The Scope of a Physician's Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?

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The Scope of a Physician’s Medical Practice: Is the Public Adequately Protected by State Medical Licensure, Peer Review, and the National Practitioner Data Bank?

William P. Gunnar, M.D.

INTRODUCTION

I am a cardiac surgeon. In 1996, I was asked by a referring cardiologist, an electrophysiologist specializing in the detection and management of abnormal heart rhythms, to proctor his first twenty-five pacemaker implantations. The community hospital in which we both worked as independent physicians, each employed by separate private medical corporations, had credentialed him for surgical pacemaker implantation in either the operating room or the cardiac catheterization lab, pending my approval of his surgical technique. What was I to do? My cardiology colleague never trained as a surgeon, possessed at that time a less than acceptable understanding of sterile technique, and was in no way prepared to care for the complications associated with pacemaker implantation, including pneumothorax, cardiac perforation, vascular injury, or wound complications. On the other hand, I had been safely and successfully performing pacemaker implantations since 1989, after completing a five-year fellowship training program in thoracic and cardiovascular surgery at the Hines Veterans Medical Center.

1. In 1996, technological advances with automatic implantable cardiac defibrillators had not yet allowed surgical implantation to mirror techniques for implantable pacemakers. Currently, internal defibrillators and pacemakers are surgically positioned using virtually identical techniques.

2. Pneumothorax requires immediate placement of a tube within the chest to evacuate air; cardiac perforation demands immediate exposure of the heart to repair a disruption of the cardiac muscle; vascular injury potentially is life-threatening and requires immediate thoracic surgery; and wound complications may require removal of the pacemaker and possible placement of the pacemaker system on the surface of the heart. All are relatively rare (1-2%), but are recognized complications of transvenous pacemaker and implantable defibrillator placement.
year general surgery residency and beginning a two-year residency in thoracic and cardiovascular surgery. I was knowledgeable in all aspects of the surgical implantation of a pacemaker or an implantable defibrillator device. Previously, only thoracic surgeons were credentialed and privileged to implant pacemakers and defibrillator devices; but the cardiology staff had persuaded the hospital credentials committee to reevaluate this policy to allow non-surgeon cardiologists to perform these surgical procedures.  

My refusal to help my colleague obtain independent privileging to implant pacemakers and defibrillators would result in loss of cardiac surgical referrals to my practice and the hospital. Specifically, if I declined the request to proctor my soon-to-be-competitor's pacemaker implantations, he and his partners would preferentially admit their patients to another hospital where he had supposedly been given assurance of his credentialing for these procedures. In the end, I fulfilled an obligation to the credentialing committee through my gratuitous proctoring of my cardiologist colleague’s pacemaker implantations, and signed off on his privileges. I preserved good will but lost a significant amount of income from routine pacemaker and defibrillator implantations. 

Upon reflection of these events, I have questioned the moral correctness of the hospital credentials committee’s decision to privilege the cardiology staff to perform surgical procedures for which I spent years in training. Although I had never begrudged another physician the privilege to make a living within his or her area of expertise, I was bewildered as to how the hospital could credential another physician to perform a procedure that I and fellow surgical colleagues were better prepared to perform. In a way, my privileges to perform pacemaker and defibrillator implantations were being constructively revoked. 

In fact, my cardiology colleague had every right, under the broad privilege of his state medical license, to request and obtain hospital credentials to perform the surgical implantations of pacemakers and

3. The community hospital credentials committee membership included members of the cardiology staff, but no cardiac surgeons.

4. I continued to perform the pacemaker and defibrillator implantations, responded when the cardiologist needed help or experienced a complication in his own pacemaker and defibrillator implantations, thereby assuring the standard of care, and preformed the bulk of the emergency night, weekend, or holiday pacemaker implantations because my cardiologist colleague was not available.

5. I was not alone in this experience. Beginning in the mid-1990s, cardiologists across the country obtained privileges to perform pacemaker and defibrillator implantations. Presently, cardiology residents specializing in electrophysiology graduate with training in this surgical procedure provided not by surgeons but by attending cardiologists. In 2004, the Board of Thoracic Surgery, in response to the infrequency in which cardiac surgeons perform pacemaker and defibrillator implantations, eliminated pacemaker and defibrillator implantations from the list of required procedures for board eligibility.
defibrillator devices, even though based on training and experience I was the best man for the job. The hospital and the medical staff physicians empowered to police physician behavior through the actions of the credentials committee, peer review committee, and hospital board could freely privilege the cardiology staff to perform these surgical procedures. However, for the sake of argument, recognizing the public’s concern regarding the high incidence of medical error, rising health care costs, the continued practice of incompetent physicians, and rising medical malpractice insurance rates, I ask, “was this the correct decision?”

This commentary will address the following: the rights of the individual physician to practice freely within the broad privilege of medical licensure; the rights of the hospital to regulate an individual physician’s scope of practice through the medical staff activities of credentialing and peer review; and the public’s right to high quality, cost-efficient medical care provided by competent physicians. Part I will discuss medical school education and the process by which physicians acquire and maintain state licensure, as well as the potential for disciplinary action from the state licensing board. Part II will evaluate the impact of physician post-graduate specialty training, the determinants of a physician’s scope of practice by way of the hospital credentialing process and the rights of the hospital to grant, limit, or retract privileges through credentialing and peer review activity. Part III will discuss the rights of an individual physician facing limitation of his hospital privileges. Part IV will address the public’s limited right to information regarding certain physician behavior that could trigger the loss of hospital privileges and potential forfeiture of medical license or the ability to practice within a specialty.

6. See Joan H. Krause, Medical Error as False Claim, 27 AM. J.L. & MED. 181, 181 (2001) ("[M]edical errors have received a great deal of attention in the popular and academic press.").

7. See Kim Dixon, U.S. Health Costs Rose 9.6% in 2002, Reuters Health Information (2003) (stating that health care spending in the United States rose 10% in 2001 and 9.6% in 2002, compared to a 2002 increase in U.S. consumer prices of 2.4%. In 2002, spending on inpatient hospital care grew by 6.8% and the costs of outpatient hospital care rose by 14.6%).

8. See Jason Leo, Torts—Medical Malpractice: The Legislature's Attempt to Prevent Cases Without Merit Denies Valid Claims, 27 WM. MITCHELL L. REV. 1399, 1400 (2000) (estimating that 15% of the nation's physicians "are incompetent and should not be practicing medicine").

I. MEDICAL SCHOOL EDUCATION, STATE LICENSURE, AND POTENTIAL FOR DISCIPLINARY ACTION FROM THE STATE LICENSING BOARD

A. Obtaining a State Medical License

In 1984, after successfully completing four years of medical school at Northwestern University and one year of post-graduate training and passing the United States Medical Licensing Examination (USMLE), I became fully licensed to practice as a physician and surgeon in the State of Illinois. As far as the State of Illinois was concerned, I could practice with all the rights and privileges of any other physician as long as I abided by the standards of conduct for physicians established and enforced by the Illinois State Medical Board.\(^{10}\)

The state has a duty to enact laws that regulate the practice of medicine.\(^{11}\) In the exercise of its inherent police power, the state has an obligation to establish legislation directed at “safeguard[ing] the public health and protect[ing] the public from incompetence, deception and fraud.”\(^{12}\) Such legislation may define qualifications necessary to lawfully practice medicine and surgery, as well as require a license or certificate of competency in order to practice.\(^{13}\)

“State medical licensing laws avoid defining allowable medical practice in terms of specific procedures or methods of practice.”\(^{14}\) Theoretically, upon obtaining a professional medical license in the State of Illinois, I could practice internal medicine, neurosurgery, cardiac surgery, obstetrical care, dermatology, or any other specialty if I could obtain privileges in a hospital.
or establish a free-standing facility. Realistically, an introspective opinion of my overall knowledge and inexperience at the completion of one year of internship indicated that my capabilities included the care for minor illness in an outpatient clinic, suturing of relatively minor lacerations, and diagnosis and triage of more complicated illness to specialty care facilities; in other words, I could function as a basic primary care physician. The medical literature has shown that at this stage of my medical career I had a high likelihood of acting negligently when marginally supervised or unsupervised.

