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Med-Staff Newsletter

NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP

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EEOC Challenges Yale New Haven's "Late Career Practitioner Policy" in Discrimination Suit

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Introduction

The U.S. Equal Employment Opportunity Commission (the "EEOC") sued Yale New Haven Hospital ("Yale Hospital" or the "Hospital") on February 11, 2020, alleging the Hospital is in violation of the Age Discrimination in Employment Act ("ADEA"), 29 U.S.C. § 621 et. seq., the Americans with Disabilities Act ("ADA"), 42 U.S.C. §12101, et. seq., and Title I of the Civil Rights Act of 1991, 42 U.S.C. §1981a, by adopting and implementing a "Late Career Practitioner Policy" ("Policy") in 2016.[1] This article examines the nature of the age-based screening policies, the Hospital's Policy, and the underlying law at issue in this case.

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Events and Webinars

- John Synowicki and Erin Muellenberg will be presenting at the annual conference for the **National Association of Medical Staff Services (NAMSS)** on October 5- 8, 2020.
- John Synowicki will present a webinar for the **Tennessee Association of Medical Staff Services** on October 21, 2020. John will present on *"Hiding in Plain Sight,"* which examines troubling crimes and cases involving physicians.
- John Synowicki will present at the annual conference for the **Maine Association of Medical Staff Services** on November 6, 2020. John will present on *"Credentialing and Sharing Information Across Entities"*; *"NPDB Reporting – What is Reportable?"*; and *"Hiding in Plain Sight."*
- Alexis Angell is speaking at the **AHLA Fundamentals of Health Law** program November 11 – 13. Topic is *Medical Staff, Credentialing, and Peer Review Fundamentals*

  Register here: https://communities.americanhealthlaw.org/fundamentals2020/registration-information
- **POLSINELLI PRESENTS:**
  Polsinelli Med Staff Webinar
  November 11, 2020,
  12:00pm - 1:30pm CST
  "How Hospitals Should Adjust Their Practitioner Investigations, Hearings and Appeals for the New Normal"
  Sherri Alexander and Alexis Angell
- **January 2021:** *"Virtual Med-Staff Conference."* Dates and times will be announced soon.

United States Physicians Are Aging

Ensuring competence of senior physicians is increasingly important as United States physicians advance in age. According to the American Medical Association's ("AMA") Physician Master File, physicians in the United States over age 65 account for 15% of the active workforce, and those between ages 55 and 64 make up 27% of the active workforce. This includes approximately 336,000 of 800,000 physicians in active patient care.[2] One in four physicians in the United States is over the age of 65, and the number of physicians in this age group quadrupled between 1975 and 2013.[3] The issue for health care providers and entities is how to discern whether a senior physician is competent to continue practicing.

Some Health Care Providers and Entities Have Implemented Age-Based Screening Requirements for Physicians

Some hospitals, like Yale Hospital, have instituted age-based screening requirements for physicians over a certain age, and there is growing interest in such policies.[4] Age-based policies require physicians over a certain age to undergo periodic physical and cognitive exams as a condition of renewing clinical privileges.[5]

> **While there are many approaches to age-based screening, these four elements are often included in screening policies:**
> **1. a physical examination;**
> **2. peer assessment;**
> **3. other co-workers' assessments; and**
> **4. a cognitive assessment.[6]**

Recognizing the significance of this issue, the AMA[7] and the American College of Surgeons ("ACS")[8] support age-based screenings to evaluate physicians' mental health and review their treatment of patients. The AMA Council on Medical Education report states "formal guidelines on the timing and content of testing of competence may be appropriate and may head off a call for mandatory retirement ages or imposition of guidelines by others."[9] ACS has recommended surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment starting at age 65 to 70.[10] The ACS also recommends that surgeons voluntarily assess their neurocognitive functions using confidential online tools and self-disclose any concerning findings.[11]

Legal Considerations for Age-Based Policies

It is estimated that "only 5 to 10 percent of U.S. hospitals mandate screening of late career physicians."[12] Some hospitals cite concerns for litigation risk. The federal government and the majority of states have "enacted some form of prohibition against age discrimination in employment."[13] Senior physicians negatively affected by age-based policies could potentially sue health care facilities based on claims under Title VII, the ADEA, and the ADA.

While courts have held some hospitals liable under Title VII,[14] the ADEA,[15] and the ADA,[16] many hospitals have successfully defended against such claims. The ADEA, for example, prohibits the arbitrary use of age in decisions that impact the employment status of an individual. If the hospital can demonstrate that the age-based testing program is reasonably necessary for public safety, the program may not violate the ADEA.

