Medical Staff Bylaws, Peer Review and Judicial Intervention

by Arthur J. Timins

State law[1] and The Joint Commission (TJC) each require that self-governing medical staffs of hospitals be organized on the basis of medical staff bylaws. Two of the important subjects of such bylaws involve credentialing physicians to become or remain members of the medical staff, and corrective action involving penalties up to the potential revocation of existent medical staff membership and privileges. Because both of these subjects entail professionals evaluating other professionals, credentialing and corrective action together are considered 'peer review.' The goal of all peer review is to make available to the public competent professionals and to exclude those who are less than competent.

As the ultimate authority in every hospital is vested in its governing body, the medical staff bylaws and each peer review determination must be ultimately approved by that governing body.[2] Yet, as the governing body typically includes lay people, it usually bases many of its decisions on the expert recommendations of the professional medical staff. And, the terms of the medical staff bylaws typically mirror this two-step dynamic.

According to the TJC "the organized medical staff creates a written set of documents that describes its organizational structure and the rules for its self-governance...[which] are called medical staff bylaws..."[3] At the pinnacle of authority within the medical staff is the medical executive committee, which "acts on the behalf of the medical staff between meetings of the organized medical staff..."[4] TJC requires the medical staff bylaws describe "[t]he process for appointment and reappointment" to membership on the medical staff, and TJC also requires that such bylaws further describe both [substantive] "indications" and "[t]he process for recommending termination or suspension of medical staff membership and/or termination, suspension, or reduction of clinical privileges."[5]

The process for credentialing typically commences with the submission of an application for membership, with background and references that, after investigation, proceeds through a credentials committee to the medical executive committee. The committee usually then votes whether or not to recommend the appointment or reappointment of the applicant to the governing body.

The process for corrective action generally commences at the request of an officer of the medical staff or an officer of the hospital, following the receipt of a complaint against a member of the medical staff. After an initial investigation of that complaint, the affected member of the medical staff is afforded the opportunity to respond. The investigative phase typically concludes with the medical executive committee making a recommendation regarding the complaint to the hospital's governing body.

If the recommendation during the credentialing process or the recommendation during the process for corrective action is sufficiently unfavorable, the affected practitioner will have the right to a fair hearing before an *ad hoc* committee of his or her peers. And, if the recommendation of the *ad hoc* committee continues to be unfavorable, the practitioner usually will have the right to appeal to the governing body before it makes a final decision in the matter.

Traditionally—at least prior to 1958—while governmental hospitals were deemed subject to the due process and equal protection requirements of the U.S. Constitution, a "rule of non-review" was thought to exempt private hospitals from judicial scrutiny in matters of peer review.[6]

However, in 1958 the New Jersey Supreme Court rejected the contention of a 'private hospital' that it had the unfettered discretion to exclude a physician from practice at that hospital. The Court found instead that the physician was entitled to a hearing in accordance

with medical staff bylaws agreed to by the hospital, because following approval by the hospital, those bylaws constituted a contract among the parties.[7]

Then, in 1961, the New Jersey Supreme Court undertook a series of decisions which "focused upon the triadic relationship between private hospitals, doctors and patients" that led to the recognition that bylaws and peer review were subject to judicial intervention in the furtherance of "public policy."[8]

In *Falcone v. Middlesex County Medical Society*,[9] the Court reasoned that "public policy" dictated that the power of a hospital to exclude a physician from its staff "should not be unbridled but should be viewed judicially as a fiduciary power...for the advancement of the interests of the medical profession and the public generally." Then, in *Greisman v. Newcomb Hosp.*,[10] the Supreme Court directed that a hospital consider the plaintiff's membership application notwithstanding a medical staff bylaw requirement that he must be a graduate of a medical school approved by the American Medical Association and must be a member of the county medical society. The plaintiff, a graduate of an osteopathic college, did not satisfy these criteria, though he held an unrestricted license to practice medicine in the state of New Jersey. The Court, in declaring the bylaws restriction invalid, concluded:

> ...courts would indeed be remiss if they declined to intervene where, as here, the powers were invoked at the threshold to preclude an application for staff membership, not because of any lack of individual merit, but for a reason unrelated to sound hospital standards and not in furtherance of the common good.

And, in *Doe v. Bridgeton Hospital Association, Inc.*,[11] the court, relying on *Greisman*, recognized "the obligation of a quasi-public entity to serve the public," and stated that,

> ...[only] when the practice or regulation [of a hospital] enhances standards of medical care or public welfare, broad judicial support is warranted.

Otherwise such a practice or regulation of this nature is "unsupportable and arbitrary."

In *Nanavati v. Burdette Tomlin Memorial Hospital*,[12] a case involving corrective action, a physician brought a lawsuit challenging a hospital's decision to terminate his staff privileges due to his alleged inability to work with others. The court, applying the same public policy concepts that it had earlier applied in cases involving credentialing, explained,

> ...[a] hospital need not wait for a disruptive doctor to harm a patient before terminating his or her privileges. Nonetheless, more should be required than general complaints of a physician's inability to cooperate with others. To constitute disruptive behavior meriting termination of staff privileges, hospital authorities should present concrete evidence of specific instances of misbehavior...*that will adversely affect health care delivery*...
>
> ...We believe we strike the appropriate balance by requiring that the hospital establish that 'prospective disharmony *will probably have an adverse impact on patient care*.'... (emphasis supplied).

