

## **New Jersey Hospital Medical Staffs and Medical Staff Peer Review Litigation**

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A key distinction between an occupation and profession is that the latter is self-regulating. In a hospital, the self-regulation of the practice of medicine falls to the entity known as the organized medical staff.<sup>1</sup> The medical staff is a juridical entity separate and apart from the hospital's body corporate.<sup>2</sup> But, it does so in collaboration with the hospital's governing body.<sup>3</sup>

A physician cannot practice at a given hospital unless he or she is a member in good standing of that hospital's medical staff. So, medical staff membership is critical to many physicians (like surgeons, and emergency physicians) whose practices require access to a hospital's facilities. For that reason, denials of membership or adverse disciplinary actions by medical staffs engender a fair share of litigation even though medical staffs enjoy a measure of qualified immunity under federal law.<sup>4</sup> As a result, New Jersey has a well-evolved body of case law governing the medical staff's proper exercise these two critical, core functions. Before an aggrieved physician can get into court, though, he or she must exhaust their rights to an internal, administrative hearing process commonly known as the "fair hearing process."<sup>5</sup> Medical staff litigation is not solely confined to the courtroom.

In the balance of this article, we will explore the basic law underlying the litigation of medical staff issues.

### **The Rules of Engagement**

#### **Medical Staff Bylaws**

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<sup>1</sup> In addition to hospitals most other licensed health facilities (e.g., ambulatory surgery centers and nursing homes) have organized medical staffs. For the sake of brevity in this article we will not separately make reference to them but include them in our use of the word "hospital." That is, we will use "hospital" to mean all health facilities with organized medical staffs.

<sup>2</sup> The medical staff is in most instances an unincorporated membership organization that can sue and be sued. *Corleto v. Jersey Shore Medical Center, ?*

<sup>3</sup> [cite here to jcaho and state law which requires such]

<sup>4</sup> The frequency of such litigation can be easily understood when one considers that a physician faced with exclusion from a staff or an adverse peer review action may be branded for life with the modern day, medical equivalent of Hester Prynne's scarlet letter. All exclusions from staff membership and adverse peer review actions related to the quality of care issues must be reported to the a federal database (the National Practitioner Data Bank). This database reporting is conducted through the State Board of Medical Examiners and must be consulted by every medical staff and managed care entity when considering the grant of membership or privileges to a physician. If membership or privileges have been granted a physician the database must be again consulted before re-appointment but no later than two years since the last time it was consulted.

<sup>5</sup> That is unless the aggrieved physician is being denied a "fair hearing" by a medical staff or is concerned with the integrity of the hearing process. *See, Ende v. Cohen, ?*

New Jersey medical staffs are required to have bylaws, and it is these bylaws that govern the medical staff's conduct of its business.<sup>6</sup> The staff's bylaws have their genesis with the staff acting as a body politic, but do not take effect until approved by the hospital's governing body. The bylaws, also, constitute a contract between the hospital and the medical staff, as well as a contract between the hospital and each member of the medical staff.<sup>7</sup> The bylaws serve as a roadmap for appointment, reduction, expansion or termination of staff membership and privileges. Accordingly, bylaws are the most important document governing and directing the relationships between hospitals and their medical staffs, and in turn, medical staffs, and their members or prospective members.

When a medical staff does not follow or fails to enforce its own bylaws, it can be sued under various legal theories<sup>8</sup>, including breach of contract. Often, aggrieved physicians assert claims not only against the hospital and medical staff themselves, but against individual physicians and administrators who have not complied with the bylaws' mandates and requirements.<sup>9</sup>

Medical Staff Policies, Procedures, Plans, etc.

The State mandates that bylaws include certain policies and procedures or "rules and regulations."<sup>10</sup> Thus, most bylaws include statements that an applicant will abide by all policies, rules and regulations that apply to a practitioner's activities as a medical staff member or otherwise. Thus, these rules and regulations constitute at the very least a supplement to the bylaws, and are equally binding on all members of a medical staff

These rules and regulations are created to specifically implement the general principles found in bylaws and the policies of the hospital. For example, they may set forth certain criteria for privileges in particular departments or they may provide rules for record keeping or required attendance at meetings.

