LIABILITY ISSUES IN HEALTH CARE CONTRACTING AND CREDENTIALING

Cory M. Sutker
Cooper & Scully, P.C.
900 Jackson Street, Suite 100
Dallas, TX 75202
214/712-9500
Fax 214/712-9540
cory.sutker@cooperscully.com

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Cooper & Scully, P.C.

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I. INTRODUCTION

In recent years, hospitals have become a popular target of a different type of litigation. While tort reform has dampened the litigious spirit of many disgruntled patients and their attorneys, the landmark verdict in *Texas Health Systems v. Poliner* has peaked the interest of physicians who feel that they have unfairly fallen victim to the hospital's credentialing process and business practices. Realistic or not, the prospect of *Poliner*-type verdicts has made hospitals more vulnerable to attack from physicians who are left on the outside looking in. This paper will highlight the issues and allegations (addressed in *Poliner*) that commonly accompany the resulting litigation.

II. *POLINER* AT A GLANCE

Following an investigation into several cases of prospective substandard medical care, a peer review committee temporarily suspended Dr. Poliner's cardiac catheter lab and echocardiography privileges at Presbyterian Hospital of Dallas. After the decision was upheld by the Hospital's Board of Trustees, Dr. Poliner filed suit in federal court against the Hospital and several physicians, asserting antitrust claims, breach of contract, defamation (libel and slander), tortious interference with business, violations of the Deceptive Trade Practices Act ("DTPA"), and intentional infliction of emotional distress. *Poliner*, No.3:00-CV-1007-P, 2003 WL 22255677 (N.D. Tex. September 30, 2003).

In September 2003, the United States District Court for the Northern District of Texas dismissed Plaintiff's DTPA and antitrust claims against all of the Defendants. Relying on statutory immunity, the court also dismissed all claims against the physicians who were sued solely because of their participation on the peer review committee that investigated Dr. Poliner's care.[1] The Court left the remaining claims to be tried in front of a jury based on the conclusion that a fact issue existed as to whether Defendants acted maliciously. *Id.; see also Poliner*, No.3:00-CV-1007-P, 2006 WL 770425 at *1-*2 (N.D. Tex. March 27, 2006).

In August 2004, after a two-week trial, the jury found for the Plaintiff on all the remaining claims and deemed the Defendant's conduct to be malicious and without justification or privilege. *Id.* The jury awarded compensatory and exemplary damages in the amount of $366,211,159.30. *Id.*[2] Defendant's subsequently filed a Motion for New Trial and a Motion for Remittitur.

On September 18, 2006, the Court entered a Memorandum Opinion and Order granting, in part, the Motion for Remittiur, finding that the maximum recovery shown by the evidence was $21 million in actual damages and $1,542,106.20 in punitive damages. *Poliner*, No.3:00-CV-1007-P (N.D. Tex. September 18, 2006). The Court stated that, if Plaintiff accepted the remittiur, Defendant's Motion for New Trial would be denied and a judgment would be entered in Plaintiff's favor. If Plaintiff did not accept the remittitur, a new trial would be conduct solely as to damages. To date, no judgment has been entered.[3]

III. PEER REVIEW IMMUNITY IN CREDENTIALING CASES

Assuming that the hospital completed peer review prior to its credentialing decision, the first line of defense is to assert immunity under federal and state law.[4]

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[1] Although all of the Defendants, including the Hospital, moved for summary judgment as to all claims on the basis of immunity, the Court determined that fact issues existed with regard to whether the remaining Defendants complied with the statutes' requirements and were, thus eligible for immunity. *Poliner*, 2003 WL 22255677 at *8 - *16.

[2] In its March 2006 Memorandum Opinion, the Court indicated that Plaintiff's damages would be somewhat limited by the "one satisfaction rule". The rule states that "[a] party is not . . . entitled to a double recovery, which exists when a Plaintiff obtains more than one recovery for the same injury". *Id.* at *6-*7,

[3] Although Plaintiff accepted the remittitur, he also made a request for interest. Essentially, then, Plaintiff has accepted more than has been offered by the Court.