"The interests of the public, the physician, and the hospital in the peer review process have been recognized by the United States Congress by passage of the Health Care Quality Improvement Act" (HCQIA) in 1986.[13] HCQIA is intended to encourage both peer review and that the peer review is fair. Prior to HCQIA, participants in the process risked being sued by physicians who claimed prejudice from peer review. HCQIA grants qualified immunity from suit to such participants in the process if there was adequate notice and a fair hearing. Basically, to deprive participants in the process of HCQIA immunity an aggrieved practitioner must prove by a preponderance of the evidence that he or she was subjected to adverse action while those participants had failed to act in the reasonable belief that their action was in furtherance of quality healthcare, and/or their action did not follow a sufficient investigative effort, and/or there was inadequate notice and/or an unfair hearing.

Federal statutory law embodies certain procedural requirements, including that the practitioner have not less than 30 days to request a hearing.[14] These procedural requirements of the federal statute essentially parallel and extend prior New Jersey common law. In *Garrow v. Elizabeth General Hospital and Dispensary*,[15] the New Jersey Supreme Court had explained that "[f]undamental fairness dictates that the hospital apprise the physician of specific charges," that the physician "be afforded the opportunity to appear and present witnesses and material in support of his position and to contradict or explain" that which is asserted against him. However, a formal hearing and adherence to rules of evidence are not required, and there is a right to counsel, whose role is subject to reasonable rules laid down by the hospital. Underlying data upon which the board of trustees is relying should be made available (at the doctor's expense) prior to the hearing, and if new information is to be utilized the physician should be provided the opportunity to meet or explain it.

Substantively, however, it is not unusual for medical staff bylaws to proclaim, for example, that corrective action may be recommended if a practitioner's professional conduct 'may be' detrimental to patient care or 'disruptive to hospital operations' or 'in violation of the rules, regulations, policies or procedures' of the medical staff or the hospital. But, these substantive standards arguably may not satisfy *Nanavati*, which explicitly required a finding that there *"will probably" be an "adverse" effect on healthcare delivery.* (emphasis supplied).

Also, it is not unusual for bylaws to authorize corrective action where a practitioner's professional conduct is 'considered to be lower than the standards or aims of the medical staff.' But this standard, according to at least one commentator, may be too vague to provide any protection to the interests of physicians—and, the public and hospital as well. It has, accordingly, been reasoned by that commentator that *"[a]bsent...clearly articulated, objective criteria, all of the participants in the peer review process will be denied HCQIA immunity."*[16] (emphasis supplied).

Inasmuch as the New Jersey Supreme Court has already declared that "a decision revoking privileges is even more important" and "merits a closer look than a decision" involving credentialing, the fairness and sufficiency of substantive standard(s) for corrective action may well be a subject warranting future attention.[17] ■

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Endnotes

1. N.J.A.C. 8:43G-16.1 to 16.6.
2. Overview to MS.01.01.01. of JCAHO (Effective 3/31/11).
3. Introduction to MS.01.01.01.
4. Introduction to MS.01.01.01. and EP23 of MS.01.01.01.
5. EP27, EP30 and EP33 of MS.01.01.01.
6. Craig W. Dalton, Understanding Judicial Review of Hospitals' Physician Credentialing and Peer Review Decisions, 73 *Temple Law Review* 597, 630-634 (2000).
7. *Joseph v. Passaic Hospital Ass'n*, 26 N.J. 557, 566, 569 (1958).
8. *Bloom v. Clara Maas Medical Center*, 295 N.J. Super. 594, 607-610 (A.D. 1996).
9. 34 N.J. 582, 597 (1961).
10. 40 N.J. 389, 404 (1963).
11. 71 N.J. 478, 486-489 (1976).
12. 107 N.J. 240, 254 (1987).
13. 42 U.S.C.A. Sections 11101-11152.

14. 42 U.S.C.A. Section 11112 (Standards for Professional Review Actions) requires adequate notice which includes the "reasons for the proposed action," and the provision of "a list of witnesses expected to testify." The hearing shall be before a mutually acceptable arbitrator, or hearing officer or panel of individuals who are "not in direct economic competition with the physician involved." That physician shall have a right to representation, a record shall be made of the proceedings, copies of which will be available to the physician at a reasonable charge; the physician shall have the right to call, examine and cross examine witnesses, and to present relevant evidence, "regardless of its admissibility in a court of law," and a right to submit a written closing statement. Following the completion of the hearing, the physician is entitled to receive the written recommendation of the arbitrator, hearing officer or panel, and, thereafter, a written decision of the governing body.
15. 79 N.J. 549, 564-568 (1979).
16. Katherine Van Tassel, Hospital Peer Review Standards and Due Process. Moving from Tort Doctrine Toward Contract Principles Based on Clinical Practice Guidelines, Vol. 36: 1179, *Seton Hall Law Review* (2006), wherein it is also declared at p. 1184 that "the list of process protections are all empty formalities if, after the proceedings are completed, the decision-makers can decide to take whatever actions their personal inclinations dictate."
17. *Nanavati v. Burdette Tomlin Memorial Hospital, supra*, 107 N.J. at p. 250.