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Med-Staff Newsletter

QUARTERLY NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP

Academic Medicine: Navigating Inherent Complexity in Corrective Action Processes

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Academic medical centers ("AMCs") are unique and complex organizations that include both a teaching hospital and a medical school, with medical staff members often serving dual roles at both institutions. The inherent complex structure of AMCs poses distinct challenges in navigating the corrective action process. This article explores the typical structure of AMCs and examines some of the challenges that arise in navigating different corrective action processes.

Structure of AMCs

While every AMC is unique, there are some common characteristics that many share: (1) the hospital and school are often tethered together from an organizational, governance and/or legal perspective; (2) the hospital is a principal site for the education of medical students, residents, and fellows; (3) medical staff leaders of the hospital work with medical school leaders to direct activities to foster the appropriate clinical, teaching, and research environment in the hospital; and (4) providers often have multiple roles at both the hospital and medical school, such as faculty, medical staff, administrators, and researchers.

An AMC hospital operates pursuant to accreditation requirements, most often those of The Joint Commission, as well as the Center for Medicare & Medicaid Services ("CMS") Conditions of Participation ("CoPs"), and other State laws and requirements. Typically, the hospital will be organized by departments based on types of clinical services. These departments are headed by service chiefs that report to hospital administration, and usually serve on the medical executive committee of the medical staff. The services chiefs are also responsible for communicating directly with medical school leadership regarding clinical issues and may also hold a leadership role within the medical school. At times, the service chief also serves in a medical school leadership role.

An AMC medical school is likewise typically organized by clinical service departments led by a department chair, which often mirror the clinical departments of the hospital, in addition to non-clinical departments. The medical school department chairs report to the dean of the medical school, but also regularly communicate with hospital administration regarding the clinical departments' needs, funding and other issues that could impact staffing the hospital's clinical services. Medical schools are accredited by two organizations: one for the educational program, and another for the resident and fellowship program. The Liaison Committee on Medical Education is the primary accrediting body for education programs for Doctor of Medicine programs, and the Commission on Osteopathic College Accreditation is the primary accrediting body for education programs for Doctor of Osteopathy programs The Accreditation Council for Graduate Medical Education ("ACGME") is the main accrediting body for resident and fellowship programs; although there are other specialized accrediting bodies for certain programs.

Within an AMC hospital there are two primary categories of providers: medical staff members and house staff, i.e., residents and fellows. House staff are doctors of medicine or osteopathy, podiatry, and dentistry in approved training education programs in the hospital and are supervised by medical staff members with appropriate clinical

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privileges. The sponsor of the residency or fellowship program, the Instutional Sponsor, must meet extensive requirements related to the learning environment. The Graduate Medical Education Committee ("GMEC") and the Designated Institutional Official are responsible for promulgating and enforcing policies and procedures governing graduate medical education and all issues associated with the academic progression of residents and fellows. The GMEC is also responsible for overseeing policies that provide the resident or fellow with due process for any action taken during the residency (e.g., suspension, non-renewal, non-promotion, or dismissal). In reviewing complaints that implicate both a house staff member and medical staff member, the AMC must consider hospital, medical staff, and GME policies and procedures.

Parallel "Lanes" of Corrective Action

Because of the hybrid approach of AMCs, and the myriad of structures, there are unique intersections of corrective action processes between the hospital and medical school, as well as between medical school faculty, medical staff, and house staff. As such, it is important to understand and manage the various "lanes" of investigations and corrective actions processes, while also recognizing that inappropriate conduct and clinical concerns can trigger multiple corrective action processes. These processes can often occur simultaneously. These various corrective action processes will be memorialized in institutional policies such as medical staff bylaws, graduate medical education policies, and hospital policies, as well as in contractual agreements such as academic affiliation agreements, employment agreements, and other contractual relationships. As such, an adverse action for physician misconduct or clinical concerns can take various concurrent forms, including but not limited to employment actions, faculty code processes to terminate faculty appointment, removal from providing services under a contractual agreement, and termination of privileges under the medical staff bylaws.