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The United States Supreme Court explained: "The ADEA is not an unqualified prohibition on the use of age in employment decisions, but affords the employer a 'bona fide occupational qualification' defense."[17] Specifically, the ADEA provides that it does not violate the ADEA to take an action based on age when "age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business, or where the differentiation is based on reasonable factors other than age."[18] But this defense "has only 'limited scope and application' and 'must be construed narrowly.'"[19]

Yale Hospital's "Late Career Practitioner Policy"

Yale Hospital developed a multistep-step assessment process for all clinicians age 70 and older who apply for, or seek to renew, medical staff privileges. The first step in this assessment is a screening with multiple tests to evaluate cognitive ability.[20] Specifically, a neuropsychologist administers these tests, which include: rudimentary information processing; visual scanning and psychomotor efficiency; processing speed and accuracy under decision pressure; concentration and working memory; visual analysis and reasoning; verbal fluency; memory—visual and verbal; prefrontal self-regulation; and executive functioning.[21] According to the Hospital, "the cognitive screening battery of tests was developed and designed to balance brevity with broad coverage of abilities relevant to clinical practice. The instrument was constructed to account for the cognitive decline and neurodegeneration commonly associated with aging."[22]

The final step in this assessment is reviewing the cognitive test results by the Hospital's Medical Staff Review Committee (the "Committee") that provides its recommendations to the medical staff credentialing panel.[23] The Committee does not, however, provide pass or fail determinations to the medical staff credentialing panel. Instead, the Committee provides a range of decisions based on the cognitive functioning level of the clinician in review.[24]

Based on a study issued by the Hospital in relation to this Policy, this assessment process has been performed on 145 clinicians since October 2016. The majority of those assessed were physicians; however, dentists, psychologists, physician assistants, midwives, podiatrists, and Advanced Practice Registered Nurses were also assessed because of the Policy's implementation. Of those assessed, 57.4% scored within normal limits and received their medical staff credentials—these clinicians will continue to be re-assessed every two years; 24.1% scored below the normal limits but had no deficit—these clinicians received their medical staff credentials but were recommended for annual cognitive re-screening; and 12.7% had inadequate scores resulting in a protected practice environment or the clinician opting to discontinue his or her medical practice.[25]

The EEOC's Claims against Yale Hospital's Policy

The EEOC contends that the additional medical examinations are solely due to the provider's age with no particularized suspicion that the provider's eyesight or neuropsychological ability may have declined.[26] The EEOC believes the Policy violates the ADEA because it "subjects employees to the stigma of being singled out due to their age," which ultimately has the "effect of depriving medical providers age 70 and older from equal employment opportunities."[27] The EEOC also alleges that the ophthalmologic and neuropsychological exams are medical examinations that violate the ADA's prohibition against subjecting employees to medical examinations that are not job-related and consistent with business necessity.[28] Last, the EEOC claims that the medical examination interferes with the clinician's right to enjoy their employment free from unlawful medical examinations.

The EEOC is seeking a permanent injunction enjoining the Hospital from engaging in any employment practice that discriminates based on age, an injunction against the Hospital's Policy, instatement, reinstatement, front pay, back wages, liquidated damages, punitive damages, and costs. It is unclear if the Hospital employs physicians or merely credentials them as independent contractors.

Yale Hospital's Response

On May 13, 2020, the Hospital filed its answer and affirmative defenses in response to the EEOC's allegations.[29] The Hospital's answer largely focuses on two issues: (1) the employment status of the complainant medical providers, and (2) the medical staff's role in developing and implementing the Policy. As to the first issue, the Hospital denied the existence of any employment relationship between the Hospital and any physician whose association with the Hospital is merely by virtue of holding or exercising medical staff privileges.[30] The Hospital asserts that without

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proving an employment relationship between the parties, the provisions of the ADEA and ADA at issue would not apply.

As to the second issue, the Hospital contends that even if an employment relationship exists between the Hospital and any of the aggrieved parties, it was not the Hospital that developed and implemented the Policy, but rather the Hospital's medical staff.[31] As such, the provisions of the ADEA and ADA would not apply.

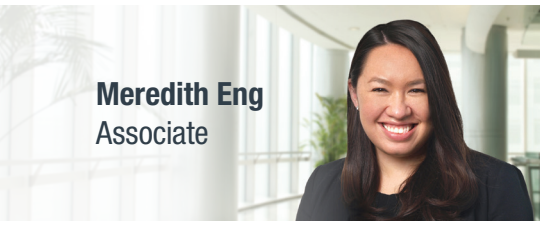
Conclusion

Age-based assessment of physician competence has long been controversial. As the medical field continues to develop its own stance on the practical aspects of age-based screenings, the legal structure surrounding this topic will also materialize.

The EEOC litigation is in the initial pleadings phase. While the EEOC has implied it will continue to scrutinize the adoption and implementation of policies that utilize age-based assumptions, it is not clear how the district court will rule on the age discrimination claims. Polsinelli is continuing to monitor developments in this case.

