



Med-Staff Newsletter

QUARTERLY NEWSLETTER FROM THE MEDICAL STAFF PRACTICE GROUP



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Principal

January Brings a New Set of Medical Staff Leaders: Now What?

With the New Year comes new medical staff leaders and a new set of growing pains. Contrary to what many of us believe, some simple steps can lessen the pain.

Education is first and foremost, but what that education covers is organization-specific and will vary based on your organization's medical staff governance structure. Even if you send your medical staff leaders to external education programs, consider developing and implementing an internal orientation program specific to your organization. An internal leadership orientation program is beneficial

in preparing leaders to know your organization. A full day retreat with administration and governing board representatives has the collateral benefit of team building. An internal medical staff leadership orientation program may include the following:

- The roles and responsibilities of the organized medical staff, including the legal role of responsibility to the governing board for the quality of medical care provided to patients of the hospital as required by the Medicare Conditions of Participation 42 CFR 482.22, The Joint Commission MS.03.01.01, and other legal and regulatory agencies;
- The authority to take action when warranted as set forth in the hospital's or organization's governance documents (e.g., bylaws, rules, regulations, policies, procedures);
- The medical staff's governance structure (e.g., departments, committees, reporting processes);
- The roles and responsibilities of key players (e.g., Medical Staff Office, Administration, Governing Board, Quality Department, Risk Management, Chief Medical Officer, etc.);

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Events

- **POLSINELLI PRESENTS:**
The Organized Medical Staff for Leaders: What you Need to Know about Self-Governance and the Issues You Face
Ventura Beach Marriott
Friday, January 20 2020
8:00am – 4:00pm
Email Sinead McGuire for more information smcguire@polsinelli.com
- **#MeToo and Medical Staffs: Handling Allegations of Physician Sexual Misconduct**
Strafford Webinars
Tuesday, January 28, 2020
1:00pm -2:30pm EST
Speaking: Sherri Alexander and Alexis Angell
- **POLSINELLI PRESENTS:**
Emerging Trends Impacting Health Care Providers Conference
Stoneleigh Hotel
Thursday, February 20, 2020
8:30am -2:30pm
Email Sinead McGuire for more information smcguire@polsinelli.com
- **MD-Staff User Conference**
Thursday, Feb 27 and 28th 2020
Las Vegas, NV
MGM Grand
Speaking: Erin Muellenberg on “Hiding in Plain Sight: Credentialing Lessons” 2020. Marriott Ventura, Ventura, California

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- Chain of command and relevant individual contact information;
- Credentialing and privileging: what to look for and when to ask for more information (Conditions of Participation 42 CFR 482.12);
- Well-being, aging, disruptive behavior, code of conduct, provider health and welfare issues, burn-out of providers and leaders (The Joint Commission);
- Interventions, disciplinary actions, reporting (State and National Practitioner Data Bank requirements);
- Indemnity and peer review protections (Health Care Quality Improvement Act);
- Payment and time sheets; and
- Anything else important to your organization.

A leader’s ability to know where to obtain information is key to effective leadership and decisive response. Provide digital or other access to all governance documents, contact information for key individuals, and other relevant information. Your orientation program can be especially effective when past leaders are present and willing to impart their knowledge. If you have an in-person orientation, consider posing hypothetical interactive case studies as an opportunity to test skills, generate discussion, and emphasize lessons.

Leadership program sustainability is vital and dependent on the integrity of the processes in place. For the future, consider a Leadership Development Committee whose purpose is to identify and grow medical staff leaders. Also, consider establishing an annual or biannual leadership retreat with administration and representatives of the governing board. By fostering open communication and discussion between the intertwined bodies, the organization can progress forward and avoid unnecessary distractions caused by ineffective or inaccurate communication.

While it will cost some time and require effort to develop an internal orientation program, the return on investment is significant and will directly benefit the organization.



A Balancing Act: As Physicians Age, Hospitals and Health Care Providers Work to Promote Patient Safety and Career Longevity for Senior Physicians¹

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The physician population in the United States is aging each year. Efforts by hospitals to ensure patient safety by evaluating competence of late-career or senior physicians have created controversy. Ultimately, promoting competence of senior physicians and patient safety is a shared responsibility and must be resolved with input and consideration from all stakeholders. This article examines the significance of the issue, approaches considered by health care providers and entities, and legal considerations for age-based screening policies.

United States Physicians Are Aging

Promoting competence of senior physicians is increasingly important as United States physicians advance in age. According to the American Medical Association's ("AMA") Physician Master File, "42% of practicing physicians in the United States are 55 years old or older. This includes approximately 336,000 of some 800,000 physicians who currently are in active patient care."¹ One in four physicians in the United States is over age 65, and the number of physicians in this age group quadrupled between 1975 and 2013.² The issue for health care providers and entities is how to discern whether a senior physician is competent to continue practicing.

Health Care Providers and Entities Must Assess Competence of Senior Physicians

Health care entities should evaluate their specific culture and in cooperation with the medical staff, determine how best to address concerns relating to competence and safety of senior physicians. Three primary approaches have been proposed: (1) case-by-case assessment of senior physician competence; (2) age-based mandatory retirement policies;

and (3) age-based screening policies. Each approach is discussed below.

Case-by-Case Assessment of Senior Physician Competence

Hospitals and physicians have long been required to assess the ability of each physician to provide quality health care to patients. Hospitals require verification of all physicians' health status at appointment and reappointment and rely upon existing credentialing, peer review, and physician wellness policies to address reported concerns regarding potential impairment, including age-related impairment. Health care entities that employ or privilege physicians have an obligation to assess physicians' health in the hiring and privileging process.³ In addition, physicians must maintain their health and wellness, and if a health issue arises, they must seek appropriate help and honestly assess their ability to continue practicing safely.⁴ In addition, physicians are ethically obligated to report impaired colleagues when they believe a possible impairment interferes with the colleague's ability to practice safely.⁵ Often, a hospital will establish a health and wellness committee, comprised of physician peers, to confidentially review concerns regarding a practitioner's health. If a health concern is raised

¹ AMN HEALTHCARE, 2016 SURVEY OF PHYSICIANS 55 AND OLDER 2 (2016), https://www.amnhealthcare.com/uploadedFiles/MainSite/Content/Healthcare_Industry_Insights/Industry_Research/2016%20Survey%20of%20Physicians%2055%20and%20older.pdf.

² Staff Writer, Competency and Retirement: Evaluating the Senior Physician, AM. MED. ASS'N., June 23, 2015, <https://wire.ama-assn.org/ama-news/competency-and-retirement-evaluating-senior-physician>.

³ See THE JOINT COMMISSION, COMPREHENSIVE ACCREDITATION MANUAL FOR HOSPITALS, MS.06.01.05(6) (2018).

⁴ AMA Council on Ethical and Judicial Affairs, American Medical Association Code of Medical Ethics' Opinions on Physicians' Health and Conduct, Opinion 9.0305 – Physician Health and Wellness, 13 AM. MED. ASS'N. J. ETHICS 700, 700 (2011), <https://journalofethics.ama-assn.org/sites/journalofethics.ama-assn.org/files/2018-05/coet1-1110.pdf>.

⁵ Physician Responsibilities to Impaired Colleagues, AM. MED. ASS'N., <https://www.ama-assn.org/delivering-care/physician-responsibilities-impaired-colleagues> (last visited Sept. 19, 2018).