1. Employment/Contractual Action

To add further complication to the corrective action process, many physicians providing services at AMCs do so under employment agreements. The language of these employment agreements governs the relationship between the provider and the AMCs and typically the processes described in such employment agreements, offer letters or other policies will govern in addition to the medical staff bylaws. Often, employment agreements may be terminated upon notice to the employee provider if the provider breaches the terms of the agreement or fails to perform any of their obligations under the agreement. The employee provider's obligations under the employment agreements often include the performance of services in accordance with the terms of the medical staff bylaws, rules and regulations, and other policies and procedures of the hospital (including professional conduct policies). As such, a violation of the medical staff bylaws and/or policies of the hospital will typically be considered a breach of the employment agreement. The employment agreement may or may not provide the employee provider with a right to cure any alleged breach. In most circumstances, termination of an employment agreement does not give the provider hearing/appeal rights under the medical staff bylaws.

AMCs may also enter into master physician services agreements with physician groups. These master services agreements also typically require that the individual providers deliver services in accordance with the medical staff bylaws, rules and regulations, and policies and procedures of the hospital. Usually under these agreements, the hospital may demand removal of a particular practitioner (without terminating the agreement) if, in the reasonable and good faith judgment of the hospital, the practitioner is disruptive to the business or patient care operations of the hospital, or the provider fails to adhere to the applicable requirements for their clinical services. Again, removal of a provider under a master services agreement does not typically give the provider hearing/appeal rights under the medical staff bylaws.

2. Faculty Code Actions

The AMC's medical school will oftentimes have a Faculty Code that governs the relationship between faculty and the medical school. The Faculty Code provides processes for appointment and removal of faculty members. These policies are unique to each medical school, however, there are several common themes. Usually, the department chair is the critical decision-maker for both recommendations to appoint and remove faculty, and final decisions may rest with another school or university official. While faculty members are typically not entitled to hearing rights under the medical staff bylaws

CONTINUED ON PAGE 3

Table of Contents

- **Academic Medicine:** Navigating Inherent Complexity in Corrective Action Processes
- **A Practical Review:** Risks and Challenges of The Joint Commission's New Three-Year Reappointment Cycle
- Negligent Credentialing Claim Survives Summary Judgment as Wisconsin Court Determines Physician's Ethical Misconduct Could Speak to Truthfulness in Handling Patient's Informed Consent
- COVID-19 Misinformation by Physicians in California Could Cost Them Their Licenses

COVID-19: What Your Business Needs To Know

Click here to join our mailing list and receive new blog posts, event information and COVID-19 legal updates direct to your email inbox.

CONTINUED FROM PAGE 2

for removal from a faculty position, there often may be faculty appeal processes to challenge removal from the faculty before a panel of faculty peers.

3. Medical Staff Peer Review

Finally, there are corrective action procedures under the medical staff bylaws for providers who hold clinical privileges. Specific adverse events or conduct concerns may be reported to medical staff leadership and the medical executive committee. There are a wide range of corrective action processes that the medical executive committee may take or recommend including suspension of privileges, termination of privileges, collegial interventions, letters of reprimand/correction/education, proctoring, and imposing continuing medical education requirements. The Health Care Quality Improvement Act of 1986 and the medical staff bylaws will define what constitutes an adverse action recommendation entitling the practitioner to request a hearing. If the medical executive committee, after conducting an investigation, recommends an adverse action (such as termination of clinical privileges), the hospital must give notice to the provider of the recommended action and the providers right to request a hearing. The adverse recommendation will not be transmitted to the hospital's Board of Directors/Trustees for a final decision until the provider has either waived or exhausted their hearing/appeal rights. If the provider requests a hearing, one will be conducted, and the hearing panel can choose to recommend approval, modification, or rejection of the medical executive committee's recommendation. The provider and/or the medical executive committee can typically appeal the decision to an appellate panel consisting of members of the Board of Directors/Trustees. Ultimately, the adverse recommendation and, if applicable, the hearing panel and appellate panel recommendations will be forwarded to the Board of Directors/Trustees for a final determination.

Conclusion

As discussed above, these processes, while separate, can occur simultaneously. An employed physician will usually be a member of the medical staff and could also be a faculty member and an employee. As such, there could be an ongoing medical staff investigation after the physician's employment agreement is terminated. An adverse medical staff action could also cause a faculty removal action. Because of the complexity and overlap between these processes, AMC leaders and administrators are well-served by relying on counsel who can simultaneously guide them through these parallel tracks without compromising the integrity of the individual processes. For those interested in learning more about unique issues concerning AMCs, please join Polsinelli's upcoming webinar series "Spotlight on AMCs."

Click here to learn more about Polsinelli's Spotlight on AMCs Series.