While completion of medical school and passing the USMLE confirmed that the general factual knowledge I possessed was sufficient to practice within the basic standard of care of every licensed physician, it conveyed nothing of my ethical behavior, truthfulness of practice, or compassion, so-called bedside manner. All the ethical behavior and patient empathy I possessed were founded in my upbringing, neither formally taught in medical school nor tested in any way for medical licensure.

In my experience, the core expectations for physician character centered on recitation of the Hippocratic Oath during medical school orientation with an assembly of my medical school classmates, as follows:

I swear to fulfill, to the best of my ability and judgment, this covenant:

I will respect the hard-won scientific gains of those physicians in whose steps I walk, and gladly share such knowledge as is mine with those who are to follow.

15. See Katz, 432 N.W.2d at 279 ("[T]he legislature, under the guise of protecting the public health, may not arbitrarily interfere with a person's right to pursue the medical profession or impose unreasonable restrictions upon the practice of medicine.").

16. See Stewart R. Reuter, M.D., J.D., Professional Liability in Postgraduate Medical Education: Who is Liable for Resident Negligence?, 15 J. LEGAL MED. 485, 489 (1994) (citing Trautlein, Lambert, & Miller, Malpractice in the Emergency Department—Review of 200 Cases, 13 ANNALS EMERGENCY MED. 709, 710 (1984) (noting that 64 of 200 consecutive malpractice claims resulting from emergency department care in Pennsylvania "were attributable to house officers apparently functioning in a nonsupervised capacity, or to residents on rotation from specialty training or moonlighting in an unsupervised capacity").).

17. See Richards, supra note 14 at 211 ("[T]he practice of medicine is defined in terms of the diagnosis and treatment of illness in the manner used by physicians who meet the training requirements for licensure.").

18. See Erin A. Egan, et al., Comparing Ethics Education in Medicine and Law: Combining the Best of Both Worlds, 13 ANNALS HEALTH L. 303, 312 (2004) ("The birth of Western medical ethics is often traced back to the creation of the Hippocratic Oath 2500 years ago. . . . [T]he oath 'established the Western paradigm of a profession . . . as a morally self-regulating discipline.'" (internal citation omitted).
I will apply, for the benefit of the sick, all measures which are required, avoiding those twin traps of overtreatment and therapeutic nihilism.

I will remember that there is art to medicine as well as science, and that warmth, sympathy, and understanding may outweigh the surgeon’s knife or the chemist’s drug.

I will not be ashamed to say “I know not,” nor will I fail to call in my colleagues when the skills of another are needed for a patient’s recovery.

I will respect the privacy of my patients, for their problems are not disclosed to me that the world may know. Most especially must I tread with care in matters of life and death. If it is given me to save a life, all thanks. But it may also be within my power to take a life; this awesome responsibility must be faced with great humbleness and awareness of my frailty. Above all, I must not play at God.

I will remember that I do not treat a fever chart, a cancerous growth, but a sick human being, whose illness may affect the person’s family and economic stability. My responsibility includes these related problems, if I am to care adequately for the sick.

I will prevent disease whenever I can, for prevention is preferable to cure.

I will remember that I remain a member of society, with special obligations to all my fellow human beings, those sound of mind and body as well as the infirm.

If I do not violate this oath, may I enjoy life and art, respected while I live and remembered with affection thereafter. May I always act so as to preserve the finest traditions of my calling and may I long experience the joy of healing those who seek my help. 19

Observation of attending physicians and patient care during my clinical rotations in medical school brought me closer to an understanding of my obligations to truthfulness of practice and ethical behavior. At that time, no examination existed to test for bedside manner. Many fellow medical

students uncomfortable with the thought of direct patient care gravitated to specialty fields that either minimized patient contact, such as radiology or pathology, or abandoned patient care altogether to pursue careers in research. Unfortunately, physicians with poor bedside skills also pursued the clinical practice of medicine or surgery, and when they did, their clinical activities were more often associated with negligence, medical error, and a higher rate of malpractice suits compared to physicians with more competent bedside skills.20

The United States Supreme Court has determined that assuring the good character of physicians is within the state’s police power.21 Character is as important a qualification as knowledge, and if the states may require a basis of teaching, or certain examination as to the learning, the state may equally prescribe what evidence of good character will be essential to licensure.22 However, practically speaking, the states rely on the medical schools, USMLE, and training programs to define appropriate medical practice.23 Medical ethics first entered the formal medical school curriculum in the 1970s in response to “corporate transformation of the nation’s health care system and the rise of managed care and consumerism.”24 Currently, there is little uniformity among medical schools regarding teaching methods and ethics curricula.25 Recent studies have shown that approximately eighty percent of medical schools offer some formal instruction related to ethics and professionalism, yet there is a lack of consensus as to the appropriate method.26 Little emphasis, if any, is given to codes and compliance

22. Id. at 194-95.
23. See McLean, supra note 12, at 245.
24. Egan, supra note 18, at 312.
25. Id. See also Serge A. Martinez, Reforming Medical Ethics Education, 30 J.L. MED. & ETHICS 452, 453-54 (2002).
26. See Herbert M. Swick, et al., Teaching Professionalism in Undergraduate Medical Education, 282 JAMA 830 (1999) (reporting that in a survey of 116 responding medical schools, 104 (89.7%) offer “some formal instruction related to professionalism,” either through a “white-coat ceremony” or some other orientation experience, incorporating professionalism as a component of multiple courses, or teaching professionalism as a single course). See also James M. DuBois & Jill Burkemper, Ethics Education in U.S. Medical Schools: A Study of Syllibi, 77 ACAD. MED. 432 (2002) (reporting that in a survey of 87 responding medical schools, 69 (79%) required a formal ethics course but with diverse methods, including discussion/debates, readings, writing exercises, or lectures).
The only requirement contained in the Liaison Committee on Medical Education's Standards for Accreditation of Medical Education Programs provides that "[a] medical school must teach medical ethics and human values, and require its students to exhibit scrupulous ethical principles in caring for patients, and in relating to patients' families and to others involved in patient care." Unfortunately, formal didactic teaching of professionalism and ethics occurs in the first two years of medical school and may not be reinforced when the student enters the clinical setting in the third and fourth years.

Moreover, medical school courses in ethics and professionalism tend to lack rigorous study, often are graded pass/fail, lack formal assessment, and are viewed by students as inferior to other courses. "Senior medical residents identify the observation of role models as the primary mechanism for professional education." Such student-teacher interaction lacks a formal approach, is considerably variable, and demands that the student consciously weed out negative role models. Furthermore, it places demands on teachers in clinical medicine who may have been selected for their potential to establish a quality research program rather than their clinical acumen, and competes with demands on teaching physicians to prioritize maximizing profit for the medical center over addressing concerns for teaching medical students and residents.

In mid-2004, the USMLE, in response to a documented association between physicians with poor clinical skills and higher rates of malpractice,
as well as increased practice costs, established a "Clinical Skills Examination" to be administered to all of the approximately 17,000 medical students applying annually to practice medicine in the United States. The examination requires each student to take a medical history and conduct a physical examination of twelve standardized patients and, following each examination, record the pertinent history and physical findings, list diagnostic impressions, and outline any plans for further evaluations.