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regarding a practitioner, the role of the health and wellness committee is typically to encourage the practitioner to participate in an assessment of his or her competence to practice. If the practitioner refuses to submit to a health screening, the issue is often referred to the hospital's medical executive committee for review. If the medical executive committee or the Hospital's governing board takes an action that adversely affects a practitioner's ability to exercise his or her privileges for more than 30 days based on the physician's competence or conduct, the hospital must report such action to the National Practitioner Data Bank.⁶

While identifying potential impairments prior to an adverse event occurring is ideal, it is more often the case that reports regarding competence concerns result from an adverse event. Physicians who suffer from age-related cognitive or neurological conditions may not self-report because they may not perceive the decline in their health or the potential impact on patient care.⁷ In addition, physicians are hesitant to report colleagues who may suffer from age-related impairment due to empathy and respect for their colleagues' years of practice.⁸ Unfortunately, failing to report could subject patients to potentially dangerous consequences including injury and death, and expose the physician to consequences such

as medical negligence lawsuits or discipline of his or her medical license.⁹ As such, reliance on self and third-party reporting is fallible, particularly as it relates to senior physicians.

Mandatory Retirement Age

Implementing a mandatory retirement age is an across-the-board solution, that may unnecessarily restrict certain physicians, but it is the most protective of patient safety, which is why it is an option proposed by patient safety advocates. Physicians are generally opposed to mandatory retirement, arguing it does not account for the value of years of clinical experience in guiding medical decision making and patient care, the wide variability in physician practices, and the varying effects of aging on each individual physician.¹⁰ The AMA Council on Medical Education has issued its opinion that physicians should be allowed to remain in practice if patient safety is not endangered and that, if needed, remediation should be a supportive, ongoing, and proactive process.¹¹ In addition, mandatory retirement age for physicians is unrealistic given the current shortage of physicians in the United States. It is estimated that "80% of physicians are overextended or are at capacity," which creates the need for hospitals to retain physicians while simultaneously promoting patient safety.¹² According to the

Association of American Medical Colleges, "the United States will face a shortage of between 42,600 and 121,300 physicians by 2030."¹³ And, at the same time, "the number of Americans over the age of 65 will grow by 55 percent."¹⁴ As such, imposition of a mandatory retirement age would exacerbate physician shortages.

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Age Based Screening Policies

Some hospitals have instituted age-based screening requirements for physicians over a certain age, and there is growing interest in such policies.¹⁵ Age-based policies require physicians over a certain age to undergo periodic physical and cognitive exams as a condition of renewing clinical privileges.¹⁶ While there are many approaches to age-based screening, these four elements are often included in screening policies: (1) a physical examination; (2) peer assessment; (3) other co-worker's assessment; and (4) a cognitive assessment.¹⁷

⁶ 43. U.S.C. Sec. 11133

⁷ Sandra G. Boodman, Aging Doctors Face Greater Scrutiny, KAISER HEALTH NEWS, Dec. 10, 2012, <https://khn.org/news/aging-doctors-face-greater-scrutiny>

⁸ *Id.*

⁹ *Id.*

¹⁰ See Thomas Walsh, Doctors are Getting Older – Should Policies Evolve to Require Mandatory Evaluations at a Certain Age?, MedPage Today, July 21, 2017, <https://www.medpagetoday.com/publichealthpolicy/generalprofessionalissues/66801>

¹¹ See AMERICAN, *supra* note 2 at 10.

¹² See Merritt Hawkins Team, Survey of America's Physicians: Practice Patterns and Perspectives, MERRITT HAWKINS, Sept. 22, 2017, <https://www.merrithawkins.com/news-and-insights/thought-leadership/survey/survey-of-americas-physicians-practice-patterns-and-perspectives/>

¹³ AAMC News, GME Funding and its Role in Addressing the Physician Shortage, ASS'N AM. MED. COLLEGES, May 29, 2018, <https://news.aamc.org/for-the-media/article/gme-funding-doctor-shortage>

¹⁴ Mary Brophy Marcus, New Report Predicts "Troubling" Shortage of Doctors in the U.S., CBS NEWS, Mar. 20, 2017, <https://www.cbsnews.com/news/doctor-shortage-us-impact-on-health>

¹⁵ *Id.*

¹⁶ *Id.*

¹⁷ See CALIFORNIA, *supra* note 15 at 8-9.

Before engaging in age-based screening, health care entities must establish a clear policy governing assessment and credentialing of senior physicians. As with any policy, a health care organization should consult with its legal counsel to assess the policy and ensure compliance with current local and federal laws and regulations pertaining to the issue. California Public Protection & Physician Health, Inc. (“CPPPH”) guidelines for drafting such policies suggest that the policy should state clearly that it applies equally to all practitioners over a certain age, is based solely on age, regardless of performance, and that the policy is based on current literature on the subject.¹⁸ It should also specify, among other things: (1) the frequency of assessment; (2) who bears the cost; (3) that the physician must sign a release allowing evaluators’ reports to be shared with the medical staff; (4) that a committee will review the information and may recommend further evaluation; and (5) that information will remain confidential.¹⁹ The policy must explain clearly the rationale, how the age-

based screening will work, and how it could impact clinical privileges.²⁰

Recognizing the significance of this issue, the AMA²¹ and the American College of Surgeons (“ACS”)²² support age-based screenings to evaluate physicians’ mental health and review of their treatment of patients. The AMA Council on Medical Education report states “formal guidelines on the timing and content of testing of competence may be appropriate and may head off a call for mandatory retirement ages or imposition of guidelines by others.”²³ ACS has recommended surgeons undergo voluntary and confidential baseline physical examination and visual testing by their personal physician for overall health assessment starting at age 65 to 70.²⁴ The ACS also recommends that surgeons voluntarily assess their neurocognitive functions using confidential online tools and reminds physicians of their professional obligation to self-disclose voluntarily any concerning and validated findings.²⁵ It would appear a consensus is growing amongst hospitals and organizations representing physicians that some

age-based screening is necessary in the interest of patient safety.

Legal Considerations for Age-Based Policies

Although it is increasingly important for hospitals and medical staffs to address senior physician competency, it is estimated that “only 5 to 10 percent of U.S. hospitals mandate screening of late career physicians.”²⁶ Some hospitals cite concerns of litigation risk. The federal government and the majority of states have “enacted some form of prohibition against age discrimination in employment.”²⁷ Senior physicians negatively impacted by age-based policies could sue employers based on employment claims including Title VII, the federal Age Discrimination in Employment Act (the “ADEA”), and the Americans with Disabilities Act of 1990 (“ADA”). Understanding there are numerous exceptions to federal and state anti-discrimination laws, and that the facts of each case are unique, there is still appreciable risk to health care entities that impose mandatory retirement or age-based screening policies.



¹⁸ *Id.* at 6.

¹⁹ *Id.*

²⁰ *Id.*

²¹ See Staff Writer, *supra* note 4.

²² American College of Surgeons, Statement on the Aging Surgeon (January 1, 2016), available at <https://www.facs.org/about-ac/s/statements/80-aging-surgeon> (last accessed on September 10, 2018)

²³ *Id.*

²⁴ American College of Surgeons Board of Governors Physician Competency and Health Workgroup, Statement on the Aging Surgeon, AM. C. OF SURGEONS, Jan. 1, 2016, <https://www.facs.org/about-ac/s/statements/80-aging-surgeon>

²⁵ *Id.*

²⁶ Weinacker, *supra* note 25.

²⁷ 4 EMPLOYMENT DISCRIMINATION COORDINATOR ANALYSIS OF STATE LAW § 1:14 (Sept. ed. 2018).