A Practical Review: Risks and Challenges of The Joint Commission's New Three-Year Reappointment Cycle

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Effective February 19, 2023, health care facilities that use The Joint Commission ("TJC") accreditation for deemed status purposes will have the option to switch from a two-year to a three-year reappointment cycle. The decision of whether to make the switch should be taken with a good measure of caution, as any change to a longer reappointment cycle may come with potentially meaningful legal risk and practical challenges. This article examines the new changes to the time frame in which health care facilities must evaluate a licensed practitioner's ability to provide care, treatment, and services, the origin of the new standards, and the practical and legal implications for any health care facility considering switching to a three-year reappointment cycle.

Background

The new three-year reappointment time frame did not arise in a vacuum. The TJC three-year reappointment cycle was advocated for by the National Association of Medical Staff Services ("NAMSS") on the basis that a three-year practitioner reappointment cycle would better align with the payor enrollment and recredentialing schedules, governed by National Committee for Quality Assurance ("NCQA") regulatory guidelines, which are similarly on a three-year cycle. Currently, medical staff offices which perform dual credentialing functions must operate two reappointment tracks—every two years for the medical staff and every three years for provider enrollment. A three-year reappointment cycle for clinical privileges would potentially reduce the administrative burden on medical staff offices, eliminate redundancies, and in turn ease costs on health care facilities.

In response to advocacy by NAMSS and other organizations, TJC announced in an updated FAQ published November 4, 2022, that it would be expanding the reappointment time frame from two years to three years.[1] Further details were released in the December 2022 Joint Commission Perspectives Newsletter, and new prepublication standards issued shortly after.[2]

Legal Considerations

The change by TJC to a three-year reappointment cycle requirement may bring about certain practical administrative benefits, however, any health facilities considering switching their internal standards are best advised to move forward with a good measure of caution. The new TJC standards appear to be inconsistent with guidelines on reappointment from the Centers for Medicare

1 *See* https://www.jointcommission.org/standards/standard-faqs.
2 *See* https://www.jointcommission.org/standards/prepublication-standards/revisions-related-to-licensed-practitioner-evaluation-time-frames/.

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and Medicaid Services ("CMS") and certain state regulations, and we have yet to see how CMS and state legislatures will move in response to the revised TJC standards.

Currently, CMS regulations do not require a specific timeframe for reappointment. That said, through sub-regulatory guidance in Appendix A of the State Operations Manual ("SOM"), CMS recommends that, "an appraisal [of the qualifications of all practitioners appointed to the medical staff/granted medical staff privileges] be conducted at least every 24 months."[3] While CMS uses the term "appraisal," it is understood that CMS is referring broadly to the reappointment process, and not just OPPE. In the following paragraph, the SOM goes on to state, "the purpose of the appraisal is for the medical staff to determine . . . if that individual practitioner's membership or privileges should be continued, discontinued, revised, or otherwise changed." The SOM is more explicit with regard to surgical privileges, stating directly that, "[s]urgical privileges should be reviewed and updated at least every 2 years."[4]

It should be noted that the guidance set forth in the SOM is not a regulatory mandate, which creates a certain amount of grey area as to its enforceability. That said, to a certain extent this is subject to the age-old adage, "you can't fight city hall," and as such we typically recommend that hospitals follow the CMS interpretations, even when TJC takes a different position. CMS surveyors obviously follow the SOM. Therefore, if the hospital is surveyed by CMS, a three-year reappointment cycle could present a survey risk.

Additionally, the two-year reappointment time frame for hospitals to re-evaluate individual practitioner's qualifications set forth in the SOM is mirrored by many state laws. For example, the more express limit on surgical privileges is mirrored in Colorado regulations, which similarly require that, "[s]urgical privileges shall be reviewed and updated at least every two (2) years."[5] In California, the regulations states that the governing body and medical staff establish controls to reevaluate the ability of all practitioners to competently perform surgical and other procedures, "at least every two years [after initial appointment]."[6] The use of "at least" seemingly recognizes the need for ongoing reassessment that may not be captured day-to-day, and but which instead must be looked at cumulatively. This has been interpreted to require health care facilities to recredential practitioners every two years.

Practical Considerations

In addition to the legal considerations, changing to from a two-year to a three-year reappointment cycle presents many practical challenges and risks that health care facilities must consider as well. While switching to an aligned three-year reappointment cycle may bring about certain administrative benefits as discussed above, extending the existing appointment process from two years to three years may extend the length of time potential problem practitioners go unaddressed.

