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Med-Staff Newsletter

QUARTERLY NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP

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California Hospitals Cannot Use an Exclusive Contract to do an End-Run around a Medical Staff Member's Right to Notice and a Fair Hearing When Competence or Professional Conduct Is at Issue

The California First District Court of Appeal, in Economy v. The Hospital East Bay Hospitals, (Feb. 4, 2019, A150211, A150738, A15096) 31 Cal. App.5th 1147 [2019 WL 422346], held that an exclusive contract between a hospital and anesthesia group could not be used by the hospital to exclude an anesthesiologist from providing services because of competency concerns. The court found that before the physician could be excluded, the hospital first had to provide the physician with notice and an opportunity for a hearing pursuant to California statutes and common law.

The Exclusive Contract & Quality of Care

Dr. Kenneth Economy was employed by East Bay Anesthesiology Medical Group ("Anesthesia Group"), which held an exclusive contract to provide anesthesia services at The East Bay Hospital ("Hospital").[1] During a surprise inspection, the California Department of Public Heath ("CDPH") found that Dr. Economy was responsible for numerous deficiencies in the use of the drug Droperidol. According to CDPH, these deficiencies "placed patients at risk for undue adverse medical consequences," and CDPH declared that the Hospital was in immediate jeopardy until a written action plan was prepared and accepted.[2]

The Hospital immediately formed a response team and the vice president of medical affairs requested that the president of the Anesthesia Group remove Dr. Economy from the hospital's anesthesia schedule pending further investigation.[3] Dr. Economy was told that he was being taken off the schedule due to his use of Droperidol.[4] The Hospital submitted a written action plan to CDPH stating in part, that the physician responsible for the Droperidol use

[1] *Economy v. The Hospital East Bay Hospitals*, (Feb. 4, 2019, A150211, A150738, A15096) 31 Cal.App.5th 1147, 1152.
[2] *Id.* at 1153.
[3] *Id.*
[4] *Id.* at 1154.

CONTINUED ON PAGE 2 ▸

Table of Contents

Events

Erin Muellenberg will present at CAMSS Mid-Valley Chapter, Sacramento, CA, September 27, 2019, **Relationships Between Medical Staffs, Foundations, CINs, Medical Groups:** How and When to Share Information & Lessons from Credentialing and Peer Review Gone Wrong

John Synowicki will present at Greater Houston Society for Medical Services Specialists (GHSMSS), Houston, TX, October 4, 2019, **Navigating Peer Review, Interactive Case Studies:** How Would You Handle The Peer Review?

Erin Muellenberg will present at NAMSS CVO Excellence Symposium, Philadelphia, PA, October 19-20, 2019, **Legal Update & Whose Bucket Is It?**

Erin Muellenberg will present at NAMSS Annual Conference, Philadelphia, PA, October 20-23, 2019, **Hiding in Plain Sight & Interactive Case Studies:** New and Challenging Issues that Build "Character"

John Synowicki will present at NAMSS Annual Conference, Philadelphia, PA, October 21-23, 2019, **Peer Review of Employed Physicians, Interactive Case Studies**

Erin Muellenberg will present at AAMSS Annual Conference, Birmingham, AL, November 8, 2019, **Legal Update**

JANUARY 2020 – SAVE THE DATE:

The Organized Medical Staff for Leaders: What You Need to Know About Self-Governance and the Issues You Face Thursday, Jan 10th, 2020. Marriott Ventura, Ventura, California.

Contact smcguire@polsinelli.com with any questions or more information.

CONTINUED FROM PAGE 1

had not followed hospital policy, was referred to peer review and immediately suspended by his Anesthesia Group. The state surveyor approved the plan and lifted the immediate jeopardy.[5]

Peer Review and the Anesthesia Group

Peer review concluded that further education was needed and recommended that Dr. Economy attend the Physician Assessment and Clinical Education ("PACE") course at the University of California San Diego.[6] Dr. Economy's return to practice at the Hospital was dependent upon successful completion of the course.[7] The Anesthesia Group informed Dr. Economy that he needed to attend PACE before he could return to the Hospital.[8] He then requested an opportunity to appear before the peer review committee to discuss the decision.[9] His request was denied on the basis that the Medical Executive Committee was aware of his situation and his only option was to complete the PACE program.[10]

Dr. Economy's Reinstatement and Termination

Dr. Economy completed the PACE program and returned to work at the Hospital.[11] Following his reinstatement, a pharmacy manager found that Dr. Economy continued to violate the Hospital's policy for administering Droperidol.[12] As a result, the Hospital's vice president of medical affairs told the Anesthesia Group that, due to ongoing quality of care concerns, the anesthesia schedules with Dr. Economy would not be approved.[13] Once again, the Anesthesia Group removed Dr. Economy from the anesthesia schedule.[14] The Anesthesia Group informed Dr. Economy he would not be allowed to return to the Hospital and asked for his resignation. Dr. Economy refused and the Anesthesia Group terminated him.[15]