1 *EEOC v. Yale New Haven Hospital Inc.,* D. Conn., No. 3:20-cv-00187.
2 AMN Healthcare, 2016 Survey of Physicians 55 and Older 2 (2016), https://www.amnhealthcare.com/uploadedFiles/MainSite/Content/Healthcare_Industry_Insights/Industry_Research/2016%20Survey%20of%20Physicians%2055%20and%20older.pdf.
3 Staff Writer, *Competency and Retirement: Evaluating the Senior Physician,* Am. Med. Ass'n., June 23, 2015, https://wire.ama-assn.org/ama-news/competency-and-retirement-evaluating-senior-physician.
4 *Id.*
5 *Id.*
6 *See* California Public Protection and Physical Health, Inc., Assessing Late Career Practitioners: Policies and Procedures for Age-based Screening, at 8-9, (2014), *available at* https://www.cppph.org/wp-content/uploads/2015/07/assessing-late-career-practitioners-adopted-by-cppph-changes-6-10-151.pdf.
7 *See* Staff Writer, supra note 3.
8 American College of Surgeons, Statement on the Aging Surgeon (January 1, 2016), available at https://www.facs.org/aboutacs/statements/80-aging-surgeon (last accessed on September 10, 2018)
9 *Id.*
10 American College of Surgeons Board of Governors Physician Competency and Health Workgroup, *Statement on the Aging Surgeon,* Am. C. of Surgeons, Jan. 1, 2016, https://www.facs.org/about-acs/statements/80-aging-surgeon.
11 *Id.*
12 *See* Stanford Health Care, Stanford Hospital and Clinics Late Career Practitioner Policy, available at https://stanford-healthcare.org/content/dam/SHC/health-care-professionals/medical-staff/medstaff-update/late-career-practitioner-policy/docs/late-career-practitioner-policy-8-12.pdf; Ann Weinacker, *Medical Staff: MedStaff Update: Stanford to Implement a Late Career Practitioner Policy,* Stan. Health Care, 2012, available at https://stanfordhealthcare.org/health-care-professionals/medical-staff/medstaff-update/2012-august/stanford-to-implement-a-late-career-practitioner-policy.html.
13 Employment Discrimination Coordinator Analysis of State Law § 1:14 (Sept. ed. 2018). 1-6, (2012),
14 Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?,* 1 DePaul J. Health Care L. 119, 121 (1996), https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1295&context=jhcl.
15 *See* California, supra note 6 at 14.
16 *Id.*
17 *Hazen Paper Co. v. Biggins,* 507 U.S. 604, 616 (1993) (citing 29 U.S.C. § 623(f)(1) (2012).
18 29 U.S.C. § 623(f)(1) (2012).
19 *E.E.O.C. v. Exxon Mobil Corp.,* 560 F. App'x 282, 284 (5th Cir. 2014) (quoting *W. Air Lines, Inc. v. Criswell,* 472 U.S. 400, 412 (1985)).
20 Leo Cooney, M.D., Thomas Balcezak, M.D., et al. *Cognitive Testing of Older Clinicians Prior to Recredentialing,* , Journal of the American Medical Association, January 14, 2020, https://jamanetwork.com/journals/jama/article-abstract/2758602
21 *Id.*
22 *Id.*
23 *Id.*
24 *Id.*
25 *Id.*
26 *See EEOC,* supra note 1 at 7.
27 *Id.*
28 *Id.*
29 *See EEOC,* supra note 1.
30 *Id.*
31 *Id.*

Reginelli v. Boggs' Narrowing of Peer Review Privilege in Pennsylvania Is Here to Stay: *Leadbitter v. Keystone Anesthesia Consultants*



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St. Clair Hospital (the "Hospital") appealed an order granting James and Tammy Leadbitter's Motion to Compel, which required the Hospital produce the complete credentialing and privileging file of defendant Dr. Carmen Petraglia.[1]

In June 2014, Dr. Carmen Petraglia ("Dr. Petraglia") applied for appointment to the medical staff and orthopaedic surgery clinical privileges at the Hospital.[2] In consideration of his application, the Hospital reviewed a number of documents, including professional opinions relating to his competence, a Professional Peer Review Reference and Competency Evaluation, which contained evaluations of his performance submitted by other physicians, and an Ongoing Professional Practice Evaluation of St. Clair Hospital Summary Report, which contained performance-related data compiled by the Hospital.[3] After reviewing these documents, the Hospital's Credentialing Committee recommended the Hospital grant clinical privileges to Dr. Petraglia, which the Hospital did.[4] Five months later, Dr. Petraglia performed two spinal surgeries on the plaintiff, James Leadbitter, after which Mr. Leadbitter suffered a series of strokes, resulting in permanent damage to his brain and extremities.[5]