While courts have held hospitals liable under Title VII,²⁸ the ADEA²⁹ and the ADA,³⁰ many hospitals have successfully defended ADEA claims by demonstrating that an age-based testing program is reasonably necessary for public safety. The United States Supreme Court explained: “The ADEA is not an unqualified prohibition on the use of age in employment decisions, but affords the employer a ‘bona fide occupational qualification’ defense.”³¹ Specifically, the ADEA provides that it is not a violation of the Act to take an action based on age when “age is a bona fide occupational qualification reasonably necessary to the normal operation of the particular business, or where the differentiation is based on reasonable factors other than age.”³² But this defense “has only limited scope and application” and “must be construed narrowly.”³³

In the context of age-related disability of physicians, a hospital can, under the law, consider a disability in determining whether an individual can safely perform job duties. In defending an age-based assessment policy, a health care entity must demonstrate that the policy is job related, based upon business necessity, and that screening is for employees in positions affecting public safety.³⁴ Courts have held that physicians and other providers may not seek protection of disability discrimination laws where the provider poses a direct threat to the health and safety of others that cannot be eliminated by reasonable accommodation.³⁵ Under the ADA, an age-based policy for assessing competence of senior physicians should describe the process for identifying a potential impairment and, if confirmed, a process for engaging with the physician to determine whether a reasonable accommodation can be made to enable the physician to continue to practice safely.

Conclusion

Age-based assessment of physician competence has long been controversial. Discussion largely centers on mandatory retirement age, compulsory assessment of senior physicians, and reliance on existing policies for self and third-party reporting of potential impairment. Absent guidelines or standards from professional or accrediting organizations, each entity must evaluate its specific culture and in cooperation with the medical staff, determine how to promote patient safety and competence of senior physicians. Health care entities should carefully consider, draft, and implement policies that will enable physicians to continue to practice for as long as they can do so safely.



²⁸ Michael R. Lowe, *Stirring Muddled Waters: Are Physicians with Hospital Medical Staff Privileges Considered Employees under Title VII or the ADA Act When Alleging an Employment Discrimination Claim?*, 1 DEPAUL J. HEALTH CARE L. 119, 121 (1996), <https://via.library.depaul.edu/cgi/viewcontent.cgi?article=1295&context=jhcl>

²⁹ See CALIFORNIA, *supra* note 15 at 14.

³⁰ *Id.*

³¹ *Hazen Paper Co. v. Biggins*, 507 U.S. 604, 616 (1993) (citing 29 U.S.C. § 623(f)(1) (2012)).

³² 29 U.S.C. § 623(f)(1) (2012).

³³ *E.E.O.C. v. Exxon Mobil Corp.*, 560 F. App'x 282, 284 (5th Cir. 2014) (quoting *W. Air Lines, Inc. v. Criswell*, 472 U.S. 400, 412 (1985)).

³⁴ See CALIFORNIA, *supra* note 15 at 15.

³⁵ *Id.*

“A Quiet Corner of the Room, Not a Private Island”

A DISCUSSION OF THE PATIENT SAFETY WORK PRODUCT PRIVILEGE

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Iliana Peters
Shareholder



Richard Rumsey underwent an elective hospital procedure at Robert Packer Hospital (“Hospital”).¹ After he developed an infection, Mr. Rumsey sued the Hospital for medical malpractice and sought information related to the Hospital’s infection prevention guidelines.² A Pennsylvania federal court determined Mr. Rumsey could not access most of the requested documents because such documents fell within the federal Patient Safety and Quality Improvement Act (“PSQIA”) Patient Safety Work Product privilege.³

Patient Safety Work Product Privilege Under Federal Law

The Patient Safety Work Product Privilege is derived from PSQIA and its implementing Patient Safety Rule.⁴ The court described the Patient Safety Work Product Privilege as “intended to promote candor in patient safety evaluations from clinicians who may otherwise mince their words out of fear of malpractice litigation.”⁵ PSQIA’s intention is to provide for frank discussion of patient safety activities without fear that such discussion will later be used against the health care entity in litigation.⁶ Pennsylvania’s state law, the Medical Care Availability and Reduction of Error Act (“MCARE”), provides similar protections.

The privilege applies to Patient Safety Work Product (“PSWP”) as defined under PSQIA. Arguably, the privilege applies to PSWP as defined under the Patient Safety Rule as follows:

any data, reports, records, memoranda, analyses (such as root cause analyses), or written or oral statements (or copies of any of this material)

(i) [w]hich could improve patient safety, health care quality, or health care outcomes; and

(A) [w]hich are assembled or developed by a provider for reporting to a [patient safety organization or] PSO and are reported to a PSO, which includes information that is documented as within a patient safety evaluation system for reporting to a PSO, and such documentation includes the date the information entered the patient safety evaluation system; or (B) [a]re developed by a PSO for the conduct of patient safety activities; or

ii) [w]hich identify or constitute the deliberations or analysis of, or identify the fact of reporting pursuant to, a patient safety evaluation system.⁷

PSQIA and the Patient Safety Rule clarify that PSWP does not include information that is collected, maintained, or developed separately, or exists separately, from a patient safety evaluation system.⁸ While information in the patient safety evaluation system and in the patient safety organization may be PSWP, copies

¹ Rumsey v. Guthrie Med. Group, P.C., 4:18-CV-01605, 2019 WL 4687560, at *1 (M.D. Pa. Sept. 26, 2019).

² *Id.* at *1.

³ *Id.* at *3.

⁴ See 42 C.F.R. § 3.10 et seq.

⁵ *Id.* at *1.

⁶ Rumsey, 2019 WL 4687560, at *4.

⁷ 45 C.F.R. § 3.20.; 42 USC § 299b-21(7)(A).

⁸ 42 USC § 299b-21(7)(B).

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of such information outside of the patient safety evaluation system or the patient safety organization are not considered PSWP and are not protected.⁹

Patient Sought Hospital Documents Regarding Infection Controls and Protocols Under Three Categories

Specifically, Mr. Rumsey sought:

- (1) a copy of all infection prevention and infection control materials which the Hospital received prior to May 1, 2017 from its patient safety organization or other company (“Category 1”);
- (2) copies of the Hospital’s agendas, notes and any and all other written records of Hospital’s quality committee meetings from May 1, 2016 to May 1, 2017, that discuss infection prevention or infection control (“Category 2”); and
- (3) a copy of any and all correspondence and communications between the Hospital and any governmental agency within the past 5 years on the subject of infection prevention, infection reporting, infection management and infection rates (“Category 3”).

The court ruled on each of these requests.

1. Hospital’s Infection Prevention and Control Materials Protected as PSWP

Regarding Category 1, the request for the Hospital’s infection prevention and infection control materials, the court found that state law did not apply, but the requested documents fell under

PSQIA’s definition—documents that are produced by the patient safety organization for the purpose of conducting patient safety activities. As such, the documents were protected by the PSWP privilege and not ordered produced to the patient.

2. Hospital’s Meeting Notes Regarding Infection Control Protected as PSWP

For Category 2, the request for the Hospital’s agendas, notes and any and all other written records of Hospital’s quality committee meetings discussing infection prevention or infection control, the court called such records the “quintessential example of patient safety work product privilege.”¹⁰ The court determined that “agendas, notes, and other written records from these meetings are squarely work product and are ‘deliberations or analysis of’ a patient safety evaluation system. These are protected under PSQIA and the MCARE Act, as well as Pennsylvania’s Peer Review Protection Act.”¹¹ As with Category 1, the patient did not receive the requested documents.