Amending bylaws can prove arduous because even the smallest change often requires the vote of the entire medical staff and hospital administration. Thus, allowing certain requirements to be addressed in ancillary rules and regulations provides medical staffs with greater flexibility in amending these rules.

The Health Care Quality Improvement Act of 1986

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<sup>6</sup>NJAC 8:43G-16.1(a); N.J.A.C. 8:43G-16.2(a).

<sup>7</sup> *Joseph v. Passaic Hospital Association*, 26 N.J. 557 (1958); See also American Medical Association Policy Compendium H-235.976 which states that "the medical staff bylaws are a contract between the organized medical staff and the hospital..."

<sup>8</sup> *Corleto v. Shore Memorial Hospital*, 138 N.J. Super. 302 (Law Div. 1975); The New Jersey courts have held that a hospital and its medical staff can be held liable for negligence when they fail to enforce their bylaws.

<sup>9</sup> See, e.g., *Ende*

<sup>10</sup> NJAC 8:43G-16.2(a)(1).

The Health Care Quality and Improvement Act (“HCQIA”) sets forth certain requirements for credentialing physicians and peer review activity.<sup>11</sup> For example, the Act created the National Practitioner Data Bank (“Data Bank”) which is a system for reporting physicians who have had adverse professional actions taken against them. Prior to accepting any applicants to its medical staff, and every two years thereafter, HCQIA requires hospitals to request and document information reported to the Data Bank.<sup>12</sup> In addition to HCQIA violations, a hospital that does not properly credential its physicians may face liability for negligent credentialing derived from theories of corporate negligence.

HCQIA establishes certain due process requirements for peer review activities. These requirements will be discussed later in this article. If they are followed, hospitals and their medical staff can enjoy certain immunities from civil litigation for review of their colleague’s professional activities. The immunity applies, however, only in relation to physician and dentist staff members.

#### Joint Commission on Accreditation of Healthcare Organizations Standards

The Joint Commission on Accreditation of Healthcare Organizations (“JCAHO”) is a private, nonprofit organization, which evaluates medical facility compliance based on a focused set of core "standards" for quality patient care. To acquire and maintain JCAHO accreditation, hospitals must undergo an extensive, on-site review by JCAHO professionals. During the review, JCAHO evaluates performance in all areas that affect patient care.

JCAHO considers the medical staff to be a structure with certain functions related to patient care and has, accordingly, promulgated several standards specific to them. The standards currently provide for the adoption of bylaws and rules to establish a framework for self-governance of medical staff activities. Another notable standard requires "mechanisms, including a fair hearing and appeal process, for addressing adverse decisions for existing medical staff members and other individuals holding clinical privileges for renewal, revocation, or revision of clinical privileges."<sup>13</sup> Thus, in order to be accredited, JCAHO requires hospitals to have an on-going method to evaluate the quality of care provided by its physicians. This is done through its medical staff’s peer review program, at the discretion of the hospital and medical staff.

#### Statutes, Regulations and Case Law

Hospitals have been concerned with exposure for peer review activities ever since the Supreme Court’s landmark decision in *Patrick vs. Burget*.<sup>14</sup> *Patrick* involved a physician who was found to be a victim of malicious peer review. Dr. Patrick was a surgeon in a

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<sup>11</sup> Medical peer review is a process whereby physicians evaluate the quality of work done by their colleagues in relation to accepted health care standards.

<sup>12</sup> Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101, et seq.).

<sup>13</sup> JCAHO MS 1.2.

