

Medical peer review explained — part 2

by Lynne Dakers, RN, JD, Risk Management Representative

Protections against antitrust litigation

The 1980s saw a rising number of antitrust suits against hospitals and their medical staffs brought by physicians denied privileges. The Health Care Quality Improvement Act grants limited immunity for peer review actions so long as they were taken with the reasonable belief that the action was in the furtherance of quality health care; after a reasonable effort to obtain the facts; after adequate notice and hearing procedures are given to the physician involved; and if the committee action was taken in the reasonable belief that it was warranted by the facts. In essence, procedural requirements and the duty to act in good faith with the overall goal of improving quality of health care allow for the limited immunity.

The HCQIA immunizes committees, their staffs, and those persons who assist the committee in gathering information against a broad range of suits including defamation, malicious persecution, antitrust, and tortious interference with contractual relations. It does not, however, apply to civil rights claims.¹

The first federal court case to apply immunity under HCQIA was Austin v. McNamara, 731 F.Supp. 934 (C.D.Cal 1990).² It was ruled that protection was appropriate under the Act because the peer review criteria of the Act were met.

Medical staff privileges and due process requirements

The Texas Hospital Licensing Law provides that the process for considering applications for medical staff membership or privileges must afford each applicant procedural due process. (Texas Health and Safety Code, Title 4, Subtitle B, Chapter 241.101(c)). Public hospitals must rely on well-stated, reasonable rules in denying or curtailing staff privileges (substantive due process). These rules must provide to medical staff applicants at a minimum:

notice of the charges, opportunity to present and examine witnesses, right to counsel, right to a transcript of the proceedings, and a right to appeal to a higher authority.

Private hospitals have greater discretion. The hospital governing board may adopt reasonable rules and regulations, or the medical staff may adopt bylaws for staff appointment and delineation of privileges.

Since these bylaws regulate the peer review rules and regulations, it is in each physician's best interest to negotiate the terms of hospital and medical staff bylaws with an eye toward increased personal protection. (See "Proposed Physician Bill of Peer Review Rights" in Forget Fair Play: Hospital Bylaws have become Peer Review Traps, *Texas Medicine*, January, 1999.) See Appendix A.

Federal rules

This past June, the U. S. Supreme Court declined to review a decision by the U.S. District Court for the Northern District of California in San Francisco, which allowed the subpoena of peer review records in a lawsuit under the state malpractice law and the federal Emergency Medical Treatment and Active Labor Act.³ The district court ruled that the state peer review law was pre-empted by the federal rules of discovery which do not recognize a peer review privilege. The unique facts of the case, however, where the physician allegedly destroyed his notes and altered the medical record after going through peer review, will perhaps make it unlikely that this case will be followed.

A call for physician group peer review

While the protection for and encouragement of medical peer review stem from the position that the medical profession is in the best position to police itself and advance quality patient care, basing peer review

solely in the institutional setting has limitations.

First, physicians provide many services in the office environment or out-patient setting outside the scope of institutional medical staff peer review committees. Moreover, focusing review solely on the care rendered in the hospital provides an incomplete picture. "Unless there has been a readmission or a lawsuit, the hospital medical staff may not be able to ascertain if patient health after discharge has, in fact, been improved by the physician's diagnosis and treatment."⁴

Physicians who practice together in any form of multiple provider business organization have incentives to monitor the quality of care rendered by fellow practitioners. With the current state of medical malpractice litigation and the growth of consumerism in health care, physicians would be wise to disassociate themselves with colleagues providing substandard patient care.

Risk Management Considerations

In order to take advantage of the protections provided by the legislature and courts, a peer review program must be established.⁵ Bylaws, internal rules, regulations and policies should be established that show the existence of a formal, organized peer review process. The purpose of the peer review process, that is, to improve the quality of patient care, should be explicitly stated.⁶

Use extreme care that all peer review activities are kept confidential. Don't talk about peer review outside the committee. Keep all peer review documents separate from ordinary business documents. Designate all employees who gather information (e.g. nurses performing quality assurance audits) agents of the committee.⁷

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peer review (continued)

All reports must be shown to be a necessary, core component of peer review.⁸ When seeking credentialing information, have requests sent by and responses made by a peer review committee representative.

Stamp all documents “prepared in preparation for peer review.” Adopt a documentation retention system whereby quality assurance documents are destroyed within 60 days of transmittal to the reviewing physician.⁹ Peer review minutes should be distributed only to committee members during meetings and collected and destroyed when the meeting ends.¹⁰

Establish policies and procedures that conform to the requirements of the HCQIA. Develop effective mechanisms by which potential problems with a physician’s competence can be identified to facilitate the fact-finding requirements of the HCQIA.¹¹ Health care entities are encouraged to consult their attorneys to ensure that their bylaws and medical staff rules comply with the HCQIA and the Medical Practice Act. Make sure everyone knows the rules and applies them consistently.