3. Hospital’s Communications to Government Agencies Not Protected as PSWP

When considering Category 3, the request for the past five years of correspondence between the Hospital and any governmental agency regarding infection prevention, infection reporting, infection management and infection rates, the court determined

such communications are not “work product.” The court noted communications with government agencies are not part of the Hospital’s patient-safety evaluation program or its process of disclosing peer-review information to its patient safety organizations, and such correspondence would not have been generated for the purpose of reporting.¹² Thus, such communications were not privileged; though the court limited the relevant time period from five years to only two years.¹³

PSWP Privilege is a “Quiet Corner of the Room, Not a Private Island”

The court described the Patient Safety Work Product Privilege as “a quiet corner of the room, not a private island.”¹⁴ Through this privilege, medical professionals may provide frank and honest feedback to assist with patient safety, while protecting such discussions from being used against the medical professionals in litigation, as long as such discussion “remains within the confines of the patient safety evaluation system.”¹⁵



⁹ See *Id.*

¹⁰ Rumsey, 2019 WL 4687560, at *3.

¹¹ *Id.*

¹² *Id.*

¹³ *Id.* at *3.

¹⁴ Rumsey, 2019 WL 4687560, at *4.

¹⁵ *Id.*

Wisconsin Law In Favor of Protecting Employers' Freedom to Candidly Evaluate Employees: Hussain v. Ascension Sacred Heart

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Dr. Mohammed Hussain, a radiation oncologist, was hired as a locum tenens at Ascension Sacred Heart—St. Mary's Hospital ("St. Mary's") in Wisconsin for three short periods in 2011 and 2013.¹ Before providing services, Dr. Hussain signed a Statement of Application ("Statement"), which expressly incorporated St. Mary's Medical Staff Bylaws ("Bylaws").² Dr. Hussain admitted (1) he did not read the Bylaws prior to signing the Statement; (2) he did not ask any question about the Statement or Bylaws; and (3) he did not seek to modify either document.³

During and after each time Dr. Hussain worked at St. Mary's, employees complained to Kimberly Hetland ("Hetland"), manager of the Radiation Oncology Department, about Dr. Hussain and his work.⁴ Hetland then requested that St. Mary's cancel Dr. Hussain's next scheduled assignment.⁵ In January 2015, Hetland completed a written evaluation of Dr. Hussain in which

Hetland ranked Dr. Hussain's skills in medical knowledge, patient care outcomes, and professional demeanor as "below average" and, in a narrative, wrote that she "would not have [Hussain] come back even if [St. Mary's] were in dire need."⁶ This letter was given to at least two doctors who did not work at St. Mary's.⁷

In July 2018, Dr. Hussain sued St. Mary's, alleging that its issuance of the evaluation, known as a "forever letter," constituted actionable defamation and negligence.⁸ In September 2018, St. Mary's asked Dr. Hussain to complete a release of claims against St. Mary's.⁹ Dr. Hussain did not complete the release within ten days and St. Mary's filed two breach of contract counterclaims against him, alleging that Dr. Hussain breached the terms of his Statement and the incorporated Bylaws by suing St. Mary's and refusing to complete the release. St. Mary's argued that the Statement, and, by incorporation, the Bylaws, was a valid contract between Dr. Hussain and St. Mary's, in which Dr. Hussain agreed: (1) to hold St. Mary's immune from civil liability in connection with its evaluation of him and (2) to execute a release

of claims related to St. Mary's evaluation of him upon request.¹⁰

Dr. Hussain argued that the court should decline to enforce the terms of the contract as unconscionable and against public policy.¹¹ The court analyzed whether the contract was procedurally and substantively unconscionable, finding that because Dr. Hussain was presumably a well-educated individual and had other locum tenens placement options available to him at the time, the contract was not procedurally unconscionable.¹²

In an analysis of substantive unconscionability, the court must determine whether the terms lie outside the limit of what is reasonable or acceptable.¹³ The court found that the agreement was not substantively unconscionable because the release provision only prohibited suits relating to Dr. Hussain's evaluation, not liability for any claim, and there is value in protecting an employer's ability to be candid about an employee's medical skill.¹⁴ Furthermore, a finding of unconscionability under Wisconsin law requires both procedural and substantive unconscionability.¹⁵ As a result, even if the court had found the

¹ *Hussain v. Ascension Sacred Heart—St. Mary's Hosp.*, 2019 WL 5310677 (W.D. Wis.) at *1.

² *Id.* at *2.

³ *Id.* at *3.

⁴ *Id.*

⁵ *Hussain* at *3.

⁶ *Id.*

⁷ *Id.*

⁸ *Id.*

⁹ *Hussain* at *3.

¹⁰ *Id.* at *3-4.

¹¹ *Id.* at *5.

¹² *Id.* at *7.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* at *8.

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agreement to be substantively unconscionable, Dr. Hussain's claim for unconscionability would have failed because the agreement was not procedurally unconscionable.¹⁶

Dr. Hussain's claim that the contracts were unenforceable on the basis of public policy also failed. Wisconsin courts have defined public policy as "that principle of law under which 'freedom of contract is restricted by law for the good of the community.'"¹⁷ However, the court rejected this argument because the agreement at issue was specifically related to St. Mary's evaluation of Dr. Hussain, rather than releasing St. Mary's from liability for any claim of any kind, such as other agreements the courts had found unconscionable.¹⁸ Further, the court found that the Wisconsin legislature had enacted a public policy of protecting employers who provided good-faith employment references from civil liability.¹⁹

Despite these findings of an enforceable contract prohibiting Dr. Hussain from suing St. Mary's, the court proceeded to consider the merits of his negligence and defamation claims.²⁰ In order to bring a successful claim for defamation, a plaintiff must plead: "(1) a false statement; (2) communicated by speech, conduct

or in writing to a person other than the person defamed; and [that] (3) the communication is unprivileged and tends to harm one's reputation."²¹ Dr. Hussain argued that the communication's privilege (under the Wisconsin common law conditional privilege protecting communications that allow a prospective employer to evaluate an employee's qualifications) was lost because Hetland knowingly provided false information.²² Dr. Hussain, however, did not provide any evidence from which a reasonable jury could find that Hetland knowingly provided false information.²³ Additionally, Dr. Hussain failed to properly allege that any of the statements in the forever letter were false.²⁴ Consequently, the court rejected his defamation claim.²⁵

Lastly, Dr. Hussain alleged negligence and negligent hiring, training, or supervision against St. Mary's.²⁶ Specifically, he alleged that St. Mary's had a duty to have his peer evaluation completed by another physician who personally observed his work, and that the hospital breached that duty when Hetland, a dosimetrist, wrote the forever letter based on feedback from other members of the radiology department. In Wisconsin, whether one has a duty to another is

"determined by ascertaining whether the defendant's exercise of care foreseeably created an unreasonable risk to others."²⁷ While the court agreed that the forever letter was negative and that its communication to others would foreseeably harm Dr. Hussain's future employment prospects, there were no facts to suggest that the risk of harm was "unreasonable."²⁸ Additionally, Dr. Hussain plead no facts to show the court that a review by a dosimetrist rather than a physician posed an unreasonable risk of harm to him.²⁹ Furthermore, the court held that St. Mary's duty must be analyzed in the context of the parties' contractually agreed-upon limitations.³⁰ Given that Dr. Hussain specifically agreed that St. Mary's would be immune from liability for providing evaluations "that may be critical or otherwise arguably defamatory," and without more facts to support his allegation that the risk of harm from the evaluation was unreasonable, the court granted St. Mary's motion for summary judgment.³¹ Finally, Dr. Hussain's claim for negligent hiring, training, or supervision was derivative of his negligence claim, and, therefore, because the negligent claim failed, his derivative claim failed as well.³²

¹⁶ *Id.*

¹⁷ *Id.* at *8, quoting *Richards v. Richards*, 181 Wis. 2d 1007, 1015 (1994).