<sup>14</sup> 486 U.S. 94 (1986).

small town in Oregon where he practiced in a clinic. The clinic offered him a partnership but Dr. Patrick declined the offer and started his own, competing practice. They used their positions on the Hospital Peer Review Committee to attempt to withdraw Dr. Patrick's hospital privileges. Those actions ultimately led to Dr. Patrick's resignation from the Hospital. Dr. Patrick brought an antitrust action against the clinic doctors and a jury awarded him almost two million dollars in damages. The U.S. Court of Appeals for the Ninth Circuit reversed the State court decision, holding that the peer review actions were protected by absolute immunity because of the state action exception to the antitrust law. Dr. Patrick appealed to the US Supreme Court granted review.

The Supreme Court rejected the argument that effective peer review is essential to the provision of quality medical care and that any threat of antitrust liability would prevent physicians from participating openly and actively in peer-review proceedings. It held that, to the extent that Congress has declined to exempt medical peer review from the reach of the antitrust laws, peer review is immune from antitrust scrutiny only if the State effectively has made this conduct its own. Since Oregon had not done so, the Court reversed the judgment of the Court of Appeals.<sup>15</sup>

The New Jersey State Department of Health requires hospitals to have peer review procedures in place as a prerequisite for acquiring licensure.<sup>16</sup> Unfortunately, New Jersey affords its physicians only limited immunity for peer review activity. The New Jersey legislature has provided for immunity from civil liability to all persons serving as members of committees responsible for the evaluation and improvement of the quality of care rendered in hospitals.<sup>17</sup> In *Reyes v. Meadowlands Hosp. Med. Ctr.*, however, the New Jersey Supreme Court stated that there is "no provision for the results of such a process to be privileged. Therefore, those participating do so without any assurance of confidentiality."<sup>18</sup>

In *McClain v. College Hosp.*, however, the Court indicated that some protection for peer review materials could come from the judiciary's provision of protection for "self-examination or self-critical materials." This protection is similar to the disclosure exception under freedom of information laws applied to law enforcement information.<sup>19</sup> In *Payton v. NJ Turnpike*, the Court expressly declined to adopt "as a full privilege, either qualified or absolute" the protections sought for self-critical analysis materials.<sup>20</sup> Rather, the Court established a case-by-case balancing of interests.

For example in, *Christy v. Salem*, the plaintiff asserted that hospitals should not be entitled to maintain absolutely confidential peer evaluations. The Court decided that plaintiff was entitled to information in one specific line of a report that might supply a

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<sup>15</sup> 486 U.S. 95 (1986).

<sup>16</sup> N.J.A.C. 8:43-G-2.12.

<sup>17</sup> N.J.S.A. 2A:84A-22.10.

<sup>18</sup> 355 N.J. Super. 226, 233 (L. Div. 2001); See also *Bundy v. Sinopoli*, 243 N.J. Super., (Law Div. 1990).

<sup>19</sup> *McClain v. College Hosp.*, 99 N.J. 346, 357-359 (1985); See also *Wylie v. Mills* 195 N.J. Super. 332 (Law Div. 1984)

<sup>20</sup> *Payton v. New Jersey Turnpike Authority*, 148 N.J. 524, 545 (1997).

critical element in his case, and also to some purely factual material. The court held that plaintiff was not entitled to the committee's "opinions, analysis, and findings of fact." These "evaluative and deliberative materials" need not be disclosed.<sup>21</sup>

### **The Adverse Medical Staff Action**

Most commonly, medical staff bylaws allow one of their committees to make a recommendation to the hospital regarding an applicant's or member's membership and/or privileges. When a medical staff member is denied appointment, or a recommendation is made that his or her privileges and/or staff membership be reduced, restricted, suspended, revoked or not renewed, such action is considered adverse under HCQIA.(3) Adverse recommendations, in turn, give rise to certain procedural due process rights.

