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Medical Staff Year-End Review

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Practice Area: Health Law & Provider Groups and Clinics & Health Industry
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Medical staff actions and physician conduct have received much focus this year, and effective January 1, 2009, The Joint Commission on the Accreditation of Healthcare Associations ("The Joint Commission") is requiring that healthcare organizations establish policies and procedures for conflict management. This bulletin summarizes a few important medical staff issues that have developed in 2008 and provides some basic recommendations. As discussed below, providers should carefully apply the lessons learned from this year's developments to ensure that their medical staff processes include the protections necessary to avoid liability.

Disruptive Physicians
By all accounts, the majority of in-house counsel's tasks involve the management of conflict. Reportedly in recognition of the fact that such conflict can affect quality of patient care, The Joint Commission introduced a new standard addressing unprofessional behavior among health care professionals. The Joint Commission's new leadership standard, effective January 1, 2009, requires the following:

- The hospital/organization has a code of conduct that defines acceptable and disruptive and inappropriate behaviors.
- Leaders create and implement a process for managing disruptive and inappropriate behaviors.

This new standard originally accompanied a Sentinel Event Alert detailing the longstanding problems caused by disruptive conduct in the health care setting. The Joint Commission's Alert recommends several steps to address such behavior, including implementation of skills-based training, holding all team members accountable to professional standards, and developing systems that reduce the fear of retaliation for raising concerns. The Joint Commission also warns that organizations that fail to address unprofessional conduct through formal systems are indirectly promoting it; however, The Joint Commission does not specify what it considers unacceptable or disruptive behavior, or exactly how to address discipline issues. Instead, each organization needs to develop its own conflict management policies and procedures in order to reflect its unique culture, needs and values. The American Health Lawyers Association has issued a Healthcare Conflict Management Toolkit that can be used in developing policies and procedures, and The Joint Commission has suggested certain policies related to this new standard.

In part because The Joint Commission has not issued further guidance regarding the new standard, there is a fear among the physician community that the standard will lead to arbitrary enforcement. Responding to these concerns, the American Medical Association ("AMA") has asked for a one-year moratorium on the standard to allow time for medical staffs to change their bylaws to comply. Also, the one-year hold would allow the AMA, in conjunction with The Joint Commission and other organizations, to develop a model appeals process and a definition of disruptive behavior by a physician that "would rise to the level of true abusive behavior." The AMA feels that by developing clear standards, physicians would be protected from retaliation and from the use of the new standard to dampen the physician's competing economic interests.

HCQIA Immunity and *Poliner*

While hospitals and medical staffs investigate potential problems, including those addressed by The Joint Commission's new conduct standard, they also should be certain to follow requirements under the Health Care Quality Improvement Act ("HCQIA") as part of their investigations. This year, the Fifth Circuit issued a seminal reversal that sets out these requirements and the process for ensuring protection under HCQIA.

See Poliner v. Texas Health Sys., 537 F.3d 368 (5th Cir. 2008).[1] Specifically, the Fifth Circuit overturned a $33 million jury award to a cardiologist who alleged that a hospital's temporary restriction of his cardiac catheterization privileges caused injury to his reputation and career. The *Poliner* ruling strengthens the proposition that individuals participating in the peer review process generally are immune from liability. This immunity is not, however, foolproof. Providers should carefully apply the lessons learned from the decade-long history of this case in ensuring that their medical staff processes include the protections necessary to avoid liability.

In particular, providers should analyze their processes in accordance with HCQIA's four requirements for immunity from liability for participants in the peer review process:

• A professional review action must be taken in the reasonable belief that the action was in furtherance of quality health care.

The "reasonable belief " standard of HCQIA is satisfied if "the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." There is no requirement that the review result in actual improvement in health care quality, or even that the reviewer's conclusions be correct. In other words, reasonable belief is an objective inquiry, and the good or bad faith of the reviewers is irrelevant. The *Poliner* court noted that, "[i]f a doctor unhappy with peer review could defeat HCQIA immunity simply by later presenting the testimony… of a different view from the peer reviewers…or that his treatment decisions proved to be 'right'…HCQIA immunity would be a hollow shield. *Id*. at 18.

• A professional review action must be taken after a reasonable effort to obtain the facts of the matter.