Peer review documentation should be limited to objective statements of fact. Peer review materials must support any disciplinary action (or inaction). Reports should have patient and physician identifiers removed. Employ case numbers instead of using physician names. When credentialing, seek external independent reviewers when appropriate, to assure unbiased assessment of a physician’s competence.¹²

Appendix A: Proposed physician bill of peer review rights

Physicians must read hospital bylaws and be proactive in negotiating their terms. What follows are some, but not necessarily all, of the rights physicians should insist upon.

- Summary suspension should be reserved for physicians who have become dangerous to their patients because of physical or mental impairments. Summary suspension should not be used to revoke the privileges of an unimpaired physician.
- Prior releases and indemnity agreements probably are not enforceable and should be eliminated.

- A physician should have the right to request an independent, focused review before the hearing.

- The hearing panel should be selected jointly by the physician and the administration.

- The administration should bear the burden of proof by substantial evidence to revoke a physician’s privileges. The administration should have to prove that the physician’s overall practice reflects a pattern that falls below the standard of care.

A single event rarely should be the basis of termination. This burden should not be satisfied by introducing an ad hoc or credentials committee report and then requiring the physician to disprove the report.

- A physician who prevails in his peer review case with the hearing panel should have the right to have the board of trustees adopt that judgment. The board should be able to overturn the hearing panel’s decision only when the credentials committee or the administration proves through an appeal that the hearing panel’s decision was arbitrary, capricious, or unsupported by substantial evidence.

- The physician should have the right to have an attorney present, and his or her attorney should have the right to participate actively in the peer review hearing.

- All physicians should have the right to receive written notice of the charges, all relevant documents (including exculpatory records), and a list of witnesses prior to the hearing.

- If the administration limits use of the summary suspension procedure to truly impaired physicians, then adverse action reports should not have to be sent until after the hearing panel rules. If the hearing panel rules against the physician, he or she should have a right to appeal. Competent counsel should write adverse actions reports, and drafts should be shown to the physician for clarification before being sent to the National Practitioner Data Bank.

- A physician’s privileges should not be terminated for failure to disclose certain information in an application unless that information

is material, which means that if it had been disclosed, the physician’s application for privileges would be denied.

Footnotes

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4. Lowell C. Brown & Karen R. Weinstein, Is the Traditional Medical Staff Becoming Obsolete? Inside Health Law, April 1996.

5. Legal Forum: Peer Review in Practice: Carr v. Howard, Risk Management Foundation, Vol. 19, No. 4, Fall 1998.

6. Discover of Initial Credentialing Documents: Texas Supreme Court Challenges the Rules, Health Care Newsletter, June 1996.

7. Clifton M. Smart, III, JD, The Peer Review Privilege: What Documents are Protected from Discover in Litigation, Mo Med 1998 May; 1995(5):205-6.

8. Legal Report: State High Court Says Hospital Incident Reports Can be Protected, Report adapted from Risk Management Foundation monthly audiotape [Resource](#), March 1998.

9. Ibid # 7

10. How Should I Document Peer Review Discussions of Sensitive Case Reviews? Risk Management Foundation (©1996-1998).

11. Ibid # 2

12. Ibid.

Closing the gap between recommended practices and reality

Are most health care practitioners consistently providing or recommending preventive care to their Medicare patients? Most would probably answer “yes.” They would be surprised to learn that the actual utilization rates of preventive services are very low. The Texas Medical Foundation (TMF) aims to close the gap between recommended practices and actual utilization rates with the implementation of its Outpatient Quality Improvement Project. To accomplish this, TMF invites physicians, health care practitioners, and Medicare patients to participate in a national effort to reduce the morbidity and mortality associated with breast cancer, influenza, pneumonia, and diabetes.

Medicare covers many of the services which can prevent or allay the effects of these costly and often deadly conditions. However, according to Medicare claims data, only 23 percent of Medicare beneficiaries not enrolled in managed care plans had a pneumococcal vaccination between 1991 and 1997, and only 41.3 percent of female Medicare beneficiaries had a mammogram in 1997 or 1998. Additionally, according to a recent sample of Texas Medicare beneficiaries enrolled in managed care plans, only 37.1 percent of patients with diabetes had been getting yearly Hemoglobin A1C (HbA1C) tests, even though the American Diabetes Association recommends at least two per year.

Medicare beneficiaries can receive the influenza or pneumococcal vaccinations free of charge, with no coinsurance or Part B deductible. Medicare pays for one flu vaccination

per year (usually given in the fall). For pneumococcal vaccinations, one may be all a beneficiary needs. Vaccination against influenza and pneumonia prevents illness and complications that can be fatal to the Medicare population.