Proponents of the three-year reappointment requirement contend that the Ongoing Professional Practice Evaluation ("OPPE") and Focused Professional Practice evaluation ("FPPE") processes can cover any gaps resulting from a lengthened reappointment time frame. However, medical staffs sometimes struggle with meaningful use of OPPE and FPPE data and not all hospitals have sufficiently robust OPPE and FPPE processes in place to effectively capture concerns that may slip through the cracks left by a longer reappointment process. Further, OPPE data only provides information on selected metrics and does not necessarily guarantee that an individual with clinical deficiencies will be appropriately identified mid-appointment cycle. This poses a particular challenge with aging practitioners where cognitive and physical decline can occur precipitously and the impact of which may be undetected without a close review of trends or observations gathered during the reappointment process.

It is possible that switching to a single aligned three-year reappointment cycle will free up resources for more thorough and well-established OPPE/FPPE processes, but that is only theoretical at this time. Moreover, in February 2022, TJC extended the time frame for the frequency of completing OPPE from every six (6) months to every twelve (12) months, which lengthens the time during which cumulative problems could go undetected.

The reappointment process, on the other hand, is a critical opportunity for the medical staff to closely scrutinize all areas of an individual practitioner's clinical competency and quality of care – including affiliation checks with other hospitals and peer references – all of which may bring meaningful information for consideration by the hospital that would not otherwise be available through OPPE alone. Failure to conduct a thorough and frequent assessment could possibly lead to claims of medical malpractice or negligence credentialing. Furthermore, if a state agency determines a hospital should have been recredentialing on a more frequent basis under state law, a hospital's license could potentially be at risk as well.

Implementation Challenges

Beyond the practical risks of a problem practitioner potentially going unidentified for longer, switching to a three-year reappointment cycle will present many practical implementation challenges for any hospital that chooses to go forward with a lengthened reappointment process under the new TJC standards. For example, in implementing a new three-year reappointment cycle, the medical staff would need to establish a thorough, and potentially years long, transition procedure to ensure that all practitioners are appropriately processed.

3 *See* SOM, A-0340, on page 185 interpreting 482.22(a)(1).
4 *See* SOM, A-0945, page 432, interpreting 482.51(a)(4).
5 *See* 6 CCR 1011-1, Ch. 4, Part 24.6(C).
6 Cal. Code Regs. Tit. 22, § 70701(a)(7).

CONTINUED ON PAGE 5

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One option would be to incorporate the process to extend the appointment period one-by-one as each practitioner naturally comes up for reappointment. However, this would likely result in years during which different practitioners would be practicing under different reappointment time frames, all of which would need to be tracked by the medical staff office. Additionally, OPPE schedules would need to be closely monitored and updated to properly align with the new reappointment time frame. Likewise, any qualifications for clinical privileges or medical staff category assignment that are tied to the reappointment cycle, such as patient contacts or medical staff meeting participation, would need to be updated and coordinated as practitioners are transitioned to the new cycle.

Furthermore, some medical staffs collect dues from members at the time of reappointment. Thus, switching to a three-year reappointment could result in a lag in the collection of dues and potential underfunding of the medical staff. Consideration should be given to whether to assess dues more frequently or to increase dues at the time of reappointment.

In addition to revisions to the medical staff bylaws, credentialing plans, rules and regulations, and policies, the applicable hospital privileging forms would likewise need to be updated to recalculate mandatory procedure and patient volume requirements.

If a hospital were to choose to switch to a three-year reappointment cycle, all medical staff documents would need to be reviewed and updated, many of which will require a full vote of the medical staff for approval, and any applicable medical staff and hospital policies, and all privileging forms would need to be revised to accommodate the new lengthened reappointment time frame. To effectively accomplish all of these changes, hospitals and their medical staffs would be best advised to first develop a comprehensive multi-year transition plan to ensure all documents are appropriately updated, all practitioners assessed, and any OPPE and quality data is effectively coordinated.

Conclusion

The announced change by TJC to a three-year reappointment cycle was welcomed by many medical staff offices and others who work in the medical staff arena. Any hospital considering switching to a three-year reappointment cycle, however, must overcome several hurdles, both legal and practical, and there is no one-size-fits-all solution. Based on current interpretation, the changes by TJC to the time frame in which health care facilities must evaluate a licensed practitioner's ability to provide care, treatment, and services are inconsistent with CMS guidance and many state laws regarding the frequency with which hospitals must reevaluate practitioners granted clinical privileges.

