Peer Review

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A Practical Analysis of HCQIA Immunity

Peer review of a hospital’s or clinic’s medical staff is an essential and required activity designed to police the quality of patient care. To encourage peer review, the Health Care Quality Improvement Act (HCQIA) provides immunity from damages to the hospitals, clinics, physicians, and others who perform this important function. Despite this immunity, litigation initiated by physicians in response to restrictions or limitations on their privileges persists, and these dissatisfied physicians continue to test the limits of HCQIA immunity. See Garrison v. Herbert J. Thomas Memorial Hospital, 190 W. Va. 214, 438 S.E.2d 6 (W. Va. 1993).

A recent case decided by the United States Court of Appeals for the Fourth Circuit, Wahi v. Charleston Area Medical Center, 562 F.3d 599 (4th Cir. 2009), affirmed HCQIA immunity, offering valuable guidance to counsel handling physician peer review, as well as litigation arising from peer review activities. Wahi demonstrates that following organization policy and documenting compliance is essential in setting the stage for future litigation. For instance, the ability to demonstrate compliance with internal policy, when combined with HCQIA’s presumption in favor of immunity, provides an opportunity to limit discovery and obtain a summary dismissal.

Proper handling of peer review investigations, in addition to being essential to maintaining quality patient care, is necessary to protect peer reviewers or peer review bodies involved in future litigation. The risk to these peer reviewers or peer review bodies is starkly demonstrated by verdicts from juries convinced that a physician has been wronged. For example, in Poliner...
v. Texas Health Systems, 537 F.3d 368 (5th Cir. 2008), the jury returned a $360 million dollar verdict against a Texas hospital for claims arising from a suspension.

Wahi and Poliner provide a valuable blueprint for handling peer review actions and resulting litigation. This article will review Wahi and Poliner and offer practical advice for handling peer review activities, as well as litigation that may ensue.

HCQIA Immunity Reviewed

As noted by the Fifth Circuit, Congress enacted the Health Care Quality Improvement Act (HCQIA) because of “[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care,” and because “[t]here is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician’s previous damaging or incompetent performance.” Poliner v. Texas Health Systems, 537 F.3d 368, 375 (5th Cir. 2008).

Under HCQIA, when a “professional review action,” as defined by the statute, 42 U.S.C. §11151(9), meets certain requirements, those performing that review “shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.” 42 U.S.C. §11111(a). When a professional review body meets the four statutory requirements prescribed in 42 U.S.C.A. §11112(a) (West 2005), it is immune from damages. As noted in HCQIA, a professional review action must be taken

(1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C.A. §11112(a) (West 2005).

Section 11112(b) provides a “safe harbor” for physician review organizations as long as they satisfy subsection (a)(3), which requires giving the physicians involved notice of any adverse professional review action proposed to be taken, a statement for the reasons of the proposed action, and the time within which the physician or dentist may request a hearing (which may not be less than 30 days). Importantly, as stated in Wahi, “[w]hile a health care entity is ‘deemed to have met’ the subsection (a)(3) immunity requirements by following the safe harbor provisions of subsection (b), those provisions are not exclusive. ‘[F]ailure to meet the conditions described in subsection (b)] shall not, in itself, constitute failure to meet the standards of subsection (a)(3).’” Wahi, 562 F.3d at 607–08. Moreover, HCQIA presumes that a professional review action meets the standards for immunity, unless that presumption is rebutted by a preponderance of the evidence. 42 U.S.C.A. §11112(a) (West 2005).