Following the successful completion of an accredited medical school curriculum and demonstrating comprehension of the factual knowledge base embodied by the USMLE, I became fully licensed to practice in the State of Illinois, as is any physician or surgeon, regardless of age, training, and clinical expertise. Training in professionalism and ethical behavior, particularly important to my relationships with patients and physician colleagues, was the product of my character, mentoring experience, and a many-centuries-old code of honor and conduct. The future impact of the USMLE Clinical Skills Examination on medical school curriculum, physician bedside manner, rates of medical malpractice, and ultimately the cost of health care will take years and perhaps decades to determine.

B. The Property Rights of State Medical Licensure

I have been licensed as a physician and surgeon for over twenty years and have practiced without incurring a malpractice settlement or judgment, without investigation for false credentialing, fraud, crime, or false testimony as a medical expert, and without any cause of action or disciplinary action brought by a fellow physician colleague. I attribute this to my family, my training and experience, my mentors, common sense and the ethical concepts embraced by the Hippocratic Oath. The validity and privilege afforded to me by my Illinois State Medical License has never been challenged. Yet, if in the future my capability to practice my profession in either a particular hospital or the State of Illinois comes into question, examination of the law pertaining to state medical licensure indicates that I possess a property right in my state medical license associated with the value and privilege of due process under the United


34. See USMLE home page, supra note 20.

35. See Med Students Now Must Learn People Skills Too, CHI. TRIB., July 18, 2004, at C9 (noting that a third year medical student at the University of Nebraska stated that students might be better off measuring clinical skills during school; this student proposed requirements for medical schools to make student-patient role-playing evaluations a mandatory part of the curriculum).
States Constitution. 36

When laws regulating the medical profession are attacked, substantive due process requires that the exercise of the state’s police power not be unreasonable or unduly oppressive, and that the regulatory means employed by the legislature have a real and substantive relation to the objects sought to be obtained. 37 The United States Supreme Court has held, “there is no right to practice medicine which is not subordinate to the police power of the States.” 38

Beginning in the 1880s, states began to prohibit the performance of ineffective and dangerous treatments and initiate licensure and scope of practice acts to regulate the practice of medicine. 39 The United States Supreme Court first examined state regulation of the practice of medicine in Dent v. West Virginia. 40 The West Virginia law provided three ways to become licensed: (1) graduate from “a reputable medical college;” (2) practice medicine in West Virginia continuously for a period of ten years prior to the licensing act; or (3) pass an examination by members of the state board of health. 41 Dent was fined and enjoined from the practice of medicine for failing to obtain medical training at a reputable medical school, claiming a medical degree from the American Medical Eclectic College of Cincinnati, Ohio. 42

On appeal to the United States Supreme Court, Dent argued that West Virginia denied him his property right to practice his profession without due process of law and due compensation. 43 The Court held that individuals have a right “to follow any lawful calling, business, or profession” but this right is subject to state-imposed conditions for the protection of society. 44 Thereafter, the Court upheld the judgment against Dent, acknowledging that a state’s police power allowed restriction of an individual’s right to practice medicine, unless the restriction bore no relationship to the practice of

36. See Richards, supra note 14, at 213-14. See also Ruth E. Flynn, Demand for Public Access to the National Practitioner Data Bank: Consumers Sound Their Own Death Cry, 18 HAMLIN J. PUB. L. & POL’Y 251, 267 (1996) (stating that under the Constitution, physicians are protected. The various constitutional provisions that afford a physician protection include the equal protection clause, the due process clauses, the search and seizure clause, and an implied fundamental right of privacy.)
39. See McLean, supra note 12, at 245.
40. 129 U.S. 114 (1889).
41. Id. at 115-17.
42. Id. at 118.
43. Id. at 121.
44. Id.
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medical. The "Dent" decision is emblematic of the deference the United States Supreme Court accords state medical licensing laws to deem qualified individuals competent and worthy of a professional license. Some states hold that a physician's license can only be revoked if the board's decision is based on clear and convincing evidence, recognizing a physician's license as a property interest that warrants due process protection. The majority of states, however, require state medical licensing boards to base their decisions on a preponderance of the evidence standard; these states maintain the position that this standard does not violate a physician's due process rights and that the interest of public safety substantially outweighs the private interest of an individual physician.

A physician's ability to obtain a license to practice medicine, with all the property protections of due process and compensation, requires a basic level of training. Once licensed by a state medical board, a physician's property rights will be constitutionally protected, establishing a high threshold for license revocation or suspension for disciplinary actions, particularly in states that adhere to a clear and convincing standard. Overall, a licensed physician may practice with few restraints from the state medical licensing board.

45. Id. at 114.
47. See Widmer, supra note 10, at 398.
C. Disciplinary Actions Suspending or Revoking Physician State Medical Licensure

The state medical board, "authorized to regulate the medical profession for the general welfare of its citizens," not only determines the scope of the medical license, but also establishes conduct that may not be performed by licensed physicians. Ultimately, medical licensure protects the public from incompetent medical care and deception regarding practitioner qualifications. Through inference, one assumes the guide for state medical boards is the standard of care and physician conduct as defined by the minimum qualifications acceptable for successful completion of medical school education and the passing of the USLME.

State medical licensing boards "may revoke a physician's license to practice medicine for malpractice, gross negligence, . . . professional incompetence, or similar acts." Even so, revocation or suspension of a physician license by a state disciplinary action is extremely rare. When the state medical licensing boards have acted, the typical disciplinary actions levied against a physician have been a direct response to drug or alcohol abuse or the inappropriate prescription of medications. There are many reasons for the ineffectiveness of state medical licensing boards in revoking or suspending the medical license of incompetent physicians. First, decisions brought against physician under the broad authority of the


51. See Mark Hall, Institutional Control of Physician Behavior: Legal Barriers to Health Care Cost Containment, 137 U. Pa. L. Rev. 431, 454 (1988); Batty v. Ariz. State Dental Bd., 112 P.2d 870, 877 (Ariz. 1941) (noting that the purpose of medical licensure is to "protect the public from those who are not properly qualified"); State ex rel. Lacerenza v. Osborn, 52 A.2d 747, 749 (Conn. 1947) (stating that statutes are designed to safeguard the public); Bartron v. Codington County, 2 N.W.2d 337, 342 (S.D. 1942) (stating that the purpose of medical licensure is to establish a high standard of competence and to protect patients from the ministrations of a quack); Kelly v. Carroll, 219 P.2d 79, 85 (Wash. 1950) (stating that the purpose of medical licensure is to "eliminate incompetent persons from holding themselves out to treat the public").

52. See Kara M. McCarthy, Doing Time for Clinical Crime: The Prosecution of Incompetent Physicians as an Additional Mechanism to Assure Quality Health Care, 28 Seton Hall L. Rev. 569, 588 (1997).

53. McCarthy, supra note 52, at 584.

54. Id.


56. McCarthy, supra note 52, at 585-87.
state medical licensing boards are subject to judicial review. Second, limited budgets and understaffing of the state medical licensing boards preclude defending potential lawsuits from physicians contesting disciplinary actions. Third, physicians have difficulty judging their peers, leaving a paucity of information available for critical evaluation of an incompetent physician. Fourth, there are often lengthy delays in the process by which the state medical boards pursue an incompetent physician. Fifth, due process requirements demand more than circumstantial evidence. Lastly, the courts have tended to support state efforts through state licensing board decisions to limit physicians' scope of practice only in regard to regulated narcotics, abortions, and physician-assisted suicide.

In sum, state medical licensing boards require a minimal qualification for physicians to establish and maintain a medical license. In contrast, a high threshold exists for revocation or suspension of a physician's established medical license. In fact, very few cases involving physician incompetence are ever discussed by state licensing boards. Therefore, state medical licensing boards cannot be relied upon to act efficiently and consistently in order to effectively police physician misbehavior and incompetence.