James Leadbitter and his wife ("Plaintiffs") filed complaints in Pennsylvania state court, alleging various theories of negligence against the Hospital, Dr. Petraglia, and others.[6] In May 2017, Plaintiffs requested the Hospital produce Dr. Petraglia's "complete credentialing and/or privileging file."[7] In response, the Hospital redacted portions of the credentialing file it claimed were privileged and produced only those documents it deemed discoverable.[8] Plaintiffs filed a Motion to Compel production of Dr. Petraglia's complete and unredacted credentialing file, arguing that they were entitled to the documents under the Pennsylvania Supreme Court's decision in *Reginelli v. Boggs,* 645 Pa. 470, 181 A.3d 293 (2018).[9] In its response, the Hospital argued that the credentialing file was protected from discovery under Pennsylvania's Peer Review Production Act (63 P.S. § 425.1, et seq.) ("PRPA") and the Health Care Quality Improvement Act (42 U.S.C. § 11101) ("HCQIA").[10]

The trial court granted Plaintiffs' Motion to Compel and ordered the Hospital to produce Dr. Petraglia's unredacted credentialing file. The Hospital appealed and argued (1) the professional opinions and performance evaluations relating to Dr. Petraglia's competence and his Ongoing Professional Practice Evaluation are protected from disclosure under PRPA, and (2) responses to statutorily required inquiries of the National Practitioner Data Bank ("NPDB") are protected from disclosure under the HCQIA and 45 C.F.R. § 60.20(a) (stating that information reported to the NPDB is confidential and shall not be disclosed except in certain circumstances.)[11]

Professional Opinions, Performance Evaluations, and Ongoing Professional Practice Evaluation Not Protected Under Pennsylvania Law

The Hospital argued that the professional opinions and performance evaluations of Dr. Petraglia are peer review documents and therefore are not discoverable under PRPA.[12] The Superior

1 *Leadbitter v. Keystone Anesthesia Consultants,* No. 1414 WDA 2018, 2020 WL 702486, at *1 (Pa. Super. Ct. Feb. 12, 2020).
2 *Id.*
3 *Id.*
4 *Id.*
5 *Leadbitter,* at *2.
6 *Id.*
7 *Id.*
8 *Id.*
9 *Id.*
10 *Leadbitter,* at *2.
11 *Id.* at *3.
12 *Id.*

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Court of Pennsylvania agreed that these documents are peer review documents as defined in PRPA because they were prepared by professional health care providers and the documents evaluated the quality and efficiency of services ordered or performed by Dr. Petraglia.[13] However, the court stated that PRPA's application must be analyzed in light of the Supreme Court of Pennsylvania's holding in *Reginelli.*[14]

In *Reginelli,* the Supreme Court of Pennsylvania held that the peer review privilege only applies to peer-reviewed documents of a "review committee" and not to the documents of a "review organization."[15] The *Reginelli* court stated that PRPA defines a "review committee" as "any committee engaging in peer review" and a "review organization" as "any hospital Board, committee or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto."[16] Further, the *Reginelli* court concluded that credentialing review is not "entitled to protection from disclosure under PRPA's evidentiary privilege" because "[r]eview of a physician's credentials for purposes of membership (or continued membership) on a hospital's medical staff is markedly different from reviewing the 'quality and efficiency of service ordered or performed' by a physician when treating patients.'"[17] Stated simply, the Supreme Court of Pennsylvania held that credentialing documents were not entitled to the peer review privilege under Pennsylvania law.

Consequently, following *Reginelli,* in *Estate of Krappa v. Lyons,* the Superior Court of Pennsylvania held that the PRPA privilege does not shield evaluations generated by a credentialing committee from disclosure.[18] Here, the court found that the Hospital's credentialing committee was a "review organization" because it reviewed the professional qualifications and activities of Dr. Petraglia when considering his application for privileges at the Hospital.[19] Thus, the PRPA privilege did not apply and the credentialing file was not protected from disclosure.[20]

NPDB Query Responses

Under the HCQIA, hospitals are required to report certain information to the NPDB and request information from the NPDB at the time a physician applies for privileges and every two years thereafter.[21] As a result, the court stated that the purpose for which the information is used is credentialing.[22] While the HCQIA protects information reported pursuant to the HCQIA as confidential, it does not prevent the disclosure of such information by a party that is authorized to make the disclosure under state or federal law. As the court concluded in the first issue, professional evaluations in Dr. Petraglia's credentialing file are not protected from disclosure. As a result, because the HCQIA's confidentiality provisions follow state law, the court found that the HCQIA does not prohibit the production of the NPDB query responses.[23]

Conclusion

This case marks the third time Pennsylvania courts have held that documents created for the purpose of credentialing are not entitled to peer review protection under PRPA, signaling that *Reginelli's* narrow interpretation of the law will have a lasting impact on the credentialing and privileging process in Pennsylvania. What is yet to be seen is whether, and to what extent, this decision will corrupt the credentialing process by chilling evaluators' candor, as suggested by *Reginelli's* dissent.[24]

> *"[r]eview of a physician's credentials for purposes of membership (or continued membership) on a hospital's medical staff is markedly different from reviewing the 'quality and efficiency of service ordered or performed' by a physician when treating patients.'"* – *Regnelli court*

13 *Id.*
14 *Id.*.
15 *Leadbitter,* at *3 (citing to *Reginelli* at 305-306).
16 *Id.* at *4 (citing to *Reginelli* at 305).
17 *Leadbitter,* at *4.
18 *Id.* at *4; 211 A.3d 869, 875 (Pa. Super. 2019).
19 *Leadbitter,* at *4.
20 *Id.*
21 *Id.* at *5 (citing 42 U.S.C. §§ 11133, 11135).
22 *Id.* at *5.
23 *Id.*
24 *Reginelli,* at 315 (Wecht, J., dissenting).