Protection for peer review activities is available by statute in all 50 states and the District of Columbia. Like HCQIA, these statutes generally provide immunity for those who participate in a peer review process. In addition, many state statutes protect as confidential communications and documents that are part of the peer review process. See Virmani v. Novant Health, Inc., 259 F.3d 284, 290 (4th Cir. 2001) (cited in Laurie K. Miller and Rena K. Seidler, Protecting and Preserving the Peer Review Privilege—Solutions for Corporate Counsel Representing Hospitals, Health Care Corporations, and Health Care Providers (Chapter 8, Evidentiary Privileges For Corporate Counsel, DRI 2008). For example, West Virginia’s peer review statute, §30-3C-3 provides for confidentiality, stating,

[t]he proceedings and records of a review organization shall be confidential and privileged and shall not be subject to subpoena or discovery proceedings or be admitted as evidence in any civil action arising out of the matters which are subject to evaluation and review by such organization and no person who was in attendance at a meeting of such organization shall be permitted or required to testify in any such civil action as to any evidence or other matters produced or presented during the proceedings of such organization or as to any findings, recommendations, evaluations, opinions or other actions of such organization or any members thereof....

Similar to HCQIA, West Virginia and other states provide immunity to peer review organizations and those supplying information or participating in good faith in the process. See W. Va. Code §30-3C-2; Mahmoodian v. United Hospital Center, Inc., 185 W. Va. 59, 404 S.E.2d 750, cert. denied, 502 U.S. 863, 112 S. Ct. 185, 116 L. Ed. 2d 146 (1991) (“statutory immunity evinces a public policy encouraging health care professionals to monitor the competency and professional conduct of their peers in order to safeguard and improve the quality of patient care.”) Other states offer similar immunity to participants in the peer review process. These statutes, as does HCQIA, generally focus on the process of peer review, extending statutory protections to hospitals, clinics and other institutions engaged in activities that fit within the statutory definitions. For example, West Virginia Code §30-3C-1, defines “peer review organization” to include any committee or organization engaging in peer review, including... any committee established by one or more state or local professional societies or institutes, to gather and review information relating to the care and treatment of patients for the purposes of: (i) evaluating and improving the quality of health care rendered; (ii) reducing morbidity or mortality; or (iii) establishing and enforcing guidelines designed to keep within reasonable bounds the cost of health care. It shall also mean... any professional standards review organizations established or required under state or federal statutes or regulations.

Courts applying the statute consider the nature of the activity in question to determine whether it fits within the statutory definitions. See State ex rel Charles Town Hospital v. Sanders, 210 W. Va. 118, 556 S.E.2d 85 (2001) (“A hospital committee that is responsible for considering applications for admission to its staff and for issuing staff privileges or credentials in accordance therewith is a “review organization” within the definition of W. Va. Code §30-3C-1 (1975). As a “review organization,” such a hospital committee may also avail itself of the health care peer review privilege, codified in W. Va. Code §30-3C-3 (1980), provided it satisfies the requisite criteria for the assertion of that privilege.”)

**Wahi v. Charleston Area Medical Center**

Wahi v. Charleston Area Medical Center arose from a series of disciplinary actions by the medical staff at the Charleston Area Medical Center against the plaintiff, a cardiovascular surgeon. 453 F. Supp. 2d 942 (S.D. W. Va. 2006), aff’d, 562 F.3d 599 (4th Cir. 2009), rehearing en banc denied, Slip Op. No. 06-2162 (4th Cir. May 8, 2009). Upon receiving complaints about the surgeon’s patient care, the medical center’s chief of staff appointed an investigative committee. The doctor’s privileges were first restricted and then suspended, and the medical center reported the actions to the National Practitioner Data Bank. Subsequently, the West Virginia Board of Medicine investigated the physician and brought charges against him. The physician, Dr. Wahi, denied any deficiency in his clinical practice and claimed that the medical center and his “competitors” had used the peer review process to retaliate against him because he was considering starting a competing heart center in Beckley, an hour away. After more reports of problems and further investigation, the hospital suspended the physician’s privileges in July 1999.

On July 30, 1999, CAMC [Charleston Area Medical Center] summarily suspended the privileges of Dr. Wahi in connection with the findings of the investigative committee. According to the complaint, Dr. Wahi requested a hearing on his suspension pursuant to the hospital’s bylaws, but a hearing has never been held. Dr. Wahi alleges that these adverse professional review actions were taken as part of a conspiracy by the defendants to monopolize thoracic and cardiovascular medicine and surgery in the Charleston, Beckley, Bluefield, and Parkersburg areas of West Virginia.