#### **Initiation**

When a physician with clinical privileges engages in behavior that is likely to affect patient safety or brings into question the practitioner's professional competence, or disrupts a hospital's operations, the medical staff, must initiate corrective action against such practitioner. This is often done through the representative set forth in the bylaws, Corrective action taken on the basis of economic or competitive matters, however, is specifically prohibited and can be the basis of medical staff litigation.<sup>22</sup>

#### **Investigation/Medical Staff Committee Action**

Once a determination is made that there is a need for corrective action against a particular physician, the medical staff, usually through a specially designated committee, conducts an investigation. Investigations are not deemed to be a "hearing" for purposes of triggering the due process requirements under HCQIA. Most hospitals, however, usually provide the aggrieved physician the right to representation by an attorney-at-law or by a member of the Medical Staff during the investigation process.

Upon conclusion of an investigation, the investigating committee drafts a written report of the results of the investigations and recommends a course of action. The course of action may include recommending rejection of the request for corrective action, a warning or letter of admonition, a letter of reprimand, probation upon appropriate terms, requirement for consultation or for supervision for the individual practitioner, reduction, suspension or revocation of clinical privileges, changing medical staff category or limitation of any staff prerogatives directly related to the practitioner's delivery of patient care; or suspension or revocation of staff membership. The investigative committee is but one element of the peer review process.

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<sup>21</sup> *Christy v. Salem*, 366 N.J. Super. at 542.

<sup>22</sup> See *Edelman v. John F. Kennedy Hospital* (No.c-2104-80 [N.J. Super. June 25, 1982], cert. denied, 96 N.J. 289 [1984]).

## Role of Hospital in the Peer Review Process

Hospitals are subject to extensive regulation, including regulations requiring the board of directors to appoint and oversee a qualified medical staff.<sup>23</sup> Therefore, hospital administrators often also take a role in the peer review process. Their role helps to ensure that appropriately qualified physicians provide services to hospital patients.

Hospitals may initiate peer review action by requesting that corrective action be taken or request the medical staff to terminate any pending investigations and proceed directly to a “fair hearing” (discussed below). Additionally, bylaws most typically require that the medical staff’s recommendations for corrective action be sent to the hospital for final approval. The hospital then usually has the right to approve or reject such approval.

Hospitals also have a reporting function. When peer review ultimately result in an “adverse action,” against a physician, HCQIA requires it to make a report such action to the Data Bank.<sup>24</sup> Additionally, New Jersey law requires hospitals also have a duty to report any final action resulting in the reduction or suspension of a practitioner’s privileges, or his or her removal or resignation from its medical staff to the State Board of Medical Examiners within 30 days of such action.<sup>25</sup>

## The Right Procedure and Procedural Rights

Any action or recommendation taken or made by a professional review body which is “based on the competence or professional conduct of an individual physician (whose behavior affects or could adversely affect the health or welfare of a patient or patients),” and which may adversely affect the physician’s clinical privileges or membership in a professional society” is afforded immunity under HCQIA.<sup>26</sup> In order to qualify for that immunity, however, the peer review process meets four general standards:

- It had an objective, reasonable belief that its action furthered quality health care.
- It made an objective, reasonable effort to obtain the facts.
- Under the totality of the circumstances, the physician being reviewed received adequate notice and hearing (i.e., due process) procedures.
- The organization had a reasonable belief that its actions were warranted.

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<sup>23</sup> N.J.A.C. 8:43B-2.1(a)(5); *Desai v. St. Barnabas Medical Center*, 103 N.J. 510; “Only those physicians duly qualified and competent to exercise and have privileges at the hospital; that the medical staff had the duty to investigate and then recommend that only licensed, capable and qualified physicians exercise the various privileges at the hospital.” *Corleto v. Shore Memorial Hospital*, 138 N.J. Super. 302 (1975).

<sup>24</sup> HCQIA; 45 CFR § 60.9(a)

<sup>25</sup> N.J.S.A 26:2H; NJAC 8:43G-16.1(k); See also NJSA 45:9-19.5(a).

<sup>26</sup> 42 U.S.C. § 11151(9).

Once these four criteria are met, HCQIA provides for due process throughout the entire peer review.

