

Peer Review Report

News, analysis
and commentary
on Medical Staff
credentialing,
privileging, peer
review and
governance

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2007 Medical Staff Standards Changes

Practitioner Monitoring Will Require People, Paper

Final 2007 Joint Commission Standards governing Medical Staff privileging and credentialing have issued, raising the importance of our ongoing discussion of those standards.

Since November of last year when JCAHO's first draft issued, we have been discussing the significant changes these will bring about. In the last issue, we talked about privileging.

In this issue, we will take up the most significant of changes pertaining to credentialing and performance monitoring. If this is the first you've heard of these changes, you have a lot of catching up to do, because they will require new paper, new processes and, probably, new people.

JCAHO's major change in the credentialing process is its suggested use of six "general competencies" adopted from the Accreditation Council for Graduate Medical Education and the American Board of Medical Specialties. Residents are judged on these six areas, JCAHO reasons; why not expect hospitals to evaluate current competence using the same measures:

- Patient care
- Medical knowledge
- Practice-based learning and improvement
- Interpersonal and communication skills
- Professionalism
- Systems based practice

(See Medical Staff Standards, page 6)

Peer Review Privacy Is Not A Lost Cause

Kentucky Confidentiality: Elusive But Obtainable

If you have any role in peer review in Kentucky, you know that there is no statutory confidentiality protection for peer review records in a malpractice action. Despite decades of trying, the Kentucky legislature has been unable to draft a peer review confidentiality statute that the Kentucky Supreme Court was happy with.

What you may not know is that there is a way to obtain a good deal of confidentiality protection by way of the attorney client privilege. Although not absolute, structuring your peer review system to include the use of lawyers may help keep malpractice lawyers out of your files.

In this article, we'll take a brief look at Kentucky peer review confidentiality legislation, including how it got to where it is today. Then, we'll turn to Kentucky's attorney client privilege and see how using that very different privilege can help, at least until something better comes along.

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Kentucky Peer Review Confidentiality . . . (cont'd)

As you know, simply not doing peer review is not an option. Good risk management requires it. Good patient care requires it. And, oh yeah, the Joint Commission requires it – in increasingly larger and more thoroughgoing doses.

The problem is that if peer review information is not protected from disclosure to the rest of the world, no one will willingly do it, or do it well. The fundamental basis for peer review is that candid assessments by peers are the key to improvement. If those assessments are publicized, participants will just clam up.

Most states have peer review statutes that do two things: (1) Protect participants with immunity (federal law does this too); and (2) Preserve the confidentiality of peer review documents and other information.

Kentucky, in 1976, enacted a statute that did these two things. Only the first –immunity – survives intact.

In 1977, the Kentucky Supreme Court issued the first of three decisions that took the life out of the confidentiality statute. The Kentucky constitution requires every legislative enactment to confine itself to one subject, and the body of the act must relate to the title. *McGuffey v. Hall* held that the subject of peer review confidentiality did not sufficiently relate to “AN ACT relating to health care malpractice claims or insurance.” The confidentiality provision was therefore unconstitutional.

OK, said the legislature in 1980, how about “AN ACT relating to the establishment of certificate of need, licensing and regulation of health facilities and health services”? Plaintiff Sweasy sues. The legislature, sensing trouble again, revised the law twice in 1988 to reformulate the language under “An Act Relating to Health Care” and “An Act Relating to Civil Actions.” *Sweasy v. King's Daughters Memorial Hosp.* reached the Supreme Court a year later.

The Court again ruled the statute unconstitutional, saying (1) the 1980 act’s title was even less related than the one we tossed in *McGuffey* and (2) you can’t rely on the 1988 formulations, because those were passed after this litigation started.

The legislature, more than a little frustrated, tried once more in 1990. Using the same statutory language, it began:

WHEREAS, the protection afforded to peer review participants for review functions relating to acts occurring from July 15, 1980, has been eliminated by the Supreme Court's decision in *Sweasy v. King's Daughters Memorial Hosp.*, Ky., 771 S.W.2d 812 (1989), and the lack of such protection *inhibits open and candid peer review*; and

WHEREAS, there is an urgent need to promote effective peer review for *the protection and welfare of the public . . .* (emphasis added).

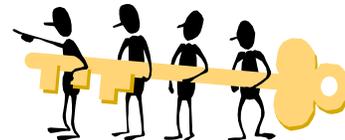
Well, that’s pretty clear isn’t it? Not so fast. In 1999, the Kentucky Supreme Court in *Sisters of Charity Health Systems v. Raikes* held that the confidentiality provisions could only have been intended by the legislature to apply to suits in which a doctor sues over a bad peer review result. They could not have meant to have it apply to malpractice plaintiffs — after all, that would tilt the playing field against plaintiffs. So, although the legislature could have extended the reach of the statute to malpractice plaintiffs, it has to use clearer language. The prohibition against use “*in any civil action in any court*” just wasn’t clear enough.