The physician filed an 11-count civil action against the medical center and several physicians who participated in the peer review of his patient care and treatment. The thrust of the complaint was that the peer review activities were instituted to stop him from starting a competing heart center, and that the medical center had violated his rights in failing to provide him with a hearing.

The physician alleged that the defendants

1) engaged in an antitrust conspiracy under the Sherman Act (15 U.S.C. §1); 2) engaged in antitrust monopolization under the Sherman Act (15 U.S.C. §2); 3) violated his Fifth and Fourteenth Amendment Due Process rights; 4) retaliated against him in violation of his First Amendment rights; 5) breached the contract between CAMC and Dr. Wahi; 6) conspired to deny him Due Process in violation of his rights under the Fifth and Fourteenth Amendments; 7) defamed him by reporting him to the Data Bank; 8) invaded his privacy and disclosed confidential information; 9) violated his civil rights under 42 U.S.C. §1981; 10) conspired to obstruct justice and deny equal protection in violation of 42 U.S.C. §1985; and 11) neglected to prevent the conspiracy alleged in Count 10 in violation of 42 U.S.C. §1986. See Order at 3–4.

The defendants moved to dismiss on several grounds, focusing primarily on HCQIA immunity.

**Order on Motion to Dismiss and Establishing Limited Discovery**

United States District Judge Joseph R. Goodwin issued an order dated October 27, 2004, granting the motion in part and allowing limited discovery related to the immunity issue. Judge Goodwin denied the defendant’s motion to dismiss based on the primary jurisdiction doctrine, under which federal courts may stay actions and defer to the involved administrative agency. The court declined to stay the action because the peer review committees at the medical center were not administrative agencies within the meaning of the doctrine, and “[r]eferral of this case to the peer review body would not promote any sort of national or even statewide uniformity.” Order at 6.

Allowing limited discovery, the court directed the parties to agree on a discovery plan, including certain specifications, which included:

* The discovery was abbreviated to 90 days.  
* Each side was limited to 10 interrogatories and 10 requests for admissions.  
* Depositions required five days notice. Each deposition was limited to one hour of direct examination, 30 minutes of cross-examination and 10 minutes of redirect examination.  

The court further limited discovery to several discrete issues:

* Whether the medical center afforded the physician the opportunity to proceed with a peer review hearing following the suspension of his privileges;  
* The procedures used and investigations undertaken by medical center in the professional review action against the physician;  

**Wahi and Poliner provide excellent performing peer review in hospitals, clinics, or other institutions and their counsel.**
• Whether the medical center’s board of trustees retained the ultimate decision-making authority regarding the physician’s staff privileges;
• Any matters reasonably related to the claims described in counts five, six, nine, ten, and eleven of the complaint, or reasonably related to defenses of them.

Order at 18–19.

The order directed the parties to complete discovery and file briefs focusing on two issues:
• Whether the defendants are entitled to immunity from civil liability under HCQIA for all remaining counts except the civil rights claims.
• Whether any issues of material fact exist regarding the remaining claims.

After discovery, during which the parties exchanged documents and completed depositions, the defendants moved for a summary judgment, relying strongly on HCQIA immunity. The plaintiff voluntarily dismissed all the defendant physicians, except one, before the summary judgment motion deadline. The one remaining physician was the medical center’s chief operating officer.

**Order Granting Summary Judgment**
Judge Goodwin granted the motion, finding that the hospital was immune under HCQIA: “it is clear that the suit arises as the result of the recommendations and activities of a health care entity in regard to the competence and professional conduct of Dr. Wahi, and whether he will continue to have privileges at CAMC [the medical center].” Wahi v. Charleston Area Medical Center, 453 F. Supp. 2d at 949. To qualify for immunity, the court determined that the peer review action must have been taken in “reasonable belief that quality health care was being furthered,” as judged under a standard of objective reasonableness given “the totality of the circumstances.” Id. at 950.

