Med-Staff Newsletter

QUARTERLY NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP

Flattening the Curve: Are Vaccination Mandates a Viable Strategy for Hospitals?

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Severe acute respiratory syndrome coronavirus 2 ("SARS-CoV-2") vaccines hold promise to control the pandemic and help restore normal social and economic life, even as variant threats loom. Since December 2020, the U.S. Food and Drug Administration ("FDA") has issued three emergency use authorizations ("EUA") for vaccines having demonstrated a high efficacy of preventing COVID-19 caused by SARS-CoV-2, with more vaccines in various stages of testing.[1] The Centers for Disease Control and Prevention ("CDC") claims there is a growing body of evidence suggesting fully vaccinated people are less likely to have symptomatic infection or transmit the virus to others.[2] However, as seen in new clusters of infection around the country, even highly effective vaccines cannot curb the pandemic without high population vaccine coverage and maintenance of other mitigation strategies. Amid the COVID-19 vaccine rollout, U.S. hospitals, health systems, and medical staffs are actively developing strategies and policies aimed at minimizing the spread of COVID-19 to protect their patients, visitors, employees, and staff. This issue is likely to become more prominent over time, especially if any of the EUA vaccines are fully approved by the FDA or the need to vaccinate a large share of the U.S. population becomes urgent in the face of threatening variants, even as some individuals continue to show reluctance to vaccination.

> *This article examines the nature of vaccination mandates in hospitals and the underlying legal issues surrounding this topic.*

[1] *FDA Takes Key Action in Fight Against COVID-19 By Issuing Emergency Use Authorization for First COVID-19 Vaccine*, U.S. FOOD AND DRUG ADMINISTRATION (Dec. 11, 2020), https://www.fda.gov/news-events/press-announcements/fda-takes-key-action-fight-against-covid-19-issuing-emergency-use-authorization-first-covid-19.

[2] *Science Brief: COVID-19 Vaccines and Vaccination*, CENTERS FOR DISEASE CONTROL AND PREVENTION (last updated May 27, 2021), https://www.cdc.gov/coronavirus/2019-ncov/science/science-briefs/fully-vaccinated-people.html.

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Legal Considerations for Vaccination Policies

History of Hospitals and Health Systems Routinely Requiring Vaccination of Medical Staff Members

The constitutionality of immunization requirements was first addressed by the Supreme Court of the United States in 1905. In 1902, a vaccination mandate was issued in certain locations in Massachusetts in response to a smallpox outbreak. In *Jacobson v. Massachusetts*, the state allowed cities to enforce mandatory, free vaccinations for adults if the municipality determined it was necessary for the public health or safety of the community; those who refused the vaccines were subject to a fine. The Court considered whether a state's broad authority to regulate individual rights to protect the general health, safety, morals, and welfare of society as a whole, extended to mandatory vaccinations. Ultimately, the Court held that mandatory vaccination is justified by the necessity to protect public health and welfare.[3]

The *Jacobson* decision led to the implementation of school entry requirements for immunization. School entry rules have shown tremendous success in reducing the incidence of vaccine-preventable diseases among children in the United States.[4] Courts have consistently upheld the constitutionality of immunization as an entry requirement.[5] The success of those school entry rules laid the groundwork for hospitals and health systems to establish influenza vaccine requirements for healthcare workers.

Public health officials frame the issue of vaccine mandates for health care professionals as one of patient safety. According to the American Journal of Preventative Medicine ("AJPM"), "the literature shows that outbreaks of influenza in healthcare facilities are a significant source of patient illness and death, and that vaccination of healthcare professionals can reduce patient death rates in these facilities by preventing transmission of influenza from healthcare workers to patients."[6] A number of professional societies, including the Advisory Committee on Immunization Practices ("ACIP"), recommends influenza vaccination for all healthcare professionals to reduce transmission to vulnerable patients.[7] As such, institutions have increasingly adopted influenza vaccination mandates, employing multiple disciplinary steps up to and including termination of unvaccinated health care workers without medical contraindications or religious objections.[8] However, healthcare professionals have had mixed responses to such mandates. According to the AJPM, "a substantial majority of healthcare professionals reported . . . that an influenza vaccine mandate was important for protecting patients (96.7%) and employees (96.4%), and 89.6% said that a mandate was an important professional ethical responsibility. Despite this, 72.0% thought an influenza vaccine mandate was coercive, and 17.7% thought it violated their contract."[9]

[3] *Jacobson v. Commonwealth of Massachusetts*, 197 U.S. 11, 25 S. Ct. 358, 49 L. Ed. 643 (1905).
[4] Megan C. Lindley, MPH, et al., *Assessing State Immunization Requirements for Healthcare Workers and Patients*, AMERICAN JOURNAL OF PREVENTIVE MEDICINE 32(6) (2007).
[5] *See Phillips v. City of New York*, 775 F.3d 538 (2d Cir. 2015) (Court found that New York's vaccination requirement for public school students does not violate the free exercise of religion); *Workman v. Mingo Cty. Bd. of Educ.*, 419 F. App'x 348 (4th Cir. 2011) (Court found that a parent did not have fundamental substantive due process rights to refuse to have her child immunized as required by West Virginia's vaccination requirements for public school students).
[6] *See* Megan C. Lindley, *supra* note 4 at 459.
[7] Lisa A. Grohskopf, MD, et al., *Prevention and Control of Seasonal Influenza with Vaccines: Recommendations of the Advisory Committee on Immunization Practices — United States, 2020–21 Influenza Season*, ADVISORY COMMITTEE ON IMMUNIZATION PRACTICES 69(8): 1-24 (Aug. 21, 2020).
[8] Marci Drees, MD, MS, et al., *Carrots and Sticks: Achieving High Healthcare Personnel Influenza Vaccination Rates without a Mandate*, INFECTION CONTROL & HOSPITAL EPIDEMIOLOGY 36(6): 717 (2015).
[9] Samantha I. Pitts, MD, MPH, et al., *A Systematic Review of Mandatory Influenza Vaccination in Healthcare Personnel*, AMERICAN JOURNAL OF PREVENTIVE MEDICINE 47(3): 337 (2014).

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Regardless of the mixed feelings among healthcare providers about influenza vaccination mandates, the efficacy of the influenza vaccine has resulted in a multitude of immunizations becoming common entry requirements for healthcare professionals to limit their risk of exposure to vaccine-preventable diseases. While those requirements vary among institutions, the CDC recommends that healthcare professionals stay-up-to date with the following vaccines: Hepatitis B, Influenza, MMR ("Measles, Mumps, and Rubella"), Varicella, and TDP ("Tetanus, Diphtheria, and Pertussis").[10] As with school entry requirements, legal challenges to immunization entry requirements for healthcare professionals have been unsuccessful.[11]

Federal Government's Power to Mandate Vaccinations

At present, the federal government's authority to institute a general vaccine mandate has not been tested in the courts. The Commerce Clause of the U.S. Constitution grants Congress the power to regulate commerce between states as well as with foreign countries.[12] Drawing on this authority, the Public Health Service Act ("PHSA") authorizes the U.S. Health and Human Services' Secretary—who, in turn, may delegate this authority to the CDC and FDA—to adopt quarantine and isolation measures to prevent the spread of communicable disease among states.[13] However, this authorization does not specifically mention federal vaccine mandates. In the absence of a federal mandate, employers must rely on guidance from a variety of federal and state organizations when considering their own vaccination policies. For example, California's Department of Fair Employment and Housing has taken the position that employers may require employees to receive an FDA-approved vaccination against COVID-19 so long as the employer does not discriminate or harass employees or job applicants on the basis of a protected class.[14]

Equal Employment Opportunity Commission Guidance

In December 2020, the Equal Employment Opportunity Commission ("EEOC"), in response to the EUAs granted by the FDA, published guidance outlining employer compliance mandates under the Americans with Disabilities Act ("ADA"), Title VII of the 1964 Civil Rights Act ("Title VII") and the Genetic Information Nondiscrimination Act ("GINA"). Overall, this guidance suggests employers may mandate COVID-19 vaccinations so long as their policies retain reasonable accommodations for those with medical conditions and sincerely held religious beliefs.

Occupational Safety and Health Administration Guidance

On May 21, 2021, the Occupational Safety and Health Administration ("OSHA") updated its guidance to clarify the recordability of adverse side effects suffered by employees due to a COVID-19 vaccination.[15] Per the new guidance, "OSHA does not want to give any suggestion of discouraging workers from receiving COVID-19 vaccination or to disincentivize employers' vaccination efforts.

[10] *Recommended Vaccines for Healthcare Workers*, CENTERS FOR DISEASE CONTORL AND PREVENTION (last reviewed May 2, 2016), https://www.cdc.gov/vaccines/adults/rec-vac/hcw.html.