This may have you shaking your head, but that is where the law stands today. If you are a physician suing a hospital because of a termination and you want documents, forget it. But if you’re a malpractice plaintiff suing the doctor and want peer review records from the doctor’s hospital, you’re in.

Until the legislature tries again to come up with the right title and the right words to satisfy the court, all is not lost. The attorney client privilege may go a long way to protecting peer review information under the right structured circumstances. To see how this might work, let’s look at a recent Kentucky attorney client privilege case, *The St. Luke Hospitals v. Kopowski*.

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Despite decades of trying, the Kentucky legislature has been unable to draft a peer review confidentiality statute that the Kentucky Supreme Court was happy with.



The attorney client privilege might be one key to protecting peer review information under the right structured circumstances.

Kentucky Peer Review Confidentiality . . . (conclusion)

In this 2005 case, a newborn baby died at St. Luke. The hospital risk manager immediately called their lawyer, presumably for advice about what to do. The lawyer said, "Interview the witnesses and get their statements." Three nurses gave signed statements to the risk manager, and the risk manager sent the statements to the lawyer.

The parents of the baby sued, found out about the statements and demanded copies of the statements in discovery. The nurses had been a little fuzzy on the facts at their deposition, and the plaintiff argued that the statements were needed to fill in the gaps.

The Kentucky Supreme Court answered with an emphatic "no." The statements were protected by Kentucky's attorney client privilege rule. The unanimous court said:

1. The communications in question were made to "facilitate the rendition of professional legal services."
2. The privilege protects communications not just between a lawyer and a "client" but also between and among representative (including employees) of the lawyer and the client.
3. The two steps in the chain – risk manager interviews with nurses and later sending the statements to the lawyer – were the same for privilege purposes as if the lawyer interviewed the nurses himself.
4. There is no exception to the rule just because the plaintiff "needs" the documents.

As the *St. Luke Hospitals* case indicates, the attorney client privilege enjoys a much warmer reception in the Supreme Court than the peer review privilege. A Kentucky hospital could thus structure its peer review system to use an attorney as an integral part of its functioning.

This makes sense on several levels. First, it provides the medical staff and administration with a resource to identify and resolve issues with benefit of legal experience from the very first step. Second, retained counsel can be a readily available planning and information source that avoids guessing about what bylaws say or what state peer review cases say. Third, a lawyer trained in peer review can help leaders strategize different courses of action and the likely legal consequences of their choices. Finally, the lawyer can help the client navigate the various peer review steps, providing assistance at (or for) interviews, drafting letters and following complex bylaws, manual and rules provisions.

And, of course, the communications are confidential to the extent facilitation of legal advice is the object.

Caution: This concept is not bulletproof. The attorney client privilege will not protect every communication. Communications not intended to facilitate the giving of legal advice may be discoverable. Business advice, as opposed to legal advice, is not protected.

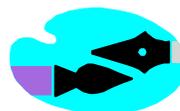
Should you decide on this route, take great care to work with a lawyer with experience in peer review. It would be very tempting for the average lawyer to burden your peer review process with cumbersome protections that, as a practical matter, make the process unworkable. In the end, the process should inspire confidence in the medical staff and administrative decision makers to act on their own. With a few carefully designed legal consultations, you'll produce both a better answer and a record that has a better chance of protection from discovery.

With any luck, the Kentucky legislature will try again soon to get a peer review confidentiality statute past the courts as a more direct answer to the problem.



There is no exception in Kentucky to the attorney-client privilege just because the plaintiff "needs" the documents.

The attorney client privilege will not protect every communication. . . . Take great care to work with a lawyer with experience in peer review.



Legal Analysis: Data Bank Reports of Investigations

Not All Physician Resignations Are Reportable

A recent federal court decision teaches a boatload of lessons on the subject of physician investigations and when they have to be reported to the data bank.

Costa v. Leavitt, a case decided in July by the Federal District Court in Nebraska, concerned a physician who sued to remove an unfavorable data bank report. He won.

If you are an administrator, a medical staff leader, a staff member or a medical staff office professional, this case is for you. It nicely summarizes what an investigation is, when it starts, how it must be conducted and what you must or may do with the results. It also suggests some important strategy tips in dealing with investigations.

The facts in the case tell a common story.