Medicare also helps pay for one screening mammogram per year for female beneficiaries aged 65 or older (or age 40 or older in women with disabilities who qualify for Medicare). Because mammograms can identify cancerous tumors in the breast that are too small to palpate, they are crucial in the early detection of breast cancer. Beneficiaries pay only 20 percent of the cost of the mammogram with no Part B deductible.

For patients with diabetes, Medicare provides coverage for glucose monitors, test strips, lancets, dilated eye exams, laser treatment for diabetic retinopathy and cataract surgery, insulin pumps, and outpatient diabetic education. Beneficiaries pay for 20 percent of these services after the annual Part B deductible.

Much of the difficulty in recommending and/or providing these and other preventive services in a consistent, comprehensive manner is due to a “system issue,” not a “professional issue.” Physicians do not intentionally provide less than optimal care. However, the processes within their clinic may not support optimal care. Additionally, patient adherence to recommended services continues to be a challenge. Paired with the ever-increasing demands of today’s office environment, these can be difficult obstacles to overcome.

TMF can help in the implementation of a systematic approach to providing care which can translate into a time-efficient practice. TMF is pleased to offer free “tool kits” to health care providers which include preventive care flow sheets, patient education materials, and information about Medicare’s coverage of flu and pneumococcal vaccinations, mammography, and diabetes testing and services. TMF is also offering free office staff training, workshops, and office education videos for those physicians participating in the TMF Outpatient Quality Improvement Project.

With TMF’s help, practitioners can improve the rates of preventive services provided to not only Medicare patients, but all of their patients, and therefore demonstrate continued commitment to improving quality of care and life for Texans.

To inquire about participating in the Outpatient Quality Improvement Project, or to order free provider tool kits and other materials such as preventive care flow sheets, contact Bob Abel, projects coordinator, by calling (800) 725-9216, or by email: txpro.babel@sdps.org.

TMF is Texas’ peer review organization (PRO), a private, nonprofit organization under contract with the Health Care Financing Administration (HCFA — the agency administering the Medicare program) to conduct quality improvement activities and quality assurance review for the Medicare program. There is a PRO for every state which conducts similar activities to support the national goals of HCFA.

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Inside INSURANCE

So you think you might be sued. Now what?

by *Theo van Eeten*

One day the dreaded phone call or letter arrives, announcing that you should prepare to answer questions about the “damage” you’ve done to one of your patients. What to do?

Even though no one likes to have this experience, it is the reason you have been paying premiums, and your first action should be to call the TMLT claim department.

The first item of business is not for TMLT to tell you what to do, but rather to tell you what not to do:

1. Don't write a narrative to help you out. Anything you write down can be “discovered” by the opposing party. While our work papers are confidential, anything you put on paper can be read by the opposing attorneys. Narratives by witnesses are discoverable as well.

2. Don't call the plaintiff's attorney. No matter how tempting it is to explain your side of the story, plaintiff's counsel may not be quite as understanding as you had hoped.

3. Don't change any records after the fact. While this may seem common sense advice, it has happened. It always comes to light and will undermine your chances of a successful defense.

4. Don't count on it going away soon. The average life of a lawsuit is 18 months to 2.5 years. Some cases take 5 years or longer. Your participation and cooperation in the process is vital to bring the case to a resolution.

5. And last but not least, don't do anything unless asked by your defense team.

So now that you know what not to do, what will happen when you call TMLT? First, we will assign a claim supervisor and claim technician to your case. This team will work with you, the attorney, experts and other individuals within the TMLT claim department to bring your case to a conclusion. The claim team serves as central coordinators for your case, and will work with you throughout the case and keep you informed.

Second, the “complaining” party is supposed to give 60 days notice before a lawsuit is filed. This will allow us time to review the records, and gives us an opportunity to find out if other physicians have treated the same patient. It also gives us a chance to have you request hospital records (TMLT does not have access to the hospital records). While the lawsuit

papers are not supposed to be filed until 60 days after you have been notified, in reality the lawsuit can come at any time.

As soon as you receive the lawsuit, or any other legal papers for that matter, forward them immediately to TMLT. We will assign an attorney based on venue (location) of the suit, expertise in certain areas, type of damage alleged and several other factors. The attorney will contact you and, in each case, a defense plan is drafted with the claim supervisor's input.

Unless the lawsuit is dropped, the majority of cases go to voluntary or court-ordered mediation. The attendance of all parties is required at most mediations. Some cases cannot be resolved in a reasonable manner and go to trial. It is essential to the defense of the case that the physician is present in the courtroom.

There is no question that getting sued is costly, always emotional and definitely time consuming, but that's where your TMLT defense team shines and supports you every step of the way. Our goal is to seek the most favorable and expeditious outcome possible on your behalf.