Ultimately, each health care facility must weigh for itself the relative legal and practical risks and implementation challenges of switching to a three-year reappointment cycle against the potential administrative simplification of operating a single aligned reappointment process for credentialling providers to both participate with a payor and provide direct patient care. Whatever path a hospital chooses to follow, it should do so in close consultation with legal counsel to thoughtfully evaluate the legal risks and practical challenges posed at each step in the transition process.

Negligent Credentialing Claim Survives Summary Judgment as Wisconsin Court Determines Physician's Ethical Misconduct Could Speak to Truthfulness in Handling Patient's Informed Consent

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The Wisconsin Court of Appeals recently reversed a circuit court's grant of summary judgment in favor of a plastic surgery center and determined that the plastic surgery center failed to demonstrate that a patient's alleged injury from a violation of her informed consent was "too attenuated" to a plastic surgeon's known prior unethical conduct. This decision highlights the importance of performing due diligence during the credentialing process (during initial appointment and at re-appointment), including fully investigating concerns or "red flags," such as ethical misconduct identified in the National Practitioner Data Bank ("NPDB") reports and state licensing documents. It also provides a helpful refresher on the elements of a negligent credentialing claim, along with the public policy considerations that could result in dismissal of a claim despite all other elements being satisfied.[1]

Plastic Surgeon's History of Misconduct and Disciplinary Actions

Dr. John Siebert, a plastic surgeon, initially applied for privileges with Transformations Surgery Center (the "Center") in 2007.[2] Following the credentialing process, Dr. Siebert was granted privileges and the Center reevaluated his privileges every two years thereafter.[3] Starting in 2012, the Center received NPDB reports that showed Dr. Siebert had been sanctioned by the State of New York Department of Health ("NYSDH") for having a sexual relationship with a patient and had previously lost privileges at multiple medical facilities.[4] In 2013, Dr. Siebert provided the Center with a signed consent order resolving the NYSDH's charges against him.[5] Despite the Center's Medical Staff Bylaws mandating that it investigate an applicant's ethical behavior, the Center performed no further investigation into the New York incidents during Dr. Siebert's re-appointment.[6] Dr. Siebert's licensing documents submitted to the State of Wisconsin from 2010 to 2016 also showed that Dr. Siebert misrepresented the status of his license in New York, and records from a 2013-2015 Wisconsin Department of Safety and Professional Standards investigation into the New York incidents revealed that Dr. Siebert had falsified a post-operative report regarding one of the incidents.[7] According to the Wisconsin Court of Appeals' decision, the Center failed to review these documents when it reappointed Dr. Siebert.[8]

Plaintiffs Sue Center Alleging Negligent Credentialing

In 2018, Dr. Siebert performed a bilateral breast augmentation on one of the Plaintiffs during which Dr. Siebert inserted breast implants that were over 100 cc larger than the ones the Plaintiff previously selected.[9] Plaintiffs filed suit against the Center, alleging that Dr. Siebert violated the patient's informed consent by inserting different sized implants and that the Center negligently credentialed Dr. Siebert.[10] The circuit court granted the Center's motion for summary judgment, concluding that Plaintiffs failed to show a "causal nexus" between the Center's credentialing of Dr. Siebert and the injury from Dr. Siebert's violation of the patient's informed consent.[11] Specifically, the circuit court determined that Dr. Siebert's prior misconduct in New York was "too attenuated" from and "dissimilar" to ignoring a patient's informed consent.[12]

Determining the Applicable Analysis: Cause-In-Fact Versus Public Policy Considerations

In its decision, the Wisconsin Court of Appeals noted that negligent credentialing claims are based on general principles of negligence, meaning that a plaintiff must prove four elements: (1) a duty of care owed by the defendant; (2) breach of that duty; (3) a causal connection between the conduct and the injury; and (4) actual loss or damage as a result of the injury.[13] Even if all four elements are satisfied, however, a court

1 The Wisconsin Court of Appeals also reviewed the circuit court's decision denying Plaintiffs' motion to amend their witness list, ultimately affirming the circuit court's decision. This article focuses on Plaintiffs' negligent credentialing claim.
2 *Connaughty, et al. v. Transformations Surgery Ctr., Inc., et al.*, No. 2021AP2188, 2022 WL 16641915, at ¶ 7.
3 *Id*.
4 *Id*. at ¶ 8.
5 *Id*.
6 *Id*. at ¶¶ 6, 8.
7 *Connaughty*, at ¶¶ 9-10.
8 *Id*.
9 *Id*. at ¶ 11.
10 *Id*. at ¶ 12.
11 *Id*. at ¶ 13.
12 *Connaughty*, at ¶ 13.
13 *Id*. at ¶ 17.