Dr. Costa, an obstetrician, was involved in an incident that caused some concern on the part of the hospital CEO, Mr. Joseph. Mr. Joseph brought his concerns to a Quality Assurance Committee meeting, where he presented a short written statement. There are no minutes from the meeting, and there was no evidence that the committee did anything with Mr. Joseph's concerns.

That's not to say Dr. Costa was not the target of concerns in many other quarters. At a medical staff meeting, a great many medical staff members voiced concerns about his use and supervision of his physician assistant. There was also some talk about his criticism of the way the hospital was run. At the close of discussion, the staff voted to reject Dr. Costa's reappointment application. (Their bylaws called for this.)

Within hours of this decision, which had to go to the board for final approval, Dr. Costa resigned. Mr. Joseph then filed a report with the National Practitioner Data Bank. The report stated that Dr. Costa had resigned while under investigation for competence and professional conduct issues.

Let's pause a moment to review what the Health Care Quality Improvement Act says about Data Bank reports.

The HCQIA says that a health care entity (such as a hospital) that takes a "professional review action" lasting more than 30 days for reasons related to competence or professional conduct must report that action to the Data Bank. It must also report physician resignations of privileges (i) while the physician is under investigation for competence or conduct matters or (ii) in return for not conducting an investigation (sort of like a "plea bargain" as the *Costa* court put it).

Notice, as the *Costa* court explained, that the statute does not require or authorize reports of resignations to avoid an investigation where it merely looks like one is coming or someone threatens one. There must be an actual investigation under way for a report to be appropriate.

What is an "investigation"? The HCQIA does not define it. Here are two places to look for the answer.

First, look at your medical staff bylaws. When I draft bylaws, I include a very specific provision on what an investigation is, how it starts, and who gets to start one. This not only tells a medical staff whether they have begun an investigation, it also avoids both the ambiguity of not knowing or the inadvertent blundering into one without intending it.

Second, look at the National Practitioner Data Bank Guidebook, which guides parties on their filing obligations. It has an interpretive section that, in the absence of a bylaws provision, might help identify one. Several points are worth noting about this guidance. The Guidebook says:

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Federal law does not require or authorize reports of resignations to avoid an investigation where it merely looks like one is coming or someone threatens one.



Bylaws should include a very specific provision on what an investigation is, how it starts, and who gets to start one.

Data Bank Reports . . . (conclusion)



**Minutes, minutes,
minutes. If it isn't
written down, it didn't
happen.**

- Committees, not individuals, conduct investigations
- Investigations focus on one particular physician
- An investigation must pertain to competence or professional conduct
- Routine or general reviews do not qualify
- Investigations are usually precursors to action against privileges
- Investigations end only when the entity (usually the board) makes a final decision.

Returning to the facts in *Costa*, the court sided with Dr. Costa and directed the Secretary of Health and Human Services to remove the data bank report. There was no evidence of an investigation and thus nothing to report.

What about the QA meeting? Well, for one thing, there was no record of what was decided by the committee. For another, the bylaws said that an investigation begins only after a written request for action to the medical executive committee. There was no evidence the QA committee did that either. Mr. Joseph tried throughout the litigation to characterize his individual efforts as an investigation, but individual efforts do not qualify.

What about the medical staff meeting, where the staff voted to reject Dr. Costa's application? Presumably, the QA meeting could have been a "precursor" to the final action, but what evidence there was indicated that the reasons for the staff rejection were concerns about his PA use and his derogatory statements about administration. There was some indication that the staff mentioned the incident first brought up at the QA meeting, but the minutes do not reflect any conclusions.

What are the lessons in *Costa*? There is something for everyone:

- Medical Staff leaders:** Make sure you define what an investigation is in your medical staff bylaws and that you follow those provisions closely. Once you start an investigation, resignations must be reported. Tactical note: A threatened investigation may cause a physician to quietly withdraw, without a reporting obligation. This may save you a lot of money and trouble, to be weighed against allowing a problem physician to resurface somewhere else in the nation.
- Medical Staff Office professionals:** Minutes, minutes, minutes. Record accurately what goes on at meetings and be sure they are ratified and approved by the body. As is often said, "If it isn't written down, it didn't happen."
- Committee chairpersons:** QA committee general assessments or even peer review committee assessments are ordinarily not investigations, particularly if your bylaws are careful to say they are not. Any other conclusion would make the work of these committees less thorough out of fear that they might prematurely trigger a reporting requirement.
- Administrators:** Ordinarily, you have access to the medical staff corrective action machinery in the form of the right to request a medical staff investigation. With the possible exception of summary suspension powers, however, that's usually as far as it goes. Do not carry personal grudges (as Joseph appears to have here) and file data bank reports that are either untrue or unnecessary. At least one federal court has held a CEO personally liable for a defamation verdict based upon a knowingly false data bank report.
- Physicians:** If you are ever the subject of a data bank report, there are administrative mechanisms that encourage the hospital to make a voluntary amendment of an erroneous data bank report or require the mandatory correction or withdrawal of such a report. If you and the hospital disagree, you may have a legal right, as Dr. Costa did, to have a court decide who's right.