As discussed earlier, HCQIA further conditions peer review immunity on the availability of certain due process rights. The New Jersey courts have clarified that due process means that an applicant for medical staff privileges must be treated with “fundamental fairness” and that the methods used to make the decision must protect the applicant’s rights.<sup>27</sup> For example, the physician must be afforded notice and hearing rights which include, among other criteria, being informed of the reasons for the proposed action against him, notifying him that of his right to request a hearing pursuant to the provisions of the medical staff bylaws, and notifying him of the time limits specific to the process.<sup>28</sup>

### Triggering a Hearing

Under HCQIA, after a physician is the subject of an adverse recommendation or an adverse action by the medical staff, the physician has the right to a “fair hearing.”<sup>29</sup> Not all adverse recommendations are alike, however. Under HCQIA, only denial of initial staff appointment, reappointment, suspension of staff membership, revocation of staff membership, denial of requested advancement in staff rank, reduction in staff rank, limitation or restriction of the right to admit patients, denial of requested service/division/section affiliation, denial of requested clinical privileges, reduction in clinical privileges, suspension of clinical privileges, revocation of clinical privileges.<sup>30</sup> On the other hand, mere admonitions and warning do not trigger fair hearings or give rise to procedural due process rights.

### Notice of Right to Hearing - Timing Can Be Everything

HCQIA provides that the aggrieved physician has not less than 30 days from the receipt of notice to request a hearing. The medical staff must strictly adhere to the notice timelines set forth in their medical staff bylaws. Otherwise, an aggrieved physician may be able to claim that his due process rights under HCQIA were violated. If the physician asserts a successful claim, the entire peer review body could lose all immunity for their actions.

### Demand for Hearing

Similar to the notice requirements, an aggrieved physician must make a written demand for a hearing. He or she must do so within the dates set by the bylaws or risk waiving any rights to a hearing. It is critical that the bylaws provide reasonable time for the aggrieved physician to respond to a notice of adverse action.

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<sup>27</sup> See *Garrow v. Elizabeth General Hospital*, 79 N.J. 549 (1979); *Gresiman v. Newcomb*, 40 N.J. 389 (1963).

<sup>28</sup> *Guerrero v. Burlington Cty. Memorial Hosp.*, 70 N.J. 344 (1976),

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Hearing Body: Hearing Committees, Presiding Officers, ADR?

HCQIA allows the use of a hearing panel or, a hearing officer or arbitrator to conduct the fair hearing.<sup>31</sup> Hence, most bylaws provide medical staffs to choose the vehicle best suited for their particular needs. Each choice comes, however, with its own advantages and disadvantages.

Hearing panels are often appointed by the chief medical staff officer and can result in an impartial fact-finding panel. These panels, however, may not always be the best choice where the medical staff is very small.

Some hospitals appoint an arbitrator or hearing officer if they cannot locate a panel that is willing, unbiased or qualified. Hearing officers can be a good choice, especially when they are attorneys who are knowledgeable in due process rights and hearing procedures. Furthermore, they can draft any written decisions required by law or the bylaws, thereby relieving hearing panel physicians from this often difficult task.

Arbitrators may also be a good choice. Many bylaws often authorize them to render a final decision. Such a decision, however, may usurp the ultimate responsibility for patient care given to hospitals under New Jersey law. Furthermore, the use of both hearing officers and arbitrators can prove costly to both the medical staff and hospital.

#### Discovery

HCQIA does not mandate any formal right to discovery in a fair hearing process. State law, however, requires that the aggrieved physician be allowed to have copies of all relevant reports and materials, including, but not limited to underlying data referenced in materials provided to the body responsible for initiating or recommending their adverse action.<sup>32</sup>

Furthermore, hearing officers are usually allowed to rule on requests for and deadlines related to discovery. The discovery most often requested is of the hospital bylaws themselves, the documents that comprise a physician's own credentials files and any underlying patient records. Discovery demands often are required to be relevant. Therefore, only certain parts of a physician's credentials files are usually made available.<sup>33</sup> Such discretionary provision of discovery can aid in limiting the scope of the hearing to the current action.