Reviewing the four HCQIA immunity prerequisites, the court found that the medical center had acted after numerous reports and complaints about the physician’s competence and inability to practice within the scope of his privileges. He had received adequate notice of his right to a hearing. Further, the medical center had corresponded with him numerous times “regarding the proposed actions, his right to request counsel, a summary of his rights at any subsequent hearing, as well as an opportunity to appear and speak at any committee meetings where concerns were raised regarding [his] privileges.” Id. at 953. The court further found that the doctor’s own correspondence and communications from his lawyers indicated that he had understood and been aware of the applicable procedures. Id. at 953–54. Finally, the court found that the medical center had a reasonable belief that its action was warranted, based on the several internal and external peer reviews that it had performed. Id. at 954–55. The court rejected the doctor’s assertion that because various peer review committees had reached different conclusions, all of their opinions had to be rejected.

Additionally, the court found that the physician “failed to offer sufficient evidence upon which a reasonable jury, examining all the facts in the light most favorable to him, could find by a preponderance of the evidence that the professional review process failed the test for reasonableness as laid out in §11112(a).” Id. at 955.

As to the state law breach of contract claims, the court rejected the physician’s assertion that the medical center bylaws constituted a contract under West Virginia law. Id. at 956. The court further found that he had been afforded procedural due process under the bylaws because the medical center had provided notice to him and an opportunity to appear in response to the charges against him. The court granted summary judgment on the breach of contract claim. Id.

Addressing the 42 U.S.C. §1981 claim, the court determined that the medical center had made an offer of privileges that the doctor had accepted, forming a “contract” for purposes of Section 1981. However, the court determined that a four-year statute of limitations applied to the claim, and, therefore, the action was time barred. Assuming that the physician had an employment contract and the statute of limitations had not run, the court further found that he had not presented any direct evidence that the medical center had intentionally discriminated against him. Id. at 956–60.

The physician also alleged that the medical center conspired with the West Virginia Board of Medicine to deny him a medical license, a civil conspiracy under 42 U.S.C. §1983. Finding that the physician did not offer a “scintilla” of evidence of communication between the medical center and the West Virginia Board of Medicine beyond that required by law, the court granted a summary judgment. Id. at 960. The physician appealed to the United States Court of Appeals for the Fourth Circuit.

**Fourth Circuit Opinion Affirming Summary Judgment**
The Fourth Circuit affirmed the summary judgment on all claims made by the physician. The opinion is a resounding affirmation of the immunity afforded physician peer reviewers and physician peer review organizations under HCQIA. By an order entered May 8, 2009, the Fourth Circuit denied the physician’s petition for a rehearing en banc.

Affirming summary judgment under HCQIA, the Fourth Circuit stated that due to the presumption of immunity under HCQIA, courts must apply an “unconventional standard in determining” whether summary judgment is appropriate: “whether a reasonable jury, viewing all facts in a light most favorable to [the physician], could conclude that he had shown, by a preponderance of the evidence, that [the hospital’s] actions fell outside the scope of section 11112(a).” 562 F.3d at 607, citing Gabaldoni v. Washington County Hosp. Ass’n, 250 F. 3d 255, 260 (4th Cir. 2001). In determining whether a health care entity has met these four requirements, the court must apply an objective test that “looks to the totality of the circumstances” to determine whether the action satisfies the §11112(a) provisions. Id., citing Imperial v. Suburban Hosp. Ass’n, 37 F. 3d 1026, 1030 (4th Cir. 1994).

The court affirmed the medical center was a “professional review body” as defined in HCQIA. Id. at 606, 42 U.S.C.A. §111251(ii) (West 2005) (“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.”)