The Lawsuit

Dr. Economy sued the Hospital, alleging it violated his right to both notice of charges and a peer review hearing under California Business and Professions Code section 809 et seq. He also alleged that his common law due process rights were violated, relying upon Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802.[16] Dr. Economy prevailed and the trial court found the Hospital had violated Dr. Economy's due process rights under both California Business and Professions Code section 809 et seq. and Anton v. San Antonio Community Hospital (1977) 19 Cal.3d 802. The trial court concluded the Hospital was required to provide Dr. Economy with a formal notice of charges and peer review hearing before removing him from the schedule which effectively terminated his privileges.[17] The court awarded Dr. Economy nearly $4 million in damages for lost and future income.[18] The Hospital appealed the judgment.[19]

The Appeal

The Court of Appeal affirmed the judgment and award of lost income for Dr. Economy, holding the Hospital violated his rights to notice and a fair hearing by directing his employer to remove him from the schedule.[20] The appellate court rejected the Hospital's argument that no fair hearing was required because it never formally rescinded Dr. Economy's

[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.* at 1155.
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 1158.
[18] *Id.* at 1160-61.
[19] *Id.* at 1147
[20] *Id.* at 1160.

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privileges; it was the Anesthesia Group that removed him.[21] The court explained, if it were to accept the Hospital's argument, Dr. Economy's "right to practice medicine would be substantially restricted without due process" and "the Hospital's decision not to accept any schedule on which [Dr. Economy] was included effectively prevented [Dr. Economy] from exercising clinical privileges at the Hospital and engaging in the practice of medicine."[22] Therefore, the decision not to approve the anesthesia schedules that included Dr. Economy was "the functional equivalent of a decision to suspend and later revoke [Dr. Economy's] clinical privileges."[23]

The Lesson

This case serves as a compelling reminder that a hospital's use of an exclusive contract to exclude a physician from practicing for a quality of care or professional conduct reason must be scrutinized under applicable state law to determine if notice and fair hearing is required. Here, the court clearly held that California common law and statutes provide physicians with due process rights before a hospital may exclude their ability to practice under the terms of an exclusive contract due to their competence or conduct.

[21] *Id.* at 1158

[22] *Id.* at 1158-59

[23] *Id.* at 1158

Maintenance of Certification: To MOC or Not to MOC?

Many hospitals and medical staffs include, as part of their medical staff bylaws, a requirement that physicians obtain initial board certification in the physician's specialty and continuously maintain board certification ("Maintenance of Certification" or "MOC"), as one element of demonstrating ongoing clinical knowledge and competence.

MOC requires physicians to engage in continuous learning and quality improvement, pass an MOC examination, generally every 10 years and to complete various MOC learning activities between examinations. By including MOC as a requirement for initial or renewed medical staff membership and clinical privileges, hospitals and their medical staffs may screen applicants to include those physicians who can demonstrate a higher level of current clinical knowledge and competence, as evidenced by MOC, among other factors.

The Medicare Conditions of Participation for Medical Staff ("CoPs"), 42 C.F.R § 482.12(7), require a hospital's governing body to ensure that the grant of medical staff membership or clinical privileges is not based solely on board certification. But the CoPs do not prohibit hospitals and their medical staffs from requiring initial board certification or MOC, so long as board certification or MOC is not the sole criteria.

MOC has come under legal challenges in the past few years. We address two cases and state anti-MOC legislation below.

Kenney v. American Board of Internal Medicine

The largest certifying body for internal medicine, the American Board of Internal Medicine ("ABIM"), is currently defending an antitrust and Racketeer Influenced and Corrupt Organizations Act ("RICO") challenge to the requirement that internal medicine physicians purchase ABIM's MOC program.

On December 6, 2018, four internists filed a class action suit, *Kenney, et al. v. American Board of Internal Medicine,*[1] against ABIM on behalf

[1] *Kenney v American Board of Internal Medicine,* Cause No 2118-CV-05260-RK (E.D. Penn.)

CONTINUED ON PAGE 4

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of 200,000 internists required by ABIM to purchase its MOC product. The current causes of action include antitrust violations (alleging monopoly power in the MOC market and the illegal tying of initial board certification and MOC) and RICO violations, (alleging that ABIM was "unjustly enriched" through its MOC product). The complaint alleges that ABIM controls the market for initial board certification of internists, with more than 80% of internists purchasing initial ABIM certifications, and that ABIM controls more than 95% of the market for MOC of internists.[2]

ABIM filed a motion to dismiss the lawsuit on March 18, 2019. ABIM's motion to dismiss is currently pending. If the court denies ABIM's motion to dismiss, resolution of this case could take years. Ultimately, if the physician-plaintiffs win the *Kenney* lawsuit, this could impact ABIM's future MOC product offerings.

Notably, *Kenney v. ABIM* is not a class action against hospitals and medical staffs but was brought against ABIM, an independent evaluation organization. The class action is based on the allegation that MOC creates unnecessary administrative burden and expense for internists. Notwithstanding the *Kenney* case, hospitals and medical staffs are still free to incorporate initial board certification and MOC requirements into their respective medical staff bylaws, unless prohibited by state law.

