state agencies administering or supervising the administration of state health care programs (as defined in 42 USC 1128(h));
- state law or fraud enforcement agencies;
- law enforcement officials and agencies; and
- health plans.

Such a report could therefore negatively impact the physician's future employment opportunities, or negatively affect credentialing and privileges. As such, it is critical that you inform your physician-client of any mandatory reporting requirements, and the potential consequences of such reporting.

V. Conclusion.

From the moment you first meet with a physician-client, there are important factors to consider and safeguards to take. This is true not only in the context of a peer review fair hearing proceeding, but also for purposes of potential litigation, or statutory, licensing, and regulatory actions. To ensure that you are covering all essential steps, it may be helpful to follow an outline when preparing for the peer review proceeding. An example of such an outline can be found in **Addendum A**. By following the steps detailed in this white paper, you are well on your way to an effective representation of your physician client.

Addendum A

Outline for Preparation of Physician Peer Review Proceedings

- I. Complete Statement of Background Facts
 - A. Educational Qualification
 - B. Prior Peer Review Proceedings
 - C. Events Leading Up to Peer Review
 - D. All Communications with Hospital and Staff
 - E. Any Outside Independent Reviews
 - F. Licensing Complaints or Consent Orders
 - G. Convictions including Misdemeanors or Traffic Violations
 - H. Malpractice Claims including Notice of Intent to Sue related to proceedings
 - I. Status of Investigation
 - J. Notice and Written Communications

- II. Independent Background Check
 - A. Perform Website Search of Physician for Credentialing Issues
 - B. Verify Licensing status, e.g. from LARA
 - C. Case search for malpractice

- D. On-line patient complaints
- III. Relevant Records
- A. Hospital Bylaws applicable to relevant time frame
 - B. All Credentialing Policies relevant to peer review proceedings
 - C. All policies or addendums referenced in Bylaws related to peer review proceedings
 - D. Employment Agreement with Hospital, if relevant
 - E. Employment Manual if Physician is Hospital Employee
 - F. Credentialing File
 - G. Physician Employee file, if applicable
 - H. Physician's National Practitioner Data Bank records
 - I. Relevant Medical Records, if applicable
 - J. Medical Executive Meeting Minutes related to investigation
 - K. All notices, correspondence and communications from Hospital
- IV. Notice to Hospital about Physician Representation
- A. Letter notifying of attorney representation
 - B. Request all information that forms the basis to initiate peer review proceedings
 - C. Analyze Notice to make sure that complies with HCQIA
 - D. Challenge Notice, if applicable, to require compliance
 - E. Request production of bylaws and/or policies from Hospital governing action
 - F. Request names and specialties of all persons on peer review panel
 - G. Request Meeting with Chair to allow physician to present position
- V. Discuss Settlement
- A. Initiate negotiations with Hospital Attorney
 - B. Determine if settlement feasible
 - C. Suggest Mediation, if possible

- D. Draft a proposed written settlement
 - E. Importance of reporting and licensing issues in any proposed settlement
 - F. Propose remedial efforts, e.g. monitor, proctor, continuing education
 - G. Resignation (caution: NPDB; employment risks; third-party payer credentialing)
- VI. Preparation for Peer Review Proceeding
- A. Examine whether Notice of Hearing complies with HCQIA
 - B. Make sure physician is given all HCQIA protections for hearing
 - C. Request that peer review proceedings be transcribed by court reporter
 - D. Challenge panel members that have conflict or bias
 - E. Retain Expert to review relevant medical records and provide opinion
 - F. Request all medical records relevant to review
 - G. Comply with healthcare privacy laws, e.g., Business Associate Agreements
 - H. Obtain credible letters of support for physician
 - I. Suggest the possibility of mutually acceptable arbitrator
 - J. Exchange Witness and Expert List with Hospital attorney
 - K. Exchange Exhibit Binders with Hospital attorney
 - L. Prepare Lay witnesses for hearing, including direct and cross-examination
 - M. Prepare Expert for hearing, including cross-examination
 - N. Prepare for Cross-examination of Hospital Witnesses
- VII. Hearing
- A. Opening Statement
 - B. Present Witnesses
 - C. Track Exhibits (Identify, Mark, Admit)
 - D. Exhibits should be properly marked as peer review (caution: not overbroad)
 - E. Cross-Examination of Hospital Witnesses
 - F. Closing Argument

VIII. Post-Hearing

- A. Submit a written statement at the end of the proceedings
- B. Identify exhibits and record to support statement
- C. Suggest remedy in statement based on record and Bylaws;
Consider attaching all or portions of transcript

IX. Final Decision

- A. Review decision for whether HCQIA compliant
- B. Challenge decision if not HCQIA compliant, and request revision
- C. Examine Bylaws to determine if there is a review process for the decision

Addendum B

Sample Settlement Agreement Language

This Resignation Agreement and Release ("Agreement") is made between _____ (hereafter referred to as "Physician") and _____ Hospital, on behalf of itself, its parent, subsidiaries, affiliates, successors, officers, directors, employees, agents and attorneys, and all related entities, including, but not limited to, _____, and their officers, directors, employees, agents and attorneys.