57. Widmer, supra note 10, at 396.
58. McCarthy, supra note 52, at 585.
59. Id.
60. Id. at 587.
61. Id. at 586-87.
62. See Minnesota ex rel. Whipple v. Martinson, 256 U.S. 41, 46-47 (1921) (holding that the state's police power provides undeniable authority to regulate the administration, sale, prescription and use of dangerous and habit-forming drugs); Whalen v. Roe, 429 U.S. 589, 602-06 (1977) (holding that physician reporting to the state of narcotic prescriptions is a valid public health function that did not pose an unconstitutional burden on the patient's right of privacy); Planned Parenthood of Southeastern Pa. v. Casey, 505 U.S. 833, 900-01 (1992) (holding that physician reporting to the state of abortion-related information was a valid public health function that did not pose an unconstitutional burden on the patient's right of privacy) Roe v. Wade, 410 U.S. 113, 155 (1973) (stating that the state's rights to regulate medical practice is only limited when it uses that right to impermissibly interfere with the constitutional rights of patients); Washington v. Glucksberg, 521 U.S. 702 (1997) and Vacco v. Quill, 521 U.S. 793 (1997) (holding that the state's police power extends to regulation and banning of physician-assisted suicide).
63. See McCarthy, supra note 52, at 588.
64. See id. at 588-89.
65. See OFFICE OF ANALYSIS AND INSPECTIONS, OFFICE OF THE INSPECTOR GENERAL, MEDICAL LICENSURE AND DISCIPLINE: AN OVERVIEW 16 (1986) (quoting one board executive director: "[w]e just can't seem to do anything with malpractice. In fact, we've never had a disciplinary action based on malpractice. It's such tender legal ground, even though we have a statute.").
66. See Adler, supra note 55, at 692.
II. IMPACT OF PHYSICIAN POST-GRADUATE SPECIALTY TRAINING, DETERMINANTS OF PHYSICIAN’S SCOPE OF PRACTICE BY WAY OF THE HOSPITAL CREDENTIALING PROCESS AND THE RIGHTS OF HOSPITAL TO GRANT, LIMIT, OR RETRACT PRIVILEGES THROUGH CREDENTIALING AND PEER REVIEW ACTIVITY

A. Physician Specialty Training and Implications for Hospital Staff Privileging

Specialty training and board certification is a voluntary process and is neither legally required of the physician in order to practice medicine nor encouraged by the specialty board organizations as a limiting criterion for hospital credentialing and privileging. Nevertheless, greater than ninety percent of United States medical school graduates participate in postgraduate residency training and upon completion of such training apply for board certification. "The American Board of Medical Specialties (ABMS) defines a specialty board as a separately incorporated, financially independent body that determines its requirements and policies for certification, selects members of its governing body in accordance with procedures stipulated in its bylaws, accepts candidates for certification from persons who fulfill its stated requirements, administers examinations, and issues certificates to those who submit to and pass its examinations." The ABMS currently recognizes twenty-four boards. Board certification generally requires graduation from a Liaison Committee on Medical Education (LCME)-accredited medical school or its equivalent, completion of an Accreditation Committee for Graduate Medical Education (ACGME)-accredited residency, and successful performance on a

68. Id. at 73-74.
69. Id.
71. Smith, supra note 62, at 74-75. The LCME is composed of representatives from the American Medical Association (AMA), the Association of American Medical Colleges (AAMC), the Committee for Accreditation of Canadian Medical Schools, the United States federal government, and medical students. Id.
72. Smith, supra note 67, at 75. The ACGME is an association formed by the AMA, AAMC, ABMS, the American Hospital Association, and the Council of Medical Specialty
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By the early 1990s, specialty boards began to issue "time limited" certificates requiring a recertification process to maintain status as a "board certified" specialty physician. Specialty board certification has been associated with "increased salary opportunities, lower malpractice insurance rates, admission to hospital staffs, election to membership in professional societies, and credibility as an expert witness." Health care institutions often limit medical staff privileges to those that are board eligible or certified, excluding physicians not eligible for board certification. Additional benefits of board certification include peer recognition, improved patient referral, and membership and promotion in prestigious professional societies. Specialty training following medical school graduation and successful specialty board certification is also associated with a higher standard of care.

In reality, the most fundamental benefit of specialty board certification is medical staff privileges, particularly for specialists with hospital-based practices. The American Hospital Association (AHA) encourages policies that limit hospital privileges to those physicians that are board eligible. Ultimately, the governing board of the health care entity is responsible for "failures in quality which cause an unreasonable risk of injury to patients." Such governing boards, comprised chiefly or entirely of non-

Societies, an organization composed of the various medical specialties. Accreditation requirements and decisions affecting the respective specialties are made in conjunction with the appropriate Residency Review Committee (RRC), a specialty-specific committee with representatives of the AMA, the applicable specialty board, and relevant specialty societies. See Smith, supra note 67, at 77. In addition, the period of board eligibility is finite, typically lasting two years, during which the candidate may sit for the board certification examination on three occasions.

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physicians, must rely upon the hospital medical staff to evaluate the quality of care provided by individual physicians.\(^{82}\) The hospital credentialing process establishes physician fitness to practice at the facility and the scope of privileges.\(^{83}\)

B. Hospital Malpractice Liability Recognizes Institutional Control Over Physician Decision-Making

"Early cases held that hospitals were only responsible for accidents caused by administration, not medical, actions."\(^{84}\) Modern cases reject this premise and instead recognize direct corporate responsibility for the quality of medical treatment within hospitals.\(^{85}\) In *Bing v. Thunig*, the Court of Appeals of New York held that hospitals are vicariously liable for the negligence of medical employees.\(^{86}\) In *Darling v. Charleston Community Memorial Hospital*, the court recognized corporate responsibility for the supervision of care rendered in the institution, even by independent physicians.\(^{87}\) The *Darling* decision, considered by some scholars to be one of the most influential hospital law opinions in modern times, rejected the hospital's contention that control of physician behavior constitutes the unauthorized practice of medicine and paved the way for hospital control of physician members of the hospital medical staff.\(^{88}\)

The *Darling* court's creation of direct institutional responsibility for patient care requires only that hospitals exercise care in the selection of physicians and take some corrective action when deficient practice is detected.\(^{89}\) Institutional oversight is not the exclusive purview of

\(^{82}\) Id.

\(^{83}\) Id. The hospital's credentialing committee refers to past physician performance and recommendations from peer physicians to determine an individual physician's hospital privileges and scope of practice.

\(^{84}\) See Hall, *supra* note 51, at 457.

\(^{85}\) See *id.* at 458 (citing Fridena v. Evans, 622 P.2d 463 (1980); Tucson Medical Ctr., Inc. v. Misevch, 545 P.2d 958 (1976); Darling v. Charleston Cmty. Mem'l Hosp., 211 N.E.2d 253 (1965), cert. denied, 383 U.S. 946 (1966); Bost v. Riley, 262 S.E.2d 391, cert. denied, 269 S.E.2d 621 (1980)).

\(^{86}\) See *Bing v. Thunig*, 143 N.E.2d 3, 8 (1957).

\(^{87}\) See *Darling*, 211 N.E.2d at 257.

\(^{88}\) Hall, *supra* note 51, at 458-59.