Association of American Physicians & Surgeons, Inc. v. American Board of Medical Specialties

This case was originally filed in 2013 in the Northern District of Illinois (Cause No. 1:14-cv-02705) as a restraint of trade (Sherman Act Section 1) claim alleging a per se restraint of trade. The original petition also alleged a cause of action for negligent misrepresentation under Illinois state law. The Association of American Physicians & Surgeons, Inc. ("AAPS") specifically alleged that the American Board of Medical Specialties ("ABMS"), through agreements with The Joint Commission, precluded doctors from receiving privileges at hospitals if they did not participate in the MOC program provided by ABMS. The AAPS claimed these agreements reduced the supply of physicians available to treat patients and limited patients' access to their own physicians by precluding them from receiving privileges at certain hospitals that adopt MOC requirements.[3]

AMBS filed a motion to dismiss for failure to state a claim under F.R.C.P. Rule 12(b)(6).[4] On September 30, 2017, the court dismissed AAPS's claims, finding that AAPS failed to allege sufficient facts to suggest that ABMS has sufficient market power to restrain trade and failed to allege evidence of an agreement suggesting a per se unlawful restraint of trade such as a horizontal agreement among competitors to fix prices or divide markets. Further, the court found that AAPS failed to identify any false statements of material fact sufficient to state a claim for negligent misrepresentation under Illinois state law. The motion to dismiss was granted without prejudice and the court permitted AAPS the opportunity to amend the complaint to cure the deficiencies identified in the court's opinion.

AAPS amended its complaint in January of 2018 and added a class action claim. AAPS also added claims for deceptive trade practices under Illinois state law.[5]

In March of 2018, ABMS filed another motion to dismiss on the basis of failure to state a claim. In the alternative, the motion seeks to strike AAPS's class action allegations. ABMS's current motion to dismiss primarily relies on the same grounds as the initial motion to dismiss, specifically that AAPS failed to provide evidence `of a per se restraint of trade and failed to provide evidence that ABMS has sufficient market power to retrain trade. The motion has been fully briefed at this time and is awaiting final disposition.[6]

State Anti-MOC Legislation

Several states have passed legislation to limit MOC requirements. Oklahoma was the first state to do so when it passed Oklahoma Statute, Title 59, § 492 in 2016. Section 492 amended Oklahoma's Allopathic Medical and Surgical Licensure and Supervision Act (the "Act"), to prohibit a requirement that physicians maintain certification or MOC as a condition of licensure, reimbursement, employment or admitting privileges at a hospital in Oklahoma.[7] In December 2017, however, the Oklahoma Attorney General ("AG") issued an opinion on hospital privileging and constitutional aspects of requiring MOC. The AG concluded that despite the amendment to the Act, an Oklahoma hospital may still refuse to grant medical staff membership or privileges to a physician based on lack of medical specialty board certification, but that board certification must not be the only basis for granting privileges. The AG Opinion reasoned that the amendment to the Act did not alter a hospital's authority under other statutes and administrative rules

[2] See Note 1, *supra.*
[3] *Association of American Physicians & Surgeons, Inc. v. American Board of Medical Specialties,* Cause No. 14-cv-02705 (N.D. Ill., Eastern Division);
[4] 2014 WL 12513395
[5] 2018 WL 7368810
[6] 2018 WL 7368919
[7] Oklahoma Statute, Title 59, § 492

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to require specific medical training as a condition to granting hospital privileges.[8]

Following Oklahoma's anti-MOC legislation, Arizona, Georgia, Kentucky, Maine, Maryland, Missouri, North Carolina, South Carolina, Tennessee, Texas and Washington have all passed some form of anti-MOC legislation. In particular, Georgia law outright prohibits MOC from being used as a condition for state licensure or as a prerequisite for staff privileges in state medical facilities, reimbursement from third parties or malpractice insurance coverage. The Georgia law does not appear to prohibit a hospital from inquiring into a physician's MOC status.

The Texas MOC legislation provides that hospitals and health facilities may not differentiate between physicians based on MOC; however, there are a number of exceptions to the law notably that hospitals may differentiate on the basis of MOC if the medical staff votes to authorize the ability of the hospital to differentiate on the basis of maintenance of certification.[9]

MOC and the Medical Staff, What's Next?

Nothing in the *Kenney* case, the *Association of American Physicians & Surgeons, Inc.* case, the CoPs or federal law prohibits hospitals and their medical staffs from using MOC as a factor in determining whether to grant a physician medical staff membership and privileges as one indicator of individual physician competence. Hospitals and their medical staffs are advised, however, to look to state laws to determine the extent to which any state law anti-MOC legislation prohibits the medical staff from requiring MOC.

[8] Okla. A.G. Opinion 2017-13

[9] Tex. Occ. Code Sec. 151.0515.

Adam Chilton
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CASE UPDATE: Gomez v. Memorial

A judge in the 333rd District Court of Harris County, Texas awarded a doctor $6.3 million dollars based on a jury verdict against a hospital at which the doctor formerly held privileges, in Miguel A. Gomez, III, M.D. and Miguel A. Gomez, M.D., P.A. v. Memorial Hermann Hospital System, et al., Cause No. 2012-53962 (hereinafter the "Gomez Case").[1] The doctor was awarded damages on his claims of defamation and business disparagement at trial. We previously provided a summary of the arguments and facts presented at trial. On August 15, 2019, the Court of Appeals First District affirmed the judgment of the trial court.[2] The appellate court opinion provides several interesting points of law on the publication requirement of defamation and proving causation of damages in the medical profession.