[4] Of course, to be eligible for peer review immunity, the health care provider (i.e hospital or practice group) must have a bona fide peer review process in place. It is not enough to

A. Healthcare Quality Improvement Act

In the federal context, the Healthcare Quality Improvement Act ("HCQIA") governs peer review immunity. 42 U.S.C. § 11111, *et seq.* Recognizing the "increasing occurrence of medical malpractice and the need to improve the quality of medical care," Congress enacted HCQIA to provide for effective peer review and monitoring of substandard care. 42 U.S.C. § 11101; *Austin v. McNamara, M.D.*, 979 F.2d 728, 733 (9th Cir. 1992). To facilitate the process, the statute also provides immunity to peer review participants. 42 U.S.C. § 11111(a); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 911 (8th Cir. 1999).

Immunity under HCQIA is not absolute; rather, to be eligible for the statutory protection, the peer review (or "professional review") action must be taken (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are 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 meeting the notice requirements above. 42 U.S.C. § 11112(a).

The reasonable belief requirement (the first element) is based on an objective inquiry. Thus, it is does not matter if the initial concerns are proven to be medically sound, nor does it matter if the inquiry resulted in an incorrect decision. *Poliner*, 2003 WL 22255677 at *9; *see, e.g., Lee v. Trinity Lutheran Hospital*, 408 F.3d 1064, 1071 (8th Cir. 2005). Reasonable fact gathering (the second element) is a fluid process that depends on the totality of the circumstances leading up to the peer review action in that particular case. *See, e.g., Sugarbaker*, 190 F.3d at 914. Notably, with regard to the notice requirement (the third element), HCQIA does not require that the physician in question be permitted to participate in the review of his care. *Singh v. Blue Cross/Blue Shield of Massachusetts*, 308 F.3d 25, 40 (1st Cir. 2002).

Interestingly, a professional review action is presumed to have complied with these statutory requirements unless the plaintiff can rebut the presumption by a preponderance of the evidence. *Id.*

B. Texas Peer Review Statutes

In Texas, peer review activity is governed by the provisions in the Texas Occupations Code.[5] Generally, immunity is provided to (1) a person who, in good faith, reports or furnishes information to a peer review committee; and (2) members of peer review committees "if that member . . . acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to that person." TEX. OCC. CODE ANN. § 160.010(a)(2). Given the need to show actual malice, "Texas has clearly taken the additional step of providing more protection to the activity of medical peer review than the HCQIA provides." *Roe v. Walls Regional Hospital, Inc.*, 21 S.W.3d 647, 653) (Tex.App.–Waco 2000, no pet.).

Under current Texas law, actual malice exists if the person either acts with the specific intent to cause injury to the claimant. *St. Luke's Episcopal Hospital v. Agbor*, 952 S.W.2d 503, 506 (Tex. 1997), *citing* TEX. CIV. PRAC. & REM. CODE § 41.001(7). With regard to statements, actual malice exists if a person makes a statement with knowledge of its falsity or with reckless disregard of whether it is true. *Poliner*, 2003 WL 22255677 at *15; *Randall's Food Mkts. v. Johnson*, 891 S.W.2d 640, 646 (Tex. 1995).

Actual malice cannot be demonstrated by mere negligence, a lack of investigation, or the failure to act as reasonably prudent person. *Shearson Lehman Hutton, Inc. v. Tucker*, 806 S.W.2d 914, 924 (Tex.App.– Corpus Christi 1991, writ dism'd).

IV. DISCOVERY PROTECTED BY THE PEER REVIEW PRIVILEGE

The records and proceedings of a medical peer review committee are confidential and the communications made to the committee are privileged. *Irving Healthcare System v. Brooks*, 927 S.W.2d 12 (Tex. 1996).

simply undertake a fact-finding mission and characterize it as "peer review." To be legitimate, the process must operate under written bylaws approved by the governing board and be authorized to evaluate the quality of medical and health care services or the competence of physicians. TEX. OCC. CODE ANN. § 151.002(a)(8).

[5] HCQIA does not preempt state peer review statutes. To the contrary, HCQIA defers to state laws which may provide equal or greater protection to peer review activities. 42 U.S.C. § 11115(a).

The fact that a physician files a lawsuit based in large part on the peer review proceedings conducted with respect to his conduct, does not serve to make the records or communications discoverable. Peer review material may be used in litigation in the unlikely event that the peer review committee waives the privilege in writing. Also, if the defendant uses the confidential information to their benefit during the litigation, the physician may do the same in rebuttal.

The Texas Supreme Court made the following observation regarding the equity issues inherent in the discovery of peer review materials during credentialing litigation:

> There unquestionably is friction in this legislative scheme. It recognizes on the one hand that communications made to a medical peer review committee may be actionable, and on the other, forecloses some avenues of discovery of those communications. It may be possible in some instances that privilege from discovery . . . could effectively bar proof of a medical practitioner's claim that a participant in the peer review process acted maliciously or without good faith.

