Recent Legal Developments That Are Going to Make Medical Peer Review in Texas Harder (But More Important Than Ever)

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Texas Lawyer
January 15, 2020

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The courts have been relatively quiet in Texas this past year when it comes to cases addressing medical peer review. The Texas Legislature, however, has been hard at work passing laws that raise the risks and reduce the protections for health care organizations engaging in medical peer review.

Meanwhile, recent changes to the National Practitioner Data Bank reporting requirements close perceived loopholes for reporting physician resignations and restrictions of clinical privileges, thereby making peer review activities subject to greater scrutiny.

In other words, the stakes have never been higher.

Accordingly, it is more important than ever to conduct medical peer review correctly in order to improve quality of care and police incompetent physicians, all the while meeting federal reporting requirements and avoiding legal liability.

This article addresses recent changes in law and policy and how health care organizations can still engage in effective medical peer review in Texas.

Removal of TCPA protections for medical peer review

The Texas Citizens Participation Act, Chapter 27 of the Texas Civil Practices and Remedies Code ("TCPA"), was once a highly effective tool for addressing spurious legal actions arising out of medical peer review. Texas appellate courts uniformly held that communications addressing physician competence were related to health and safety and were thus considered protected activities under the law. *See, e.g., Batra v. Covenant Health Sys.*, 562 S.W.3d 696, 708–09 (Tex. App. 2018), reh'g denied (Nov. 5, 2018), *review denied* (June 14, 2019); *Mem'l Hermann Health Sys. v. Khalil*, No. 01-16-00512-CV, 2017 WL 3389645, at *6 (Tex. App. Aug. 8, 2017).

Consequently, the TCPA's requirement that a plaintiff present "clear and specific evidence" of each claim at the outset of litigation, coupled with the threat of mandatory fees and sanctions occasioning a case dismissal, created a significant obstacle to litigation. Accordingly, the TCPA served for years to deter plaintiffs from filing many a questionable claim arising out of the medical peer review process.

Not so any more. Effective Sept. 1, 2019, the TCPA no longer applies to a legal action in which a moving party raises a defense pursuant to Section 160.010, Occupations Code, Section 161.033, Health and Safety Code, or the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101 et seq.). *See* Tex. Civ. Prac. & Rem. Code. § 27.010(a)(8). These statutes, which are explicitly cited in the TCPA, are the very state and federal laws that grant health care entities and their medical peer review committees a presumption of immunity against claims for damages arising out of adverse professional review actions and medical peer review activities.

In other words, if a health care entity conducting peer review raises as a defense that it is entitled to immunity under state or federal law for its role in a plaintiff's medical peer review, the TCPA's protections fall by the wayside. If the organization doesn't raise that defense, however, it loses its presumption of immunity. The Texas Legislature appears to have decided you get one set of protections (presumed immunity that is usually resolved by summary judgment) or the other (TCPA-a shot to knock out the case at the beginning of the lawsuit), but not both.

Texas's New Anti-Retaliation Policy

Any health care organization that has dealt with a significant number of medical peer review matters has encountered the physician who seeks to cloak the process of reviewing his or her competence as one of retaliation for raising concerns about patient care. Myriad are the stories of a physician who, faced with a pending investigation for bad outcomes or inappropriate behavior, has sought to change the narrative into one of a "whistleblower" fighting against the "system."

A new Texas law may actually assist with this shift of the narrative. Effective Sept. 1, 2019, Texas Occupations Code chapter 162 has now been modified to require the Texas Medical Board to maintain a process to promptly and efficiently act on complaints filed by physicians with the Board regarding the care or services provided by, or the policies of, a health organization subject to that chapter. Such reports are also privileged, confidential, and not subject to discovery. And if a violation is ultimately found, the Board may revoke the organization's Board certification, refuse to certify the organization, or impose an administrative penalty.

In addition, health organizations subject to this chapter are now required to implement and comply with their own policies under which the organization "may not terminate, demote, retaliate against, discipline, discriminate against, or otherwise penalize a physician for … filing in good faith a complaint. Such "Anti-Retaliation" Policies must be in effect no later than Jan. 1, 2020. Tex. Occ. Code § 162.005.

The upshot of these new rules may be a significant chilling effect on medical peer review. If a physician with bad outcomes senses an investigation around the corner, he or she may preemptively file a complaint with the Board about perceived deficiencies in the care or services provided by, or the policies of, nonprofit health organization. The Board is then obligated to act promptly and investigate. Such activities may deter hospitals and their medical staffs from conducting investigations at all.

NPDB Reporting Changes

Federal law has long required hospitals to report to the National Practitioner Data Bank adverse professional review actions that restrict a physician's clinical privileges for more than 30 days. *See, e.g.*, 42 U.S.C. § 11133(a). The law also included a requirement to report physicians who resigned from the medical staff under or sought to avoid an investigation. Failure to report to the NPDB any triggering event can result in civil monetary penalties and loss of legal immunity for the organization.

And things have recently gotten even harder. On Oct. 26, 2018, the National Practitioner Databank released its third edition, in which it further clarified when the reporting requirements applied. Among those clarifications were the following:

- **Proctoring**: If a requirement is imposed that a proctor must be present for a practitioner to perform surgery, and the requirements last longer than 30 days, it is reportable.
- **Abatements**: Any agreement not to exercise privileges during an investigation is reportable, and a leave of absence that restricts privileges during an investigation is reportable.
- **Quality Improvement Plans**: Resignation while under a "quality improvement plan" may be reportable if that plan otherwise meets the definition of an "investigation" under the NPDB Guidebook.

These clarifications in the reporting requirements are designed to close perceived loopholes which may have previously allowed hospitals to come to agreements with physicians with substandard competence to walk away the medical staff without reporting the physician's care or any follow up peer review.

It appears that the NPDB really expects hospitals and their medical staffs to follow the letter of the law and live up to their reporting requirements, and no backroom agreements will be tolerated.

Analysis

Health care organizations have always had to carefully navigate between their obligations to ensure proper policing of their medical staffs and the specter of protracted litigation from a physician who sees his or her practice improperly scrutinized. With these recent changes in state and federal law, however, everything is even more complicated. Reporting requirements are more stringent than ever, but so are the risks if medical peer review is not conducted properly or if done in a manner than can be perceived as retaliation.

But there is a way through it all: proper investigations, timely notice to affected parties, clear and full documentation, adherence to confidentiality and privilege requirements, drafting and implementing medical staff bylaws that contain clear and compliant procedural review plans, and full due process in the event of adverse professional review action, are all necessary if a health care organization is going to navigate these choppy waters. And there is no substitute to getting appropriate legal counsel involved early (either through in-house counsel or external representation).

No one can prevent a physician who sees an NPDB report on the horizon from filing a lawsuit. But a health care organization engaged in proper medical peer review can increase the likelihood of early case dismissal and a favorable outcome if the process is correctly followed. At the end of the day, professional peer review remains the best method to improve the quality of medical care and restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's incompetent performance. *See* 42 U.S.C. § 11101. And health care organizations still have medical committee and medical peer review committee privileges and immunities under Texas, along with federal immunities that are some of the best in the business.

It is just now more important than ever to get medical peer review done right.

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