[11] *Fallon v. Mercy Cath. Med. Ctr. of Se. Pennsylvania*, 877 F.3d 487, 490 (3d Cir. 2017); (A hospital employee brought action against a hospital following his termination for failure to comply with the hospital's vaccination policy, alleging religious discrimination under Title VII of the Civil Rights Act of 1964. The Court rejected the employee's beliefs supporting his refusal to receive flu vaccination were not protected religious beliefs under Title VII.); *Brown v. Children's Hosp. of Philadelphia*, 794 F. App'x 226, 227 (3d Cir. 2020) (to state a claim under Title VII of the Civil Rights Act of 1964, "it is not sufficient merely to hold a sincere opposition to vaccination; rather, the [hospital employee] must show that the opposition to vaccination is a religious belief. . .in assessing whether beliefs are religious, we consider whether they 'address fundamental and ultimate questions having to do with deep and imponderable matters,' are 'comprehensive in nature,' and are accompanied by 'certain formal and external signs.'" (quoting *Africa v. Pennsylvania*, 662 F.2d 1025, 1032 (3d Cir. 1981)).

[12] U.S. Const. art. I, § 8, cl. 3.

[13] Public Health Service Act, Pub. L. No. 104-321; Codified at 42 U.S.C. § 247d.

[14] *FAQ: DFEH Employment Information on COVID-19*, CA DEPARTMENT OF FAIR EMPLOYMENT AND HOUSING (Mar. 4, 2021), https://www.dfeh.ca.gov/wp-content/uploads/sites/32/2020/03/DFEH-Employment-Information-on-COVID-19-FAQ_ENG.pdf.

[15] *Protecting Workers: Guidance on Mitigating and Preventing the Spread of COVID-19 in the Workplace*, OCCUPATIONAL SAFETY AND HEALTH ADMINISTRATION (last updated Jun. 10, 2021) https://www.osha.gov/coronavirus/safework.

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As a result, OSHA will not enforce 29 CFR 1904's recording requirements to require any employers to record worker side effects from COVID-19 vaccination through May 2022."[16] This guidance is likely a welcome relief to employers considering mandatory vaccination policies because it ensures that employees' adverse reactions are not registered on a company's OSHA recordkeeping logs through May 2022. By avoiding those recordkeeping requirements with OSHA, a mandatory COVID-19 vaccination policy presents minimal risk of negatively affecting employers' insurance rates or, in some industries, their ability to bid for work.

State Action

A number of states have proposed bills that would prohibit employers from mandating COVID-19 vaccinations prior to full approval by the FDA. These states currently include: Alabama, Arizona, Connecticut, Illinois, Iowa, Kansas, Kentucky, Maryland, Minnesota, New York, Oklahoma, Pennsylvania, Rhode Island, South Carolina, South Dakota, Texas, and Washington.[17] At this time, none of these bills have been enacted as law. In contrast, New York has also introduced a bill that would require vaccination if the state fails to achieve herd immunity.[18] Texas recently passed SB 968, a bill which prohibits businesses from requiring customers to provide documentation of vaccination.[19] While no such bill has been passed for employees, customer vaccination prohibitions—commonly referred to as vaccine passport prohibitions—could be a precursor for employee vaccination prohibitions in these states. As such, these bills highlight the need for hospitals and health systems to carefully review state and local laws prior to enacting vaccination policies—including a vaccination mandate.

Do Physicians Have a Responsibility To Be Vaccinated?

Aside from hospitals mandating their employees be vaccinated, physicians may have an ethical responsibility to be vaccinated. According to the American Medical Association's ("AMA") Code of Ethics, physicians are ethically obligated to accept the COVID-19 vaccination. Per Opinion 8.7—Routine Universal Immunization of Physicians—when a safe effective vaccine is available, physicians have a responsibility to accept immunization in the interest of protecting their patients, their colleagues, and the community.[20] Additionally, Opinion 8.4—Ethical Use of Quarantine and Isolation—holds that vaccination is a part of a physician's overall responsibility in responding to public health crises.[21] This ethical responsibility is not absolute. The AMA's Council on Ethical and Judicial Affairs has adopted the position that a physician must determine how readily transmissible the disease is and weigh the risks to patients with whom the physician is in contact with relative to the risks of immunization to the physician.[22] The greater the risk to the patient, the stronger the ethical obligation for a physician to be immunized.

In addition to the AMA, a number of professional societies emphasize the importance of vaccination entry policies for healthcare professionals.[23]

Recent Actions by U.S. Hospitals and Health Systems

Houston Methodist Hospital ("Houston Methodist"), which comprises an academic medical center and six community hospitals in Texas, implemented a policy on March 31, 2021, requiring all 26,000 employees, including residents and fellows, to be vaccinated against COVID-19.[24] Houston Methodist allowed employees until June 7, 2021 to comply with this policy.[25] All non-compliant employees without an approved exception were subject to suspension and eventual termination.[26] On June 7, 2021, Houston Methodist suspended 178 workers

[16] *Id*.
[17] H.B. 214, Reg. Sess. (Al. 2021), S.B. 1648, 55th Leg., 1st Reg. Sess. (Az. 2021), H.B. 5402, Gen. Assemb., Jan. Sess. (Ct. 2021), H.B. 3682, 102nd Gen. Assemb., Reg. Sess. (Il. 2021), S.F. 193, 89th Gen. Assemb., 2021 Sess. (Ia. 2021), S.B. 213, 2021 Sess. (Ks. 2021), S.B. 98, Gen. Assemb., 2021 Reg. Sess. (Ky. 2021), H.B. 1171, 442nd Gen. Assemb. (Md. 2021), H.F. 2511, 92nd Leg. (Mn. 2021), S.B. 408, 55th Leg., 1st Sess. (NM. 2021), A.B. A04602, Reg. Sess. (NY. 2021), S.B. 765, 58th Leg., 1st Sess. (Ok. 2021), H.B. 262, Gen. Assemb., Reg. Sess. (Pa. 2021), H.B. 5989, Gen. Assemb., Jan. Sess. (RI 2021), H.B. 3511, Gen. Assemb., 124th Sess. (SC 2021), H.B. 1159, 96th Leg., Sess. 663 (SD 2021), H.B. 1687, 87th Leg., Reg. Sess. (Tx. 2021), H.B. 1305, 67th Leg., Reg. Sess. (Wa. 2021).
[18] A.B. A11179, Reg. Sess. (NY 2020).
[19] S.B. 968, 87th Leg., Reg. Sess. (Tx. 2021).
[20] *Routine Universal Immunization of Physicians*, AMERICAN MEDICAL ASSOCIATION (last visited Jul. 9, 2021) https://www.ama-assn.org/delivering-care/ethics/routine-universal-immunization-physicians.
[21] *Ethical Use of Quarantine & Isolation*, AMERICAN MEDICAL ASSOCIATION (last visited Jul. 9, 2021) https://www.ama-assn.org/delivering-care/ethics/ethical-use-quarantine-isolation.
[22] *Report: Amendment to Opinion 8.7, "Routine Universal Immunization of Physicians"*, AMERICAN MEDICAL ASSOCIATION, COUNCIL ON ETHICAL AND JUDICIAL AFFAIRS (Nov. 2, 2020) https://www.ama-assn.org/system/files/2020-12/nov2020-ceja-report-2.pdf.
[23] E.g., Infectious Disease Society of America, The Society for Healthcare Epidemiology of America, The Society for Post-Acute and Long-Term Care Medicine, The Association for Professionals in Infection Control and Epidemiology, and The Society of Infectious Diseases Pharmacists.
[24] *COVID-19 Vaccine Requirement FAQ*, HOUSTON METHODIST HOSPITAL (last visited Jul. 9, 2021) https://hrportal.ehr.com/LinkClick.aspx?fileticket=WYkUeEqq6Ck%3D&portalid=78.
[25] *Id*.
[26] *Mandatory COVID-19 Vaccine Procedure—Phased Implementation*, HOUSTON METHODIST HOSPITAL (last reviewed Apr. 15, 2021) https://hrportal.ehr.com/LinkClick.aspx?fileticket=WbwcMj8SRPg%3d&portalid=78.