Medical Staff Standards (cont'd)

It's a little unclear what to make of this change. The introduction to the credentialing standards relating to "experience, ability and current competence" states that a hospital "may" include assessment of these six areas. There are no standards or elements of performance (EPs) that require their use.

Later in the standards, however, the peer references EP requires that each peer reference must contain written information about four out of the six measures. What JCAHO probably means is that the six measures themselves are not intended to be credentialing standards. But you do have to ask questions (and collect peer references) on at least some those areas.

The final version of JCAHO's medical staff standards announced in July of this year differs quite a bit from that proposed a year ago, particularly in the new area they call "performance evaluation." Let's be clear then about two brand new phrases: Focused Professional Practice Evaluations and Ongoing Professional Practice Evaluations.

Focused Professional Practice Evaluations (or FPPEs), JCAHO says, may be necessary under two circumstances.

In one situation, you may have a physician who has no "documented evidence" that she can perform a requested privilege. This may be either because she's on staff, but has never exercised this privilege, or because she's a new applicant.

JCAHO's original draft gave medical staffs the option of determining which of its procedures required monitoring. That's gone in the final standard. Effective in 2008, *all* new applicants and all existing members requesting new privileges will have to undergo a time-limited period of FPPE. What to look at, how, for how long, when external sources may be necessary, and when the period may be extended is up to the medical staff to define.

The second situation in which FPPEs are used is when a question arises concerning a physician's ability to provide safe, high quality care. If this sounds like peer review, it's because it probably is. JCAHO continues its historical refusal to use the phrase "peer review" in the standards, however, compounding the uncertainty. At least one clue lies in JCAHO's deletion, without comment, of the "Focused Review" provisions of MS 4.90, which walked, talked and looked a lot like what a basic peer review process might look like.

Gone from this version of FPPEs is most of its prior guidance on what this new process must specifically contain. Instead, the "criteria," "methods," "triggers," "measures" and "circumstances" are left mostly up to the medical staff. But you'd better have criteria, methods, triggers, measures and circumstances, or you'll bust the elements of performance requiring them.

The second new concept in JCAHO's so-called "evidence based" approach to credentialing involves Ongoing Professional Practice Evaluations (or OPPEs). Unlike FPPEs, OPPEs – as the term "ongoing" implies – requires ongoing data collection and measurement of every practitioner in the hospital.

The idea is that past credentialing efforts had been static, subjective and anecdotal. This new requirement will force the collection and analysis of real data to help decide whether to renew, revise or revoke a privilege.

Who decides what to collect? The EPs say it starts with the individual departments and must be approved by the medical staff.

What's being measured? The original draft said both "clinical practice" and "professional behavior." The final says "professional practice." Why JCAHO took two clear phrases and fuzzed it up is unclear, leaving hospitals to guess whether a physician's "behavior" must be measured or not.

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Ongoing Professional Practice Evaluations require ongoing data collection and measurement of every practitioner in the hospital.

Medical Staff Standards (conclusion)

What are the candidates for data collection? Specifically listed are operations and their outcomes; blood and pharmaceutical utilization; requests for tests and other diagnostic procedures; length of stay; mortality and morbidity; use of consultants; and others the medical staff may add.

Where will this data come from? Periodic chart review; direct observation; monitoring of diagnostic and treatment techniques; and discussions with “others.” “Others” specifically include consulting physicians, assistants at surgery, nursing and administrative personnel. By implication from the new FPPE requirements, presumably the results of focused evaluations would be included as well.

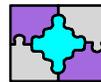
One additional data source, the subject of a separate new standard, would be the hospital’s internal complaint process. Every hospital now has to have a process where persons – other physicians, nurses, other hospital employees and patients – may voice “clinical practice and/or competence concerns.” The process must have adequate mechanisms for the “collecting, investigating and addressing” of such concerns. Hospitals must “uniformly investigate[] and address[]” all such concerns to enhance patient safety and quality care.

What’s to be done with all this information? Foremost, it must be “factored” into individual privilege decisions. (The original draft said “decisive factor,” but the final standard backs off a bit.) In addition, it must be fed back into the medical staff’s general performance improvement process.