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may dismiss a claim if it finds, as a matter of law, that considerations of public policy warrant dismissal.[14]

The court explained that both cause-in-fact and public policy considerations comprise the "legal cause" of a negligent credentialing claim.[15] While cause-in-fact is typically a factual question for the jury, public policy considerations (formerly referred to in Wisconsin as "proximate cause") present legal questions for the court to decide.[16]

In a negligent credentialing case, the cause-in-fact is met by proving: (1) the doctor's negligent act was a cause-in-fact of the injury; and (2) the negligent credentialing by the facility was the cause-in-fact of the negligent act of the doctor.[17] Regarding the public policy considerations, a court may consider whether: (1) the injury is too remote from the negligence; (2) the injury is wholly out of proportion to the culpability; (3) it is too highly extraordinary that the negligence would have brought about the harm; (4) allowance of recovery would place too unreasonable a burden on the tortfeasor; (5) allowance of recovery would likely open the way for fraudulent claims; or (6) allowance of recovery would enter a field that has no sensible or just stopping point.[18] Any one of these factors may be invoked to preclude liability.[19]

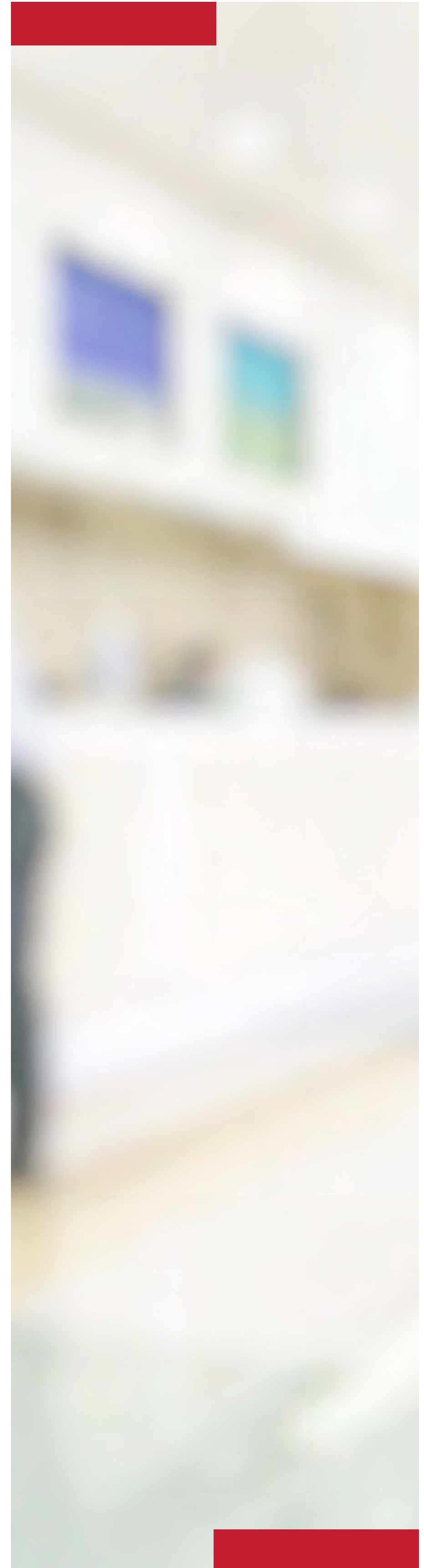
Court Rejects Conclusory Public Policy Argument

In its motion for summary judgment, the Center did not argue that Plaintiffs failed to prove the cause-in-fact element.[20] Rather, the Center relied on the public policy consideration that the causal connection between Dr. Siebert's prior misconduct and the patient's injury was "too attenuated" and had no relationship to his violation of the patient's informed consent by arguing that ethical considerations were not relevant to a physician's handling of informed consent with patients.[21]

The court rejected what it considered to be conclusory arguments by the Center and concluded that Dr. Siebert's "unethical and dishonest conduct" (having a sexual relationship with a patient, falsifying an operation report, and misrepresenting prior misconduct on multiple occasions) could reasonably make it foreseeable that Dr. Siebert would later ignore a patient's informed consent.[22] In support of its decision, the court pointed to the Center's bylaws, which mandated that the Center investigate all records pertinent to a physician's "ethical qualifications" and that doctors must be honest with their patients.[23] The court concluded that Dr. Siebert's ethical misconduct could reasonably bear on his truthfulness and ethical character in handling a patient's informed consent, and that a doctor's dishonesty could result in harmful consequences to patients.[24]