Reviewing the four prerequisites for immunity under HCQIA, the court found that the physician had “waived his claims
as to the first, second, and fourth requirements of the subsection (a) HCQIA immunity test on appeal.” *Id.* at 607. The court then focused on the sole remaining factor, whether “adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances.” The physician had argued that the medical center had simply failed to hold a hearing and was, therefore, not entitled to HCQIA immunity. The court squarely rejected this argument, finding that the statute’s “plain language” refuted it: “[F]ailure to meet the conditions described [in subsection (b)] shall not, in itself, constitute failure to meet the standards of subsection (a)(3).” *Id.* at 607–08.

The physician argued that since the medical center had “summarily suspended him for more than 14 days without first finding that he posed an imminent danger to his patients and without conducting a post-suspension investigation,” it could not claim immunity under HCQIA. The court stated that §11112(c) “sets out distinct ways in which a health care entity can be immune under HCQIA without having complied with the usual requirements for claiming immunity.” *Id.* at 608. Noncompliance did not strip the medical center of immunity. Rather, it “must meet the usual standard of qualifying for immunity set forth in subsection (a)(3).” *Id.* Concerning a hearing, the Fourth Circuit found that although the medical center had not held a hearing, its procedures had been fair under the circumstances. *Id.* at 609.

The Fourth Circuit then reviewed in detail the long proceedings between the medical center and the physician, which included numerous written exchanges, suits, and proceedings before the West Virginia Board of Medicine. The Fourth Circuit concluded that the physician had been fairly treated, as required by HCQIA. In its detailed analysis, the Fourth Circuit noted that the plaintiff had been well acquainted with disciplinary actions:

> [I]n considering whether the procedures provided by the health care entity are fair ‘under the circumstances,’ the... allegations against [the plaintiff] cannot be considered in a vacuum. These allegations were simply the latest in [the plaintiff’s] tumultuous history with CAMC [the medical center]... Since his reappointment in 1995, [the plaintiff] had been the subject of numerous reports and complaints calling his professional competence and conduct into question,... [which] arose from a multitude of discrete incidents, were made by different individuals, and were known to [the plaintiff]. After all, [the plaintiff] had been through the suspension process previously at CAMC, including the prior reports to the NPDB [National Practitioner’s Data Bank].... [The plaintiff] was aware of the consequences for failing to abide by the Bylaws and Procedures Manual. He was not a first-time offender who was unfamiliar with the responsibilities of his position at CAMC or the consequences for his failures in July 1999. *Id.* at 613.

Analyzing the circumstances, the Fourth Circuit concluded that the medical center had demonstrated entitlement to immunity and further found that the physician had failed to rebut the statutory presumption of immunity under HCQIA. The Fourth Circuit therefore affirmed the district court’s holding that the medical center was entitled to immunity under HCQIA and its refusal to grant injunctive relief, finding that the physician had not proved that the medical center had committed wrong or was not a “state actor” for purposes of §1983 claims because the NPDB statute did not confer to the medical center powers traditionally reserved to the state, and it did not transform the medical center’s actions into state action. *Id.* at 616. Further, the court held that the physician had failed to amend his complaint to include a defamation claim, making it unreviewable on appeal, and his breach of contract claim failed because the medical center bylaws had not formed a contract under state law. *Id.* at 617. Finally, the Fourth Circuit rejected the argument that the medical center had breached confidentiality required by 45 C.F.R. §60.13 in making disclosures to the press, finding that the NPDB statute “does not prevent the entity who reported NPDB from disclosing the mere fact that a report was filed.” *Id.* at 618.

**Poliner v. Texas Health Systems**

Another recent case affirming HCQIA immunity for peer reviewers, *Poliner v. Texas Health Systems*, 537 F.3d 368 (5th Cir. 2008), arose from a $360 million-dollar verdict against a hospital and its chief of staff for defamation: “[T]his extraordinary judgment rests on limited restrictions of Dr. Lawrence Poliner’s privileges at Presbyterian Hospital over a period of fewer than twenty-nine days to investigate concerns involving his handling of several patients.” *Poliner*, 537 F.3d at 369.