¹⁸ *Id.* at *8.

¹⁹ *Id.*

²⁰ *Id.* at *10.

²¹ *Id.* at *10, quoting *Togerson v. Journal/Sentinel, Inc.*, 210 Wis. 2d 524, 534 (1997).

²² *Id.* at *11.

²³ *Id.*

²⁴ *Id.*

²⁵ *Id.* at *12.

²⁶ *Id.*

²⁷ *Id.* at *12, quoting *Shannon v. Shannon*, 150 Wis. 2d 434, 443 (1989).

²⁸ *Id.* at *12.

²⁹ *Id.*

³⁰ *Hussain* at *12.

³¹ *Id.*

³² *Id.* at *13.



Text Messaging and Other Communications During Peer Review Process Suggest Improper Motivation and Create Genuine Dispute of Material Facts, Precluding Summary Judgment

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Associate



A recent decision by the United States District Court for the Southern District of California highlights the role and impact verbal and written communications — including text messages — may have in litigation resulting from lost job opportunities or an unfavorable peer review determination.

In July 2016, Dr. Jason Toranto, a pediatric plastic surgeon and craniofacial surgeon, filed a lawsuit against various defendants alleging that they engaged in illegal, retaliatory, defamatory, and anti-competitive conduct against him.¹ Dr. Toranto alleged that the conduct resulted in both a lost job opportunity and denial of privileges following, what he considered to be, a “sham peer review” process.² Dr. Toranto asserted various causes of action, including violations of the Sherman Antitrust Act,³ defamation, and tortious interference with prospective economic advantage. Among the named defendants were Children’s Hospital of Orange County (“CHOC”), Children’s Hospital of

Orange County Medical Staff (“CHOC Medical Staff”), Dr. Amanda Gosman (“Dr. Gosman”), Rady Children’s Hospital-San Diego (“Rady’s”), and Dr. Daniel Jaffurs (“Dr. Jaffurs”) (collectively, “Defendants”).

In summary, Dr. Toranto alleged that Dr. Jaffurs, Dr. Toranto’s former colleague, made false and defamatory statements about him, initially resulting in the denial of an employment opportunity at CHOC.⁴ Dr. Toranto claimed that even after he moved to a different city, Dr. Jaffurs, in concert with Dr. Gosman (Chief of Plastic Surgery at Rady Children’s Specialists of San Diego and University of California San Diego), continued making false and defamatory statements about him to various facilities, including Rady’s.⁵ Dr. Toranto alleged that another physician, the Chief Medical Officer (“CMO”) at CHOC, also made false statements about him to Rady’s.⁶ Dr. Toranto asserted that Rady’s ultimately conducted a sham peer review process, denying his application without speaking to or meeting with him and otherwise failed to follow an objective peer review process.⁷

Defendants filed motions for summary judgment. Dr. Gosman and Rady’s argued that they were

entitled to summary judgment on the antitrust claims because Dr. Toranto failed to demonstrate they were competing in the same relevant market or the market in which Dr. Toranto claimed was being monopolized.⁸ They further argued there was no evidence their statements about Dr. Toranto were false or defamatory, that they did not act with malice or fraud, that a diligent and thorough investigation regarding Dr. Toranto’s application for privileges had taken place, and that their statements were protected under the Health Care Quality Improvement Act and California law because they were made during professional review activities.⁹

The court rejected their arguments, concluding that genuine issues of material fact existed on all applicable causes of action.¹⁰ In support, the court referenced numerous communications in the record involving Dr. Jaffurs and Dr. Gosman, the majority of which appeared to have been designed to prevent Dr. Toranto from obtaining privileges at Rady’s, including:

- *Dr. Jaffurs: “I did everything I could to help [Dr. Gosman] with keeping [Dr. Toranto] away.”¹¹*

¹ *Toranto v. Jaffurs, et al.*, No. 16CV1709-JAH (NLS), 2019 WL 4416137 (S.D. Cal September 13, 2019).

² *Id.* at *1.

³ 15 U.S.C. §§ 1-7.

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.*

⁸ *Id.* at ** 5-6.

⁹ *Id.* at ** 5-7.

¹⁰ *Id.* at * 7.

¹¹ *Id.* at * 6.

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- *Dr. Gosman to Dr. Jaffurs: “Ugh ok thanks so much for all your help. I don’t know how to stop him[.]”*¹²
- *Dr. Jaffurs: “Did [Dr. Gosman] manage to keep [Dr. Toronto] out?”*¹³
- *Dr. Gosman to Dr. Jaffurs: “U called him a little [expletive] because he clearly is one[.]”*¹⁴
- *Dr. Gosman telling Dr. Toronto that there was no need for another craniofacial surgeon at Rady’s when Rady’s internal documents demonstrated otherwise.*¹⁵

CHOC and the CHOC Medical Staff argued, inter alia, that: (1) Dr. Toronto’s claims were based specifically on the conduct of Dr. Jaffurs, and they were not liable for Dr. Jaffurs’ conduct under a respondeat superior theory as Dr. Jaffurs was not an agent of CHOC; (2) they were civilly immune under federal and state law for their participation in peer review and credentialing proceedings and for communications made in the course of those proceedings; and (3) there was no evidence of a conspiracy or that CHOC was in competition with Dr. Toronto.¹⁶

The court rejected these arguments and, again, found there were genuine issues of material fact suitable for trial on all applicable issues, including civil immunities.¹⁷ The court found that Dr. Toronto had sufficiently set forth specific

instances demonstrating that both Dr. Jaffurs and the CHOC CMO had held themselves out as agents of CHOC, that Rady’s had performed a sham peer review, and that Dr. Jaffurs either had actual knowledge that his statements were false or potentially acted with malice.¹⁸

Dr. Jaffurs argued that, similar to his co-defendants, he was entitled to civil immunity under federal and state law and that Dr. Toronto had waived his right to sue Dr. Jaffurs when Dr. Toronto signed a standard release or waiver with his application for privileges.¹⁹ The waiver stated that Dr. Toronto was releasing from liability “any and all individuals and organizations who provide information to the Hospital or its Medical Staff concerning [his] professional competence, ethics, character and other qualifications for staff appointment and clinical

¹² *Id.*
¹³ *Id.*
¹⁴ *Id.*
¹⁵ *Id.* at * 7.
¹⁶ *Id.* at ** 3-5.
¹⁷ *Id.* at * 5.
¹⁸ *Id.*
¹⁹ *Id.* at * 7.

privileges[.]”²⁰ Dr. Jaffurs further argued there was no evidence he acted in concert with other defendants to harm competition, no evidence he engaged in intentional wrongdoing or acted with malice, and no evidence that his statements were false.²¹ Dr. Jaffurs asserted that his statements were his personal opinions and that he was expressing his concerns about Dr. Toranto’s clinical care.²²

The court also denied Dr. Jaffurs’ motion. The court concluded that Dr. Jaffurs’ motivation in making the statements about Dr. Toranto — and the impact his motivation might have on applicable civil immunities — were triable genuine disputes of material fact that precluded the entry of summary judgment.²³

The Defendants’ arguments were not helped by the text messages available in black and white and read by the

judge. All persons participating in peer review should be aware that all written communications, including text messages, which are commonly and often quickly exchanged, may ultimately be evidence reviewed by a judge or jury.