One final change in the standards is noteworthy. The original draft was peppered with provisions stating “the organization or the medical staff” must do such and such. The frequency of this seemed a clear intention to give hospital administrations some clout if the medical staff failed to act.

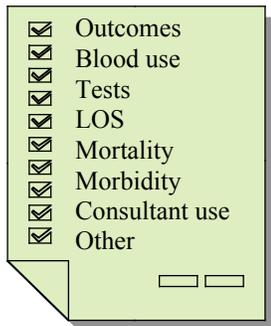
All of those references to the “organization” have been removed. In all cases, the medical staff, its committees or departments are responsible for taking all these credentialing initiatives. As always, the governing body retains the authority to approve or reject medical staff recommendations. The change removes any doubt that both administration and the medical staff must work together and restores the traditional role of the medical staff as prime mover.

These changes have been in the works for a year now. We are less than two months from implementation. If you have not yet created and documented the many mechanisms and processes (and hired the people!) necessary to implement these significant changes, time is running out.



Quick Hits:

- As expected, the trial judge in the *Poliner* abusive peer review case (reported last issue) further reduced the \$70 million **verdict to \$22.5 million**. The latter number is now a final judgment, entered October 13. Appeal will follow.
- JCAHO put out for a **third consecutive field review** controversial Medical Staff Standard 1.20, EP 19. This standard and its accompanying element of performance describe **what bylaws must contain** and what may be relegated to other medical staff documents. Hospitals and their lawyers have complained that, among other things, the demands of this standard would require significant bylaws revisions. Comment period ended October 27. No word yet on when a fourth review might commence . . .



OPPEs must be factored into individual privilege decisions. In addition, information must be fed back into the medical staff’s general performance improvement process.



Commentary

Kentucky Confidentiality: Time To Try Again?

By Richard A. Setterberg, Esq.

If there is one thing that is more hazardous than predicting elections, it is predicting what happens after them. With Election Day behind us, the talking heads have only just begun telling us what it all means. Look for heavy use of the words “seismic” and “tectonic shift.”

I personally plan to stay well out of these debates. If any one of us stopped to measure the breathless expectations on the day after Election Day against actual later accomplishments, we’d waste less time with the tea leaf readers and get on with our real lives.

There was a development, however, that deserves at least passing mention in these pages: The Kentucky Supreme Court election results.

Judicial elections often pass well under the radar of many voters, so you might be interested in following, if you didn’t check the results: Of the seven sitting justices, five were up for re-election. One was unopposed. That left a majority – four seats – up for grabs. Of those four, one incumbent won, one lost. In all, there will be three new faces.

Why is this significant to PEER REVIEW REPORT? It has been several years since the Kentucky legislature tried to enact a peer review confidentiality law. It may be time to try again.

As the article in this issue explains, the court has been relatively antagonistic to any peer review law that protects documents and information from malpractice plaintiffs. It twice declared statutes unconstitutional. On the third occasion, in 1999, it construed the law narrowly, saying the legislature *could have* written a broader law but did not.

Whether you agree with the five-justice majority or the two-justice dissent (which argued that the legislature *did* write the law broadly) is no longer important. All of the justices sitting on this 1999 decision are gone. All seven.

Judges properly pay close attention to precedent. But if the Kentucky legislature passes a new law – presumably one that cures all constitutional, language and intent issues – it’s a whole new ball game. And a whole new bench to interpret what the new law says.

It is impossible to say in advance what this new court would do with a new peer review confidentiality protection statute. For one thing, the legislature has not yet acted.

Judicial philosophy will likely play a large role. Watch for what this bench does with statutory interpretation cases in the coming months and years. Does it apply laws as written (strict construction) or craft judicial solutions regardless of actual legislation (activism)?

If you believe in strict construction, this Election Day may not have been your best day at the polls. The three candidates who publicly declared themselves strict constructionists in the Kentucky Candidate Information Survey all lost. Their opponents either declined to answer the survey (two) or described themselves as more moderate (one).

Still, what the new court will do with an as-yet unwritten law is nothing but wild speculation. There’s only one way to find out, and that is for the legislature to try again. Properly drafted, Kentucky may eventually have a law, like the vast majority of other states, that protects the confidentiality of peer review documents in malpractice cases.



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Richard A. Setterberg Co., L.P.A. publishes and distributes PEER REVIEW REPORT free to inform clients and others about issues and developments concerning medical staff matters. It is not legal advice. For further information on issues or topics in this newsletter as they may apply to particular facts, please contact the editor at (513) 733-1759 or rascolpa@cinci.rr.com.

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