Credentialing and Peer Review of Health Care Providers: The Process and Protections

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INTRODUCTION

In his recent novel *Monday Mornings*, renowned neurosurgeon and national medical celebrity Dr. Sanjay Gupta brings healthcare peer review into the public eye. *Monday Mornings* provides a look inside the morbidity and mortality conferences of a group of surgeons at Chelsea General Hospital in southeast Michigan. These peer discussions depict groups of surgeons openly talking about their errors and, occasionally, their personal failings. *Monday Mornings* is fictional, but Dr. Gupta based the book on ten years of real-life experience attending similar meetings and hearing about the mistakes made by even the most talented surgeons, some of which had tragic consequences.1 The book does not have a clear message about the effectiveness of peer review—after all, it had to be salacious enough to get picked up as a soon-to-be-aired David E. Kelley television series. Dr. Gupta, however, has used the book as a springboard to talk about the importance of frank and honest discussion about medical error as a tool for increasing patient safety.

According to some estimates, there are as many as 100,000 deaths attributable to medical error in the United States each year. While subject to its share of criticism, peer review is viewed as an essential tool in combating medical error and preventing injury and death. Every hospital administrator and lawyer practicing in a hospital setting should be aware of the beneficial uses of peer review, as well as the litigation dilemmas it sometimes creates. This paper describes the peer review process, the framework of legal protections meant to strengthen that peer review process, and some of the issues that arise in related litigation. Because laws regulating the peer review process are a mix of federal and state regulations, this paper cannot comprehensively address every issue. Rather, it is meant to provide an overview of some frequently occurring issues, as well as to look at some important case law, with an inevitable focus on the jurisdictions where the authors practice.

THE PHYSICIAN CREDENTIALING AND PEER REVIEW PROCESSES: HISTORY, PROCEDURE, AND PURPOSE

Professions, by their nature, are composed of individuals with extensive specialized education, training, and knowledge. This specialization creates a knowledge disparity that makes it difficult for a generalist legislature or other regulatory body to regulate the specifics of professional practice. It also makes regulation especially important, as the customers of a

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1 See, e.g., *Dr. Sanjay Gupta on Combating Medical Errors*, CBS News: Good Morning America (March 11, 2012) http://www.cbsnews.com/8301-3445_162-57395032/dr-sanjay-gupta-on-combating-medical-errors/?tag=contentMain;contentBody
professional are typically unable to evaluate the quality of services rendered by that professional. This knowledge disparity is especially prevalent in the medical profession, where constant changes in technology and advancements in procedure render it particularly difficult to regulate. Thus, self-evaluation of the medical profession is necessary and inevitable. One element of medical profession self-regulation is the establishment of state licensing boards made up primarily or exclusively of physicians. A second important component—the focus of this paper—is the peer review processes that take place in hospitals, whereby physicians evaluate the qualifications and quality-of-care of colleagues.

Peer evaluation among physicians has occurred for hundreds of years, mostly as an informal and voluntary process. Over time, credentialing and participation in peer review processes spread and became both more heavily regulated and essentially mandatory for physicians who practice in hospital settings. Currently, establishing a peer review committee is a requirement for a hospital to participate in the Medicaid and Medicare programs, and many states require hospitals to use a peer review committee as a requirement for licensure.

Medical peer-evaluation happens at two stages: The credentialing stage and the review of care stage. The credentialing stage is the process by which a hospital evaluates whether a particular physician is qualified to practice or continue to practice at that hospital. This determination is made when a physician initially applies for privileges at a hospital and when the physician is up for “re-privileging” or “re-credentialing,” typically once every two years. The review of care stage involves hospital investigations into questionable professional conduct by a physician, including conduct that may result in a medical malpractice lawsuit. Typically, both credentialing stage peer review and review of care stage peer review would be initiated through a standing committee of the hospital. However, if the standing committee or any subsequently involved decision-making body of the hospital makes an adverse recommendation that would trigger a right of appeal by the affected physician, an ad hoc committee would usually be appointed to hear the appeal. Review of care evaluation can lead to the implementation of a corrective action, including a restriction, suspension, or elimination of privileges. Neither the credentialing nor the review of care committee makes the final decision about a physician’s privileges, but committee recommendations form the basis upon which the hospital’s governing body makes its decision.

