

MEDICAL STAFFS, PEER REVIEW AND FAIRNESS

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It is self-evident that most medical practitioners require membership on hospitals' organized medical staffs to practice their professions. It is also clear that hospitals' by-laws, which provide for professional peer review, govern the mechanics of such practitioners' admission to and continued status on those staffs.

Organized medical staffs are themselves recognized legal entities that are required by law to be subject to governing by-laws. Each set of by-laws amounts to a contract between the hospital and such staff, as well as a contract between the hospital and each member of the staff. As such they must be separately approved by the hospital's governing board and by the medical staff, which is an unincorporated association of its members.¹ The purpose of this article is to urge medical staffs to advocate for the maximal fairness of the peer review process to their members.

What "fair hearing" or "due process" rights may medical practitioners presently expect respecting the peer review process?

Reported court decisions in New Jersey dealing with peer review issues routinely reflect a hesitance of the judiciary to intervene, judges typically expressing the sentiment that "[i]n so specialized and sensitive an activity as governing a hospital, courts are well advised to defer to those with the duty to govern."² Essentially based on the same rationale, the doctrine of "Exhaustion of Administrative Remedies" is commonly

¹ Corleto v. Shore Memorial Hospital, 138 N.J. Super. 302, 311-312 (LD 1975).

² Nanavati v. Burdette Tomlin Memorial Hosp., 107 N.J. 240, 251 (1987) and Guerrero v. Burlington County Mem. Hosp., 70 N.J. 344, 356-357 (1976).

employed to foreclose any possible judicial involvement until after the peer review process has completely run its course.³

However, the New Jersey Supreme Court has also recognized that, while a decision denying staff privileges to a new applicant is important, “a decision revoking those privileges is even more important to a physician with an established practice.” The “stakes are higher for all concerned” and an adverse hospital decision “merits a closer look” in this context.⁴

The general outline for peer review generally is that after one of the medical staff’s committees makes a recommendation respecting a member’s privileges, an investigation follows and, if necessary, there is then a hearing and, ultimately, a review and final decision of the governing body of the hospital.

This process is the subject of the Health Care Quality Improvement Act (HCQIA).⁵ That federal statute, on its face, requires that any professional review action must be taken only “in the reasonable belief that ... [it is] in furtherance of quality health care,” and only may be pursued “after reasonable” investigation, and “adequate notice and hearing procedures are afforded to the physician involved” and ultimately “in the reasonable belief that the action is warranted.”⁶ Other provisions require notice of “not less than 30 days,” the provision of “a list of witnesses” and that the hearing officer not be “in direct economic competition with the physician involved.”⁷ While these standards are generally of some help, they are mostly non-specific and the statute goes on to provide that,

³ Garrow v. Elizabeth General Hospital and Dispensary, 79 N.J. 549, 560 (1979).

⁴ Nanavati v. Burdette Tomlin Memorial Hospital, *supra*, 107 N.J. at p. 250.

⁵ 42 U.S.C.A. §11101-11152.

⁶ 42 U.S.C.A. §11112(a).

⁷ 42 U.S.C.A. §11112(b).

“[a] professional review action is presumed to have met the ... standards necessary ... unless the presumption is rebutted by a preponderance of the evidence.”⁸

So the burden is shifted to the practitioner to prove that his treatment was unfair.

Upon closer inspection, moreover, actual case law discussing specific procedures reveals the importance of the specific language of the by-laws. For example, while the New Jersey Supreme Court may be stated to have recognized some right to counsel during the peer review process, the court also explained:

“[c]ounsel’s participation and his role will be subject to the reasonable rules laid down by the Hospital’s board of trustees or other authorized persons and management and control of the hearings will rest with the person or persons in charge ...”⁹
(emphasis supplied).

The same court also ruled that “relevant and material underlying data” should be made available to the physician, “at his expense.”¹⁰ However, what was “relevant and material” was not specified. In another matter a court recognized the right of the practitioner to subpoena witnesses only because the hospital by-laws explicitly afforded that physician with the right to “call and examine witnesses.”¹¹

To assure that maximally fair procedures are employed where so much is at stake, organized medical staffs must assert themselves to secure such rights as the right of counsel starting with the investigatory stage, the right to the disclosure of the identity of one’s accusers, the right to a transcript of all proceedings (and who is to pay for it), the

⁸ 42 U.S.C.A. §11112(a).

⁹ Garrow v. Elizabeth General Hospital and Dispensary, *supra*, 79 N.J. at pages 566-567 (1979).

¹⁰ Garrow v. Elizabeth General Hospital and Dispensary, *supra*, 79 N.J. at p. 567.

¹¹ In the Matter of Ahmad Mossavi, M.D., Petitioner, 334 N.J. Super. 112, 120-123 (Ch. Div. 2000).

right to call witnesses, the right to specific documentary discovery (and, again who pays), and the most thorough possible specifics as to what must be included in a hearing notice.