\(^{89}\) See I. Trotter Hardy, Jr., *When Doctrines Collide: Corporate Negligence and Respondeat Superior When Hospital Employees Fail To Speak Up*, 61 TUL. L. REV. 85, 98 (1986) (noting that *Darling* has been followed when hospitals have failed to screen physicians' credentials or terminate their staff privileges). See also Arthur F. Southwick, *Hospital Liability: Two Theories Have Been Merged*, 4 J. LEGAL MED. 1, 44 (1983) (noting that none of the case decisions since *Darling* has endeavored to imply a direct supervisory role for lay hospital administrators or trustees).
management but is substantially influenced by physician participation.90 Tensions exist between the institutional requirement to impose cost-sensitive treatment protocols, the tendency to influence medical judgment with financial rather than medical factors, the preservation of clinical autonomy, and the prohibition of the unlicensed practice of medicine.91

"[M]edical peer review is premised on physician responsiveness to professional rather than lay supervision."92 "Peer review encompasses a wide range of professional activities, including the informal, collegial oversight and interaction that occur within medical group practices and hospital medical staffs."93 Quality assurance is an independent function of peer review activity, separate from cost-containment practice, and directed at singling out those individual practitioners who lack essential skills or are neglectful of their patients' welfare.94 Hospital-based peer review typically consists of a physician committee whose function is to review and evaluate the quality of care provided by their colleagues on the medical staff.95 Such a process for peer review is required by Medicare96 and the Joint Commission on Accreditation of Healthcare Organizations (JCAHO).97

Following the Darling decision, most states passed peer review statutes in order to protect physicians on peer review committees who terminated incompetent physicians, often extending immunity from civil action to anyone present at the peer review committee proceeding and those who

90. See Weiss v. York Hosp., 745 F.2d 786, 796 (3d Cir. 1984) (holding that the medical staff with the authority to evaluate applications for privileges on behalf of the hospital, effectively operates as an officer of the hospital). See Gregory G. Peters, Comment, Reallocating Liability to Medical Staff Review Committee Members: A Response to the Hospital Corporate Liability Doctrine, 10 AM. J.L. & MED. 115, 128 (1985) ("While the [hospital governing] board retains control over administration and managerial supervision, it must delegate clinical evaluation responsibilities to the medical staff. Since the board is composed primarily of lay members of the community, it lacks the capacity to police the clinical aspects of a physician’s practice.").

91. See Hall, supra note 51, at 461-63.

92. See id. at 462.


94. Id. at 1127-28.

95. See Adler, supra note 55; at 696. In the author’s experience, the typical hospital peer review committee is chaired by the chief medical officer and membership includes the chairpersons of the hospital clinical departments (Anesthesia, Emergency Medicine, Medicine, Mental Health, Obstetrics and Gynecology, Radiology, Rehabilitation, and Surgery) and a physician elected from the medical staff membership at large.


97. JCAHO, established in 1952, is a private regulatory group consisting of private physicians and hospital representatives that sets the industry standards and guidelines for peer review activities. Accreditation by JCAHO qualifies a hospital facility to participate in Medicare.
provided information to the committee. 98 "The proponents of peer review emphasize that medicine is such a specialized field that physicians and others within the medical community are the only individuals with the knowledge required to evaluate meaningfully the qualifications and performance of other medical practitioners." 99 Critics of peer review, however, have claimed that physicians may not adequately protect the interests of the public-at-large because: (1) physicians have a reluctance to pass judgment on their colleagues; 100 (2) wrongful termination of clinical privileges may have a devastating effect on a physician’s career, making peer review physicians cautious in their decisions; 101 (3) physicians on peer review committees are not compensated for their time and energy; 102 (4) physicians have concerns that contribution to the termination of a colleague may result in loss of referrals, respect, and friends; 103 and (5) physician members of the peer review committee fear that terminated physicians may bring lawsuits against them individually. 104

In the absence of a peer review process, the public would be forced to rely upon the unattractive alternative of the judicial system, tort law, and the successful adjudication of incompetent physicians with malpractice suits. 105 To terminate incompetent physicians based upon a history of malpractice suits would have many potential negative impacts. For example, the tort system experiences considerable delays and may be substantially inefficient, allowing incompetent physicians to continue to practice while


100. See Adler, supra note 55, at 697.


102. See Adler, supra note 55, at 697.

103. See Hammack, supra note 98, at 442.


105. See Hammack, supra note 98, at 443.
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adverse cases are adjudicated by the court system. Additionally, the modest predictive value of malpractice claims history due to the relative rare occurrence of malpractice suits in comparison to the rate of medical error could result in wrongful termination of competent physicians. Finally, the cost of health care would further escalate as the number of lawsuits increases and physicians respond with a “defensive medicine” approach.106

In the mid-1980s Congress enacted legislature in response to the negative impact of rising medical malpractice insurance rates, the cost of defensive medicine, the ineffectiveness of the state licensing board system to discipline incompetent physicians, and the high likelihood that physicians with a revoked or suspended medical license in one state would merely move to another state and resume practice.107 The Health Care Quality Improvement Act of 1986 (HCQIA) formalized federal support for the peer review system and constituted a significant step toward identifying and removing incompetent physicians from the practice of medicine.108 Overall, the HCQIA provides legal immunity for peer review activities and establishes a national clearinghouse for information on physicians.

Specifically, to fall under the umbrella of immunity from federal or state law, the HCQIA mandates that the professional peer review activities must be taken:

(1) in the reasonable belief that the action was taken in the 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

106. See id. at 443-45.
107. See Adler, supra note 55, at 684-92 (citing a study in which at least forty-nine of 122 physicians disciplined by a state medical board relocated to another state and continued practicing medicine).
108. 42 U.S.C. §§ 11101-52 (2004). In the first section of HCQIA Congress set forth the findings underlying the Act:

(1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
(2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physicians previous damaging or incompetent performance.
(3) This nationwide problem can be remedied through effective professional peer review.
(4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
(5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review. Id.
the action was warranted by the facts known after such reasonable effort
to obtain facts and after meeting the requirement of paragraph (3).$^{109}$

The HCQIA does not extend immunity to actions brought by the Federal
Trade Commission (FTC), the Department of Justice (DOJ), state
authorities pursuing antitrust or civil rights claims, or disciplined physicians
with private suits seeking injunctive or declaratory relief.$^{110}$

Albeit limited and qualified, the HCQIA established significant
immunity to peer review activity, particularly shielding either physician
members of the committee or physicians providing good faith information
to the committee from liability for damages resulting from an antitrust suit
brought by a disciplined physician.$^{111}$ The HCQIA left undisturbed the
discovery rights established by state peer review privilege statutes,$^{112}$ and
the due process requirement of adequate notice and hearing has been
broadly interpreted.$^{113}$ Furthermore, physicians protected by the immunities
of the HCQIA may seek attorneys' fees from unsuccessful disciplined
physician-plaintiffs.$^{114}$

The HCQIA also established a National Practitioner Data Bank (NPDB)
to which the following three reports must be filed: (1) physician payments
to settle malpractice claims,$^{115}$ (2) disciplinary actions taken by state boards