I. Background

Dr. Miguel A. Gomez ("Gomez") is a cardiothoracic and general surgeon with experience in robotic-assisted surgical procedures.[3] Gomez previously held privileges and medical staff membership at Memorial City Hospital (the "Hospital"), which is owned and operated by Memorial Hermann Hospital System ("Memorial").[4]

Gomez claimed Hospital representatives joined in a scheme to destroy Gomez's reputation and ability to practice medicine in the West Houston and Katy communities when they learned Gomez intended to split his practice with another hospital, Methodist West. Gomez alleged the Hospital representatives discouraged other doctors from referring patients and cases to Gomez to prevent him from diverting potential revenue from the Hospital to Methodist West, which opened in 2009.[5]

According to Gomez, Byron Auzenne ("Auzenne") (the Heart and Vascular Service Line Leader) began to review the Society of Thoracic Surgeons ("STS") cardiovascular surgery mortality data and ultimately created a statistical model of individual cardiovascular surgeon mortality rates, which allegedly showed Gomez had a higher than average mortality rate.[6] Gomez alleged that the individual surgeon mortality rate generated by the Hospital was misleading, statistically

[1] Plaintiffs Miguel A. Gomez and Miguel A. Gomez, P.A. (collectively "Gomez"). For the purposes of summarizing the alleged facts, the paper relies on Gomez's Fifth Amended Petition ("Gomez Pet."), the Amended Appellate Brief submitted by Gomez on May 21, 2018 ("Gomez Brief"), and the Appellate Brief submitted by Memorial ("Memorial Brief").

[2] Case: 01-17-00632-CV; 2019 WL 3819516.

[3] Gomez Pet. ¶ 5.2.

[4] Gomez Brief P. 4.

[5] Gomez Pet. ¶ 9.4.

[6] Gomez Brief P. 14.

CONTINUED ON PAGE 6

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flawed and not a good measure of surgeon quality.[7] This data was presented at a meeting of the Clinical Programs Committee Cardiovascular and Thoracic Subcommittee, arranged by the Memorial Hermann Physician Network.[8]

At trial, Gomez presented two statements to the jury that formed the basis of his claims for business disparagement and defamation.[9] Cyndi Pena ("Pena"), formerly a physician liaison for Methodist West, testified that Jennifer Todd ("Todd"), a physician liaison for the Hospital, reached out to Pena because Todd heard that Gomez planned to practice at Methodist West.[10] Pena testified that Todd told her to "[b]e careful," because "there's things being said here, and they're pertaining to the bad quality, mortality rate. There was – I heard bad quality, high mortality rates, unnecessary surgeries."[11] Gomez testified that, after the meeting between the Clinical Programs Committee Cardiovascular and Thoracic Subcommittee, Gomez approached Auzenne and asked him why the statistical data was being presented.[12] Gomez testified Auzenne stated, "he had spoken to CEO Keith Alexander and they had discussed it" and "they felt that the data needed to be shared, that we needed to be a transparent organization, that this was a safety issue."[13] Gomez further testified Auzenne told him that "they were going to share [the data]. They felt compelled to share the data with all the doctors."[14]

II. Summary of Issues on Appeal[15]

Memorial argued on appeal that the Auzenne statement was not published to a third party, as required by Texas law, because it was made only to Gomez. Memorial contended that the jury did not strictly interpret the jury charge, but rather subjectively interpreted the statement loosely to satisfy publication of the data regarding individual surgeon's mortality rates.[16]

On appeal, the court held Gomez's defamation complaint was based upon the use and publication of the data itself, not Auzenne's comment to Gomez. The court found the jury was entitled to read the jury charge in a common-sense manner and determine that it was analyzing the publication of the data as defamatory, rather than the statement from Auzenne to Gomez. As such, the appellate court found that the trial court record contained evidence that the data was published to third parties.[17]

In its second point of appeal, Memorial argued that Gomez failed to prove the statement made by Todd to Pena caused any harm to Gomez. Memorial pointed out Pena did not testify that this statement affected her esteem of Gomez, and, in fact, she later hired Gomez as the Co-Director of Cardiovascular Robotics for the entire Methodist System and the Senior Advisor for CV Surgery Service Department at Methodist.[18]

In its fourth point of appeal, Memorial argued that the case was tried on the theory that Gomez's cardiovascular surgeries declined and this was solely caused by a whisper campaign by the Hospital. Memorial claimed, however, Gomez never connected his lower surgical numbers to any particular instance of defamation. Finally, Memorial argued that Gomez did not produce sufficient evidence to prove damages for mental anguish.[19]

On appeal, the court considered the second and fourth appeal points together and held that the arguments did not take into account evidence presented that: (a) Gomez felt pressured to resign his privileges at the Hospital; (b) Gomez changed the nature of his practice after the false information was presented; and (c) Gomez performed significantly fewer cardiovascular surgeries and the nature of the surgeries and procedures he performed required less skill than the surgeries he was performing before the defamation was published. The court also found that Gomez presented sufficient evidence of both the damages that these statements caused to his reputation and the resulting mental anguish he suffered.[20]