Brooks, 927 S.W.2d at 18. The *Poliner* Court noted that unfettered access to peer review materials would have a chilling effect on the peer review process. *Poliner v. Texas Health Systems, et al.*, 201 F.R.D. 437, 438 (N.D. Tex. 2001).

V. COMMON CREDENTIALING AND CONTRACTING ALLEGATIONS

A. Antitrust Claims

A seemingly staple allegation in cases based on negative credentialing decisions or exclusive agreements with other providers is that the defendants' exclusionary practices constituted an unlawful combination and conspiracy in violation of state and/or federal antitrust laws.

In Texas, Congress enacted the Texas Free Enterprise and Antitrust Act to "maintain and promote economic competition in trade and commerce . . . and provide the benefits of that competition to consumers in the state." TEX. BUS. & COM. CODE § 15.04. To that end, the statute sets forth general categories of unlawful practices. *Id.* at § 15.05. Among the violations, the statute holds that "[e]very contract, combination or conspiracy in restraint of trade or commerce is unlawful." *Id.* at § 15.05(a). It further states that "[i]t is unlawful for any person to monopolize, attempt to monopolize, or conspire to monopolize any part of trade or commerce." *Id.* at § 15.05(b).

By the statute's own terms, it is to be construed in harmony with comparable federal statutes to the extent it continues to promote the overall purpose. *Id*. at § 15.04. Thus, when examining restraint of trade allegations in the state law context, Texas courts look to federal case law in the area. *Gonzalez v. San Jacinto Methodist Hospital*, 880 S.W.2d 436, 441 (Tex.App.– Texarkana 1994, writ denied). The Sherman Antitrust Act, a highly litigated statute, serves as the federal counterpart to the Texas Free Enterprise and Antitrust Act and contains nearly identical proscriptions against (1) contracts, combinations or conspiracies in restraint of trade; and (2) monopolies or attempted monopolies. 15 U.S.C. §§ 1 & 2, respectively.

One of the prevailing federal cases to analyze an alleged violation of the Sherman Antitrust Act in the healthcare context is the United States Supreme Court's opinion in *Jefferson Parish Hospital District v. Hyde*, 466 U.S. 2 (1984), *abrogated on other grounds by Ill. Tool Works, Inc. v. Indep. Ink*, 126 S.Ct 281 (2006). In the facts underlying *Hyde*, East Jefferson Hospital entered into an "Anesthesiology Agreement" which restricted the use of the hospital's anesthesia department to a select group of physicians. An obstetric anesthesiologist who was not part of this exclusive agreement (characterized by the Court as a "tying" arrangement) brought legal action looking to have it deemed unlawful.

While the Court noted that certain tying arrangements are so unreasonable on their face so as to not warrant any type of analysis, it noted that the arrangement between the Hospital and anesthesiologists did not fit this mold. Instead, the unreasonableness of the agreement depends on the effect it had on the actual market conditions and whether a substantial volume of commerce is foreclosed by the agreement. *Id*. at 16. With regard to the hospital's agreement, specifically, the Court stated that its analysis "must focus on the hospital's sale of services to its patients, rather than it contractual arrangements with the providers of anesthesiological services." It further held that "[o]nly if patients are forced to purchase [the contracted physicians'] services as a result of the hospital's market power would the arrangement have anticompetitive consequences. If no forcing is present, patients are free to enter a competing hospital and to use another anesthesiologist." *Id.* at 24-25. The Court also noted that, ultimately, allowing the complaining physician to practice at the hospital would not change the complexion

of the market place. While the range of choice in doctors would expand by one, the restraints on the patient's freedom to select a specific anesthesiologist would still remain. *Id.* at 30-31.

In *Reazin v. Blue Cross and Blue Shield of Kansas,* 899 F.2d 951 (5th Cir. 1990), the Fifth Circuit summarized the analysis used in *Hyde* and similar cases, holding that "the adverse impact must be on competition, not on any individual competitor or plaintiff's business." *Id.* at 960.

Applying similar principles to a situation where the physician sued for being removed from the hospital's staff, the Court in *Ginzburg v. Memorial Hospital*, 993 F.Supp. 998 (S.D. Tex 1997), held that "an antitrust plaintiff must prove that the challenged conduct affected the prices, quantity or quality of goods or services and not just his own welfare." *Id*. at 1015.