The facts of *Poliner* are similar to those in *Wahi*. The plaintiff physician, a cardiologist, had a number of complaints about his care, which led to a summary suspension of his privileges to perform catheterizations. The hospital informed him that it was instituting a review, and he agreed, in writing, to an abeyance of his privileges during the process. An ad hoc committee of physicians was appointed and reviewed 44 of the physician’s cases and found deficient care in half of them. They also requested and received an external review, not only of the physician’s cases, but of other cardiologists’ cases as well. The physician was informed of the results, given access to the patient files and a meeting was scheduled with the review committee. The physician sought to delay the meeting, but it went forward and the committee recommended that the hospital suspend his catheter laboratory and echocardiography privileges. The hospital accepted the recommendation. The physician, who had counsel, requested a hearing on the suspension. A hearing was held, and the hearing committee recommended upholding the suspension based on the evidence that was available at...

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the time, but reinstating the physician’s privileges with conditions.

The physician, the plaintiff, filed suit, alleging federal antitrust claims, as well as state antitrust, Deceptive Trade Practices Act, and numerous other tort claims. The defendants moved for summary judgment based in part on immunity under HCQIA.

The district court granted partial summary judgment under HCQIA but found a fact issue as to whether [the hospital’s] threat to summarily… suspend [the physician] if he did not agree to the abeyance [the physician’s] consent. If [the physician] had not freely agreed, the court reasoned that the abeyance was then in fact a summary suspension. If this was so, the court concluded that there were fact issues as to whether Defendants satisfied HCQIA’s standards. Thus, the court denied HCQIA immunity, as well as state law immunity, to [the hospital and other defendants.]

Polinier, 537 F.3d at 374.

The case proceeded to a jury trial on the summary suspension issue. The court excluded evidence of the physician’s later suspension. The physician argued that “under the Medical Staff bylaws, a summary suspension was allowed when a doctor posed a ‘present danger to the health of his patients,’ and he posed no such danger. Rather, [the physician] suggested that he was suspended because his solo practice was a competitive threat to the dominant cardiology group at [the hospital], that [the chief of staff] ‘had it in for him.’” Id. at 375.

The case was submitted to the jury, which found for the physician on all of his remaining claims. The jury awarded in aggregate more than $360 million in damages, $90 million of which were for the defamation claims. Almost all of the damages awarded were for mental anguish, injury to career, and punitive damages. Two of the physicians that plaintiff originally sued settled after the trial. Plaintiff then elected to recover under his defamation theory against the hospital and its chief of staff. The district court reduced the defamation damages to $10.5 million for injury to career, $10.5 million for mental anguish, and $1.5 million in punitive damages, and further awarded prejudgment interest, which totaled over $11 million.

On appeal, the Fifth Circuit found that the summary suspension and the extension of the suspension were “professional review actions” within the meaning of HCQIA: “[f]or the purposes of HCQIA immunity from money damages, what matters is that the restriction of privileges falls within the statute’s definition of ‘peer review action,’ and what we consider is whether these ‘peer review actions’ satisfy HCQIA’s standards, and not whether the ‘abeyances’ satisfy the bylaws.” Id. at 378.

Similar to Wahi, the physician had argued that the hospital had failed to comply with its medical staff bylaws. The court rejected this argument, stating “[p]rovided that a peer review action as defined by the statute complies with those standards, a failure to comply with hospital bylaws does not defeat a peer reviewer’s right to HCQIA immunity from damages.” Id. at 381.

The Fifth Circuit wrote, To allow an attack years later upon the ultimate “truth” of judgments made by peer reviewers supported by objective evidence would drain all meaning from the statute. The congressional grant of immunity accepts that few physicians would be willing to serve on peer review committees under such a threat; as our sister circuit explains, “the intent of [HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.” At the least, it is not our role to reweigh this judgment and balancing of interests by Congress.

Id. at 384–85.

Rejecting the physician’s claims and reversing the jury verdict, the Fifth Circuit stated, “[i]n any other [physician] failed to rebut the statutory presumption that the peer review actions were taken in compliance with the statutory requirements, the evidence independently demonstrates that the peer review actions met the statutory requirements.” Id. at 385.

