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TOP HEALTHCARE LAWYERS 2023

OUR DANGEROUSLY OVER-BURDENED MEDICAL STAFF PEER REVIEW HEARINGS

By Lowell C. Brown

California lawyers representing clients in hospital medical staff peer review hearings know our state's system is broken. The hearings are too lengthy and costly, in both financial and human terms. The process's two companion goals – protecting patients while preserving fairness to accused physicians – are now significantly out of balance.

How did this happen? It is a story combining good intentions, on one hand, with a lack of sensible procedural rules on the other.

1. ADMINISTRATIVE HEARINGS OR COURT TRIALS?

To practice in a hospital, physicians must join the hospital's medical staff and qualify for privileges to practice there. Physicians subject to loss or reduction of their medical staff privileges in hospitals and other medical care facilities may challenge such actions under principles of "fair procedure," the common law equivalent to due process. Business and Professions Code §809 governs fair procedure hearings and was intended to provide an efficient process to assure patient safety while protecting physician rights.

Sadly, that process has become unrecognizable. Once straightforward inquiries into hospital medical practice, peer review hearings now increasingly resemble procedurally choked court litigation. A hearing can last for several years. Meanwhile, the physician too often continues to treat, and endanger, hospital patients.

This is not because of ill intent on anyone's part. Rather, it is a matter of rules that allow lawyers excessive leeway. For example, I am aware of a peer review hearing where physician leaders who took the underlying corrective action were bombarded with twenty-six written procedural motions, including motions in limine, and 120 requests for production. Unsurprisingly, the hearing took three years and twenty-nine evidentiary sessions to complete. I know of another hearing in which after six years passed, evidentiary sessions had not yet begun due to the physician's repeated objections to proposed hearing panel members. Allocating blame in such procedural travesties is pointless; they are unjustifiable no matter who is at fault.

Courts have rules in place to address – and stop – such procedural jousting. In medical staff hearings, the governing statute, §809, is silent about such matters. Attorneys for the parties respond to the resulting vacuum by simply filling the hearing with a glut of procedure.

2. RETALIATION LAWSUITS

Making matters worse, in 2007 the State Legislature passed an amendment to Health & Safety Code §1278.5, which conferred special whistleblower rights on physicians who complain or raise issues internally about quality-of-care matters. According to the 2007 amendment's sponsors, the legislation's purpose was to help avoid "sham peer review" actions against physicians, or adverse actions taken solely in retaliation for a physician speaking out.

The result has been perverse. Instead of stopping sham peer review, §1278.5 has produced sham whistleblower lawsuits that impede legitimate peer review action. One attorney who represents physicians in these matters told me he considers it his ethical duty to advise his physician clients, when they believe corrective action is approaching, to immediately seek whistleblower status. How? By complaining about a quality-related problem at the hospital – poor nursing care, equipment, or whatever it might be. During the 120-day period following a complaint, the law considers any peer review action taken or threatened against a physician as retaliatory by default.

Abuse of the statute is a significant disincentive to medical staff leaders contemplating action against a physician whom they see as a danger to patients. Peer reviewers wonder if they will find themselves not only in a time-consuming medical staff hearing with their physician peer, but also in a simultaneous lawsuit involving the same facts and witnesses. Superimposing a lawsuit on an ongoing hearing doubles the related burden and expense. For example, the physician's attorney may seek to harass an administrative hearing witness by taking that witness's deposition concurrently with that witness's testimony in the hearing. The threat of a whistleblower lawsuit has thus become a useful intimidation tool.

3. WHAT CAN BE DONE?

The Legislature should consider the following actions to support patient safety efforts by enabling medical staffs to take necessary action protecting both patients and the rights of accused physicians:

- Allow medical staffs to require mediation of all medical privileges disputes, in hopes of avoiding the burdensome and lengthy hearings.
- Where mediation fails, allow medical staffs to choose mandatory arbitration in certain cases. Medical staffs already have this right, but the arbitrator selection process leaves excessive room for a dilatory response from the physician. Requiring a prescribed, efficient process would help avoid prolonged multi-session administrative hearings by removing the problem of scheduling hearing sessions around the calendars of three to five practicing physicians.
- Give peer review hearing officers or arbitrators the authority to set hearing dates for the parties. Presently, hearing officers lack any real authority other than to rule on procedural motions. The parties schedule hearings at the convenience of both sides; in some cases, a party may have little incentive to move the matter forward.
- Give hearing officers the authority to limit frivolous procedural motions. As noted above, there are no limits to filing motions, many of which attempt to import inapplicable rules from the Evidence Code or Code of Civil Procedure into administrative hearings. The resulting disputes bring the process to a halt while both sides brief and argue the motion and wait for the hearing officer's written ruling.
- Enact barriers against sham retaliation claims by enabling early attack by defendants in such cases. This is especially useful where a medical staff hearing is pending or underway. The above pre-filing mandatory mediation provision would help considerably. Also, the law could forbid depositions in retaliation lawsuits until after the evidentiary portion of the hearing ends.

Provider organizations must be free to deal with dangerous physicians quickly. The accused physicians should have fair and speedy hearings. To satisfy both needs, the stakeholders should reduce, or even eliminate, the extraneous burdens on medical staff peer review. Taking steps like those above will help medical staffs and hospitals do the job the law asks them to – protect patients against substandard medical practice. Doing so simply requires the will to move forward. Working with the stakeholder trade associations and the Medical Board of California, the Legislature could begin a new era of fair but no-nonsense peer review.

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