In *Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc.*, 123 F.3d 301 (5th Cir. 1997), the Court determined that a plaintiff attempting to establish a monopoly must define the relevant market. That is, a plaintiff must present evidence concerning where the ultimate consumers of the relevant medical services (i.e. patients) could go for alternative services. The fact that a patient could not readily turn to other hospitals (as is often the case in small towns), may lend credence to the monopoly claim. In large cities with numerous hospitals, however, the claim is difficult to sustain.

B. Breach of Contract

To establish a breach of contract, a plaintiff must show (1) there was a valid, enforceable contract; (2) the defendant(s) breached the contract; and (3) plaintiff suffered damages as a result of the breach. *Ryan v. Superior Oil Co.*, 813 S.W.2d 594, 596 (Tex.App.–Houston [14th Dist.] 1991, writ denied).

In a dispute between a physician and his practice group (his employer), the terms of the employment contract usually drive a breach of contract claim. In a dispute between a physician and a hospital, however, breach of contract claims have a more unique basis given that most physicians operate as independent contractors and do not have a specific employment agreement with the hospital. In such a case, the plaintiff-physicians look to the bylaws of the hospital and/or medical staff.

Procedural rights set forth in the hospital bylaws may constitute contractual rights between physicians and the adopting hospital, but rights created by medical staff bylaws are not necessarily binding on a hospital if they do not define or limit the power of the hospital as it acts through its governing board. *See, e.g., Stephan v. Baylor Med. Ctr.*, 20 S.W.3d 880, 887-88 (Tex.App.–Dallas 2000, no pet.).

In instances, like *Poliner*, where the hospital board approves the medical staff bylaws and/or the hospital and medical staff bylaws work in conjunction with each other in terminating or otherwise qualifying staff privileges, the medical bylaws may create contractual rights. *Poliner*, 2003 WL 22255677 at *8; *see also East Texas Med. Ctr. v. Anderson*, 991 S.W.2d 55, 62-63. (Tex.App.–Tyler 1998, pet. denied). Regardless, it is important that a hospital adhere to the bylaws' due process provisions regarding investigations, adjustments to staff privileges, hearings and notice.[6]

C. Tortious Interference

1. With existing contracts

To prove tortious interference with existing contracts, the physician must establish (1) a valid contract; (2) the defendant(s) willfully and intentionally interfered with the contract; and (3) the interference was the proximate cause of the physician's injuries. *Butnaru v. Ford Motor Co.*, 84 S.W.3d 198, 207 (Tex. 2002).

To sustain the claim, the plaintiff must also show that the defendant either had actual knowledge of the contract or had knowledge of such facts and circumstances that would lead a reasonable person to believe there was a contract in which the plaintiff had an interest. *Davis v. Hydpro*, 839 S.W.2d 137, 139-40 (Tex.App.–Eastland 1992, writ denied.)

2. With prospective business

To establish tortious interference with prospective business, a physician must show that (1) there was a reasonable probability that he would have entered into a

[6] In the past, alleged violations of due process have also been met with allegations that the hospital violated the Texas Health Hospital Licensing Law. TEX. HEALTH & SAFETY CODE § 241.001 *et seq.* Generally, the law requires that hospitals afford each physician due process in the process of granting, renewing, modifying, or revoking staff membership and privileges. *Id.* at § 241.101. However, violation of this provision does not create a private cause of action for physicians. *Stephan v. Baylor Med. Ctr.*, 20 S.W.3d at 886. Additionally, the provision does not apply when a physician's staff privileges have been affected by the administrative decision of a hospital to enter into an exclusive provider agreement. *Tenet Health Ltd. v. Zamora*, 13 S.W.3d 464, 470 (Tex.App.–Corpus Christi 2000, pet. dism'd).

relationship with a third party; (2) the defendants intentionally interfered with the relationship; (3) the defendants' conduct was independently tortious or unlawful; and (4) the interference was the proximate cause of the physician's injuries. *Finlan v. Dallas ISD*, 90 S.W.3d 395, 412 (Tex.App.–Eastland 2002, pet. denied).

Exclusive contracts with other healthcare providers cannot form the basis of a tortious interference claim. The Texas Supreme Court has held that such contracts justify, as a matter of law, the interference with another party's prospective business relations. *Calvillo v. Gonzalez*, 922 S.W.2d 928, 929 (Tex. 1996).

In credentialing cases, the viability of a tortious interference claim directly depends on a showing that the hospital wrongfully terminated or modified the physician's staff privileges.