Invoking Privilege: Illinois Decision Provides Refresher on How to Protect Documents from Discovery under the Illinois Medical Studies Act and Insurer-Insured Privilege

Rebecca Lindstrom
Associate

The Illinois First District Appellate Court affirmed a trial court's finding that investigative documents prepared by a hospital following a sentinel event were not privileged from discovery under the insurer-insured privilege or the state's peer review statute, known as the Illinois Medical Studies Act.[1]

The three documents at issue – a Sentinel Event Report, Investigation Summary, and Narrative of Investigatory Findings ("Narrative of Findings") – were prepared by employees of Chicago Behavioral Hospital (the "Hospital") following a patient death.[2] In accordance with the Hospital's policy, a Hospital employee investigated the sentinel event and prepared a Sentinel Event Report and Narrative of Findings.[3]

The Sentinel Event Report was provided to and reviewed by the Hospital's Quality Review Committee with the intention of increasing knowledge about the event, providing strategies for prevention of the event reoccurring, and improving patient safety.[4]

The Hospital's Director of Performance and Risk Management prepared an Investigation Summary for the Performance Improvement and Risk Management Department, as part of the Hospital's quality review process, and provided it to the Hospital's Quality Improvement Committee.[5] Pursuant to the Hospital's policy, such Investigation Summaries were automatically prepared after each sentinel event involving death or serious injury at the Hospital to evaluate the Hospital's quality assurance process and identify necessary changes to improve patient safety and reduce patient morbidity and mortality.[6]

The Narrative of Findings contained summaries of interviews conducted with care providers. The Narrative of Findings was primarily prepared to be submitted to the Hospital's liability insurance provider to ensure the Hospital would receive liability insurance coverage in the event of a related lawsuit.[7]

The patient's family filed a wrongful death action against the Hospital.[8] During discovery, the Hospital refused to produce the three documents, arguing that the Sentinel Event Report and Investigation Summary were privileged under the Illinois Medical Studies Act and the Narrative of Findings was privileged under the insurer-insured privilege.[9]

After an *in camera* inspection of the documents and privilege log, the trial court ruled that the Hospital had failed to meet its burden of establishing the three documents were privileged.[10] The Hospital filed a Motion to Reconsider and submitted its Policy and Procedure Manual for investigating sentinel events, along with an affidavit of the Hospital's Director of Performance and Risk Management that outlined the investigative steps taken following the patient's death and the manner in which the documents had been created and used by the Hospital.[11]

1 *Ritter v. 2014 Health, LLC, d/b/a Chicago Behavioral Hospital, et al.,* 2020 IL App (1st) 190370-U, 25, 30, 33; 735 Ill. Comp. Stat. Ann. 5/8-2102 (West 2020).
2 The Hospital defined "sentinel event" as "an unexpected event involving death or serious physical or psychological injury or the risk thereof." *Ritter* at 6.
3 *Id.* at 6, 8.
4 *Id.* at 6.
5 *Id.* at 7.
6 *Ritter,* at 7.
7 *Id.* at 8.
8 *Id.* at 4.
9 *Id.* at 2.
10 *Ritter,* at 4.
11 *Id.* at 5.

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The trial court denied the Hospital's Motion to Reconsider and again ordered the documents be produced.[12] The Hospital refused to produce the documents. In response to an Emergency Motion to Compel, the Hospital requested the trial court find the Hospital in "friendly contempt" to permit the Hospital to file an interlocutory appeal.[13] The trial court granted the request, held the Hospital in civil contempt, and imposed a $1.00 penalty.[14]

On appeal, the Hospital argued the Sentinel Event Report and Investigation Summary were privileged under the Illinois Medical Studies Act because they were prepared in the course of the Hospital's quality review process – with the Sentinel Event Report prepared to provide information to the Hospital's Quality Review Committee and the Investigation Summary prepared for the Quality Improvement Committee.[15] As for the Narrative of Findings, the Hospital argued it was privileged under the insurer-insured privilege because it was created for the purpose of obtaining insurance coverage for an anticipated lawsuit and to protect the Hospital's interests.[16] The appellate court disagreed.