The court further stated, [b]ecause Defendants are immune under HCQIA, we have no occasion to consider Defendants’ other substantial arguments that we must reverse and render judgment based on state law immu

### Discussion and Analysis

Wahi and Polinier provide excellent guidance for those performing peer review in hospitals, clinics, or other institutions and their counsel. Critical to the Wahi court’s analysis were the detailed correspondence between the medical center’s review committees and counsel and the physician, which demonstrated notice and an opportunity to be heard. These letters carefully documented the professional review process from beginning to end and showed that the physician had access to records, received the reports by the committees and outside experts, and had opportunity to respond in writing and to be heard. In Polinier, the court recognized the physician had been afforded similar protection. The hospital provided records to him, allowed him to meet with the committee performing the peer review, and provided a hearing. Both cases recognize that a physician peer review process does not have to precisely follow an institution’s governing documents, but instead must only provide fair procedures given the total circumstances as required by HCQIA. Both cases establish that physician professional review action must be judged by an objectively reasonable standard, based on the facts known at that time.

Wahi and Polinier establish several important points. These translate into concrete, practical suggestions for handling a physician peer review process, as well as ensuing litigation. An institution that conducts
Many institutions provide participating physicians with an agreement to defend and indemnify at the start of the peer review process.

Determine If Outside Peer Review Is Appropriate

Sometimes institutions are forced or choose to use external peer reviewers. This process can be very costly, particularly if the medical staff is capable of participating in the process, but finds it “less confrontational” to have someone else take the lead in addressing professional quality issues. At the same time, it can be very effective for matters deemed too “political” to address internally, such as in specialty practice areas if only a few physicians practicing that specialty are on the staff. External review may be the only option when questions arise about the practices of a particular medical department or subsection. Some suggestions:

- Use outsider professional reviewers for significant cases. A physician under investigation can be very sensitive to perceived bias or conflict of interest if his or her peers and competitors review his or her patient care. Using independent, outside, professional reviewers can help blunt allegations of discriminatory or anti-competitive intentions, as well as to provide additional viewpoints and extra layers of reviews, which, additionally, can give the medical staff peer reviewers support for and confidence in their own review of a physician’s patient care. It will be money well spent.

- When using outside professional reviewers, send them reviewers complete copies of all medical records about which there are concerns, all relevant institution policies and procedures, and all written responses by the affected physician concerning the patient care and treatment at issue.
• When using outside reviewers, allow the investigated physician to review the medical records and other information provided to reviewers, and designate additional patient medical records and materials for review.
• We do not recommend submitting medical records of other physicians practicing in the same specialty as the physician under review to external reviewers. Focus a review on the practices of that particular physician under investigation and curb impulses to preemptively strike potential claims that the physician might make. The key question is whether the conduct or patient care of the physician under investigation meets professional standards, not whether he or she performs better or worse than other physicians at your institution.

Document the Peer Review Process
Affidavits and sworn testimony will never replace simple, contemporaneous documentation in supporting an institution’s actions that limit or eliminate a medical professional’s practice privileges. Missteps in documenting the peer review processes may result in exposure to both an institution and those participating in a peer review. An institution should carefully and properly document the information upon which it acts and the manner in which it notifies a physician of its concerns. Additionally, an institution must make sure that a physician is fully advised and given the opportunity to explain or rebut them. It is crucial to properly document all steps required by HCQIA. Some suggestions:
• Carefully document each peer review and disciplinary action step while complying with your institution’s policies and procedures as outlined in its governing documents.
• Carefully document every act or failure to act that deviates from policy and procedure. While no one wants to point out how and why a procedure was not followed, fully documented, timely explanations in the record can provide support for a court to find that institution met the requirements of HCQIA, although it also imprecisely followed its governing documents.
• Bear in mind the type of documentation relied on by an institution. Letters and reports prepared during a review process, which are generally revised at the time for accuracy, provide the safest foundation upon which to defend an action. E-mails, voice-message transcripts and handwritten notes typically do not receive enough editing scrutiny to prevent misinterpretation when presented on a 4 x 8 foot viewing screen at a trial.