20 *Id.*
21 *Id.* at * 8.
22 *Id.*
23 *Id.*



Surgeon's Anti-Trust and Third Party Beneficiary Claims Dismissed: McGary v. Williamsport Regional Medical Center

Erin Muellenberg
Principal



Meredith Eng
Associate



Dr. Susan McGary, a Board-Certified surgeon, practiced cardiothoracic surgery at Williamsport Regional Medical Center (the “Medical Center”) for ten years and, for some time, was also one of the two leaders of the Medical Center’s cardiothoracic surgery program.¹ While holding this position, the Medical Center created a credentialing criteria requiring applicants for cardiothoracic surgery privileges to have performed at least 100 heart surgeries and 100 lung surgeries within the previous year (referred to as the “100/100 criteria”).²

Dr. McGary left employment with the Medical Center in 2007, but decided to return in 2011. The Medical Center did not offer her a position because it claimed it did not have enough work to support another cardiothoracic surgeon. As a result, Dr. McGary opened a private practice but still required privileges at the Medical Center in order to perform surgery. At the time Dr. McGary applied for privileges, she did not meet the

100/100 criteria.³ Once Dr. Scott Croll, Chairman of the Medical Center’s Surgery Department, and Dr. John Burks, Director of the Medical Center’s Heart and Vascular Institute, realized Dr. McGary did not meet the 100/100 criteria, they deemed her application incomplete and did not submit it for further review.⁴

Upon learning her application was not submitted for review, Dr. McGary suggested that the 100/100 criteria was excessively stringent and, at the request of the Medical Center’s Chief Medical Officer, Dr. George Manchester, researched credentialing criteria at other hospitals in the area.⁵ Based on this research, the Medical Center relaxed its credentialing criteria.⁶ Dr. McGary, however, believed she was still ineligible for privileges and filed a lawsuit.

The district court dismissed Dr. McGary’s claims against the Medical Center for violations of equal protection and due process under the Constitution, but allowed her claims of anticompetitive conduct, breach of contract, interference with prospective contractual relationships, and conspiracy in restraint of trade to move forward. Ultimately, the district court granted the Medical Center’s motion for summary judgment. The United States Court of Appeals for the Third Circuit affirmed the district court’s decision.

Claims for Anti-Competitive Behavior

Dr. McGary alleged multiple claims of anti-competitive behavior. The first claim of anti-competitive behavior, brought under Section 1 of the Sherman Act, which prohibits conspiracy in restraint of trade, failed because the Third Circuit found the Medical Center’s parent company, Susquehanna Health, was incapable of conspiring with its wholly owned subsidiary in violation of Section 1 of the Sherman Act.⁷ Dr. McGary’s claim for civil conspiracy in restraint of trade was also rejected on these grounds.⁸ Additionally, there was no evidence that the individual physician defendants were in competition with one another or would be in competition with Dr. McGary, except for Dr. Osevala.⁹

Dr. McGary alleged that Dr. Osevala was motivated by his own personal economic interest—specifically, an incentive bonus and the fear of losing his job—because Dr. Osevala recommended to Dr. Manchester that the Medical Center was too small to support two cardiothoracic surgeons.¹⁰ The Third Circuit, however, held that in order to prove concerted action between a hospital and its staff, “there must be something ... such as a conscious commitment by the medical staff to coerce the hospital into accepting its recommendation”; a recommendation

¹ *McGary v. Williamsport Regional Medical Center*, 755 Fed.Appx. 723, 725-26 (Third Cir. 2019).

² *Id.* at 726.

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.*

⁷ *Id.* at 728-29.

⁸ *Id.* at 732-33.

⁹ *Id.* at 728.

¹⁰ *Id.* at 727-28.

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alone would not be sufficient to prove concerted action.¹¹

Section 2 of the Sherman Act prohibits conspiracy, attempt, and actual monopolization of commerce.¹² Here, the Third Circuit held that Dr. McGary's claim failed because she did not explain or produce any evidence supporting an economic motive that the Medical Center had to deny a qualified surgeon practice privileges, as the Third Circuit previously required in *Weiss v. York Hospital*.¹³ The appellate court rejected Dr. McGary's claim of attempted monopolization on the same grounds.¹⁴

State Law Claims

Under Pennsylvania law, Dr. McGary alleged that defendants breached her contractual right to have her application reviewed according to the process set forth in the Medical Center's Medical Staff Bylaws on the basis of a third-party beneficiary theory.¹⁵ The appellate court denied this claim because Dr. McGary failed to cite to any Pennsylvania court decision recognizing an applicant for staff privileges as a third-party beneficiary of the Medical Staff Bylaws of a private hospital.¹⁶ Thus, the Third Circuit concluded that because Dr. McGary did not

meet the standard for surgical privileges, it would not infer she had a right to protection as a third-party beneficiary of the Bylaws.¹⁷ Finally, the court denied Dr. McGary's claim of intentional interference with prospective contractual relations because there was no evidence that defendants adopted or applied the credentialing criteria to prevent Dr. McGary from practicing at the Medical Center. The Third Circuit recognized that the criteria was adopted prior to Dr. McGary applying for privileges and the purpose of adopting the criteria was to ensure quality patient care.

¹¹ *Id.* at 728.

¹² *Id.*

¹³ *Id.* at 729.

¹⁴ *Id.* at 730.

¹⁵ *Id.* at 730-31.

¹⁶ *Id.*

¹⁷ *Id.* at 731.



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Delaware Health System Wins Summary Judgment Against Physician Terminated from Medical Staff: *Talley v. Christiana Care Health System*

Following the suspension, conditional renewal, and subsequent termination of medical staff privileges at a hospital operated by Christiana Care Health System, Dr. Lynn Talley (“Physician”) brought claims against Christiana Care for breach of contract, defamation, interference with prospective economic advantage, tortious interference with contractual relations, and breach of the implied covenant of good faith and fair dealing.¹ In *Talley v. Christiana Care Health System*, the United States District Court, District of Delaware, granted summary judgment to Christiana Care, at least in part, because Christiana Care followed the processes in its bylaws and credentials manual.

The Facts

Physician is a board-certified OB-GYN who was a member of the Medical-Dental Staff at a teaching hospital operated by Christiana Care Health System (the hospital and Christiana Care Health System are collectively referred to as the “Hospital”), from 1982 until she was terminated on July 15, 2016.² On March 24, 2016, following an incident with a patient, the Physician became subject to a precautionary suspension in

accordance with Hospital’s Medical-Dental Staff Credentials Manual (“Credentials Manual”).³ The OB-GYN Peer Review Committee reviewed the suspension on March 30, 2016, and determined Physician’s behavior to be “At-Risk.”⁴ The following day, the OB-GYN Credentials Committee recommended the Physician’s precautionary suspension be terminated, subject to conditions.⁵ On April 1, 2016, however, the new OB-GYN Department Chair, Dr. Hoffman, reviewed the Credentials Committee’s recommendation and determined it should be modified.⁶ He sent the Credentials Committee’s recommendation, along with his own recommendation, to the Hospital’s Medical Executive Committee (“MEC”).⁷ Upon review, the MEC decided to continue the “precautionary suspension” as a “summary suspension,” and set out a number of conditions for the Physician to meet in order for her privileges to be reinstated.⁸ The Physician agreed to abide by the conditions, and the summary suspension was lifted on April 23, 2016.⁹

In February of 2016, prior to her suspension, the Physician submitted an application to renew her privileges at the Hospital, and this application was still pending during and after her suspension.¹⁰ The OB-GYN Credentials Committee reviewed the Physician’s application on April 5, 2016, but deferred making a recommendation on the application until Dr. Hoffman “had the opportunity to seek additional input.”¹¹ Dr. Hoffman met with Hospital’s Chief Clinical Officer and in-house counsel, and recommended that the Physician’s privileges only be renewed for a four-month term, rather than the typical two-year term, subject to certain conditions.¹² The Medical-Dental Staff Peer Review Committee, the Medical-Dental Staff Credentials Committee, and the MEC each reviewed and endorsed the recommendation.¹³ On May 9, 2016, the Hospital’s Board approved and implemented the conditional renewal.¹⁴ The most significant condition of the Physician’s renewal was that she have “[n]o further workplace concerns regarding behavioral or clinical issues that are found by the [OB/GYN] Peer Review Committee to constitute ‘at risk’ or ‘reckless’ behavior.”¹⁵

¹ *Talley v. Christiana Care Health System*, No. CV 17-926-CJB, 2019 WL 5102926 (D. Del. Oct. 9, 2019).