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\begin{align*}
109. & \quad \text{42 U.S.C. §11112(a) (1998). } \text{See Williger, supra note 93, at 33 (noting that the} \\
& \quad \text{state requires that the activities be reasonable, based on the objective standard, rather than} \\
& \quad \text{merely subjective and supported by good faith. Further, HCQIA establishes a presumption} \\
& \quad \text{that the peer review activity meets these requirements, unless rebutted by a preponderance of} \\
& \quad \text{the evidence).} \\
110. & \quad \text{See Adler, supra note 55, at 719 n.177 (stating that if the professional review} \\
& \quad \text{actions being challenged fail to meet the standards of §11112, no immunity is provided and a} \\
& \quad \text{suit brought by a disciplined physician can be tried without the protections provided by} \\
& \quad \text{the HCQIA).} \\
111. & \quad \text{See id. at 720.} \\
112. & \quad \text{See id. at 726-27 (noting that the HCQIA differs with respect to discovery rights in} \\
& \quad \text{administrative disciplinary proceedings).} \\
113. & \quad \text{See Williger, supra note 98, at 33. See also Adler, supra note 55, at 727 (noting} \\
& \quad \text{that the full set of procedural rights under HCQIA need not be provided to a physician where} \\
& \quad \text{a peer review committee investigates a matter but does not take adverse action, where the} \\
& \quad \text{peer review committee suspends a physician for fourteen days or less during on-going} \\
& \quad \text{investigation for further action, or when immediate suspension or restriction of clinical} \\
& \quad \text{privileges are imposed where an imminent danger exists to the health of any individual).} \\
114. & \quad \text{42 U.S.C. §11113 (1998) (explaining that a substantially prevailing defendant can} \\
& \quad \text{seek attorney’s fees and costs if the plaintiffs claim, or the claimant’s conduct during the} \\
& \quad \text{litigation of the claim was “frivolous, unreasonable, without foundation, or in bad faith”).} \\
115. & \quad \text{42 U.S.C. §11131(b) (1998). The HCQIA requires the following information to be} \\
& \quad \text{reported:} \\
& \quad \text{(1) the name of any physician or licensed health care practitioner for whose} \\
& \quad \text{benefit the payment is made, (2) the amount of the payment, (3) the name (if} \\
& \quad \text{known) of any hospital with which the physician or practitioner is affiliated or} \\
& \quad \text{associated, (4) a description of the acts or omissions and injuries or illnesses upon}
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of medical examiners;\textsuperscript{116} and (3) sanctions adopted by hospitals and other health care entities.\textsuperscript{117} Health care entities must request physician information from the NPDB when considering the granting of staff privileges to a physician and every two years for existing staff physicians.\textsuperscript{118}

"The purpose of the NPDB is to impede the movement of incompetent physicians from [s]tate to [s]tate without disclosure or discovery of the previous damaging or incompetent performance."\textsuperscript{119} In this manner, the immunity privileges of the HCQIA work in conjunction with the NPDB.\textsuperscript{120} The peer review committee's duty to report to the state medical licensing board any review action that adversely affects the clinical privileges of a physician and to properly and timely request physician information from the NPDB, provided the peer review committee's actions are in good faith and reasonable, will establish immunity under the HCQIA.\textsuperscript{121} Failure of the health care entity to report required information will result in forfeiture of immunity for a period of three years.\textsuperscript{122}

Thus, the hospital peer review committee is the cornerstone of hospital credentialing and review of individual physician clinical activity, thereby facilitating the hospital's duty to deliver quality medical care to the public. Federal and state statutes work jointly to provide protections for peer review activity by extending confidentiality and immunity to those physicians in good faith peer review and mandating the reporting of wrongful physician conduct to the NPDB. "Physicians, courts and commentators frequently laud the medical review process as the most effective and efficient method of professional self-regulation in the field."\textsuperscript{123} Alternatively, the hospital, by way of the decisions of the hospital board, credentials committee, and peer review committee, may allow any individual medical staff physician considerable freedom to practice within the broad boundaries of his or her state medical license.

\textsuperscript{120} See Williger, supra note 98, at 34.
\textsuperscript{121} See id.
III. RIGHTS OF INDIVIDUAL PHYSICIANS FACING LIMITATION OF HOSPITAL PRIVILEGES

A. Physician Protections from Adverse Medical Staff Judgments

Traditionally, physicians are not entitled to membership on a medical staff or privileges at a hospital as a matter of right.\(^\text{124}\) Although a license to practice a profession is a valuable right deserving of protection by the laws, staff membership is not afforded the same considerations as a constitutional or inherent right.\(^\text{125}\) Private hospitals have an absolute right to exclude licensed physicians from their medical staffs, and decisions regarding the granting or denial of medical staff privileges are not subject to judicial review.\(^\text{126}\) However, at public hospitals, a physician is entitled to membership or to a hearing on refusal of medical staff privileges.\(^\text{127}\)

On the other hand, the United States Supreme Court recognizes a federal cause of action by a physician against a hospital and/or medical peer review committee that has denied or revoked the physician’s medical staff privileges in violation of the Sherman Act.\(^\text{128}\) To prevail in such an antitrust claim, the physician excluded from the medical staff must show something more than a recommendation by competitors on the medical peer review committee to revoke or terminate his or her privileges.\(^\text{129}\) The most common antitrust allegation brought by physician-plaintiffs in medical staff

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124. Hayman v. City of Galveston, 273 U.S. 414, 416-17 (1927) ("It cannot... be said that all licensed physicians have a constitutional right to practice their profession in a hospital. . . .").


127. See State ex rel. Sams, 140 S.E.2d at 463.

128. Summit Health Ltd. v. Pinhas, 500 U.S. 322 (1991) (holding that the interstate commerce requirement of the Sherman Act was met by a single hospital’s revocation of one physician’s staff privileges as a result of the hospital’s peer review process. For a physician to successfully litigate an antitrust suit against a hospital for the denial of staff privileges under Section 1 of the Sherman Act, the physician must prove: (1) an effect on interstate commerce, thereby fulfilling the jurisdictional requirement; (2) a conspiracy or combination; and (3) a restraint of trade.15 U.S.C. §§ 1-7).

129. See Bozcar v. Manatee Hosps. & Health Sys., Inc., 993 F.2d 1514 (11th Cir. 1993) (vacating judgment for defendants where there was sufficient evidence to allow the jury to conclude that the hospital conspired with staff obstetrician/gynecologists to terminate privileges of competing ob/gyns; it was reasonable to infer that the hospital participated in conspiracy in order to avoid additional dissatisfaction and defections among staff ob/gyns and to minimize costs and liabilities related to plaintiff’s frequent allegations of hospital deficiencies). See also Oltz v. St. Peter’s Cmty. Hosp., 861 F.2d 1440 (9th Cir. 1988) (finding that the hospital violated antitrust laws when, facing the threat of losing its four physician anesthesiologists, conspired with the medical staff to exclude a nurse anesthetist who charged lower fees).
privilege cases is that exclusion from the medical staff constitutes a group boycott. In rural areas where there may be only one hospital or a single hospital with high-technology medical equipment, physicians who have been denied medical staff privileges commonly bring actions for Sherman Act violations under the "essential facilities doctrine."\(^{131}\)

To overcome the qualified immunity provisions provided by the peer review statutes and survive summary judgment in a defamation or antitrust action, the physician-plaintiff must prove that the denial or revocation of medical staff privileges was the result of the peer review committee members acting either in bad faith, with malice, or "without a reasonable belief that the action taken or recommendation made was warranted under the known facts."\(^{132}\) Such a burden is not insurmountable. The peer review statutes protect only the work product of the review proceeding, not the underlying substantive evidence, therefore the physician-plaintiff bringing an action against the peer review committee members is not precluded from obtaining evidence from an original source.\(^{133}\)

Furthermore, because peer review litigation often occurs in federal courts, "the Federal Rules of Civil Procedure may provide a loophole through which state peer review discovery protections can slip."\(^{134}\) Since neither the Health Care Quality Improvement Act of 1986 (HCQIA) nor federal common law specifically affords a discovery privilege for peer review committees, the work product of the peer review process may lose its immunity in federal court.\(^{135}\) Federal Rule of Evidence 501 governs privileges and states, "[t]he privilege of a witness, person, government, State, or political subdivision thereof shall be governed by the principles of the common law as they may be interpreted by the courts of the United States in the light of reason and experience."\(^{136}\) "In contrast to most state

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131. *Id.*
132. *See* Newton, supra note 123, at 740-41 (citing Smith v. Our Lady of the Lake Hosp., 639 So. 2d 730 (La. 1994) (upholding summary judgment for the defendant hospital in a suit brought by a physician against the hospital and members of the peer review committee, the court reasoning "mere allegations of malice and bad faith, even with specifications of personal animosity and possible prior overreaching of authority, will not suffice to allow an action against hospital personnel engaging in peer review").)
133. *See* Newton, supra note 123, at 736. *See also* Irving Healthcare Sys. v. Brooks, 927 S.W.2d 12, 18 (Tex. 1996) (holding that defendant’s work product was privileged in a case brought by a physician against a hospital alleging wrongful denial of staff privileges but stated, "there are several means by which confidential information may be disclosed to an affected physician.")
134. *See* Williger, supra note 98, at 34.
135. *See id.*
courts, ... federal courts have rejected the privileged character of ... academic peer review communications."