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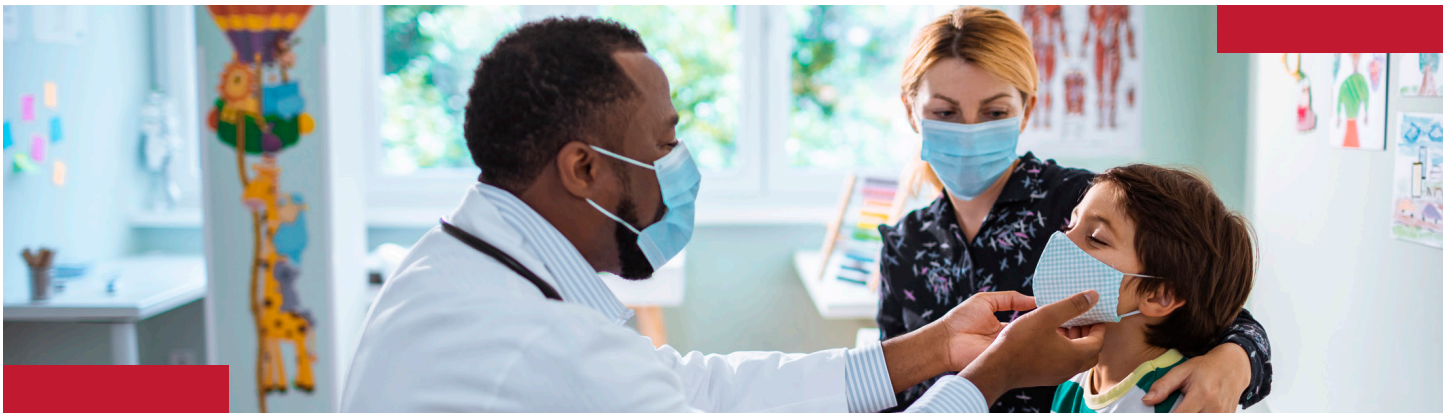

without pay for failing to meet the vaccination deadline.[27] Those employees had until June 21, 2021 to be vaccinated, or face being fired. Notably, the hospital granted exemptions or deferrals to this vaccine requirement for medical contraindications (including pregnancy) and sincerely held religious beliefs for nearly 600 employees.[28]

The policy was met with resistance. On May 28, 2021, 117 Houston Methodist employees filed a lawsuit against the hospital, requesting the court block the hospital from enforcing the policy. The lawsuit alleged the employees' refusal to comply would equate to wrongful termination under various public policy causes of action. Central to the lawsuit, the employees argued that the mandatory vaccination policy amounted to unlawful coercion (i.e., the threat of termination) for refusal to take what the employees referred to as an "experimental" vaccine.[29] In support of this argument, the employees cited to the emergency use status and lack of full approval by the FDA of the vaccines currently available.[30]

Mere weeks later, on June 12, 2021, a federal judge dismissed the lawsuit and concluded there was nothing illegal or against public policy about receiving the COVID-19 vaccine. While the court stressed that vaccine safety and efficacy were not considered in adjudicating this case, it also acknowledged that the employer's mandatory vaccination policy would, in its judgment, provide a safer work environment for employees and patients. Importantly, the court also emphasized that a private employer's mandatory vaccination policy does not amount to coercion: "[an employee] can freely choose to accept or refuse a COVID-19 vaccine; however if she refuses, she will simply need to work somewhere else."[31] The employees have appealed the court's ruling, which is pending, and The Associated Press has reported that 153 Houston Methodist workers have since resigned or been fired for failure to meet the vaccination deadline.[32]

While this case serves as an important bellwether, its application could be limited—particularly in other states that provide for more expansive public policy claims. The claim chiefly relied on by the Texas plaintiffs is extremely narrow in application and generally only applies in instances where an employee is terminated for the refusal to perform an illegal act that carries criminal penalties. In short, while the legal analysis could differ in other states, employers can now cite at least one legal opinion that has endorsed the use of mandatory vaccination policies.

A number of other hospitals and health systems including, but not limited to, SSM Health, New York-Presbyterian, RWJBarnabas Health, Johns Hopkins Medicine, The University of Maryland Medical System, University of Pennsylvania Health System, Henry Ford Health System and Indiana University Health, have joined Houston Methodist in announcing similar vaccination mandates for their employees. We anticipate this list will continue to grow in the coming months and expect additional legal challenges to those policies. These anticipated challenges will likely be state-specific and hinge on the worker laws that are applicable in each forum.

Recommendations

Vaccination policy in light of COVID-19 is a rapidly evolving topic in the United States. Any plans for medical staff workforce vaccination must be sensitive to those changes. Vaccination programs should be tapered to the specific needs of the hospital or health system's medical staff members, employees, patients, and operations. As such, it is unlikely that a single vaccination policy will be appropriate for all hospitals and health systems. Taken in combination with the complex interactions between federal and state law, hospitals and health systems should carefully consider any potential policies and programs mandating vaccination in consultation with counsel.

[27] Bill Chappell, *The Clock's Ticking for 178 Hospital Workers Suspended for Not Getting Vaccinated*, NPR (Jun. 10, 2021) https://www.npr.org/2021/06/10/1005117832/clock-is-ticking-in-vaccine-standoff-between-houston-hospital-and-178-employees.
[28] *Id.*
[29] *Jennifer Bridges, et al., v. The Methodist Hospital et al.*, 2021 WL 2221293, No. 4:21-cv-01774 (S.D. Tex. 2021).
[30] *Id.*
[31] *Id.*
[32] Jamie Stengle, *Houston Hospital Workers Fired, Resign Over COVID-19 Vaccine*, THE ASSOCIATED PRESS (Jun. 22, 2021) https://apnews.com/article/houston-coronavirus-pandemic-business-health-33e9f73c5bf1afbc7e5adb96b4715f8c.

The Broad Reach of Title IX and Academic Medical Centers: *Castro, et al. v. Yale University, et al.*

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A recent case brought by female physicians against Yale University highlights the difficulty of disentangling an academic medical center from a university when assessing the reach of Title IX of the Education Amendment Act of 1972.[1] Title IX prohibits sex-based discrimination in "any educational program or activity receiving Federal financial assistance." 20 U.S.C. § 1681(a). The District Court of Connecticut's conclusion that academic medical centers are subject to Title IX reflects a growing trend among courts and highlights the legal exposure of academically affiliated hospitals.

Female Physicians File Lawsuit Based on Sex Discrimination and Retaliation by Resident Supervisor

A group of female physicians ("Plaintiffs") brought an action against Yale University ("Yale"), Yale New Haven Hospital, Inc. ("the Hospital"), and the resident supervisor at the Hospital for sex discrimination and retaliation in violation of Title VII of the Civil Rights Act of 1964, 42 U.S.C. § 2000e, and Title IX.[2]

Plaintiffs—all female doctors in the Yale Department of Anesthesiology and involved with the residency program at the Hospital—alleged that their supervisor sexually harassed them by "making inappropriate and sexualized comments, forcibly touching and kissing them, and professionally punishing them for speaking out."[3] The offensive behavior was similar towards all of the women, and included, for example, the following: unwanted hugging, kissing, and touching; whispered sexual advances, particularly when alone with the women; and aggressive behavior and professional retaliation following rebuffed advances.[4] According to Plaintiffs, Yale and the Hospital "turned a blind eye" to the supervisor's actions and instead elevated him to the Vice Chair of Diversity, Equity, and Inclusion of the Department, despite repeated complaints about the supervisor's own behavior.[5]

Defendants moved to dismiss Plaintiffs' lawsuit on various grounds, including:

- Title IX does not apply to the Hospital, an entity "not principally engaged in the business of education";
- Title IX does not provide a private remedy based on sex;
- Plaintiffs did not establish that the Hospital had "actual notice of the alleged wrongdoing"; and
- Several of the women's relationships to an educational program or activity were "too attenuated to entitle them to Title IX coverage."[6]

Title IX Applies to Academic Medical Centers When Certain Factors Are Met

The court found that Plaintiffs adequately pled facts to demonstrate that the Hospital—a teaching hospital that receives federal funds for its residency program—is subject to the requirements of Title IX. In rejecting the Hospital's argument that academic medical centers are not postsecondary institutions, the court pointed to the "clear comment given by the Department of Education that 'Congress did not exempt academic medical centers that receive Federal financial assistance from Title IX'" and a "factual determination" is necessary to determine Title IX's applicability.[7]

To evaluate the educational nature of the Hospital's residency and fellowship programs, the court looked to a series of factors that federal appellate courts have used to determine the "educational nature" of a program or activity:

> *the structure of the program, including the involvement of instructors and inclusion of examinations or formal evaluations; whether tuition is required; the benefits conferred through the program, such as degrees, diplomas, or other certifications; the 'primary purpose' of the program; and whether regulators accrediting the institution 'hold it out as educational in nature.'*[8]

[1] Civil No. 3:20cv330 (JBA), 2021 WL 467026 (D. Conn. Feb. 9, 2021).
[2] Plaintiffs also pursued various state law claims, including sex discrimination and retaliation in violation of the Connecticut Fair Employment Practices Act, Conn. Gen. Stat. 46a-60, and tort claims of assault, battery, and invasion of privacy. *Id.* at *1.
[3] *Id.*
[4] *Id.* at *1–4.
[5] *Id.* at *1.
[6] *Id.* at *5.
[7] *Id.* at *6 (emphasis in original).
[8] *Id.* at *5.