D. Defamation

To succeed in a defamation claim, a plaintiff must prove that the defendant (1) published a statement; (2) that was defamatory concerning the plaintiff; (3) while acting with actual malice or negligence. *Gertz v. Robert Welch, Inc.*, 418 U.S. 323, 342 (1974); *WFAA-TV, Inc. v. McLemore*, 978 S.W.2d 568, 571 (Tex. 1998). As stated above, actual malice exists if a person makes a statement with knowledge of its falsity or with reckless disregard of whether it is true. *Randall's Food Mkts.*, 891 S.W.2d at 646.

A defamation claim based on statements made to a peer review committee is rarely a viable cause of action given that the immunity discussed above extends to people who report of furnish information to a peer review committee. TEX. OCC. CODE ANN. § 160.010(a)(2); 42 U.S.C. § 11111(a).

More commonly, defamation claims in credentialing cases are based on statements made to patients , colleagues, and other facilities. In some cases, the party who published the alleged defamatory statement can claim a qualified privilege. Such a privilege "applies to communications made in good faith on any subject matter in which the author had an interest or with reference to which he has a duty to perform to another person having a corresponding interest or duty." *Anderson*, 991 S.W.2d at 60.

In *Anderson*, for example, the jury found that the hospital's statements to patients that the physician had resigned amounted to slander. The Houston Court of Appeals determined that the defendant was entitled to a judgment notwithstanding the verdict based on qualified immunity. Specifically, the Court noted that the hospital had an interest in explaining the physician's absence to patients who had scheduled treatments. Further, the patients coming to the facility had a "corresponding interest" in learning the information about their doctor. *Id.* at 61.

A physician may also have a legitimate defamation claim if the hospital conveys false information to the state board of medical examiners or National Practitioner Data Bank ("NPDB") which is later published to others.[7]

Although a party is not generally liable for the republication of a defamatory statement by another, liability may attach "[i]f a reasonable person would recognize that an act creates an unreasonable risk that the matter will be communicated to a third party." *Marshall Fields Stores, Inc. v. Gardiner*, 859 S.W.2d 391, 394 (Tex.App.–Houston [1st Dist.] 1993, writ dism'd w.o.j). Given that NPDB data is often reviewed by hospitals during the credentialing process, the risk of communication to third parties is recognizable. Further, each transmission of the report is a new publication and a possible separate tort. *Stephan*, 20 S.W.3d at 889; *Wheeler v. Methodist Hosp.*, 95 S.W.2d 628, 639 (Tex.App.–Houston [1st Dist.] 2002, no pet.)

E. Intentional Infliction of Emotional Distress

A claim of intentional infliction of emotional distress requires a showing that (1) the defendant acted intentionally or recklessly; (2) the conduct was extreme and outrageous; and (3) the actions of defendant caused plaintiff severe emotional distress. *Twyman v. Twyman*, 855 S.W.2d 619, 621-22 (Tex. 1993).

Conduct is intentional if the defendant desires to cause the consequences of its act or believes the consequences are substantially certain to occur. *Toles v. Toles*, 45 S.W.3d 252, 259 (Tex.App.– Dallas 2001, pet. denied). Conduct is reckless if the defendant knows or

[7] HCQIA requires a peer review committee to report to a state board of medical examiners (1) "a professional review action that adversely affects the clinical privileges for a period longer than 30 days"; (2) the acceptance of the surrender of clinical privileges of a physician while he is under investigation for misconduct; or (3) the acceptance of the surrender of privileges in return for not conducting an investigation. Further, each state board receives information regarding the revocation, suspension or surrender of a physician's license and the denial of staff privileges. 42 U.S.C. § 11133(a)(1)*; Wheeler v. Methodist Hosp.*, 95 S.W.2d 628 (Tex.App.–Houston [1st Dist.] 2002, no pet.

had reason to know of facts that create a high degree of risk of harm to another and deliberately proceeds in conscious disregard of that risk. *Twyman*, 855 S.W.2d at 624.

To warrant the characterization of "extreme and outrageous," the conduct "must go beyond all possible bounds of decency and be regarded as atrocious, and utterly intolerable in a civilized community." *Tiller v. McClure*, 121 S.W.3d 709, 713 (Tex. 2003). Ordinary employment disputes do not rise to an extreme and outrageous level. *GTE Sw. v. Bruce*, 998 S.W.2d 605, 612-613 (Tex. 1999).