² *Id.*

³ *Id.* at 4.

⁴ *Id.* at 4. Under Christiana Care’s Culture of Responsibility Physician Algorithm, a physician’s assertedly problematic conduct may be classified as “Human Error,” “At-Risk Behavior” or “Reckless Behavior.” *Id.* at note 4.

⁵ *Id.* at 4.

⁶ *Id.* at 4.

⁷ *Id.* at 4.

⁸ *Id.* at 4.

⁹ *Id.* at 4.

¹⁰ *Id.* at 3.

¹¹ *Id.* at 4.

¹² *Id.* at 5.

¹³ *Id.* at 5.

¹⁴ *Id.* at 5.

¹⁵ *Id.* at 5.

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Thereafter, the Physician was involved in at least two more patient-related incidents, which were referred to the OB-GYN Peer Review Committee.¹⁶ Four members of the committee met with the Physician to discuss the incidents.¹⁷ The OB-GYN Peer Review Committee then met and determined that both of the cases amounted to “At-Risk Behavior” and recommended the Physician receive “coaching” to remedy the issues.¹⁸ Because the “at-risk” findings violated the conditions set forth in the conditional renewal of the Physician’s privileges, the Physician’s privileges were terminated.¹⁹

Breach of Contract

This case was largely viewed by the court as a dispute over the provisions of two contracts: The Hospital Medical-Dental Staff Bylaws (the “Bylaws”) and the Credentials Manual.²⁰ The Physician argued that the Hospital failed to follow the specific procedures in the Bylaws and Credentials Manual in terminating her privileges, and was therefore in breach of contract.²¹ The court determined the Hospital’s conduct conformed to the contractual provisions, and granted summary judgment to the Hospital on each breach of contract claim.²² Relying on state contract law, the court found that (1) the Hospital followed the applicable procedures in the Bylaws

and Credentials Manual in terminating the Physician’s privileges; (2) under the Credentials Manual, shortening the term of Physician’s privileges was not a reduction of privileges; (3) the Credentials Committee’s failure to meet with the Physician did not amount to a breach of the contract; and (4) Physician did not suffer damages as a result of alleged breaches because even if the Hospital failed to follow certain applicable procedures outlined in the Bylaws and Credentials Manual in terminating the Physician’s privileges, the result would have been the same (i.e., termination of Physician’s privileges).²³

Breach of Implied Covenant of Good Faith and Fair Dealing

“The covenant [of good faith and fair dealing] is best understood as a way of implying terms in [a contractual] agreement, whether employed to analyze unanticipated developments or to fill gaps in the contract’s provisions.”²⁴ Physician argued that the Hospital breached the implied covenant and acted in an “arbitrary and unreasonable manner” by (1) terminating her privileges without providing her an opportunity to be heard; (2) terminating her privileges even though outcomes in her cases were not as bad as those for other physicians; and (3) allowing Dr. Hoffman to circumvent the review

system, leading to her termination.²⁵ The court rejected her arguments, and granted summary judgment to Hospital.

First, the court found that Physician was given an opportunity to be heard when she met with four members of the OB-GYN Peer Review Committee prior to the OB-GYN Peer Review Committee’s meeting.²⁶ Second, the Hospital did not act arbitrarily or unreasonably in determining that Physician’s conditional reappointment could be terminated for at-risk behavior (even if her behavior did not result in a “poor outcome”), because Physician agreed to be bound by the Credentials Manual and the terms of her conditional reappointment and “... could not have reasonably assumed that one of the fruits of the bargain was that she could never be terminated for at-risk behavior that fell short of causing a poor outcome (regardless of whether other physicians currently on staff at the Hospital have previously been involved in different cases that resulted in such “poor” outcomes).”²⁷ Finally, Dr. Hoffman’s actions at issue in this case were governed by express contractual terms and could not be a basis for the application of the implied covenant.²⁸

¹⁶ *Id.* at 5.

¹⁷ *Id.* at 6.

¹⁸ *Id.* at 6.

¹⁹ *Id.* at 6.

²⁰ *Id.* at 7 (“In this case, there is no dispute that two relevant contracts existed—the Bylaws and the Credentials Manual—or that both parties are bound by the terms of these contracts.”).

²¹ *Id.* at 7.

²² *Id.* at 8. The court took a holistic view of the Bylaws and Credentials Manual, rather than reviewing each allegedly breached provision in isolation. For example, in rejecting one of Physician’s breach of contract claims, the court states that “...the Court need not and should not read Section 1.C [of the Credentials Manual] in isolation. Instead, it should also consider the content of the Bylaws and the remainder of the Credentials Manual. And in doing so, the Court concludes that the provisions of Article 3 of the Credentials Manual (not Article 1.C of the Credentials Manual) clearly apply to the factual scenario at play.” *Id.*

²³ *See Id.* at 7-13.

²⁴ *Id.* at 13, citing *Dunlap v. State Farm Fire & Cas. Co.*, 878 A.2d 434, 441 (Del. 2005).

²⁵ *Id.* at 14.

²⁶ *Id.* at 14.

²⁷ *Id.* at 14 (internal quotations omitted).

²⁸ *Id.* at 15.

Defamation and Tortious Interference

Finally, the court granted summary judgment to the Hospital on the Physician's claims for defamation, interference with prospective economic advantage, and tortious interference with contractual relations.²⁹ Each of these claims was premised on statements allegedly made by a Hospital employee during the Physician's suspension.³⁰

The Physician alleged she was defamed when a Hospital-employed nurse told one of her patients that Physician was no longer practicing at the Hospital because she lost her privileges, and told the spouse of another patient that the Physician

was no longer on staff at the Hospital.³¹ The Physician relied only on inadmissible hearsay to support her claim.³² The nurse, however, stated on the record that she told patients that the Physician "wasn't seeing patients in the hospital[.]" a truthful statement during the Physician's suspension, but did not otherwise make the alleged untrue and defamatory statements.³³ The Physician could not establish her defamation claim because "the record did not contain any admissible evidence that the allegedly defamatory statements were actually made by [Hospital's] employee(s)."³⁴

Conclusion

The court relied on state contract and tort law in granting summary judgment

to the Hospital. The Bylaws and Credentials Manual were contracts entered into between the Hospital and the Physician. This case did not turn on the substance of the provisions of the Bylaws and Credentials Manual, or whether those provisions were reasonable. Rather, the question before the court was whether the Hospital's conduct conformed to the specific provisions of the Bylaws and Credentials Manual.

This case demonstrates how important it is for committees and leaders of medical staffs to understand and follow the procedures in the medical staff's governing documents when making decisions related to the privileges of medical staff members.

²⁹ *Id.* at 16.

³⁰ *Id.* at 16.

³¹ *Id.* at 16.

³² *Id.* at 17.