The appellate court found that the Hospital had failed to satisfy its burden and ordered that all three documents be produced.[17] The appellate court acknowledged that the Illinois Medical Studies Act protects disclosure of the mechanisms of the peer review process, including information gathering and deliberations leading to the ultimate decision rendered by a peer review committee, but importantly clarified that it does not protect against the discovery of information generated before the peer review process begins or after the peer review process ends.[18] The appellate court emphasized that (1) in order for the privilege to apply, a hospital committee must be engaged in the peer review process, and (2) the Illinois Medical Studies Act does not protect documents that were created before a peer review committee or its designee authorizes an investigation of a particular incident.[19]

The appellate court found that there was no evidence that the authors of the Sentinel Event Report and Investigation Summary had been directed to create the documents by a peer review committee.[20] While the Sentinel Event Report was later reviewed by a peer review committee, and the Investigation Summary subsequently provided to the Quality Improvement Committee, the documents had not been prepared at the request of a peer review committee.[21] A peer review committee – and not the Hospital itself – was required to designate individuals to investigate the incident in order for the resulting documents to be protected by the privilege.[22]

The appellate court also noted that if hospitals were allowed to invoke the privilege in situations where a peer review committee was simply provided earlier-acquired information after the fact, hospitals would be able to effectively insulate from disclosure all adverse facts known to its medical staff, except for those matters contained in medical records.[23]

In relation to the Narrative of Findings, the appellate court explained that the insurer-insured privilege, as an offshoot of the attorney-client privilege, only extends to communications between an insurer and insured where the insurer has a duty to defend.[24] A party seeking to invoke the privilege must prove: "(1) the identity of the insured; (2) the identity of the insurance carrier; (3) the duty to defend the lawsuit; and (4) that a communication was made between the insured and agent of the insurer."[25]

The appellate court noted that in cases where the privilege was found to apply, specific evidence had been submitted demonstrating the statements at issue were made in the context of a duty to defend the particular lawsuit.[26] In this case, the appellate court found that the

12 *Id.* at 10.
13 *Id.* at 11.
14 *Ritter,* at 11.
15 *Id.* at 13.
16 *Id.* at 26.
17 *Id.* at 25, 30.
18 *Ritter,* at 16.
19 *Id.* at 23.
20 *Id.* at 25.
21 *Id.*
22 *Ritter*
23 *Id.*
24 *Id.* at 27.
25 *Id.*
26 *Id.* at 29.

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Hospital failed to put forth sufficient facts to demonstrate a duty to defend the lawsuit.[27] The appellate court was not persuaded by the Hospital's argument that the author of the Narrative Findings had assumed that the insurer had a duty to defend.[28] The appellate court referenced the fact that the Hospital had not provided terms of its insurance policy and that it remained unknown whether the insurer was aware of a potential claim at the time the Narrative of Findings was provided.[29] Finding a lack of factual support for a duty to defend, the appellate court found that the Hospital failed to demonstrate that the insurer-insured privilege applied and, therefore, ordered the Narrative of Findings be produced.[30]

This decision highlights the importance of understanding both the peer review privilege and insurer-insured privilege and the steps that must be taken at the outset to protect discovery of peer review information in Illinois.

27 *Id.*
28 *Id.* at 30.
29 *Id.*
30 *Id.*

Physician's Antitrust Claim Against American Board of Orthopaedic Surgery Fails:

Ellison v. Am. Bd. of Orthopaedic Surgery, Inc.

Dr. Bruce Ellison ("Dr. Ellison"), an orthopaedic surgeon, exclusively practiced in California. Dr. Ellison sought to expand his practice and researched obtaining privileges at hospitals in New Jersey.[1] During this process, he learned that New Jersey hospitals required board certification as a condition for medical staff membership and privileges. Dr. Ellison was not board certified by the American Board of Orthopaedic Surgery ("ABOS"). Dr. Ellison did not seek privileges at New Jersey hospitals.

After determining that his lack of certification would effectively bar his practicing in New Jersey, Dr. Ellison brought an action against the ABOS based on allegations of antitrust laws. In his Second Amended Complaint, Dr. Ellison claimed that the ABOS prevented him from obtaining board certification unless he first held hospital medical staff privileges.[2] Conversely, hospitals refused to grant privileges to those who were not board certified. Dr. Ellison alleged this was a "scheme" between the hospitals and the ABOS to reduce competition at hospitals by excluding surgeons who practice exclusively at ambulatory surgery centers or other places that do not offer medical staff privileges.[3] He further alleged this "scheme" induced surgeons to be board certified, participate in ABOS programs, and pay fees to ABOS.[4]

Defendant ABOS oversees the board certification program for physicians specializing in orthopaedic surgery. The ABOS administers its board certification exam in many locations throughout the United States, including in New Jersey, and collects "up to a million dollars or more annually" from physicians located in New Jersey seeking or maintaining certification.[5]

While not named as defendants, Dr. Ellison's claims also involved two other entities, the American Board of Medical Specialties ("ABMS") and the American Hospital Association ("AHA"). The ABMS oversees educational and professional evaluation of all certified physicians. The ABOS is a member of the ABMS, which regulates physician certification in the United States.