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With these factors as a backdrop, the following allegations, among others, convinced the court to conclude that the Hospital is subject to Title IX:

- Yale and the Hospital have a "contractual arrangement formally integrating" the Hospital with Yale to share both staff and resources;
- Instructors at the Hospital are employed by both Yale and the Hospital;
- The Hospital receives federal funding because of its status as a "teaching hospital"; and
- The Hospital's website boasts that it is the "'primary teaching hospital of Yale School of Medicine,'" thereby affiliating itself with Yale and holding itself out to the public as an educational institution.[9]

Accordingly, Plaintiffs pled sufficient facts to survive the Hospital's motion to dismiss their Title IX claims.

Employees of Educational Institutions May Bring a Lawsuit for Sex-Based Discrimination Under Title IX, Even If They Also Seek Remedies Under Title VII

The court also addressed whether Title IX provides a private right of action for employment discrimination based on sex—an issue not yet tackled by the Second Circuit. In the absence of controlling precedent, the court approached its analysis grounded in the primary purpose of Title IX's private right of action: it is an "enforcement tool used to hold educational institutions accountable for their actions."[10] As such, the "educational nature of the employer, not the position of the litigant, determines its applicability."[11] The court ultimately construed Title IX "with the breadth intended by Congress," and held that "employees of educational programs may bring suit against their federally-funded employers for sex-based discrimination, including retaliation, even if they could also seek remedy by suit under Title VII."[12]

The potential overlap between Title IX and Title VII's private rights of action did not deter the court because "the enforcement mechanisms of each statute apply to different categories of employers and serve independent ends."[13] Specifically, Title VII provides a means for individual employees to challenge the discriminatory actions of their employers, while Title IX "encompasses both individual redress and systemwide compliance by recipients of federal funds."[14] The court therefore rejected Yale and the Hospital's argument that Title IX does not allow for a private right of action for employment discrimination based on sex.

Yale and the Hospital May Have Had "Actual Notice" of the Title IX Violations

Yale and the Hospital's attempts to escape liability by blaming the other for lack of notice of the Title IX violations fared no better. To succeed under a Title IX claim, a plaintiff must demonstrate, among other things, that "the educational program or activity was deliberately indifferent to the alleged discrimination."[15] The Hospital insisted that it did not have actual notice of the supervisor's abusive behavior because Plaintiffs either failed to make any complaints or only informed Yale staff and faculty members, rather than the Hospital staff.[16] Yale relied on the same arguments, alleging that Plaintiffs either failed to make a complaint or only complained to members of the Hospital staff.

Plaintiffs, on the other hand, alleged that they made complaints to individuals who were employed by both Yale and the Hospital and were persons of authority at both institutions.[17] In addition, the Hospital's employee handbook directed residents and fellows to file harassment complaints through Yale. Because "both institutions could be at fault," the court denied dismissal on these grounds.[18]

Attending Physicians May Pursue Title IX Claims

The court also rejected an argument by the Hospital that its relationship with three of the attending physician-plaintiffs was too attenuated to sustain claims against the Hospital under Title IX. As these Plaintiffs were employed by the Hospital and served as faculty members of Yale who participated in the residency program at the Hospital, the court could not "disentangle[]" their relationship with the Hospital from the Hospital's relationship with Yale.[19] Accordingly, the court denied the Hospital's motion to dismiss on this basis.

Takeaway

The relationship between a university and an academic medical center is complex and the line between the two institutions is not always clear. As courts increasingly find that Title IX applies to academic medical centers, universities and teaching hospitals alike should work to promote policies to properly handle discrimination and retaliation claims arising from residency and fellowship programs. Implementing a robust system for evaluating such claims on the front-end will help avoid litigation that would otherwise be difficult to successfully defend with a motion to dismiss in light of the factual determinations necessary to assess the connection between a university and an academic medical center.

[9] *Id.* at *7.
[10] *Id.* at *8.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*
[15] *Id.* at *10.
[16] *Id.*
[17] *Id.* at *11.
[18] *Id.*
[19] *Id.* at *13.

Different Committee, Different Scope: Delaware Court Holds Credentials Committee Documents May Be Subject to Discovery

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Deborah Palmer ("Plaintiff"), as the surviving spouse of Vance Palmer ("Mr. Palmer"), brought multiple claims against defendants Christiana Care Health Services, Inc. ("Hospital") and neurosurgeon Bikash Bose, M.D. ("Dr. Bose").[1] Plaintiff alleged Dr. Bose negligently performed an unnecessary surgery on Mr. Palmer's brain.[2] Mr. Palmer suffered a stroke during the surgery and passed away approximately one year later due to stroke complications.[3] Plaintiff also alleged that the Hospital was aware of Dr. Bose's reputation for performing negligent surgeries.[4] At the time of Mr. Palmer's surgery, Dr. Bose had been named in 31 medical malpractice lawsuits and the Hospital had been named as a co-defendant in 15 of the 31 lawsuits.[5] Plaintiff alleged that, despite the considerable number of malpractice lawsuits, the Hospital failed to take action to limit Dr. Bose's ability to practice at the Hospital.[6]

As part of the lawsuit, Plaintiff sought documents from the Hospital and Dr. Bose. Plaintiff specifically sought information about any Hospital peer review meetings held concerning Dr. Bose, including the meeting dates, creation of, membership of, and results of any such peer review meetings.[7] The Hospital did not produce documents in response to the Plaintiff's request and cited the protections of Delaware's peer review statute.[8]

After reviewing Delaware peer review precedent in a variety of contexts, the Delaware Superior Court held that the scope of peer review discovery depends on:

- The peer review committee being queried; and
- The claim upon which discovery is sought.[9] Here, the court differentiated between quality assurance committees and credentialing committees.[10]

The court stated quality assurance committee discussions represent the core of what a peer review privilege must protect.[11] For example, the court stated quality assurance committees discuss cases of morbidity, mortality, and other sentinel events.[12]

On the other hand, the court found that a credentialing committee's role is more akin to a personnel decision than examining what occurred during a surgery.[13] Therefore, the court determined that credentialing a practitioner is less likely to implicate the core values expressed in the peer review statute and was not subject to protection under the Delaware peer review statute.[14]

The court held that to the extent the Hospital conducted peer review of Mr. Palmer's surgery, such consideration was not subject to discovery because this review encompassed the essence of the peer review privilege.[15] However, to the extent Plaintiff sought information concerning the credentialing of Dr. Bose, the court allowed discovery to potentially support Plaintiff's arguments that the Hospital acted in bad faith when it continued to recredential Dr. Bose.[16] Ultimately, discovery concerning Dr. Bose's credentialing at the Hospital was allowed regarding:

- The dates and times of any Credentials Committee meetings where Dr. Bose's credentials were considered;
- Identification and production of any documents submitted to the Credentials Committee for consideration, provided the documents were not produced exclusively for use by the Credentials Committee; and
- Any documents produced by the Credentials Committee that were shared with a different person, group, or entity concerning Dr. Bose's credentialing at the Hospital.[17]

Takeaway

The Delaware Superior Court considered credentialing activities to be more akin to a personnel decision than a protected discussion of quality concerns. The court looked to the "core values" expressed in Delaware's peer review statute to determine what is, and what is not, protected by the peer review privilege. This case demonstrates that the scope of the peer review privilege is not purely defined by the Delaware peer review statute, but is also refined by case law.

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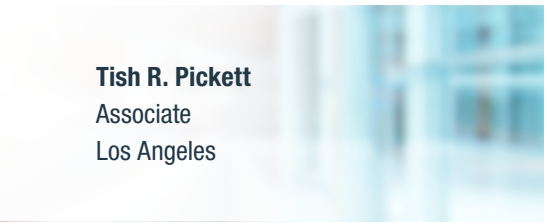
[1] *Palmer v. Christiana Care Health Servs., Inc., C.A.* No. N19C-01-294 CEB, 2021 WL 673462 *1 (Del. Super. Ct. Feb. 22, 2021).
[2] *Id.*
[3] *Id.*
[4] *Id.*
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id. See* 24 Del. C. § 1768.
[9] *Id.* at *5.
[10] *Id.* at *4.
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.* at *5.
[15] *Id.*
[16] *Id.*
[17] *Id.*

Prescription Practices Called into Question: Iowa Court Applies Four-Factor Test to Physician's Defamation Claim Based on Report to State Medical Board



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The Supreme Court of Iowa recently reversed the judgment of a district court and remanded the matter with instructions to enter summary judgment in favor of Hamilton County Public Hospital, operating as Van Diest Medical Center ("the Hospital"). The Supreme Court found that the Hospital's alleged defamatory statements to the Iowa Board of Medicine ("IBM") concerning Dr. Mark Andrew were nonactionable opinions—even though some of the Hospital's statements implied criminal conduct.