[7] Gomez Brief P. 14-17.
[8] Gomez Brief P. 30-31.
[9] Gomez Brief P. 23-30.
[10] Gomez Brief P. 26.
[11] Gomez Brief P. 26-27.
[12] Gomez Brief P. 32.
[13] *Id.*
[14] *Id.*
[15] See Note 2, *supra*
[16] *Id.* at 15.
[17] *Id.* at 17-19.
[18] *Id.*
[19] *Id.* at 20-21.
[20] *Id.*

Meredith Eng
Attorney

The Breadth of the Peer Review Privilege: *Willis v. Highland Medical Center*

2019 IL App (1st) 181541-U
Appellate Court of Illinois, First District
Case No. 1-18-1541

Plaintiff Magen Willis, as Special Administrator of the Estate of Towanda Willis, filed a medical negligence suit against defendants, alleging improper medical treatment of the decedent.[1] During discovery, the Plaintiff sought production of Defendant Dr. Chen Wang's "credentialing file," which was maintained by Defendant South Shore Hospital ("South Shore"). South Shore asserted that most of the file was privileged pursuant to sections 8-2101 and 8-2102 of the Medical Studies Act (the "Act") and refused to produce them.[2] Defendants submitted a privilege log, the requested documents under seal and an affidavit of South Shore's Medical Staff Offices manager in support of the privilege claim.[3]

The circuit court reviewed the documents and ordered South Shore to produce more than 100 of the 150 page document for which South Shore had claimed a privilege.[4] Subsequently, South Shore filed and the court rejected a number of motions to protect the documents from disclosure.[5] Eventually, the circuit court granted South Shore's request that the court find it in friendly contempt for its refusal to comply with the circuit court's discovery orders and imposed a $50 fine for South Shore's refusal to comply.[6] South Shore timely appealed on the grounds that the credentialing file was privileged pursuant to sections 8-2101 and 8-2102 of the Act.[7] The appellate court reversed the circuit court's orders to produce the documents, the finding of contempt and imposition of the fine, holding that each of the documents South Shore refused to produce were privileged under the Act.[8]

South Shore had refused to produce several sets of documents. The first set of documents contained letters to and from physicians listed as references for Dr. Wang in connection with an application for reappointment, confidential professional peer references and responses, a letter to another hospital regarding a reappointment application, physician responses to requests for confidential peer reviews, and reappointment questionnaires.[9] The appellate court held these documents were all responses to requests to doctors for letters of reference for Dr. Wang or peer evaluations of Dr. Wang's professional qualifications sought by or provided to South Shore's Credentials Committee and Executive Committee, or a designee of those committees in the context of granting staff privileges — and therefore privileged pursuant to the Act.[10]

Other documents withheld included reappointment provider profiles, reappointment status reports, a medical staff reappointment profile, two reappointment worksheets, a reappointment profile of clinical performance, reports titled "Primary Responsibility-Conclusions Statistics by Indicator," a physician activity profile, two medical staff member privileges and performance records, a professional activity study, two physician activity profiles, and a letter to Dr. Wang from the Chair of the Department of Surgery at South Shore discussing a preliminary copy of an "aggregate quality improvement report" that was not final "pending peer review." The appellate court recognized that all of these documents contained information that was originally generated by South Shore's Surgical Quality Review Committee during a peer review process.[11] The information was subsequently reviewed by the Credentialing Committee as part of evaluating Dr. Wang for re-credentialing at South Shore.[12] The appellate court held these documents would clearly fall within the privilege provided by the Act, as they were comprised of information generated originally by a hospital committee during a peer review process for the purposes of reducing morbidity and mortality and improving patient care, with that information subsequently reviewed by a credentialing committee for the purpose of internal quality control and evaluation of a doctor for re-credentialing.[13] Furthermore, there was no evidence to support a contention that the information was generated or available outside of South Shore's committees.[14]

Additionally, the appellate court found that a letter to Dr. Wang discussing an ongoing inquiry by South Shore's Executive Committee into his charting and referencing the scheduling of a future meeting of the Executive Committee to discuss the matter was privileged under the Act.[15] The court determined the Act "specifically protects from disclosure all information and statements of a hospital's Executive Committee used in the course of internal quality control (735 ILCS 5/8-2102) and the Act has been interpreted 'to protect against the disclosure of the mechanisms of the peer review process, including information gathering and deliberation leading to the ultimate decision rendered by a hospital peer review committee.'"[16]

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[1] *Willis v. Highland Medical Center,* 2017 IL App (1st) 170807-U, ¶4.
[2] *Id.*
[3] *Id.*
[4] *Id.* at ¶5.
[5] *Id.* at ¶¶ 5-10.[6] *Id.* at ¶¶ 11-12.
[7] *Id.* at ¶ 14.
[8] *Id.*
[9] *Id.* at ¶ 22.
[10] *Id.* at ¶ 23.
[11] *Id.* at ¶¶ 26, 30, 33-34.
[12] Id. at 27, 30, 34.
[13] Id. at ¶ 32.
[14] Id. at ¶ 32.
[15] Id. at ¶¶ 33, 35.
[16] Id. at ¶ 35, citing Green v. Lake Forest Hospital, 335 Ill. App. 3d 134, 137 (2002).

Matthew Melfi
Attorney

Telemedicine or In-Person:
The Standard of Care Remains the Same

The standard of care for telemedicine services is no different than the standard of care for in-person medical services, as evidenced by a recent admonition by the Colorado Medical Board.