1 *Ellison v. Am. Bd. of Orthopaedic Surgery, Inc.,* No. CV168441KMJBC, 2020 WL 1183345, at *1 (D.N.J. Mar. 12, 2020).
2 *Id.*
3 *Id.*
4 *Id.* at 2.
5 *Ellison,* at 1.

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The AHA is a nonprofit organization of which 90% of all hospitals are members.[6] It also provides education and resources for hospital administration.

Dr. Ellison argued that the AHA and the ABMS entered into agreements to "provide money-making programs in connection with board certification by [defendant] ABOS and other specialty groups."[7] He claimed that in order to further these agreements, the AHA put pressure on hospitals to require physicians be board certified.

Dr. Ellison claimed he was personally victimized by this process because he was unable to obtain privileges in New Jersey or ABOS board certification. Dr. Ellison passed the written portion of ABOS's exam and was qualified to take the oral portion of the exam.[8] However, ABOS later denied him the opportunity to take the oral exam because he did not have medical staff privileges at any hospital.[9] Thus, Dr. Ellison argued he was "confronted with the proverbial catch-22: without medical staff privileges he cannot take Part II of the certification [oral] exam, but without the certification he cannot acquire medical staff privileges."[10] There is a common exception to the staff-privileges prerequisite for physicians who have completed their residency within the last seven years, but that exception was unavailable to Dr. Ellison at the later stage of his career.[11]

Dr. Ellison's antitrust allegation was that this practice reduced competition to hospitals "by shutting out surgeons like himself," who practice exclusively at ambulatory surgery centers (which do not provide medical staff privileges), thereby reducing the number of orthopaedic surgeons available to patients.[12] He believed this resulted from the ABOS colluding with hospitals in requiring certification and these organizations thereby restricted the market for orthopedic surgeons in violation of the Sherman Act.[13]

The Sherman Antitrust Act provides that "every contract, combination in the form of trust or otherwise, or conspiracy, in restraint of trade or commerce among the several States . . . to be illegal."[14] Courts will nullify those contracts which unreasonably restrain competition. "In order to sustain a cause of action under §1 of the Sherman Act, the plaintiff must prove: (1) that the defendants contracted, combined, or conspired among each other; (2) that the combination or conspiracy produced adverse, anti-competitive effects within relevant product and geographic markets; (3) that the objects of and the conduct pursuant to that contract or conspiracy were illegal; and (4) that the plaintiff was injured as a proximate result of that conspiracy."[15]

The court found that Dr. Ellison failed to prove his Sherman claim. First, Dr. Ellison failed to prove that the hospitals in New Jersey had an agreement with the AHA which restrained trade. The court noted that a hospital requiring certification of physicians has a legitimate medical purpose that is not aimed at impacting trade.[16] It went on to note that hospitals can exclude physicians from their medical staff for a variety of reasons, including professional competence.[17]

Dr. Ellison further failed to show a "substantial foreclosure of the market" due the agreement.[18] Dr. Ellison could not show that the ABOS exerted any influence on the decision of granting privileges or any evidence the ABOS was receiving any monetary benefit from these actions. The court declined to address the other factors, since Dr. Ellison could not even establish an agreement. Because Dr. Ellison could not show an agreement or any impact on trade, his Sherman Act claim failed and the court proceeded to dismiss his complaint.[19] Dr. Ellison filed an appeal, which is pending.

6 *Id.* at 2.
7 *Id.*
8 *Id.* at 3.
9 *Ellison,* at 3.
10 *Id.*
11 *Id.* at 3.
12 *Id.*
13 *Id.* at 4.
14 15 U.S.C. § 1.
15 *Ellison,* at 6.
16 *Id.* at 7.
17 *Id.*
18 *Id.* at 9.
19 *Id.* at 10.

Proctoring as a Restriction of Privileges – A Case Study: *Columbus Clinic, P.C. v. Williams*

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The Court of Appeals of Georgia recently issued a decision concerning proctorships and whether they constitute a restriction of a physician's clinical privileges.[1] The various trial court and appeals court decisions are especially interesting in light of changes to the National Practitioner Data Bank's guidance regarding the reporting of certain proctorships.