Other types of discovery such as depositions are usually discouraged as they can be very costly to both parties. Depositions may be acceptable, however, in cases where a party can demonstrate a specific need and is willing to pay the costs associated with them

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<sup>31</sup> 42 USC § 412[b][3][A].

<sup>32</sup> *Garrow v. Elizabeth General Hospital*, 79 N.J. 549 (1979).

<sup>33</sup> This is not to say that we agree with limiting discovery in that manner. We are just reporting what frequently happens. Indeed, to the contrary, we believe that discovery in medical staff litigation should be sufficient broad to allow an aggrieved physician to have a fair opportunity to vindicate himself.

## Conduct of the Hearing

### *Burden of Proof*

The burden of proof most often falls on the charging party. Accordingly, the medical staff or the hospital has the initial obligation to prove the charges against the aggrieved physician.<sup>34</sup> Some short-sighted hospitals<sup>35</sup> seeking to discourage staff litigation have convinced their medical staffs to place the burdens of going forward and of persuasion firmly on the aggrieved physician. In those instances, the aggrieved physician must prove—sometimes by clear and convincing evidence—that the adverse staff recommendation or action lacks any substantial factual basis or that such basis or the conclusions drawn from same are either arbitrary, unreasonable, or capricious.<sup>36</sup>

### *Evidence*

Evidentiary matters are usually addressed at a pre-hearing conference in order to avoid the surprise of unanticipated written or oral testimony, for both parties. It is important to note that, in New Jersey, parties to a staff hearing are not bound by statutory or common law rules of evidence.<sup>37</sup> Generally speaking, however, evidentiary rulings should be made to promote fundamental principles of fairness and justice and to aid in the ascertainment of truth.<sup>38</sup> Thus, all relevant evidence is usually admissible, with few exceptions. For example, if a hearing officer is appointed, he or she often has the right to exclude any evidence if its probative value is substantially outweighed by the risk that its admission will either necessitate undue consumption of time or create substantial danger of undue prejudice or confusion. Generally, hearsay is also permitted in a staff hearing.<sup>39</sup>

### *Confrontation*

Both under federal and state law, aggrieved physicians have a right to confront and cross-examine witnesses and to be represented by counsel in the presentation of their case<sup>40</sup>. An aggrieved physician thus has the opportunity to appear, cross-examine, confront adverse witnesses, and present evidence. Often, however, other physicians are reluctant to serve as witnesses either in support or against the aggrieved practitioner. New Jersey law, therefore, allows for the issuance of subpoenas to compel witnesses in the fair hearing context.<sup>41</sup>

## Record

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<sup>34</sup> HCQUIA § 412[b][3][C]; *Garrow v. Elizabeth General Hospital*, 79 N.J. 549 (1979).

<sup>35</sup> We write “short-sighted” because we believe that such efforts make a mockery of the entire peer review process and undermine the very fairness of what was once called by the hospital industry the “fair hearing process.”

<sup>36</sup> *Guerrero v. Burlington County Memorial Hospital*, 70 N.J. 344 (1976).

<sup>37</sup> N.J.A.C. 1.15(c).

<sup>38</sup> N.J.A.C. 1:1-15.1(b).

<sup>39</sup> HCQIA § 412[b][3][C][i]; *Garrow v. Elizabeth General Hospital*, 79 N.J. 549 (1979).

<sup>40</sup> *Garrow v. Elizabeth General Hospital*, 79 N.J. 549 (1979); [42 USC § 11112\(b\)\(2\)](#).

<sup>41</sup> *In re: Mossavi*, 334 N.J. Super. 112.