A recent article reviewed health care antitrust cases between 1985 and 1999, identifying 542 opinions in a database representing 394 separate antitrust disputes.\footnote{138} Federal district courts accounted for 347 opinions (64%), federal appeals courts for 191 opinions (35%), and the United States Supreme Court a mere 4 opinions (1%).\footnote{139} Private antitrust suits dominated public ones in terms of the number of cases resolved by the courts. Litigation by public enforcement agencies generated only 22 of the 394 health care antitrust disputes (6%) compared to 372 disputes (94%) brought by private plaintiffs.\footnote{140}

Of the total number of private disputes, physicians in solo or small group practice represented the largest plaintiff group, accounting for 195 disputes (53%).\footnote{141} "Hospitals constituted the largest defendant pool (225 disputes; 61%), followed by solo or small group physicians (124 disputes; 33%)."\footnote{142} The most common plaintiff-defendant pairing was physicians against hospitals (166 disputes; 45%) and the second most common pairing involved physicians against physicians.\footnote{143}

This study revealed that the most common type of private claim brought by a physician against a hospital involved a physician suing the hospital and its staff physicians who had denied the physician membership on the hospital medical staff, alleging that the action was taken to prevent competition from the newcomer (129 disputes, 35%).\footnote{144} Nearly half of these staff privilege disputes involved small cities or towns (57 disputes; 44%), with the remainder involving large cities (25 disputes; 20%), suburbs (23 disputes; 18%), and rural areas (24 disputes; 18%).\footnote{145} While the total number of disputes remained constant over the fifteen year period, staff privilege cases declined from 51 (39%) during the years 1985 to 1989, to 34 (28%) during the years 1995 to 1999.\footnote{146} When court opinions were examined in the staff privilege cases, the plaintiffs prevailed in only twelve

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\textsuperscript{137} See Bassler, supra note 98, at 698.  \\
\textsuperscript{139} Id. at 562.  \\
\textsuperscript{140} Id. at 565-66.  \\
\textsuperscript{141} Id. at 566.  \\
\textsuperscript{142} Id.  \\
\textsuperscript{143} Id.  \\
\textsuperscript{144} Hammer, supra note 138, at 568. The second, related pattern challenges a hospital's decision to grant an exclusive contract to one physician or physician group to provide professional services in a department of the hospital, such as the emergency room or radiology suite (106 disputes; 28%).  \\
\textsuperscript{145} Id. at 574.  \\
\textsuperscript{146} Id. at 597.
\end{flushright}
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opinions (7%). Only two of the staff privilege cases (2%) resulted in damage awards being awarded to the physician-plaintiff. The authors of this study concluded, among other things, that the physician-plaintiff bringing an antitrust action against a hospital and the physician staff that denied him privileges has a remarkably low rate of success either for award of damages or for equitable relief. This may be the result of the physician-plaintiff’s attorney failing to effectively counsel his or her client in pursuing a staff privilege antitrust dispute. Further, the “courts recognize the [inherent] weaknesses of most medical antitrust claims and are fairly effective in weeding them out.” Lastly, the decline in private antitrust lawsuits brought by the fifteen year period of study represents the impact of the HCQIA.

There are several possible explanations for why physicians continue to bring private antitrust claims against hospitals and medical staff physicians for denial of medical staff privileges. First, denial of staff privileges is deeply personal and reflects on the physician’s reputation and/or competence. Second, the physician has the financial resources to subsidize the litigation. Third, lack of access to a preferred hospital may cost the physician his livelihood and he may be willing to go substantial lengths to prevent that from occurring. Finally, the antitrust claim serves as a means to anchor the dispute in federal court rather than state court.

Therefore, hospitals, through the decisions and actions of their physician member credentialing and peer review committees, may select the membership of their medical staffs and determine the scope of practice of each individual medical staff physician. State peer review statutes and the HCQIA provide considerable, albeit qualified, legal protections which

147. Id. at 575.
148. Id. at 576.
149. Id. at 596.
150. Hammer, supra note 138, at 601 (commenting that fewer claims would be filed if the plaintiff’s attorney was reimbursed on a contingency fee basis).
151. Id. at 601-02.
152. Id. at 597-98.
153. Id. at 600-01.
154. Id. at 600.
155. Id. at 601.
156. Hammer, supra note 138, at 598. See also Jacqueline Oliverio, Hospital Liability for Defamation of Character During the Peer Review Process: Sticks and Stones May Break My Bones, But Words May Cost Me, 92 W. Va. L. Rev. 739, 741 (1990) (commenting that state court “causes of action brought by physicians against Peer Review Boards, medical staffs, and hospitals include: violation of medical staff bylaws, breach of contract, violation of due process and equal protection, conspiracy, tortious interference with a contractual business relationship, intentional infliction of emotional distress, . . . and defamation [of character].

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allow hospitals to extend, deny, or revoke any individual physician’s medical staff privileges or scope of practice. A physician bringing state and federal causes of action against a hospital and physician members of the hospital’s medical staff for the denial or revocation of staff privileges has an expensive, uphill battle with little chance of success.

IV. PUBLIC’S LIMITED RIGHTS TO INFORMATION REGARDING CERTAIN PHYSICIAN BEHAVIOR THAT COULD TRIGGER LOSS OF HOSPITAL PRIVILEGES AND POTENTIAL FORFEITURE OF MEDICAL LICENSE OR ABILITY TO PRACTICE WITHIN A SPECIALTY

A. The Public’s Limited Knowledge of Physician Qualifications

Antitrust laws protect and promote competition in the marketplace. Scholars argue whether the specific goals of antitrust laws exist solely to enhance consumer welfare through the efficient allocation of resources, or whether efficiency must sometimes be sacrificed to protect alternative values, such as wealth transfer, entrepreneurial opportunity, and the prevention of the spread of big business. Argument aside, competition in a properly functioning market is the foundation of antitrust law.

Market failures unfortunately do occur, producing an inefficient allocation of resources and economic power thereby negatively impacting business opportunity and consumer welfare. One common reason for market failure follows informational asymmetries, where “consumers of goods do not possess adequate knowledge with which to evaluate the quality” of goods. Informational asymmetries are “often seen in markets for professional services such as medicine, law or education, where the nature of the service provided is [sufficiently] complex [such that] the ordinary consumer [cannot] adequately determine the actual value of [the purchase]”. Lacking adequate knowledge concerning quality, the consumer may settle for a service of suboptimal value, which is inefficient and harmful to consumer welfare.

Currently, the general public does not have access to any of the

158. Id. at 250-51.
159. Id. at 251.
160. Id. at 252.
161. Id. at 252-53.
162. Id.
information in the National Practitioner Data Bank (NPDB). Thus, the patient consumer cannot obtain any information about a treating physician from this source regarding a history of malpractice judgments and settlement payments, disciplinary sanctions, and license suspensions and revocations. The Office of the Inspector General of the Department of Health and Human Services (OIG) can impose civil monetary sanctions on parties violating these confidentiality provisions. Patient rights advocates, motivated by a general concern for declining quality of health care, have argued that medical consumers should be able to use the NPDB to screen physicians and thereby avoid incompetent ones.