Investigation of Dr. Andrew's Prescription Practices

The Hospital hired Dr. Andrew, a general surgeon, in 2008 under an employment contract with three-year renewable terms.[1] In November 2016, a pharmacy contacted the Hospital and raised concerns about Dr. Andrew's Vicodin prescriptions for one of his patients, T.C.[2] Dr. Andrew treated T.C. over a four-year period. He performed surgery on T.C. in 2012, and eventually performed a second surgery on T.C. in 2016, after the patient rescheduled the second procedure multiple times.[3] Over the course of four years, Dr. Andrew prescribed nearly 12,000 Vicodin to T.C., who visited Dr. Andrew every two to four weeks for a total of 97 documented visits.[4] Despite T.C. having a separate primary care physician and receiving subsequent surgeries at other hospitals, Dr. Andrew continued to prescribe Vicodin to T.C. over the four-year period.[5]

The pharmacy was alarmed by the large quantities of opioids, the frequency of the refills prescribed to T.C., the dosage changes, T.C.'s switches between insurance payments and cash payments, the different residential addresses T.C. used on prescriptions, and T.C.'s use of several different pharmacies to fill the prescriptions.[6] In response to the pharmacy's concerns, the Hospital conducted its own investigation and discovered that other pharmacies had raised similar concerns.[7]

Hospital's Meeting With Dr. Andrew and His Subsequent Termination

On December 9, 2016, the Hospital's Chief Nursing Officer, Medical Director, and Dr. Scott Altman, an outside physician consultant hired to assist with personnel issues and the creation of a peer review process, all met with Dr. Andrew.[8] Dr. Andrew acknowledged T.C.'s conduct was concerning. Dr. Andrew further stated he recently discharged T.C. as a patient, although the Hospital records did not indicate T.C.'s discharge.[9] When asked whether, in hindsight, Dr. Andrew would have done things differently, Dr. Andrew admitted that he would have been more skeptical of T.C.'s questionable conduct and would likely have used a pain management plan.[10]

The Hospital terminated Dr. Andrew's employment for cause and without notice on December 15, 2016, based on its investigation into the care Dr. Andrew provided to T.C. and other patients.[11] Dr. Andrew did not undergo peer review because the Hospital exercised its administrative rights under the employment contract to immediately terminate the contract for cause.[12]

Dr. Andrew's Defamation Action

Soon after the Hospital terminated Dr. Andrew's employment, the outside physician consultant, Dr. Altman, filed a report with IBM.[13] The IBM report included a recitation of facts surrounding the Hospital's investigation of T.C.'s prescriptions, the accuracy of which Dr. Andrew did not dispute.[14] Dr. Altman's answers to some of the predefined questions formed the basis of Dr. Andrew's defamation claim against the Hospital.

[1] *Andrew v. Hamilton Cty. Pub. Hosp.*, No. 20-0023, 2021 WL 2273352, at *1 (Iowa June 4, 2021).
[2] *Id.*
[3] *Id.* at *1—2.
[4] *Id.* at 2.
[5] *Id.*
[6] *Id.*
[7] *Id.*
[8] *Id.*
[9] *Id.*
[10] *Id.*
[11] *Id.*
[12] *Id.*
[13] *Id.*
[14] *Id.*

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Question #1: "What would you like the [IBM] to do about your complaint?"

Dr. Altman's Response: "Volume of narcotic prescribing appears to be well beyond acceptable under any circumstances. It raises questions of marked naiveté, gross incompetence, and/or collusion with the patient for self-use, dealing, and/or distribution. Under any of those circumstances, should this physician's prescribing authority be reconsidered?"[15]

Question #2: "Could this be an impaired physician who needs intervention and help?"

Dr. Altman's Response: "[The second non-emergent surgery performed on T.C.] is generally not an endeavor to be taken without significant counsel and forethought. This case appears to vary significantly from the standard of care and raises questions of clinical competency. Is this a one-off or [does it] fit a pattern? His surgical competency should be reviewed. Should this physician's surgical privileges by limited by the State?"[16]

Question/Comment #3: "Other Potential Patients."

Dr. Altman's Response: "Is it possible for the [IBM] to query the Iowa (and potentially other State's) pain management plan by provider to see if this situation is a one-off or a pattern of narcotic overprescribing? If other potentially at risk patients are identified, the hospital would like to know so medical and pain management services can be provided to those patients."[17]

The second report, which was also the subject of Dr. Andrew's defamation claim, related to the Chief Nursing Officer's report to the National Practitioner Data Bank ("NPDB"). The Chief Nursing Officer believed the Hospital was required to report Dr. Andrew's for-cause employment termination.[18] The NPDB report only included a factual recitation of Dr. Andrew's treatment of T.C., the facts of which Dr. Andrew never disputed.[19] The court focused its analysis on the IBM report because the NPDB report included a recitation of undisputed facts. Defamation requires proving falsity, and Dr. Andrew did not identify any false statements in the NPDB report.

The Four-Factor Test Used to Determine Nonactionable Opinion vs. Actionable Defamation

The Hospital consistently maintained Dr. Altman's statements in the IBM report were his opinions, which were "absolutely protected under the First Amendment."[20] Since defamation lawsuits sit at the intersection of civil liability and First Amendment rights, the court started its analysis with this threshold question by applying a four-factor test.

Factors One and Two: The Precision and Specificity Factor and the "Easy to Verify" Factor

The first factor related to the precision and specificity of the alleged statements. The court had to determine if the defamatory statements had a precise core of meaning to which a consensus of understanding could exist, or in the alternative, whether the statements were indefinite and ambiguous.[21] The second factor related to the first by focusing on the degree to which the alleged defamatory statements were objectively capable of proof or disproof.[22] In other words, the court had to decide if the statements were precise and easy to verify.

Dr. Andrew objected to two portions of the IBM report. First, he objected to Dr. Altman's characterization of his prescription practices as excessive and his level of care as incompetent.[23] But during the district court proceedings, the court noted the presence of competing experts who testified on the issues of Dr. Andrew's excessiveness and whether he violated the standard of care.[24] Competing experts meant these issues were not easily verifiable, and as a result, the high court concluded that the statements were "more properly considered characterizations of specific facts, which themselves [were] not false."[25] Based on the first and second factors, the court indicated this portion of the report contained nonactionable opinions.[26]

Second, Dr. Andrew objected to a statement in the IBM report that suggested the amount of narcotics he prescribed gave rise to an inference of self-use, collusion, or drug dealing. The court recognized that the statement fell closer to an accusation of criminal conduct, which, if false, was considered defamatory *per se*.[27] Dr. Altman followed the suggestion of criminal conduct by questioning whether IBM should reconsider Dr. Andrew's prescribing authority.[28] The court gave the same scrutiny to the accusation of criminal conduct as it did to Dr. Altman's question. The court noted, "questions, like opinions, can be defamatory when they imply the existence

[15] *Id.* at 3.
[16] *Id.*
[17] *Id.*
[18] *Id.*
[19] *Id.*
[20] *Id.* at 4 (quoting *Kiesau v. Bantz*, 686 N.W.2d 164, 177 (Iowa 2004)).
[21] *Id.* at 7.
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.* at 7.
[26] *Id.*
[27] *Id.*
[28] *Id.*

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of defamatory facts."[29] Since the accusation and question were precise and easy to verify, the court signaled that the statements might be actionable defamation; however, the court cautioned that it still needed to consider the context of the statements, under the third and fourth factors, before ruling on this portion of the IBM report.[30]

Factors Three and Four: The Narrow Literary Factor and the Broadly Social Factor

The third factor focused on the narrow, literary context of Dr. Altman's statements because "the degree to which statements are laden with factual content or can be read to imply facts depends upon . . . the whole discussion."[31] In other words, the court had to consider each statement as part of the whole, including tone and use of cautionary language.[32] The fourth factor focused on the broader social context into which the statements fit.[33] When viewed in a broad social context, the court focused on the category of publication, style of writing, and the intended audience.[34]

Based on the narrow, literary context of Dr. Altman's IBM report, the court found that the statements were expressions of concern that might require further investigation.[35] Dr. Altman reported facts, which Dr. Andrew admitted were true, and then raised potential concerns using cautionary language that directly related to those facts.[36] The statements did not accuse Dr. Andrew of dealing drugs or engaging in malpractice; but read in context, the statements raised concerns that should be investigated further.[37] Therefore, the court concluded that the third factor indicated the IBM report contained nonactionable opinions.