Lessons Learned

It is essential that medical institutions look beyond a provider's technical competence and ensure their credentialing and recredentialing processes include a thorough due diligence review into a provider's prior ethical misconduct, including, among others, any claims of dishonesty, falsification, and violation of patients' trust and rights. This is especially true when such conduct has been reported or "flagged" by the NPDB or other state licensing entities. Additionally, while public policy and proximate cause arguments may preclude liability under certain negligent credentialing claims, these arguments are often very difficult to win at the summary judgment phase and require more than conclusory arguments to establish that prior misconduct is "too attenuated" to a claimed injury.



14 *Id.*
15 *Id.* at ¶ 18.
16 *Id.*
17 *Connaughty*, at ¶ 20, citing *Johnson v. Misericordia Cmty. Hosp*. 99 Wis. 2d 708, 711 (1981).
18 *Id.* at ¶ 22, citing Morgan v. PA Gen. Ins., 87 Wis. 2d 723, 737 (1979).
19 *Id.*
20 *Id.* at ¶ 26.
21 *Id.* at ¶¶ 28-29.
22 *Connaughty*, at ¶ 27.
23 *Id.* at ¶ 29.
24 *Id.*

COVID-19 Misinformation by Physicians in California Could Cost Them Their Licenses

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California Assembly Bill 2098, signed by Governor Gavin Newsom on September 30, 2022, authorizes the Medical Board of California and the Osteopathic Medical Board of California (collectively the "Medical Boards") to sanction doctors for "unprofessional conduct" should they share information about COVID-19 that is not consistent with what the Medical Boards deem to be the official "scientific consensus." The list of potential sanctions includes possible revocation of a physician's license.

Current California law requires the applicable board to take action against any licensed physician or surgeon who is charged with unprofessional conduct. AB 2098, which is codified as California Bus. & Prof. Code 2270 and became effective on January 1, 2023, expands the designation of unprofessional conduct to include the dissemination of COVID-19 specific disinformation or misinformation.

AB 2098 aims to mitigate the spread of false information surrounding COVID-19 by preventing health care providers from disseminating unproven information about the virus to the public. These actions will now be considered "unprofessional conduct," and the Medical Boards have the authority to decide if an instance constitutes a violation of the statute and whether to take action against the practitioner.

The bill states "it shall constitute unprofessional conduct for a physician and surgeon to disseminate misinformation or disinformation related to COVID-19, including false or misleading information regarding the nature and risks of the virus, its prevention and treatment; and the development, safety, and effectiveness of COVID-19 vaccines."[1] Misinformation is defined in the bill as "false information that is contradicted by contemporary scientific consensus to an extent where its dissemination constitutes gross negligence by the licensee."[2] The bill defines disinformation as "misinformation that the licensee deliberately disseminated with malicious intent or an intent to mislead."[3] Physicians are required to treat COVID-19 patients based on the consensus of the Centers for Disease Control and Prevention or the California Department of Public Health treatment protocols. The bill articulates a concern with the dissemination of misinformation in the age of social media, where it can spread more quickly and widely than ever before. This action by the state legislature underscores that because physicians, doctors, and surgeons possess a high degree of public trust, they must be held responsible for the information they disseminate to the general public.

The legislation specifically targets three types of misleading information concerning COVID-19. The first is nonfactual information about the nature of the virus, such as inaccurate comments about its severity. For instance, it would be prohibited to say COVID-19 is comparable to less serious diseases. Second, the bill targets the dissemination of inaccurate information regarding COVID-19 treatment, including promoting unproven treatments and therapies. Third, the bill prohibits providers from giving inaccurate information concerning COVID-19 vaccines.

In his signing statement, Governor Newsom said, "To be clear, this bill does not apply to any speech outside of discussions related to COVID-19 treatment within a direct physician patient relationship."[4] Further, in order to assuage concerns regarding the potential chilling effects this legislation could have on new treatments related to COVID-19, Governor Newsom clarified that discussing emerging ideas or treatments and the risks and benefits of same does not constitute misinformation or disinformation under the bill.