The strongest argument presented by patient rights advocates "for giving medical consumers information about their physicians is based on the doctrine of informed consent, which holds that to avoid committing a battery or negligence a physician must fully inform a patient of all risks associated with a procedure." If the patient is not fully informed, the consent is meaningless. The informed consent doctrine encompasses the patient's right to know information regarding a physician's ability to practice medicine that might affect the patient's willingness to consent. Therefore, the goal of patient rights advocates is to obtain as much relevant information as possible regarding a treating physician to best empower the patient in making a treatment decision.

Consequently, the Health Care Quality Improvement Act of 1986

166. 42 U.S.C. § 11137(b)(2) (1995 & Supp. I 2004) (imposing a penalty of not more than $10,000 if information is illegally obtained or disclosed).
167. Pape, supra note 165, at 978.
168. Id. at 986.
169. Id.
170. See Moore v. Regents of Univ. of Cal., 793 P.2d 479, 483 (Cal. 1990) (holding that a patient has a right to know a physician's economic incentives); see also Estate of Behringer v. Med. Ctr. at Princeton, 592 A.2d 1251, 1283 (N.J. 1991) (finding no discrimination where a hospital required a surgeon to disclose his HIV status to potential surgical patient); see also In re Milton S. Hershey Med. Ctr. of Pa. State Univ., 595 A.2d 1290, 1302 (Pa. 1991) (upholding a court order allowing a hospital to inform potential patients of a physician's HIV status on grounds that the potential danger to patients outweighs the physician's privacy interest).
171. See Pape, supra note 165, at 986-87 (arguing that the informed consent theory fails to provide adequate justification for releasing all physician information to the general public because the information needed for consent implies a specific treatment and a specific patient-physician relationship).
(HCQIA), in effect, through its privacy protections of physician information, establishes a physician property right in the information collected by the NPDB. Privacy protections are necessary because the data collected is never expunged and is without opportunity for retrieval; reporting to the NPDB is inconsistent; physicians are not granted a hearing before malpractice is reported; and public dissemination of the physician's NPDB information may cause loss of patient referrals, income, or employment. "The medical profession argues that exposing physicians to such publicity threatens both their reputation and privacy."177

CONCLUSION

The United States health care system faces a number of problems today, including the rising cost of health care delivery, a high rate of medical error, the substantial cost of defensive medicine, and rising medical malpractice insurance rates. The continued practice of incompetent physicians negatively impacts the quality and cost of health care. Medical error is not always the result of physician negligence; physician incompetence will also produce medical error, which can result in patient injury or death. Revoking the privileges of an incompetent physician has been the goal of the federal and state governments, the state medical licensing boards, and hospitals through the oversight of credentialing and peer review activity.

Unfortunately, incompetent physicians continue to practice, protected by the considerable rights embodied by their medical license and a minimal professional standard. State medical licensing boards cannot be expected to revoke or terminate a physician's medical license when the professional standard for acquiring a medical license is merely a medical school education, one year of post-graduate training, and passing the United States Medical Licensing Examination (USMLE). Thankfully, the USMLE has acted on the known correlation between physician incompetence and deficiencies in professional and ethical training through the addition of a standardized "Clinical Skills Examination." However, the effect of this

172. See Pape, supra note 165, at 993 n.120 (explaining that placing of information into data banks reinforces the "concept of property rights because it gives a more concrete form to the information, which then becomes a commodity that can be bought and sold on the open market").
173. See Flynn, supra note 36, at 266-68.
174. See id. at 267 (arguing that the NPDB "creates a situation where, because of differences in state disciplinary standards, two physicians, having engaged in the same conduct, may not" both be reported).
175. See id. at 268.
176. See Flynn, supra note 36, at 268.
177. See Pape, supra note 165, at 989.
modification to the requirements of state medical licensure on limiting physician incompetence will take years to determine.

Currently in the United States, the cornerstone for policing physician behavior is credentialing and peer review by the hospital medical staff. Remarkably, physicians are unable to adequately police themselves. Physicians do not uniformly acknowledge, investigate, and reprimand incompetent physician behavior, despite the immunity and confidentiality extended to peer review activities by state and federal statute. The fear-of-lawsuit argument does not account for physicians’ reluctance to adequately judge their peers since historical data shows the physician-plaintiff has a near-zero chance of success. Further, the disciplined physician bringing an action against a peer review physician or hospital is deterred by the potential responsibility for the defendant’s legal fees under the mandates of the Health Care Quality Improvement Act of 1986 (HCQIA).

Therefore, Congress must mandate further requirements of the peer review process. Specifically, legislation is needed to standardize guidelines for peer review reporting of below-standard physician conduct. Without nationally standardized guidelines for peer review to compliment the HCQIA, reporting to state medical licensing boards and the National Practitioner Data Bank (NPDB) is inconsistent comparing hospital-to-hospital and/or state-to-state. The potential exists for incompetent physician behavior to go unrecognized. For example, the physician might have a large practice important to hospital revenue, or the physician might be popular with the members of the peer review committee members, and might never be objectively scrutinized. The state medical licensing boards and the NPDB must receive reliable reporting of physician activity that falls below the standard of care. Such nationally recognized guidelines would compliment technological advancements and the reality of telemedicine.¹⁷⁸

Furthermore, the federal government must acknowledge through legislation that the public is best served when the delivery of specialty health care is provided by board certified physicians. Physicians practicing highly technical procedures requiring additional training must be required to show knowledge of a heightened professional standard embodied by board certification. Residency training and specialty board certification must have greater significance regarding scope of practice. For example, physicians unable to successfully meet the requirements of the Board of Thoracic Surgery should not be allowed to perform open heart surgery, and physicians without board certification in neurosurgery should not perform brain surgery.

Board certification establishes a higher and appropriate standard of care for physicians practicing within the scope of the specialty. The tort system recognizes a heightened standard of care for the delivery of specialty health care. Recent court decisions support the oversight of medical expert testimony by the professional societies that establish criteria for board certification, thereby assuring that medical expert testimony represents the accepted and heightened standard of care for board certified physicians. Specialist physicians delivering patient care below the standard of care established by the minimum knowledge and skill requirements of board certification are practicing negligently. By definition, those physicians who never trained in a subspecialty, or trained and failed to pass or maintain board certification, do not acknowledge or understand the established standard of care for the given specialty.

Unfortunately, at the present time, physicians who fail to meet the standards established by the professional specialty boards may practice that specialty under the broad privilege of a state medical license. Hospitals that have difficulty attracting board certified physicians may elect to credential non-board certified specialty physicians in order to establish a specialty care program. Hospitals should not have this option. This view is consistent with the philosophy of the American Hospital Association (AHA). At a minimum, hospitals must be required to support programs of highly technical specialty procedures with board certified physicians.

Federal legislation that establishes board certification for the practice of specialty medical care would result in lowered rates of medical error, physician negligence, physician incompetence, and medical malpractice insurance premiums for the specialties with the highest current rates. Health care delivery costs would decrease and the quality of the health care delivered to the public would improve.

The free market and physician competition among specialists would be preserved; however, federal legislation that limits the delivery of specialty

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179. See Michael D. Brophy, Ruling May Signal New Chapter in Expert Testimony of Medical Society Members, MED. MALPRACTICE L. & STRATEGY, May 2002, at 1; Austin v. American Ass’n of Neurological Surgeons, 253 F.3d 967, 973 (7th Cir. 2001) (holding that Dr. Austin, representing medical expert testimony for the plaintiff, testified unprofessionally and was liable to sanctions by the professional society).

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sexual licensing, and as such, the public must be reassured that the physician performing specialized care is appropriately credentialed and his professional activity monitored.