Finally, the court turned to the last factor of the broader social context. Dr. Altman's IBM report raised concerns directly to Iowa's medical licensing board. Reports of this nature are confidential, mandatory in some cases, and broadly serve the purpose of notifying the medical licensing board that a physician may be placing the public at risk.[38] There is also a strong policy justification for recognizing the Hospital's concerns as non-defamatory opinion rather than actionable assertions of fact because the quality of health care is best promoted by favoring candor in the medical peer review process.[39] Dr. Andrew argued that the IBM report should have only recited the facts and not provided views of the concerns raised by those facts. The court disagreed. The court stated that Dr. Andrew's argument ignored the context in which the statements were made.[40] As a result, the fourth factor established that the IBM report contained nonactionable opinions.[41]

Based on the four-factor test, Dr. Andrew's defamation claim failed because the challenged portions of the reports were nonactionable opinions.

Takeaway

The statutory scheme in most states supports, and may require, candid disclosure of information to the state medical boards while reporting valid concerns about physicians. The reports should recite specific verifiable facts that support concerns, and couch the concerns in terms of opinions or requests for further investigation by the medical board. Above all, reports should be factual, accurate, and absent of conclusory accusations. When reports are thoughtful, specific, and ultimately aim at protecting the public and the medical profession, courts are likely to support the preclusion of defamation actions, as the Supreme Court of Iowa determined in this case.

[29] *Id.*
[30] *Id.*
[31] *Id.* (quoting *Yates v. Iowa W. Racing Ass'n*, 721 N.W. 2d 762, 770 (Iowa 2006)).
[32] *Id.*
[33] *Id.*
[34] *Id.*
[35] *Id.* at 8.
[36] *Id.*
[37] *Id.*
[38] *Id.*
[39] *Id.*
[40] *Id.*
[41] *Id.* at 9.

Preclusion Doctrines and Peer Review: Arizona Hospital Peer Review Process Given Same Preclusive Effect as Court Judgment

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You only get one bite at the apple. Lawyers use this expression to describe the legal concept that a cause of action may not be relitigated after it has already been judged on the merits. The twin components of this concept are known as issue preclusion—or collateral estoppel—and claim preclusion—or, in Latin, *res judicata*. Recently, a United States District Court decision in Arizona classified a hospital's peer review hearing process, affirmed upon appeal, as an adjudicatory proceeding under Arizona law, akin to an administrative decision. In doing so, the court determined that the hospital's peer review hearing process, especially when affirmed on statutory appeal, should be afforded the same preclusive effect as a court judgment.[1]

Hospital Revokes Doctor's Privileges and Terminates Physician Services Agreements

Doctor Seyed Mohsen Sharifi Takieh, M.D. ("Dr. Sharifi") is an interventional cardiologist. For 13 years, he was an active medical staff member of multiple Banner Health network hospitals ("Banner").[2] Dr. Sharifi's relationship with each hospital was governed by a Physician Services Agreement ("PSA"). In December 2018, following a 21-month investigation, Banner terminated Dr. Sharifi's medical staff membership and clinical privileges at the Banner hospitals, and terminated each PSA between Dr. Sharifi and Banner, allegedly based on patient care issues, alteration of medical records, and disruptive behavior.[3] In his lawsuit, Dr. Sharifi alleged that Banner's actions were actually racially motivated by his Iranian nationality and Arab descent, in violation of Section 1981 of the Civil Rights Act of 1866 42 U.S.C. § 1981 ("Section 1981").[4] In his complaint, Dr. Sharifi included documentation of multiple instances where witnesses reported observing conversations where Dr. Sharifi's competitors and Banner leadership discussed Dr. Sharifi using racist terms.[5]

During his time on Banner hospitals' medical staffs, Dr. Sharifi conflicted with Banner leadership on several occasions. In 2009, Dr. Sharifi raised concerns about what he believed to be the disproportionate number of his cases sent to peer review and his belief that the peer review referrals were racially motivated. In 2014, Dr. Sharifi testified against Banner in a wrongful death action. In 2015, Banner investigated staff complaints alleging sexual harassment by Dr. Sharifi. Dr. Sharifi maintained that Banner manufactured the complaints. In February 2017, Dr. Sharifi raised patient care concerns about the Chief Medical Officer ("CMO") at Banner Baywood Medical Center ("BBMC").[6]

In March 2017, one month after raising concerns about the CMO, the BBMC Medical Executive Committee ("MEC") initiated a peer review of three of Dr. Sharifi's cases. A cardiology committee delegated by the MEC conducted the peer review and found Dr Sharifi exhibited "reckless behavior" in two cases. Dr. Sharifi successfully appealed the cardiology committee's findings to the MEC and the findings were reversed. While his appeal was pending, the MEC referred 16 more of Dr. Sharifi's cases for external review. Based on the results of the external review, Dr. Sharifi was asked to agree to prospective approval and retroactive review of each case he performed at BBMC. He refused and the MEC imposed the requirements as a corrective action due to alleged concerns related to patient care and medical record documentation.

In November 2017, Dr. Sharifi requested a fair hearing challenging the MEC's corrective action. The hearing was eventually held in September 2018. While the results of the fair hearing are not clear from the facts of the case, in December 2018, Dr. Sharifi was notified in writing by BBMC's Chief Executive Officer that his PSAs had been unilaterally revoked and his clinical privileges had been terminated.

Dr. Sharifi Files Two Lawsuits

Dr. Sharifi initiated two lawsuits following the revocation of his PSAs and termination of his clinical privileges. First, Dr. Sharifi sought injunctive relief in Arizona State court to prevent Banner from implementing the MEC's corrective action. The state court held in favor of Banner, finding that Banner's alleged reasons for revoking Dr. Sharifi's PSAs were supported by substantial evidence, and the other procedural issues that Dr. Sharifi raised regarding the peer review hearing did not support injunctive relief.[7] Dr. Sharifi appealed the Arizona State court decision. The appeal of that case is still pending as the time of this writing.

Second, in December 2019, Dr. Sharifi initiated a lawsuit in Federal court alleging that the termination of his PSAs and

[1] *Sharifi Takieh v. Banner Health*, CV-19-05878-PHX-MTL, 2021 WL 268808, at *11 (D. Ariz. Jan. 27, 2021).
[2] *Id.* at 1.
[3] *Id.*
[4] *Id.*
[5] *Id.* at 2, 3, and 16.
[6] *Id.* at 2.
[7] *Takieh*, 2021 WL 268808 at 4.

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privileges at Banner was racially motivated, in violation of Section 1981. Section 1981 prohibits discrimination based on race when making or enforcing contracts, and creates a federal cause of action for employment discrimination on the basis of race.[8] The contractual relationship in this case are PSAs between Dr. Sharifi and Banner.[9] The court focused its Section 1981 analysis on the PSAs, and did not analyze the termination of Dr. Sharifi's privileges.

Banner moved to dismiss Dr. Sharifi's Section 1981 complaint. In evaluating whether Dr. Sharifi's Section 1981 complaint should be dismissed, the court also addressed several issues regarding whether a hospital's peer review activity precludes a physician from pursuing litigation in court to contest issues that were previously decided through the hospital's peer review process.

Court Reaffirms U.S. Supreme Court's But-For Standard of Causation for § 1981 Claims

Prior to 2020, the Ninth Circuit had held that in order to survive a motion to dismiss or summary judgment against a Section 1981 claim of racial discrimination, a plaintiff must only show that race was a "motivating factor" in the underlying action. However, in 2020, the U.S. Supreme Court established the more stringent "but-for" causation standard for sustaining a Section 1981 claim.[10]

Under the current law, in order to successfully allege a Section 1981 claim of racial discrimination Dr. Sharifi was required to plead and ultimately prove that "but for" intentional discrimination on account of race, he would not have suffered the loss of a legally protected right—here, the termination of the Banner PSAs. If there exists, or if Dr. Sharifi's complaint alleges, a non-discriminatory reason for Banner's actions, then Dr. Sharifi's Section 1981 claims cannot go forward.[11]

Here, the court determined that Dr. Sharifi's complaint alleged four non-discriminatory reasons for Banner's termination of the PSAs:

- Retaliation for Dr. Sharifi's 2014 testimony against Banner in a wrongful death case;
- Anti-competitive motivation on the part of several other physicians including the then-president of the medical staff and the head of Banner's Interventional Radiology Department;
- Retaliation for Dr. Sharifi reporting patient care concerns regarding the BBMC CMO; and
- Previously suing Banner's Senior Associate General Counsel and reporting her to her state bar association.

Moreover, while Dr. Sharifi could possibly amend his complaint to remove the non-discriminatory reasons, the court also determined that Dr. Sharifi's Section 1981 claim would not be able to proceed due to the preclusive effect of Banner's peer review process.

Hospital's Peer Review Process Eligible for Preclusive Effect

The court found that Banner's peer review activity should be afforded the same preclusive effect as a judgment of a court, and, under the doctrines of claim preclusion and issue preclusion, Dr. Sharifi is barred from contesting the results or process of Banner's peer review activity. As such, the results of Banner's peer review process provide another, separate race-neutral reason for terminating Dr. Sharifi PSAs and thereby prevent him from moving forward with his Section 1981 complaint.