In consideration of the mutual promises stated in this document, it is agreed as follows:

1. It is agreed that Physician will resign from his employment effective midnight on _____ (the "Resignation Date"). As of the Resignation Date, Physician voluntarily and irrevocably resigns from his position(s) with and at Hospital and from all other Hospital committees and appointments; however, he will retain privileges at Hospital subject to the medical bylaws and other requirements to retain those privileges. To the extent that any language or provisions in any pre-existing agreements between Physician and Hospital are not consistent with this paragraph, this paragraph shall supersede such language or provisions, which will be void and of no further effect.

2. Hospital accepts Physician's resignation effective midnight on _____, and his employment file shall reflect a voluntary resignation.

3. The parties agree that all requests for references from potential employers should be directed to _____. As to any person or entity that seeks a reference for Physician because Physician is seeking new employment, unless released by Physician to say otherwise, or required by law, court order, or subpoena, Hospital will only offer the following information:

(i) that Physician voluntarily resigned from his employment with Hospital (ii) the position(s) held by him while at Hospital (iii) the dates of his employment with Hospital, if requested, (iv) salaries earned, and (v) a letter of reference which is attached as Attachment A. In addition, attached as Attachment B is a mutual announcement that will be released with regard to Physician's resignation as an employee of Hospital.

4. In return for the consideration set forth above, Physician hereby unconditionally releases and forever discharges Hospital from ANY AND ALL causes of action, suits, damages, claims and demands whatsoever which he ever had or now has against Hospital, directly or indirectly, by reason of any facts existing as of the date of execution of this Agreement, whether known or unknown, including, but not limited to, claims for defamation, wrongful discharge, breach of contract, negligence and other tort actions, and/or discrimination, harassment and/or retaliation on account of age, sex, sexual orientation, race, color, religion, marital status, handicap, height, weight, national origin, or any other classification recognized under the common law of the State of Michigan, local law and/or ordinances, and the civil rights statutes, including, but not limited to: Title VII of the Civil Rights Act of 1964; the Age Discrimination Act of 1967; the Age Discrimination in Employment Act, and/or the Rehabilitation Act of 1973; the Older Workers Benefit Protection Act; the Americans With Disabilities Act; and Family and Medical leave Act of 1993; the Elliott-Larsen Civil Rights Act; the Michigan Handicappers Civil Rights Act; the Michigan Whistleblowers Protection Act; and any and all amendments to any of same. Specifically excepted from this release is the right to enforce the terms of this Agreement and any and all rights associated with Physician's retirement plan with Hospital. Physician understands and agrees that this is a total and complete release even though there may be facts and consequences of facts which are unknown to Physician.

5. Hospital affirmatively states that at this time Hospital is not aware of any potential claims or litigation that Hospital may have against Physician.

6. Hospital has determined that no report of any adverse decision is required to be made, nor shall be made, against Physician to the National Practitioner Data Bank ("NPDB"), the Healthcare Integrity and Protection Data Bank ("HIPDB"), the Michigan Department of Community Health ("MDCH"), or any other similar database or regulatory entity, whether at the federal, state or local level based upon the termination of Physician's Employment Agreement or the execution of this Agreement. Physician's decision not to pursue rights as to any events related to these matters, Physician's execution of this Agreement, and payments made to Physician related to this Agreement are not and will not be construed in any way to be a "reportable event" for purposes of the NPDB, the HIPDB, the MDCH, or any other similar database or regulatory entity, whether at the federal, state or local level.

7. The parties agree that nothing contained herein and no actions taken by any party with respect to this Agreement shall be construed as an admission by any party of any liability, wrongdoing or obligation, all such liabilities or obligations being expressly denied.

8. All parties agree that the terms and/or details, facts, incidents, occurrences, events and transactions giving rise to this Agreement and the details and provisions of this Agreement

shall be privileged and confidential as between Hospital and Physician. Neither party shall reveal any such information to any other person or entity, either directly or indirectly, under any circumstances except as may be specifically requested and approved by mutual agreement of the parties, or as may be required to satisfy reporting requirements established by agencies of the federal, state or local government or otherwise required by law or court order. It has been mutually agreed that Physician may review the terms and conditions of this Agreement and the circumstances of his Hospital employment with his spouse, personal attorney, insurer(s), and tax advisor, each of whom shall be apprised of the terms of this paragraph.

¹ 42 USC 11112(a).

² Mich Comp Laws Ann §331.531 (emphasis added).