At both stages, the peer review process is intended to foster frank discussion about medical care by those who are qualified to discuss it, with an overall goal of improving healthcare and promoting patient safety. The idea is that that exacting a critical analysis of the

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competence and performance of physicians and other healthcare providers by their peers will result in better medical care. At the credentialing stage, peer evaluation and its accompanying protections are thought to be necessary for the all-important job of selecting and maintaining a well-qualified medical staff. Ongoing peer review, in response to complaints, mistakes, or general concerns about care, is intended to foster discussion and systemic improvement initiatives, as opposed to litigation, which encourages the concealment of mistakes and inadequacies.

PROTECTIONS FOR PEER REVIEW

Despite the above-described benefits, many hospitals and physicians have been reluctant to participate in peer evaluation because of the risk of potential liability and the fear of other personal and professional consequences that candid evaluation of a colleague may create. The hospital’s concern is two-fold: (1) that a negative decision may expose the reviewers to a lawsuit by the physician who is denied privileges or disciplined; or (2) that an affirmative decision may expose the committee or its members to liability if the privileged physician later makes a mistake.

To alleviate these concerns and realize the potential of peer review, Congress and every state has adopted a peer review statute to protect the interests of participants. The two main features of the peer review-protection legal framework are: (1) limited immunity from liability for peer review participants; and (2) confidentiality and/or privilege of peer review proceedings and documents. A third component of the peer review legal framework is the requirement that peer review committees report adverse actions to a state licensing agency, the National Practitioner Data Bank and other regulatory bodies, thereby increasing the effectiveness of the goal of protecting patient safety by preventing physicians from escaping a bad patient-care record through crossing state lines. The affected physicians are also required to report adverse actions to credentialing bodies, including the hospitals where they have or are requesting privileges.

**Immunity**

One important piece of the peer review protection framework is immunity from liability for peer review participants. Unlike the peer review confidentiality and privilege protections discussed below, which are primarily grounded in state law, the source for peer review immunity is federal law. In response to an explosion of medical malpractice litigation and the erosion of judicially granted antitrust immunity for peer review committees in the 1980s, Congress enacted the Healthcare Quality and Improvement Act (“HCQIA”).

HCQIA provides immunity for those involved in credentialing activities from a lawsuit, provided that the professional action was taken (1) in the reasonable belief that the action was in

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the furtherance of quality healthcare; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures were afforded to the physician involved or after such other procedures as were 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 procedural requirements listed above. A professional review action is presumed to have met the preceding standards for protection unless the presumption is rebutted by a preponderance of the evidence.

A plaintiff trying to overcome this immunity has the burden of proof to show by a preponderance of evidence that the HCQIA requirements were not met. Notably, most courts have interpreted the requirements of HCQIA as objective requirements. Thus, although a plaintiff essentially must establish malice to overcome peer review immunity, evidence of subjective bad faith on the part of peer review participants is insufficient to overcome immunity, as long as the HCQIA requirements are satisfied. The immunity afforded by the HCQIA applies to actions for damages under both federal and state law. However, it is not a grant of general immunity and does not provide immunity against injunctive relief. Although courts often decide that HCQIA applies at the summary-judgment stage, in some cases it may be deferred until the time of trial.

To safeguard the peer review participant immunity, detailed ground rules should be set out for how each physician is to be credentialed, re-credentialed, and evaluated in the case of quality-of-care concerns. The governing document for physician credentialing and standard-of-care review will usually be the hospital’s medical staff bylaws, and hospitals should ensure their bylaws track the requirements of the HCQIA. Moreover, adherence to HCQIA and internal procedures may allow a healthcare provider (including a hospital, physician, or anyone else) sued for involvement in a credentialing activity to recover costs and attorneys’ fees. If the healthcare provider meets the standards set forth by HCQIA and as reflected in the medical staff bylaws, and the healthcare provider substantially prevails in the litigation, the court shall award costs of suit, including attorneys’ fees, if it is also shown that the plaintiff’s claim or conduct during the litigation was frivolous, unreasonable, without foundation, or in bad faith.

In addition to the immunity provided by the HCQIA, at least 48 states have adopted peer review statutes, most of which grant immunity to peer review participants. Texas law, for

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6 Id. at §§11111(a), 11112(a).
7 Id. at §11112(a).
8 Wahi v. Charleston Area Medical Center, Inc., 562 F.3d 599 (4th Cir. 2009).
9 Fox v. Parma Community Gen. Hosp., 160 Ohio App.3d 409 (2005); Sugarbaker v. SSM Healthcare, 190 F.3d 905, 914 (8th Cir. 1999) ("[T]he subjective bias or bad faith motives of the peer reviewers is irrelevant").
11 Notably, despite this mandatory language, at least a few courts have found that damages under HCQIA are discretionary.
12 Id. at §11113.