On November 14, 2018, the Colorado Medical Board issued a public letter of admonition to Steven A. Schlosser, M.D., for failing to adequately document essential entries into a patient's medical record and for failing to comply with the Colorado Medical Board's policies related to the practice of telemedicine, which require physicians to appropriately evaluate patients prior to providing treatment.[1] The Colorado Medical Board ultimately decided against formal disciplinary proceedings, but Dr. Schlosser was admonished and cautioned not to repeat such conduct.

Dr. Schlosser was licensed to practice medicine in Colorado, California and Florida. Based on the Colorado Medical Board's admonishment, the Medical Board of California similarly issued Dr. Schlosser a Public Letter of Reprimand, dated April 29, 2019.[2] To date, the Florida Board of Medicine has taken no publicly reported action against Dr. Schlosser.

The disciplinary actions arose from a telemedicine encounter with a patient. The patient presented to the telemedicine company employing Dr. Schlosser to be evaluated and treated for pain relief. Certain medical personnel prescreened the patient and Dr. Schlosser approved a prescription for Naproxen. The patient subsequently complained to the Colorado Medical Board that she did not tolerate Naproxen and was concerned about receiving a prescription from a physician she had not met personally.

This case highlights that the same standard of care applies for a physician, whether a physician-patient encounter is via telemedicine or in-person. Under Colorado law, a physician must evaluate a patient prior to issuing a prescription by telemedicine and the physician must adequately document such encounters in the patient's medical record.

[1] Letter of Admonition from Donna M. Baldwin, D.O., for the Colorado Medical Board, to Steven A. Schlosser, M.D. (Nov. 14, 2018) (available at https://www.dora.state.co.us/pls/real/ddms_public.display_document?p_section=DPO&p_source=ELIC_PUBLIC&p_doc_id=779699&p_doc_key=CF727966019D789EC9C35C370D718F47

[2] Public Letter of Reprimand from Kimberly Kirchmeyer, Executive Director, Medical Board of California, to Steven Allen Schlosser, M.D. (April 29, 2019) (available at https://www2.mbc.ca.gov/BreezePDL/document.aspx?path=%5cDIDOCS%5c20190429%5cDMRAAAGL2%5c&did=AAAGL190429174404919.DID).

Laura Little
Attorney

Peer Review Privilege Significantly Narrowed in Pennsylvania: Credentialing Records Pertaining to Medical Staff Membership Denied Peer Review Privilege in Pennsylvania

Credentialing files are no longer protected by the peer review privilege in Pennsylvania. The Pennsylvania Superior Court recently affirmed an interpretation of its peer review protection statute and significantly narrowed the peer review privilege available to hospitals in the State. On May 23, 2019, the Pennsylvania Superior Court issued its decision in *Estate of Krappa v. Lyons,* 211 A.3d 869 (2019). Following *Estate of Krappa,* credentialing files maintained by a hospital's credentialing committee in evaluating physicians for initial and ongoing medical staff membership (e.g., credentialing review) are no longer protected under the State's peer review privilege. Only files created and maintained exclusively by the credentialing committee in evaluating the quality and efficiency of a provider's services when treating patients remain privileged under applicable state law.[1]

In *Estate of Krappa,* the representatives of the estate of a patient who died of cancer ("Estate") filed suit against Community Medical Center ("Hospital") and physicians who treated the patient.[2] The Estate alleged 13 different charges, including direct negligence (on the basis that delay in the patient's diagnosis attributed to the patient's death); corporate liability claims against the Hospital with respect to the hiring, training and/or supervision of the involved physicians; Hospital liability for the involved physicians' acts via ostensible agency; wrongful death; loss of consortium; etc.[3] In discovery, the Estate sought unredacted copies of the Hospital's credentialing files for the two physicians involved in the patient's care through an emergency motion to compel production.[4] The Hospital objected to the production of the credentialing files, claiming the credentialing files are privileged under Pennsylvania's Peer Review Protection Act[5] ("PRPA"). Per the Hospital's counsel, the requested files consisted entirely of the physicians' credentialing materials, which were maintained exclusively by the Hospital's credentialing committee and thus were privileged under the peer review protection provided by the PRPA.[6]

The Estate, however, cited a recent Pennsylvania Supreme Court decision, *Reginelli v. Boggs,* 181 A.3d 293 (Pa. 2018), to refute the claim of PRPA privilege. Per the Estate, *Reginelli* interpreted the PRPA to cover only privileged records created by a review committee in evaluating the quality and efficiency of physician's services, not credentialing files created in reviewing a physician's qualifications for initial and ongoing medical staff membership.[7] The Estate argued the two processes (review of services versus qualification of membership) were materially distinct and the PRPA only intended to privilege evaluations of a physician's quality and efficiency of patient services.[8] The trial court conducted an *in camera* review of the unredacted files, heard oral arguments and, ultimately, agreed with the Estate, denying privilege as to the credentialing files of the physicians.[9] The trial court entered an order, compelling production of the unredacted files. In response, the Hospital entered a notice of appeal and was granted a stay of production, pending appeal.