³³ *Id.* at 16.

³⁴ *Id.* at 17.



Michigan Court Finds That “How a Doctor Interacts with Staff May Serve as the Basis for a Reasonable Belief that the Quality of Health Care is Being Affected”: A Summary of *El-Khalil v. Oakwood Healthcare, Inc.*

Meredith Eng
Associate



Dr. Ali El-Khalil was an independent podiatrist, who maintained privileges at several hospitals in Michigan owned by Oakwood Healthcare, Inc.¹ In 2014, Dr. El-Khalil sued Oakwood Healthcare, Inc. and two physicians, alleging racial discrimination on the basis of his Arabic ethnicity in violation of the Elliott-Larsen Civil Rights Act (“ELCRA”), tortious interference with an advantageous business relationship, and defamation.² Dr. El-Khalil claimed the physicians made false allegations against him because he asserted that other physicians were incompetent and engaged in criminal activity.³

Dr. El-Khalil also claimed that, in response to his allegations, Oakwood Hospital–Dearborn initiated administrative proceedings against him.⁴ After proceeding through peer review, Dr. El-Khalil was required to attend an anger-management

program.⁵ Dr. El-Khalil successfully completed the program but asserted that the peer-review process and the resulting actions against him were malicious and made in bad faith.⁶

The trial court found that Oakwood Healthcare, Inc. and individual defendants were statutorily immune from liability and that Dr. El-Khalil had failed to state a discrimination claim under ELCRA.⁷ The case was dismissed on May 4, 2015.⁸

After the dismissal, the Vice Chief of Staff at Oakwood Hospital–Dearborn informed Dr. El-Khalil that the Medical Staff Peer Review Committee reviewed complaints from his colleagues regarding his behavior.⁹ Approximately one month later, the Oakwood Hospital–Dearborn denied Dr. El-Khalil’s reappointment application for clinical privileges on the basis of the complaints against him.¹⁰ Two other hospitals owned by Oakwood Healthcare, Inc. – Oakwood Dearborn, Oakwood Hospital–Southshore and Oakwood Hospital–Wayne – similarly denied Dr. El-Khalil’s reappointment application.¹¹

In late June 2015, Dr. El-Khalil filed

a second action, alleging breach of contract and unlawful retaliation in violation of the ELCRA as a result of his 2014 lawsuit. He alleged that his privileges at Oakwood Hospital–Southshore and Oakwood Hospital–Dearborn (“Defendants”) were not due to expire until November 2015 and that they had been suspended without proper procedures and notice.¹² Defendants moved for summary disposition and claimed immunity under the Healthcare Quality Improvement Act and Michigan’s healthcare peer-review statute and that Dr. El-Khalil’s lawsuit failed to state a claim upon which relief could be granted.¹³ The trial court granted Defendants’ motion without specifying which statute or rule supported its decision.¹⁴

After the trial court’s order, the case embarked on a long procedural journey. Dr. El-Khalil appealed the trial court’s ruling, which was affirmed by the Michigan Court of Appeals.¹⁵ The Michigan Supreme Court then vacated the Court of Appeals’ opinion and remanded it for review against the procedural standards for immunity and release and failure to state a

¹ *El-Khalil v. Oakwood Healthcare, Inc.*, 504 Mich. 152, 155 (2019).

² *Id.*

³ *Id.*

⁴ *Id.*

⁵ *Id.*

⁶ *Id.* at 155-156.

⁷ *El-Khalil v. Oakwood Health Care, Inc.*, No. 329986, 2017 WL 1244207 (Mich. Ct. App. April 4, 2017) at *1.

⁸ *El-Khalil v. Oakwood Health Care Systems, Inc.*, unpublished Order of the Third Judicial Circuit of Michigan, entered May 4, 2015 (Docket No. 14-010667-NO).

⁹ *El-Khalil*, 504 Mich. at 156.

¹⁰ *Id.*

¹¹ *Id.*

¹² *Id.* at 157.

¹³ *Id.*

¹⁴ *Id.*

¹⁵ *Id.* at 159.

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claim.¹⁶ Once again, the Court of Appeals held that the trial court's dismissal was appropriate based on Dr. El-Khalil's failure to state a claim and consequently declined to address whether dismissal was appropriate based on the grounds of immunity and release.¹⁷

Dr. El-Khalil appealed again, this time requesting that the Michigan Supreme Court review the Court of Appeals' decision on the basis that, while the Court of Appeals dismissed the case for failure to state a claim, it had actually performed an analysis for summary judgment, which carries a higher burden for him, the plaintiff.¹⁸ The Michigan Supreme Court agreed. The Court held that the Court of Appeals erred in dismissing Dr. El-Khalil's allegations for failure to present sufficient evidence of his claims, because at this stage in the litigation, he was only required to properly allege his claims.¹⁹ As a result, the Michigan Supreme Court reversed the decision of the Court of Appeals and remanded the case for consideration of Dr. El-Khalil's claims.²⁰

Finally, on November 14, 2019, the Court of Appeals re-reviewed the trial court's ruling, finding that dismissal was appropriate on the grounds of immunity and release.²¹ While

Dr. El-Khalil originally alleged that his privileges had been suspended without proper procedures and notice, he abandoned that claim. Instead, he alleged that Defendants breached the Medical Staff Bylaws by denying him privileges for reasons other than those related to the efficient delivery of quality patient care and professional ability and judgment.²² Article II, Section 2, Subsection C of Oakwood Healthcare's Medical Staff Bylaws provided that membership or particular clinical privileges would not be denied "on the basis of any criteria unrelated to the efficient delivery of quality patient care in the hospital, to professional ability and judgment, or to the community need."²³ In response, Defendants argued they were immune from liability because Dr. El-Khalil's application for privileges included a release of the defendant hospitals and employees, among others, from liability for statements made or actions taken in good faith and without malice in connection with consideration of applications for privileges.²⁴ Dr. El-Khalil then argued that Defendants' actions were malicious and not made in good faith.²⁵ The Court of Appeals rejected Dr. El-Khalil's argument, writing, "[H]ow a doctor interacts

with staff may serve as the basis for a reasonable belief that the quality of health care is being affected, regardless of his or her record as a doctor in general."²⁶

Dr. El-Khalil submitted evidence in support of his claim. The evidence included (1) a letter from the Medical Staff Peer Review Committee stating he had failed to comply with the requirements of a focused physician practice evaluation; (2) numerous e-mails, text messages, and letters from colleagues, alleging unprofessional and threatening behavior; and (3) a memorandum from a Medical Senior Staff Coordinator, stating that Dr. El-Khalil had been the subject of disciplinary action due to his behavior.²⁷ This evidence actually supported Defendants' contention that Dr. El-Khalil was denied hospital privileges because of his threatening behavior. Ultimately, the Court of Appeals declined to accept Dr. El-Khalil's allegations as true and dismissed them on the basis that Defendants were entitled to immunity under the terms of its Medical Staff Bylaws as well as state and federal laws providing immunity to individuals and entities engaged in professional review activities.²⁸

¹⁶ *Id.*

¹⁷ *Id.*

¹⁸ *Id.*

¹⁹ *Id.* at 162 and 165-166.

²⁰ *Id.* at 166.

²¹ *El-Khalil v. Oakwood Health Care Inc.*, No. 329986, 2019 WL 6045564 (Mich. Ct. App. November 14, 2019) at *2.

²² *Id.*

²³ *Id.* at *3.

²⁴ *Id.*

²⁵ *Id.*

²⁶ *Id.*

²⁷ *Id.* at *4.

²⁸ *Id.* at *6-7.

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