In 2008, Dr. Reginald Williams ("Dr. Williams") entered into an employment contract ("Contract") with Columbus Clinic, P.C. ("Clinic") to provide medical services. Section 7.1 of the Contract provided that the Clinic had the right to terminate the Contract if Dr. Williams' privileges or membership "at any hospital are terminated, revoked, suspended (other than for infrequent occurrences due to the failure to complete medical records in a timely manner), restricted, or terminated in any way (except for voluntary termination of privileges undertaken at the request and with the consent of [the Clinic])."[2]

In 2010, Dr. Williams was placed on a performance improvement plan at Doctors Hospital ("Hospital"), which included a three-month proctorship.[3] Subsequently, the Clinic informed Dr. Williams that it was terminating the Contract based upon the imposed proctorship, reasoning that such proctorship constituted a restriction of his privileges at the Hospital. Dr. Williams quickly filed suit.[4] The trial court granted summary judgment in favor of the Clinic on the basis that the language in the Contract was clear and unambiguous and that the proctorship constituted a restriction of Dr. Williams' privileges at the Hospital. Dr. Williams appealed this decision to the Court of Appeals of Georgia ("Court of Appeals").[5]

The Court of Appeals reversed the trial court's grant of summary judgment on the basis that there was a question of material fact as to whether the proctorship constituted a "restriction" of Dr. Williams' privileges. The Court of Appeals specifically looked at the National Practitioner Data Bank's ("NPDB") then-current Guidebook regarding proctorships and when proctorships constituted a restriction of privileges that required reporting to the NPDB. Ultimately, the Court of Appeals found that the imposition of a proctorship in and of itself did not necessarily mean that a practitioner's privileges were restricted. At that time, the record did not contain evidence as to the final terms of the proctorship to which the parties agreed.[6] As such, the case was remanded to the trial court.

Once the case was remanded, both parties filed motions for summary judgment on the issue of whether the proctorship constituted a restriction of Dr. Williams' privileges within the meaning of the Contract. The trial court granted summary judgment in favor of Dr. Williams after reviewing the final terms of the proctorship. Of note, the terms of the proctorship stated: (1) Dr. Williams could not schedule an elective case with less than 12 hours' notice to the proctor, unless the proctor agreed otherwise; (2) the proctor had the authority to intervene in the case if necessary to protect the patient from harm; (3) if the proctor disagreed with the decision to operate, the operation intended, or the specific technique to be used, Dr. Williams should follow the advice of the proctor, but the final decision belonged to Dr. Williams; (4) the role of the proctor was not to substitute their judgment for that of Dr. Williams, but to assist, advise as requested, observe, and report; (5)

1 *Columbus Clinic, P.C. v. Williams,* 2020 WL 1181269 (Ct.App. Georgia 2020).
2 *Id.* at 1.
3 *Id.*
4 *Id.* at 2.
5 *Williams v. Columbus Clinic, P.C.,* 773 S.E.2d 457 (Ct.App. Georgia 2015).
6 *Id.* at 461-462.

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the proctor need not concur in the selection of the surgical procedure, but the proctor's concerns or disagreement should be noted and evaluated; and (6) the proctoring requirements were not reportable to the NPDB and did not constitute an adverse action that gave rise to the right to request a hearing.[7]

The Clinic then appealed the trial court's grant of summary judgment to the Court of Appeals of Georgia. The Court of Appeals reversed the trial court's judgment and ruled that neither party had cited evidence or a principle of contract construction that resolves the ambiguity regarding whether the proctorship constituted a restriction of Dr. Williams' privileges as a matter of law; therefore, neither party was entitled to summary judgment.[8]

In support of its ruling, the Court of Appeals stated that the ability of the proctor to intervene generally indicates that the proctorship was a restriction of Dr. Williams privileges; however, the other provisions stating that the final decision regarding any procedure and the technique to be used weighs in favor of the proctorship not being a restriction of Dr. Williams privileges.[9] As such, the Court of Appeals reversed the judgment and remanded the case to the trial court.[10]

Notably, the NPDB Guidebook has been updated and the reporting requirements for proctoring have changed. Prior to 2015, the NPDB Guidebook required reporting when "[b]ased on an assessment of professional competence, a proctor [was] assigned to a physician or dentist for a period of more than 30 days [and] [t]he practitioner [was required to] be granted approval before certain medical care [was] administered."[11] If the practitioner could provide care without the proctor's "prior approval," the proctorship was not required to be reported to the NPDB and, it could be argued, was not considered a restriction of privileges.

In 2015, the NPDB updated its Guidebook and stated, "[i]f, for a period lasting more than 30 days, the physician or dentist cannot perform certain procedures without proctor approval or without the proctor being present and watching the physician or dentist, the action constitutes a restriction of clinical privileges and must be reported to the NPDB."[12] Thus, if the proctor was required to simply be present for procedures after 2015, the proctorship must be reported to the NPDB and the 2015 Guidebook specifically called such action a "restriction of clinical privileges." Arguably, pre-2015 proctorships, like that imposed upon Dr. Williams, were not considered restrictions on a physician's privileges unless the proctor had to grant pre-approval of medical procedures.

At this time, it does not appear the parties have appealed the judgment of the Court of Appeals. We will follow the case and may provide an update.

7 *Columbus Clinic,* 2020 WL 1181269 at 5-6.
8 *Id.* at
9 *Id.* at 8.
10 *Id.*
11 *See* 2001 NPDB Guidebook P. E-21.
12 *See* 2015 NPDB Guidebook P. E-37.

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