On appeal, the Hospital asserted that the trial court erroneously ordered production of the Hospital's credentialing files under a broad misinterpretation of *Reginelli.*[10] Per the Hospital, the trial court misconstrued *Reginelli* to announce a blanket rule that records of performance evaluations by credentialing committees are never given peer review protection under the PRPA.[11] Rather, the Hospital offered a different interpretation of *Reginelli:* there, the court denied peer review protection to "performance" records at issue because personnel records were created and maintained by an individual supervising physician in the daily course of business, not by a qualifying "review committee" as defined by the PRPA. The Hospital argued the *Reginelli* Court did not categorically deny the peer review privilege to credentialing materials; rather, it denied the PRPA's peer review privilege to records created outside of a qualified "review committee." Consequently, the Hospital asserted *Reginelli* should be distinguished and the appellate court should determine the physician's

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[1] *Estate of Krappa v. Lyons*, 211 A.3d 869 (2019).
[2] *Estate of Krappa* at 871.
[3] *Id.*
[4] *Id.*
[5] 63 P.S. §§ 425.1-425.4.
[6] *Id.* at 871.
[7] *Id.* at 875.
[8] *Id.*
[9] *Id.* at 871.
[10] *Id.* at 872.
[11] *Id.* at 872.

CONTINUED ON PAGE 10

CONTINUED FROM PAGE 9

credentialing files in *Estate of Krappa* are peer review protected under the PRPA. The Hospital claimed "its credentialing committee records relating to peer evaluations, performance appraisals and responses to [National Practitioner Data Bank] queries, for the initial appointment and reappointment of [the two physicians in this case], which were generated for quality improvement purposes and maintained exclusively by the [credentialing] committee, fall squarely within the PRPA … "[12] More specifically, the credentialing committee constituted a "review committee"[13] whose records remain confidential under the PRPA and the performance evaluations in its files satisfied the PRPA's definition of "peer review" materials[14] to be afforded the PRPA's protections.[15]

The Superior Court rejected the Hospital's interpretation of *Reginelli* and denied peer review protection to the physicians' Hospital credentialing files. The court found the Hospital's credentialing files did not qualify for peer review privilege, despite the credential committee's creation and ownership of the records, because the credentialing files were created in evaluating the physicians for medical staff membership, not to evaluate the physicians' quality of care.[16] The court focused on what it saw as a difference in the PRPA's definition of "review organization" and "review committee."

The first sentence of PRPA's definition of "review organization" states a "review organization" is any committee engaging in peer review.[17] The second sentence of the definition states, "[i]t shall also mean any hospital board, committee or individual reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto."[18] The Superior Court cited to the Reginelli Court's determination that the second sentence does not apply to "peer review" and, as such, those "reviewing the professional qualifications or activities of its medical staff or applicants for admission" are not considered "review committees" and are not entitled to PRPA protection. [19]

In so finding, the appellate court significantly narrowed the scope of the peer review privilege available to hospitals under the PRPA to the following rule: records produced by a credentialing committee when reviewing a physician's credentials for purposes of medical staff membership or continued membership are not granted peer review protection by the PRPA.[20] Only records created in evaluating the quality and efficiency of services ordered or performed by the physician shall be extended peer review protections.[21]

Time will tell if this significantly narrowed interpretation of the PRPA's peer review privilege will stand.

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[12] *Id* at 872.

[13] *Id.* at 874 *citing Reginelli* at 304 ("Accordingly, **although "individuals reviewing the professional qualifications or activities of its medical staff or applicants for admission thereto," … are defined as a type of "review organization," such individuals are not "review committees" entitled to claim the PRPA's evidentiary privilege in its section 425.4.");** 63 P.S. 425.4 ("The proceedings and records of a review committee shall be held in confidence and shall not be subject to discovery or introduction into evidence in any civil action against a professional health care provider arising out of the matters which are the subject of evaluation and review by such committee and no person who was in attendance at a meeting of such committee shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such committee or as to any findings, recommendations, evaluations, opinions or other actions of such committee or any members thereof: Provided, however, That information, documents or records otherwise available from original sources are not to be construed as immune from discovery or used in any such civil action merely because they were presented during proceedings of such committee, nor should any person who testifies before such committee or who is a member of such committee be prevented from testifying as to matters within his knowledge, but the said witness cannot be asked about his testimony before such a committee or opinions formed by him as a result of said committee hearings.").

[14] *Id.* at 873 citing 63 P.S. 425.2 (**"Peer review"** means the procedure for evaluation by professional health care providers of the quality and efficiency of services ordered or performed by other professional health care providers, including practice analysis, inpatient hospital and extended care facility utilization review, medical audit, ambulatory care review, claims review, and the compliance of a hospital, nursing home or convalescent home or other health care facility operated by a professional health care provider with the standards set by an association of health care providers and with applicable laws, rules and regulations.").

[15] *Id.* at 871.

[16] *Id.* at 875.

[17] 63 P.S. §§ 425.3(2).

[18] *Id.*

[19] *Id.* at 874 - 875.

[20] *Id.* at 875 ("Regarding the applicability of the PRPA, the materials in the doctors' personnel files are generated and maintained by Appellant's [i.e., Hospital's] credentialing committee. The PRPA's protections do not extend to the credentialing committee's materials, because this entity does not qualify as a "review committee." ***See Reginelli,*** 181 A.3d at 306. Accordingly, the trial court did not err in its interpretation of the PRPA, and Appellant is not entitled to relief on its claim.[5] ***See Yocabet,*** 119 A.3d at 1019.").