A record of the hearing, including pre-hearing and post-hearing actions, should always be maintained. The form of record should be sufficiently accurate to allow any body which reviews it to make an informed and valid judgment. This is important not only with respect to protecting the interests of the aggrieved physician but also assures that the best interests of the practitioner's patient are considered. Medical staff bylaws usually determine which party will bear the costs for the hearing records. They also usually require that a copy of the record be provided to each party.<sup>42</sup>

### Postponements and Adjournments: Think Twice

Bylaws normally allow for a postponement or adjournment where there is a showing of good cause by either party. Good cause can take the form of obtaining or reviewing new evidence. The right to postpone or adjourn a hearing should be used judiciously. By requesting or agreeing to an adjournment a physician may be deemed to have waived the timely hearing requirements of the bylaws or HCQIA.<sup>43</sup> Moreover, under some bylaws undue delaying tactics or other procedural abuses can occasion the loss of a physician's right to a hearing.<sup>44</sup>

### Committee Decisions, Recommendations and Reports

After a physician's hearing is concluded, HCQIA requires the hearing committee to make a written report of its findings to the body whose actions or recommendations occasioned the hearing as well as to the aggrieved practitioner.<sup>45</sup> If the action of the medical staff or of the hospital continues to be adverse to the practitioner, the aggrieved physician will be provided the option to request an appellate review by the hospital, usually through its governing board.

### Administrative Appeals

To obtain appellate review of an adverse hearing committee decision, the aggrieved physician must typically make a written request within the time limits set forth in the bylaws. The appellate review is most often limited to the record of the hearing before the hearing committee, that committee's report, and all subsequent results and actions. The physician is generally afforded the right to appear, with or without legal representation, for the limited purpose of answering questions posed by any member of the appellate review body.

As noted above, hospitals are self-governing. Such autonomy includes some discretion in the appellate review process.<sup>46</sup> Therefore, once it has had an opportunity to review all the materials and testimony presented to it, the appellate review body may then make its own determination. It may affirm, modify or reverse the adverse result or action

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<sup>42</sup> 42 USC § 412[b][3][C][ii]

<sup>43</sup> Cit to HCQIA

<sup>44</sup> HCQIA § 412[b][3][C][i] and *Garrow*

<sup>45</sup> HCQIA § 412[b][3][D]

<sup>46</sup> *Greisman v. Newcomb Hospital*, 40 N.J. 389, 403 (1963).

previously taken or recommended. Alternatively, it may refer the matter back to the hearing committee for further review and recommendation to be returned to it within a set number of days and in accordance with its instructions. In turn, the appellate body, then, usually make its recommendation to the hospital's governing body within a prescribed time limit.

### Final Hospital Governing Board Action – Is Final Really Final?

Since the organized medical staff be responsible to the governing body of the hospital,<sup>47</sup> the governing body makes the ultimate internal decision in all medical staff hearings. It must provide the aggrieved physician with written notice of its decision. If the aggrieved physician is not satisfied with the hospitals decision, he or she may seek judicial relief.

## Judicial Review and Relief

### Standards of Review

With public hospitals there has been little doubt that the fairness of the procedures employed must measure up under the Constitution, and may not arbitrarily foreclose otherwise qualified doctors from utilizing its facilities.<sup>48</sup>

With private or voluntary hospitals, initially it was not so clear that medical staff actions were subject to judicial review or what measure of fairness had to be accorded aggrieved physicians. The New Jersey Supreme Court first determined in *Greisman v. Newcomb* that the decisions of private hospitals are also subject to judicial review.<sup>49</sup> It concluded that it “must never lose sight of the fact that the hospitals are operated not for private ends but for the benefit of the public” and thus their decisions are reviewable by the State judiciary.<sup>50</sup> Accordingly, private or voluntary hospitals must also follow fair procedures when considering staff privileges, and may not arbitrarily foreclose otherwise qualified physicians from their staffs.<sup>51</sup>

The scope of judicial review available depends upon nature of the issues presented. The courts will not interfere with a hospital decision setting a standard for the grant of privileges “if it is reached in the normal and regular course of conducting the affairs of the hospital and is based on adequate information, regardless of form, origin, or authorship, that is generally considered feasible and reliable by professional persons responsibly involved in the health care field.”<sup>52</sup> Thus, courts will sustain a hospital's standard for granting staff privileges if that standard is rationally related to the delivery of

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<sup>47</sup> N.J.A.C. 8:43G-16.1.