In brief, the preclusion doctrines prevent a party from relitigating in a separate lawsuit a claim or issue that has already been decided on the merits in a previous proceeding between the parties.[12] Federal courts are required to give the decisions of state administrative agencies acting in a judicial capacity the same preclusive effect that the decision would be entitled to in the state's courts.[13] Further, if a judgment of an administrative agency entails the essential elements of adjudication, then a court must give that decision the same preclusive effect as a judgment of a court.[14] The essential elements of an adjudication include:

- Adequate notice to persons to be bound by the adjudication;
- The right to present evidence and legal argument, and a fair opportunity to rebut evidence and argument by opposing parties;
- Issues of law and fact are formulated similar to how they would be in a court, and decided according to procedures similar to those of a court;
- A rule of finality, specifying a point in the proceeding when a final decision will be rendered and by whom; and
- Such other procedural rights elements as necessary to ensure due process and conclusiveness of the proceeding.[15]

Under Arizona law, hospitals are required to establish a peer review committee to conduct non-judicial review of care provided at the hospital for the purpose of reducing

[8] 42 U.S.C. § 1981.
[9] *Takieh*, 2021 WL 268808 at 5.
[10] *Comcast Corp. v. Natl. Assn. of African Am.-Owned Media*, 140 S. Ct. 1009, 1014 (2020).
[11] *Astre v. McQuaid*, 804 Fed. Appx. 665, 667 (9th Cir. 2020).
[12] The doctrine of claim preclusion, also called *res judicata*, bars a party to a final judgment on the merits from relitigating a claim and all of the issues that would or could have been litigated in the original case as part of that claim, while issue preclusion, also called collateral estoppel, only bars a party to a judgment from relitigating those issues that were actually litigated. Any prior adjudication of an issue in another action that is determined to be sufficiently definite to be given conclusive effect should be considered to be a final judgment on the merits for the purposes of issue preclusion (see Restatement (Second) of Judgments § 13).
[13] *Univ. of Tenn. v. Elliott*, 478 U.S. 788, 796, 799 (1986).
[14] *A. Miner Contracting, Inc. v. Toho-Tolani County Imp. Dist.*, 311 P.3d 1062, 1068 (Ariz. App. 1st Div. 2013).
[15] Restatement (Second) of Judgments § 83(2) (1982).

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morbidity and mortality and improving patient care.[16] Additionally, a provider has the right under Arizona law to seek judicial review of a hospital peer review decision, along with injunctive relief to prevent the implementation of the peer review decision.[17] Here, the court found that the peer review process entailed the essential elements of an adjudication. Because Banner is required by statute to create a peer review process and Dr. Sharifi had a statutory right to seek judicial review of Banner's decision, the peer review process was akin to a state administrative agency acting in a quasi-judicial capacity, and was therefore eligible for preclusive effect on the basis of claim preclusion. Further, the court found that even if an Arizona court would not construe Banner's peer review decision as akin to an administrative agency acting in quasi-judicial capacity, the peer review process was sufficiently similar to a judicial proceeding to be eligible for the same preclusive effect as a judgment of a court on a basis of issue preclusion.

Because Dr. Sharifi was precluded from contesting the results of Banner's peer review activity, he could not contend in this case that but-for his race he would not have been subject to the peer review activity. Consequently, the results of Banner's peer review process provide a separate non-discriminatory basis for terminating his PSAs, which also led to the termination of his clinical privileges, and the court dismissed Dr. Sharifi's Section 1981 complaint with prejudice.[18] Dr. Sharifi has subsequently appealed the court's decision to the Ninth Circuit Court of Appeals. That appeal remains pending at the time of this writing.

Key Takeaways

The *Takieh* decision expands the preclusive effect afforded to a hospital's peer review and fair hearing process. Under the court's reasoning, if properly administered, a hospital's peer review and fair hearing process is the one bite at the apple. The hospital's peer review process is akin to a state administrative agency acting in a quasi-judicial capacity, and sufficiently similarly to a judicial proceeding so that the hospital's decision to revoke a physician's PSA and privileges after a fair hearing is entitled to the same claim preclusive effect as a court judgment.

If other courts apply the Arizona District Court's interpretation, the preclusive effect of peer review processes would naturally vary from state to state based on: (i) the preclusive effect afforded to the decision of an administrative agency in the state; (ii) the statutory requirement for hospitals to establish a peer review process; and (iii) the right of providers to seek judicial review of the hospital's peer review decision or other safeguards to ensure that physicians are provided adequate due process.

While the application of the court's reasoning in this case would vary from state to state, this case's holding establishes a precedent that could have a sizeable impact on the future interpretation and analysis of hospital peer review processes and their preclusive effect in subsequent litigation. Regardless of whether other courts apply the *Takieh* ruling, the court's decision should highlight for every hospital the value and importance of establishing and operating a peer review and hearing process that includes due process rights and incorporates the essential elements of adjudication. Taking such proactive steps may save a hospital time and money in relitigating peer review matters and allow the hospitals and their medical staffs to focus their efforts on improving quality care.

[16] A.R.S. § 36-445.
[17] A.R.S. § 36-445.02(B).
[18] *Takieh*, 2021 WL 268808 at 19.

The Limits of HCQIA Immunity: Disclosure of Information Outside of Professional Review Bodies and Falsity of Information

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The United States District Court for the Western District of Washington's decision interpreting the Health Care Quality Improvement Act, 42 U.S.C. § 11101, *et seq.*, ("HCQIA"), highlights specific requirements to be eligible for immunity from damages under HCQIA, specifically limiting dissemination of peer review information to professional review bodies and not promoting information that is false and known to be false.[1]

Hospital Removes Physician as Chair of Neurosurgery After Receipt of Numerous Complaints

Defendant, Dr. Charles Cobbs, originally sent a letter on November 4, 2016, to the Swedish Medical Center ("Hospital") Chief Executive Officer ("CEO") and two other Hospital administrators regarding Dr. Johnny Delashaw, Jr., a neurosurgeon and

[1] *Delashaw v. Seattle Times Co.*, No. C18-0537JLR, 2021 WL 63158, at *1 (W.D. Wash. Jan. 7, 2021).

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the Chair of Neurosurgery and Spine at the Swedish Neuroscience Institute ("SNI").[2] The November 2016 letter outlined several concerns allegedly raised by physicians, nurses, and staff about Dr. Delashaw that fell into the following categories:

- A pattern of intimidation, harassment, and retaliation;
- Discouraging the reporting of errors;
- Discouraging staff from asking questions;
- Contributing to the loss of experienced personnel;
- Jeopardizing patient safety with disruptive behavior; and
- Interfering with other physicians' referrals and practices.[3]

Over the next several weeks, Dr. Cobbs distributed the letter to several other individuals via email, including his fellow SNI surgeons, at least two other individuals who did not appear to work at the Hospital, the Hospital Medical Group's ("HMG") CEO, and another physician.[4] Additionally, Dr. Cobbs also emailed his November 4 letter to a group of individuals that he allegedly believed were part of the Hospital's Medical Executive Committee ("MEC").[5] In December 2016, the Hospital's CEO notified Dr. Delashaw that he would be removed from his role as Chair of Neurosurgery and would be moved to an administrative role as Chair Emeritus of Neurosurgery at SNI due to repeated and numerous complaints about his leadership.[6]

Dr. Delashaw Sues Dr. Cobbs Based on the Contents of His November 4, 2016 Letter

After learning of Dr. Cobbs' letter, Dr. Delashaw filed suit against Dr. Cobbs, and alleged that Dr. Cobbs' statements resulted in extreme reputational harm and loss of employment opportunities.[7] Dr. Delashaw also brought claims of civil conspiracy and tortious interference with a business expectancy against Dr. Cobbs.[8] The civil conspiracy claim was based on certain allegedly defamatory statements in Dr. Cobbs' letter, while the tortious interference claim alleged that Dr. Cobbs interfered with Dr. Delashaw's business relationship with the Hospital "through improper means, including defamation and Dr. Cobbs' violation of his obligations" to the Hospital.[9]

Immunity from Damages Under HCQIA Is Not Absolute

Dr. Cobbs filed a motion for summary judgment and argued that he was immune from damages for any defamatory statements made in his letter under HCQIA.[10] As a preliminary matter, the court found that the plain meaning of HCQIA demonstrated that Dr. Cobbs' assertion that HCQIA entitled him to summary judgment on all claims was overbroad; rather, the court concluded that HCQIA only provides immunity from liability for damages, and Dr. Delashaw sought both damages and equitable relief (i.e., Dr. Delashaw sought an order "enjoining Dr. Cobbs from making false statements about Dr. Delashaw").[11] Hence, before even determining whether Dr. Cobbs was immune from damages under HCQIA, the court reasoned that such an argument would not dispose of all of Dr. Delashaw's claims.[12]