[21] *Id.*

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Absent Clear and Convincing Evidence of Bad Faith and Malice, Immunity is Strong for Peer Review Decisions in Utah

The Court of Appeals of Utah recently upheld a district court's grant of summary judgment in favor of a hospital on the basis of qualified immunity from claims arising out of the deliberations, decisions or determinations made during the peer review process. A surgeon sued a Utah hospital following the hospital's decision to temporarily suspend the surgeon's privileges, but in *Levitt v. Iasis Healthcare Holdings, Inc.,* 442 P.3d 1211 (Utah Ct. App., 2019), the court ruled that the hospital is protected from such claims under Utah's Health Care Providers Immunity from Liability Act, absent a showing of bad faith or malice.

The question in this case was whether the hospital acted in bad faith and with malice in deciding to suspend a physician, as Utah's Health Care Providers Immunity from Liability Act provides qualified immunity to health care providers serving in certain capacities, specifically those serving on committees "established to evaluate and improve the quality of health care."[1] Health care providers are immune from liability with respect to "deliberations, decisions, or determinations made … *in good faith and without malice."*[2] Health care providers serving on such committees "are presumed to have acted in good faith and without malice, absent clear and convincing evidence to the contrary."[3]

Dr. Levitt is a neurosurgeon with medical staff appointment and privileges at Salt Lake Regional Medical Center ("SLRMC").[4] In late 2011, she applied for a two-year renewal of her membership and privileges, but SLRMC's CEO informed her by letter that she would only be granted a six-month conditional reappointment because she had several pending peer reviews.[5] Dr. Levitt sought more information and was told by various SLRMC representatives that they could not talk to her about cases being peer reviewed, to protect the peer review privilege.[6]

In early 2012, Dr. Levitt received a letter from the SLRMC Credentials Committee stating that review of her cases showed several patients with cerebrospinal fluid leaks and three wrong-site surgeries.[7] The Committee informed her that if she submitted written protocols to address these issues, she would be granted a three-month conditional

[1] *See* Utah Code Ann. §58-13-4.
[2] Utah Code Ann. §58-13-4(2)*(emphasis added).*
[3] Utah Code Ann. §58-13-4(4).
[4] *Levitt v. Iasis Healthcare Holdings, Inc.,* 442 P.3d 1211, 1212 (Utah Ct. App., 2019)
[5] *Id.* at 1212-1213.
[6] *Id.* at 1213.
[7] *Id.*

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reappointment, with the caveat that the Committee was continuing to review other cases.[8] Dr. Levitt submitted the protocols, but because of another recent incident that required "immediate action," she was issued a twenty eight day suspension of her surgical and medical privileges.[9]

Dr. Levitt then received a letter stating that her suspension would last 14 days, but that her privileges would be reinstated if she completed a proctorship.[10] Dr. Levitt requested a hearing on her temporary suspension, but she was informed via email that such a hearing would not happen on an emergent basis, that she needed to request the hearing in accordance with the bylaws, and that if she completed the proctorship during the 28-day suspension, she would not be reported to the National Practitioner Data Bank.[11] The email further cautioned Dr. Levitt that the hearing process would probably postpone decision making beyond 30 days, and her suspension would thus be reportable.[12] Dr. Levitt did not respond to the email, but completed the proctorship and her membership and privileges were reinstated.[13]

Dr. Levitt sued SLRMC and others for breach of contract, breach of the implied covenant of good faith and fair dealing, tortious interference with economic relations and civil conspiracy.[14] She alleged that SLRMC took actions to destroy her reputation.[15] The district court granted SLRMC's motion for summary judgment, concluding that SLRMC was immune from Dr. Levitt's claims under Utah law, because there was no evidence that SLRMC acted from any motive other than health care quality improvement and concern for patient care.[16]

On appeal, Levitt argued that "sufficient bad faith and malice can be inferred from the totality of the circumstances regarding the conduct of the Defendants toward her."[17] She argued that 1) SLRMC refused to provide her with reasons for its decisions, 2) a jury could infer bad faith from the "outright denial of her request for the fair hearing required in the bylaws," and 3) SLRMC maliciously and wrongfully issued the conditional reappointment and temporary suspension.[18] The court rejected each argument in turn.[19]

The court concluded that Dr. Levitt failed to produce sufficient evidence of bad faith and malice, and that the defendants are immune from her claims as a matter of law.[20] The Utah Court of Appeals affirmed the district court's ruling, stating that no jury could conclude that there is clear and convincing evidence that SLRMC acted in bad faith or with malice, and SLRMC is immune from Dr. Levitt's claims under Utah Code Ann. §58-13-4.[21]

Ultimately, the immunity provided to health care providers under Utah's Health Care Providers Immunity from Liability Act appears to be rather strong, as long as decisions are made in good faith and without malice. And, without clear and convincing evidence to the contrary, providers are presumed to have acted in good faith and without malice.

[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.* at 1214.
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.*
[16] *Id.*
[17] *Id.* at 1215.
[18] *Id.* at 1215-1217.
[19] *Id.*
[20] *Id.* at 1215.
[21] *Id.* at 1216.

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