³ MCL §331.531.

⁴ MCL §331.531(5) (emphasis added).

⁵ Mich Comp Laws Ann §331.531(3).

⁶ Mich Comp Laws Ann §331.531(4).

⁷ 42 USC 11112(b).

⁸ 42 USC 11112(b)(3)(C).

⁹ *Reid v KentuckyOne Health, Inc*, unpublished opinion per curiam of the Court of Appeals of Kentucky, issued March 18, 2016 (Docket No. 2015–CA–000092–MR).

¹⁰ MCL 333.16222(3) (emphasis added).

¹¹ *Doe v Leavitt*, 552 F3d 75, 84 (CA 1, 2009).

¹² *Id.*

¹³ *Rogers*, 139 F Supp at 134 (DDC 2015).

¹⁴ *Id.*

¹⁵ *Id.*

¹⁶ 42 USC 11112(b).

¹⁷ *Id.*

¹⁸ Amended, effective March 22, 2017.

¹⁹ 45 CFR 60.18(a)(2)(ix).

²⁰ Available online at http://www.med.umich.edu/mss/pdf/bylaws_supplement.pdf (last accessed April 28, 2017).

²¹ 42 USC 11112(b)(3)(A).

²² 42 USC 11112(b)(3)(C).

²³ *Meyers v Columbia/HCA Healthcare Corp*, 341 F3d 461, 471 (CA 6 2003).

²⁴ *Id.*

²⁵ 42 USC 11112(b).

²⁶ *Peper v St Mary's Hosp & Med Ctr*, 207 P3d 881, 885, 889 (Colo App 2008).

²⁷ *Id.*

²⁸ *Id.*

²⁹ 42 USC 11112(b)(3)(A) (emphasis added).

³⁰ *Hourani v Benson Hosp*, 211 Ariz 427, 433; 122 P3d 6, 12 (2005).

³¹ *Id.*

³² *Pariser v Christian Health Care Sys, Inc*, 816 F2d 1248, 1252 (CA 8 1987).

³³ *Id.*

³⁴ *Id.*

³⁵ *See e.g., Robinson v Care All. Health Services*, 2015 WL 4040505, at *17 (DSC June 24, 2015) (holding that “Plaintiff’s separate complaint that Dr. Hamilton, who practices with Dr. Fisher, was a member of the ad hoc committee is not a basis on which to find that the hospital treated Plaintiff unfairly for purposes of HCQIA immunity.”); *see also Wayne v. Genesis* 140 F.3d 1145, 1149 (8th Cir.1998) (finding that physician’s claim that two members of peer review committee were in direct economic competition with her was insufficient to rebut presumption that peer review process was fair under circumstances). *But see Smigaj v Yakima Valley Mem Hosp Ass’n*, 165 Wash App 837, 863; 269 P3d 323, 336 (2012) (holding that “because the process made available to Dr. Smigaj did not include neutral decisionmakers, it was not fair under the circumstances. HCQIA anticipates a hearing officer or panel not in direct economic competition with the physician involved.”).

³⁶ *Mathews v Lancaster Gen Hosp*, 87 F3d 624 (CA 3 1996).

³⁷ *Id.* at 635.

³⁸ *Id.* at 634-645.

³⁹ *Id.*

⁴⁰ *See e.g., Sugarbaker v SSM Health Care*, 190 F3d 905 9CA 8 1999) (Surgeon waived objection to alleged direct economic competitors sitting on hospital executive committee by failing to lodge timely objection).

⁴¹ Available online at <https://www.facs.org/about-ac/s/statements/8-expert-witness> (last accessed May 27, 2017).

⁴² 42 USC 11112(b)(3)(A) (emphasis added).

⁴³ 42 USC 11112(b)(3)(D).

⁴⁴ *Feyz v Mercy Mem Hosp*, 475 Mich 663, 666; 719 NW2d 1, 3–4 (2006).

⁴⁵ *Id.*

⁴⁶ *Id.* at 682.

⁴⁷ *Id.*

⁴⁸ *Id.* at 667.

⁴⁹ *See Feyz v Mercy Mem Hosp*, 475 Mich 663, 681; 719 NW2d 1, 11 (2006).

⁵⁰ *Id.*

⁵¹ 304 Mich App 1, 851 NW2d 549 (2014),

⁵² *Krusac*, 497 Mich at 262.

⁵³ *Id.*

⁵⁴ 45 CFR 60.17.

⁵⁵ *Id.*

⁵⁶ *Id.*

⁵⁷ 45 CFR 60.18(1) & (2).

⁵⁸ Pursuant to the statute, “This information will be disclosed only upon the submission of evidence that the hospital failed to request information from the NPDB, as required by § 60.17(a) of this part, and may be used solely with respect to litigation resulting from the action or claim against the hospital.”