<sup>48</sup> *Nanavati v. Burdette Tomlin Memorial Hosp.*, 107 N.J. at 247, 526 A.2d 697; *Bloom v. Clara Maass Medical Ctr.*, 295 N.J.Super. at 608, 685 A.2d 966.

<sup>49</sup> 40 N.J. 389.

<sup>50</sup> *Greisman v. Newcomb Hospital*, 40 N.J. at 395-96 (1963).

<sup>51</sup> *Belmar v. Cipolla*, 96 N.J. 199, 207-08, 475 A.2d 533 (1984).

<sup>52</sup> *Desai v. St. Barnabas Medical Center, supra*, 103 N.J. at 93, 510 A.2d 662.

health care.<sup>53</sup> A decision is so related if it advances the interests of the public, particularly patients; the hospital; or those who are essential to the hospital's operations, such as doctors and nurses.<sup>54</sup>

When reviewing decisions denying or revoking staff privileges, courts also apply a more relaxed standard of review; the courts look to see whether a decision is supported by “sufficient reliable evidence, to justify the result.”<sup>55</sup> The courts will thus sustain a hospital's internal peer review procedure if it reasonably serves an evident public health purpose.<sup>56</sup>

## **Special Cases**

Certain situations may arise where a hospital must temporarily suspend or automatically revoke a physician’s partial or full privileges prior to conducting a hearing.

### **Summary Adverse Action**

For example, a hospital may summarily suspend a practitioner’s privilege. Such suspensions are effective immediately upon imposition. The hospital may take such action when it is in the best interest of patient care or safety or for the continued effective operation of the hospital.<sup>57</sup> Furthermore, prior to suspending a physician, the hospital and involved physicians should have a reasonable factual basis for making a determination of summary suspension or risk liability for violating HCQIA and other State laws.<sup>58</sup>

Summary suspensions are not final and are subject to subsequent notice and hearing and other due process rights under HCQIA.

### **Automatic Adverse Actions**

Other actions, while not effecting patient care immediately and directly, also can trigger adverse action by the medical staff. For example, when a practitioner's license is limited, restricted, suspended or placed on probation, his or her staff membership and clinical privileges or specified services may, depending on the bylaws’ specifications, may be automatically suspended. Additionally, failure to request reinstatement after a leave of absence or failure to maintain professional liability insurance may also lead to automatic termination of privileges. These actions often do not entitle the aggrieved physician to the procedural rights afforded in other instances.

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<sup>53</sup> *Desai v. St. Barnabas Medical Center*, *supra*, 103 N.J. at 93, 510 A.2d 662.

<sup>54</sup> [cite]

<sup>55</sup> *Garrow v. Elizabeth Gen. Hosp. & Dispensary*, 79 N.J. 549, 565, 401; *Nanavati v. Burdette Tomlin Memorial Hospital*

<sup>56</sup> *Desai v. St. Barnabas Medical Ctr.*, 103 N.J. at 90-91.

<sup>57</sup> Health Care Quality Improvement Act of 1986, § 412(a)(3), (b), (b)(1), (c), 42 U.S.C.A. § 11112(c).

<sup>58</sup> State law claims may include, breach of contract, defamation, and tortious interference with business. By incorporating the imminent danger language in their bylaws, medical staff can attempt to avoid breach of contract claims.

## Adverse Action Involving Hospital Employed Physicians or Exclusive Contractors

Another special case is where a physician is employed directly by the hospital or has an exclusive contract with the hospital to provide certain services. In such instances the staff's bylaws may provide that the physician may be terminated and stripped of his staff membership without triggering any of the provision safeguards afforded other physicians faced with termination of their membership.

## **Conclusions**