Protect Peer Review Participants
In most institutions, medical staff members or other health care professionals conduct peer reviews as volunteers, for no or little compensation. A physician who undertakes peer review and, as a result, becomes involved in protracted litigation is unlikely to “volunteer” again, nor are his or her colleagues. Some suggestions:
• Defend and indemnify your institution’s peer reviewers if they are sued. Your institution should have a policy in place outlining the obligation to provide a defense and indemnify physicians who perform peer reviews. Many institutions provide participating physicians with an agreement to defend and indemnify at the start of the peer review process.
• If litigation ensues, provide separate counsel to represent each peer reviewer who receives subpoenas requiring appearance at depositions, or for personal records, such as income tax returns. It is sometimes advantageous to hire separate counsel for physicians who are named as defendants in civil actions. However, this decision must be made on a case-by-case basis.
• If the court in which you are litigating publishes its opinions, ask the court to redact the names of peer review participants from its published opinion or, if applicable, to substitute the person’s title, for example, chief of staff, for his or her actual name.

Physician’s Prior History
Some physicians will argue that prior investigations are neither relevant nor material to a current investigation, but these arguments are only partially persuasive. Although a physician should not be punished twice for the same event, an institution must be mindful that patterns develop over time. A physician’s entire history does, in fact, provide insights into his or her current situation. Prior internal complaints, peer review actions, or external information regarding practice competency may be relevant to a current concern and should be considered during the decision process. The key is to base all decisions regarding privileges on the current behavior or practice and use prior matters in an appropriate manner in connection with a review.

Practical Suggestions for Handling Peer Review Litigation
Several important points, suggested by Wahi and Poliner, are instructive to counsel defending institutions facing suits over the termination or limitation of medical staff privileges, and essential to establishing HCQIA immunity.

First, HCQIA provides the basis for early disposition by motion. The difficulty of HCQIA immunity, as with other immunities, is that it is not absolute, and institutions must sometimes begin expensive discovery before a realistic opportunity to move for summary judgment. As in Poliner, an institution may have to go to trial before obtaining immunity. HCQIA provides a vehicle through which an institution, hospital or other peer reviewer may obtain summary disposition of a case without running the risks associated with a jury trial. Even though a motion to dismiss might not succeed entirely, it can set the stage for a summary disposition after limited discovery.

Second, HCQIA provides a means of minimizing and limiting discovery to issues related to the availability of immunity to an institution. Limiting discovery should extend, as in Wahi, to particular issues related to the immunity. In addition, interrogatories and the length of depositions can also be limited to further streamline the process.

Third, in discovery, make full disclosure of the medical records, other documents, and reports of reviewing physicians and outside reviewers to a plaintiff.

Fourth, seek protection under Fed. R. Civ. P. 26 and its state counterparts to prevent the public disclosure of the identities of peer review participants and peer review information. For example, in Wahi, HCQIA Immunity> page 59

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the district judge entered a protective order, predicated on West Virginia law, which precluded the public disclosure of peer review information and permitted the parties to file under seal all such information.

Finally, focus on the facts, as established by testimony and documents, to demonstrate compliance with your institution’s medical staff governing documents and HCQIA. For an institution to avail itself of HCQIA immunity, it does not need to precisely comply with all elements of its governing documents, but it may show from a totality of the circumstances that its handling of the matter was objectively reasonable. Remember, the reasonableness of an institution’s actions is not a subjective determination, and neither good nor bad motives should be considered. Rather, a court should consider the objective, overall reasonableness of an institution’s actions.

**Conclusion**
The *Wahi* and *Poliner* cases present an excellent framework for handling internal peer review investigations and ensuing proceedings, as well as how to protect HCQIA immunity in subsequent litigation. Hopefully, this article will be of assistance to in-house and litigation counsel for hospitals, institutions, and other health care providers who participate in physician peer review processes.