Only Statements Made to Members of a Professional Review Body Are Entitled to Immunity Under HCQIA

The court then turned to the question of damages and found that Dr. Cobbs was not immune from liability for all potential damages. Instead, Dr. Cobb was entitled to immunity from damages only for claims tied to specific recipients of the letter who constituted members of a "professional review body" as defined in the HCQIA.[13] The court divided the recipients of the letter into two categories—corporate officers and possible MEC members. Regarding the former, the court found that Dr. Cobbs' communications to the Hospital's CEO and three other persons were protected because these individuals were corporate officers of the Hospital, and under HCQIA, such individuals constituted a professional review body.[14] Thus, the court concluded that Dr. Cobbs was providing information to a professional review body as defined by HCQIA when he sent the letter to these individuals.[15]

With respect to the email to the alleged MEC members, the court noted that Dr. Delashaw did not dispute that MEC members are members of a professional review body under HCQIA, but instead contended that Dr. Cobbs only established that one recipient of the email was actually a member of the MEC.[16] When examining the evidence—specifically, a text message exchange between Dr. Cobbs

[2] *Id.* at *1-2.
[3] *Id.* at *2.
[4] *Id.*
[5] *Id.*
[6] *Id.* at *1.
[7] *Id.* at *2.
[8] *Id.*
[9] *Id.*
[10] *Delashaw*, 2021 WL 63158, at *2.
[11] *Id.*
[12] *Id.*
[13] *Id.*; *see* 42 U.S.C. § 11151(11) (The term 'professional review body' means a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.).
[14] *Delashaw*, 2021 WL 63158, at *5.
[15] *Id.*
[16] *Id.*

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and another physician containing a list of names to whom Dr. Cobbs sent the email—the court found that the text messages clearly showed that Dr. Cobbs did not believe the list of names actually comprised MEC members, but instead considered them to be members of the Swedish Medical Group ("SMG") Executive Council.[17] The court further concluded that Dr. Cobbs made no arguments and submitted no evidence suggesting that the SMG Executive Council was a professional review body of the Hospital under HCQIA.[18] Although the court determined that two of the individuals from the email list were actual MEC members and were therefore members of a professional review body under HCQIA, the court held that Dr. Cobbs failed to demonstrate that HCQIA immunity applied to any other recipients of the November 4, 2016 letter apart from the Hospital's CEO, three other corporate officers, and two members of the MEC.[19]

Applying the Falsity Exception Under HCQIA

The court also addressed whether HCQIA's falsity exception applied to Dr. Cobbs' statements. Specifically, HCQIA does not provide immunity in instances where information is provided to members of a professional review body if the information is false and the provider knew it was false.[20] In such instances, there is no HCQIA immunity, even if the recipient of the false information is a member of a professional review body.[21]

In analyzing the issue of falsity, the court noted that it previously determined that all but two of the categories of Dr. Cobbs' allegedly defamatory statements in the letter were not made with a reckless disregard for truth.[22] The court explained that knowledge of falsity is a higher standard than reckless disregard for truth, and therefore found that Dr. Cobbs was immune from any damages stemming from those categories of statements made to the professional review body members.[23] As to the remaining two categories of statements (i.e., Dr. Cobbs' statements regarding (1) SNI surgeons' unanimous opposition to Dr. Delashaw, and (2) Dr. Delashaw causing mass personnel departures), the court determined there was a genuine dispute of material fact as to the falsity of these categories of statements and Dr. Cobbs' knowledge of their falsity.[24] Thus, the court held that Dr. Cobbs would not enjoy HCQIA immunity from damages relating to these two categories of statements if Dr. Delashaw could demonstrate that they are false and that Dr. Cobbs knew the statements were false when Dr. Cobbs made them.[25]

As noted, the court concluded that six of the November 2016 letter's recipients constituted members of a professional review body under HCQIA—four corporate officers of the Hospital and two MEC members.[26] As such, the court held that Dr. Cobbs could only be found liable for damages resulting from the publication of the letter to these individuals if the statements he made to them were false and Dr. Cobbs knew they were false at the time of publication.[27]

Takeaway

HCQIA can and has proven to be a valuable tool for physicians, nurses, and other healthcare providers to relay vital information to a hospital or other health care entity's peer review bodies in a manner that promotes immunity from damages for defamation and other torts. However, the immunity from damages available under HCQIA is not absolute. Immunity ultimately depends upon whether an informant, as well as the members of a professional review body, understand and comply with HCQIA's requirements. The informant must limit the dissemination of information to professional review bodies as defined by HCQIA and the informant must protect against dissemination of information that is false or known to be false. It is essential that a hospital's professional review body members and other health care providers are aware of these requirements to promote the availability of immunity from damages under HCQIA.

[17] *Id.*
[18] Id.
[19] Id.
[20] *Id.* at *6.
[21] *Id.*
[22] *Id.*
[23] *Id.*
[24] *Id.*
[25] *Id.*
[26] *Id.*
[27] *Id.*

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Oklahoma Hospital Association Annual Convention/Oklahoma Association of Medical Staff Services
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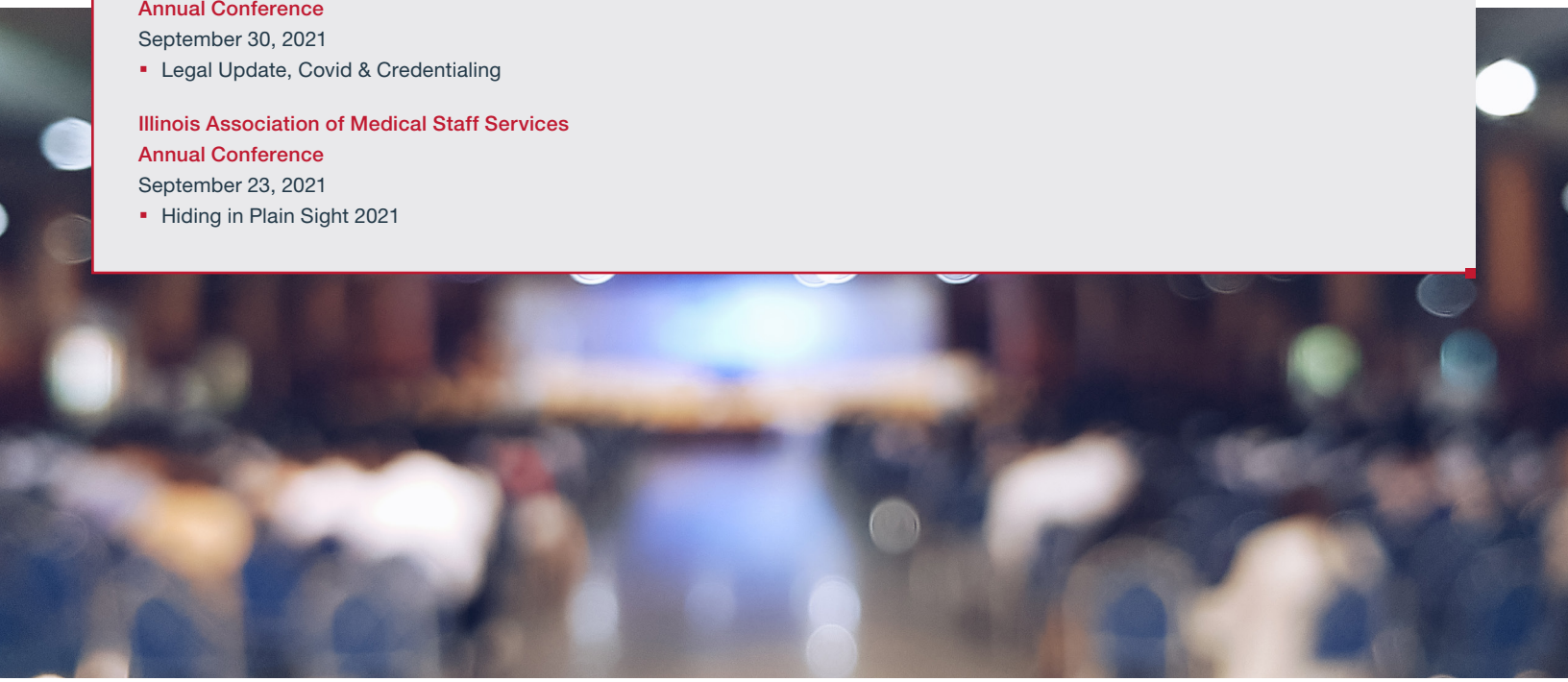
- Mock Fair Hearing
- NPDB Reporting—What is Reportable?
- Credentialing and Sharing Peer Review Information While Maintaining Privilege



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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