The *Poliner* court found that the defendants made a reasonable effort to obtain the facts, based on the Hospital administration's extensive consultation with several cardiologists and other Hospital committees. A key factor was that none of the information uncovered during the investigation was facially flawed or otherwise so obviously deficient as to make reliance on the information unreasonable. Poliner argued that because the Hospital's medical staff bylaws allow for a summary suspension of clinical privileges when a practitioner's acts "constitute a present danger to the health of his patients," further investigation was warranted before suspension and a reasonable effort was lacking. In response, the court stated that HCQIA immunity is not contingent on compliance with an individual hospital's bylaws. Rather, HCQIA imposes a separate and uniform set of standards that allow for a safe harbor for peer review actions, provided that the action complies with these standards. The court emphasized, however, that this does not mean that hospitals and committees are free to violate bylaws and state law. HCQIA immunity applies only to money damages, and practitioners may still seek appropriate injunctive and declaratory relief in response to abusive peer review.

• A professional peer review action must be taken after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances.

HCQIA provides a safe harbor set of procedural requirements that, if followed, means the health care entity is deemed to have met the adequate notice and hearing requirement. Notice and hearing procedures are not required if no professional review action is taken, and a suspension or restriction of privileges may last no longer than 14 days, during which an investigation must be conducted to determine the need for a professional review action. If the failure to suspend or restrict privileges would result in an imminent danger to the health of any individual, HCQIA's "emergency" provision also allows for immediate suspension or restriction subject to subsequent notice and hearing.

• A professional peer review action must be taken in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements above.

The *Poliner* court found that the temporary restrictions were tailored to address specific health concerns and the physician's other privileges were unaffected. There was an objectively reasonable basis for concluding that the hospital's actions were warranted, and to allow an attack on the accuracy of the peer reviewers' conclusions would "drain all meaning from the statute."

Ultimately, the *Poliner* decision upholds the reasonable standards of conduct required of hospitals and peer review organizations. The Fifth Circuit justifiably prioritized considerations of patient safety over the right of an affected physician to seek money damages. To retain immunity under HCQIA, however, such considerations must be made in conjunction with actions that are consistent with HCQIA's due process requirements.

For example, in *Stratienko v. Chattanooga-Hamilton Cty. Hosp. Auth.*, the court reviewed the summary suspension of a cardiologist's privileges. The hospital specifically suspended the physician for 30 days without providing adequate notice and hearing procedures, and failed to make a reasonable effort to obtain facts. Because HCQIA only permits summary suspension prior to investigation for 14 days or less (during which an investigation should be conducted to determine the need for a professional review action), the Court upheld the physician's claims for summary judgment purposes. The hospital's failure to adhere to HCQIA requirements lifted the immunity from liability usually afforded hospitals under this federal statute. 226 S.W.3d 280 (Tenn. 2007).

Next Steps

The core elements of any disruptive behavior policy should include those elements set out by The Joint Commission; any peer review process used for investigating such behavior should follow the outline of the HCQIA elements in order to provide immunity to the organization for its actions. Additionally, hospitals should structure their medical staff bylaws, policies and other governing documents to reflect the requirements of state law. For example, under HCQIA, good faith is irrelevant, but Wisconsin's peer review statute (Wis. Stats. §146.37) shields only any "person acting in good faith" from liability. The Wisconsin statute does not define good faith, but requires that a plaintiff present "clear and convincing evidence" to the contrary in order to prove that an action was not taken in good faith. One way to rebut a practitioner's claims that his or her peers are acting in bad faith or with a personal vendetta is to consider external peer review. The external reviewers are also shielded from immunity. In a recent case, the Wisconsin Supreme Court ruled that any participants in the peer review process acting in good faith, including external reviewers, are entitled to immunity. The external peer reviewers are immune even if they issue a "diagnosis" as part of their review that turns out to be incorrect. The immunity is lost only upon "clear and convincing evidence" to the contrary as to the good faith of the reviewers. See *Rechsteiner v. Hazelden*, 742 N.W. 2d 524 (Sept. 13, 2007).

Conclusion
Both The Joint Commission's new standard and the decision highlight the role that health care organizations play in setting expectations for behavior. Providers should be consistent and clear regarding expectationsand codes of conduct. It also should be noted that although failure to comply with internal procedures does not defeat HCQIA immunity, practitioners have other remedies available to them outside of monetary damages. Documentation and clear communication are key. Committees should fully document the data and information reviewed so that the reasonableness of their decision will stand up to later scrutiny.

[1] On October 21, 2008 Poliner filed a writ of certiorari asking the United States Supreme Court to review the Fifth Circuit's decision.