This bill has not been met without conflict and legal challenges to its constitutionality. Attorneys for Children's Health Defense and Physicians for Informed Consent have filed a lawsuit for declaratory and injunctive relief challenging AB 2098 on the basis that the law violates physicians' First Amendment rights by prohibiting them from sharing information with their patients if it is inconsistent with what the law refers to as "contemporary scientific consensus" and the "standard of care."

We will be monitoring these legal challenges and may provide an update in the near future.

1 *See* Assem. Bill 2098, 2021-2022 Reg. Sess. (Cal. 2022).
2 *Id.*
3 *Id.*
4 *See* Statement from the Office of the Governor, Sept. 30, 2022; https://www.gov.ca.gov/wp-content/uploads/2022/09/AB2098-signing-message.pdf?emrc=8a349e

Polsinelli Presents

Medical Staff Leaders and Their Legal Advisors: Managing Today's Challenges 2023 Medical Staff Conference

Part 1

Friday, February 3 | 12:00 PM - 1:30 PM

- Congress and the Executive Branch: Challenges in Making Public Policy
- 2022 HIPAA Review from a Former Regulator

Part 2

Friday, February 10 | 12:00 PM - 1:30 PM

- How to Meet NPDB Reporting Requirements During and When Settling a Peer Review Matter
- Physician Wellness and Professionalism: Prescribing Holistic and Effective Approaches

Part 3

Friday, February 24 | 12:00 PM - 1:30 PM

- Medical Staff Professional Development: Successfully Navigating AMCs
- Deconstructing Medical Staff Bylaws Amid Changing Medical Staff Structures

Part 4

Friday, March 3 | 12:00 PM - 1:30 PM

- The False Claims Act and the Medical Staff
- Criminal v. Negligence Acts in Medicine - Panel Discussion

Part 5

Friday, March 10 | 12:00 PM - 1:30 PM

In part 5 you will have the option to choose from two sessions

- Option 1: California
  - Summary Suspensions – Protecting Patients and Your Medical Staff
  - The Medical Staff's Role and Responsibilities Related to the New Allied Healthcare Practitioner Laws
  - Strategies for Managing the Disruptive Practitioner and the role of Progressive Discipline
- Option 2: Texas
  - When are Reports to the Texas Medical Board Appropriate?
  - Nurse Peer Review Under Texas Law
  - End of Life Issues

Polsinelli's Spotlight on Academic Medical Centers 2023 Webinar Series

Part 1

Tuesday, March 7 | 12:00 PM – 1:00 PM CT

- AMCs and Clinical Research: Addressing Research Misconduct Risk

Part 2

Tuesday, March 21 | 12:00 PM – 1:00 PM CT

- Structuring Relationships to Further Mission

Part 3

Tuesday, April 4 | 12:00 PM – 1:00 PM CT

- Hot Topics in Big Data

Part 4

Tuesday, April 18 | 12:00 PM – 1:00 PM CT

- The False Claims Act and the Medical Staff
- Criminal v. Negligence Acts in Medicine - Panel Discussion

Part 5

Tuesday, May 16 | 12:00 PM – 1:00 PM CDT

- The Journey to Health Care Equity: Looking Forward with AMCs

Join us for our upcoming educational series

- 2023 Medical Staff Virtual Conference | Register here
- Spotlight on AMCs Series | Register here

About Polsinelli's Medical Staff Practice

Polsinelli's Health Care attorneys guide hospitals and health systems through the medical staff governance process including credentialing, peer review, bylaws and medical staff and governing body relationships. From practitioner credentialing to hearings and appeals, and defense of litigation, our attorneys are versed in the intricacies involved in the life cycle of hospital-medical staff relationships.

Polsinelli has handled almost every type of matter involving medical staff and mid-level practitioners and has advised client on compliance with accreditation standards, hospital licensing laws, peer review laws, and federal laws governing the conduct of medical staff fair hearings. Specifically, we have extensive experience counseling hospitals on medical staff bylaws and related rules, regulations, policies and procedures, and codes of conduct. We have been active helping clients in implementing processes for effectively managing disruptive and inappropriate behaviors and in developing processes for empowering the well-being committee and managing impaired and aging providers.

Our team has experience advising through the credentialing process, advising peer review committees, representing medical executive committees in hearings and appeals, and interfacing with government entities. We also have defended hospitals and surgical centers in lawsuits filed by affected practitioners, during and after peer review.

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Polsinelli is very proud of the results we obtain for our clients, but you should know that past results do not guarantee future results; that every case is different and must be judged on its own merits; and that the choice of a lawyer is an important decision and should not be based solely upon advertisements.
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