in THE TENNESSEE COURT OF APPEALS- EASTERN DIVISION
SITTING IN KNOXVILLE

RICHARD R. PEYTON, M.D.	)	
	)	
Plaintiff-Appellant,	)	
	)	
vs.	)	**No. E2001-02477-COA-R3-CV**
	)	
	)	**Washington County Circuit Court**
JOHNSON CITY MEDICAL CENTER	)	**No. 17248**
	)	
	)	
	)	
Defendant-Appellee.	)	

BRIEF OF AMICI CURIAE TENNESSEE MEDICAL ASSOCIATION AND AMERICAN COLLEGE OF RADIOLOGY

Andrew Yarnell Beatty (#13712)
TENNESSEE MEDICAL ASSOCIATION
General Counsel
2301 21st Avenue South
Nashville, TN 37212
(615) 385-2100

TABLE OF CONTENTS

Table Of Authorities

Reported Cases:

State Statutory Provisions:

Federal Statutory Provisions:

Tennessee Rules and Regulations:

Other

INTRODUCTION AND INTERESTS OF AMICI CURIAE

Tennessee Medical Association

The Tennessee Medical Association, hereinafter "TMA", and the American College of Radiology, hereinafter "ACR", hereby respectfully submits this amici curiae brief to the Tennessee Court of Appeals in this matter.

TMA is a 167-year-old not-for-profit volunteer membership professional association made up of approximately 6600 licensed Tennessee physicians and fifty component medical societies. Its principle purposes are to promote medical science, promote medical knowledge, and securing and maintaining the highest standards of practice in medicine. TMA regularly participates in legislative efforts, rulemaking proceedings, and litigation on behalf of its members and the general medical profession. TMA members include hospital-based physicians (radiologists, anesthesiologists, pathologists, and emergency physicians) as well as other physicians and specialty physicians. A vast majority of members have clinical privileges at one or more of Tennessee's hospitals. The TMA, in turn, is a component state medical association member of the Federation of the American Medical Association.

American College of Radiology

The American College of Radiology, hereinafter "ACR", is the preeminent organization of physicians in the United States who practice the medical specialties of radiology, radiation oncology, and as clinical medical physicists. It is a volunteer membership nonprofit professional organization whose primary purposes are to improve services to patients, advance the science of radiology, study the socioeconomics of the practice of radiology, and encourage continuing education for radiologists, radiation oncologists, medical physicists, and other persons practicing in allied professional fields

such as x-ray technicians. The ACR, headquartered in Reston, Virginia, boasts a membership of over 30,000 physicians from all over the United States. Each state, including Tennessee, has a chapter of the ACR. The Tennessee chapter is called the Tennessee Radiological Society ("TRS"). By virtue of the fact that TRS is a component chapter of ACR, this brief speaks for the over five hundred members of TRS.

TMA and ACR members have a critical stake in preserving the contractual relationship that exists under the law between hospitals and medical staff members in the form of their medical staff bylaws. Our members also have an interest in the preservation and enforcement of notice and due process requirements of Johnson City Medical Center ("JCMC") medical staff bylaws as well as those of any other hospitals whose medical staff members' privileges would be necessarily terminated or reduced by similar actions.

The TMA and ACR believe that the summary suspension of a physician's medical staff privileges should be an act of last resort. Summary suspension means that without prior notice to the physician, the ability of a physician to practice medicine in a hospital, the rights of patients to be cared for by the doctor of their choice, and the ability of a physician to arguably practice medicine at all, is swept away before any notice and due process hearing opportunities are afforded the affected practitioner.

The TMA and ACR positions are closely aligned to the position of Dr. Peyton in this matter. We strongly urge the Tennessee Court of Appeals to reverse the Circuit Court for Washington County's summary judgment order in favor of JCMC on the issue of immunity from damages under the Health Care Quality Improvement Act ("HCQI") and sustain the Circuit Court's finding that there were issues of fact regarding Dr. Peyton's breach of contract claim based on JCMC's violation of its Medical Staff Bylaws. A hospital that violates its Medical Staff Bylaws is not immune from damages. Therefore,

the decision of the Circuit Court for Washington County should be reversed insofar as it applies to the grant of summary judgment to the appellee, JCMC.

The amici curiae believe that the Plaintiff-Appellant has done an exceptional job of setting forth the specific issues raised on appeal. The primary purpose of this brief is to put those issues in the broader context of their potential effect on the provision of quality medical care in Tennessee and nationwide and what constitutes proper peer review.

STATEMENT OF THE ISSUES PRESENTED FOR REVIEW

The TMA and ACR adopt the issues presented for review as previously submitted in the Brief of Plaintiff-Appellant, Richard R. Peyton, MD.

STATEMENT OF THE CASE

The TMA and ACR adopt the statement of the case as previously submitted in the Brief of Plaintiff-Appellant, Richard R. Peyton, MD.

STATEMENT OF FACTS

The TMA and ACR adopt the statement of facts as previously submitted in the Brief of Plaintiff-Appellant, Richard Peyton, MD.

SUMMARY OF ARGUMENT

The Supreme Court of Tennessee has held that a hospital's bylaws are an integral part of its contractual relationship with its medical staff. As such, both parties should be bound and Appellants' hospital privileges at JCMC should not have been summarily terminated without an adequate or fair hearing process being made available as required in the summary suspension section of the JCMC bylaws. The "Fair Hearing" was made available for the sole purpose of determining whether or not the summary suspension was

reasonable under the facts presented prior to the investigation required under the JCMC Bylaws in Article IV. The Board for Licensing Health Care Facilities in rules and the American Medical Association in policy recognize the importance of the relationship between the hospital medical staff and governing body as defined in bylaws. Failure to follow hospital bylaws will result in interference in the physician-patient relationship and a reduction in patient choice of their physician. In addition, Medical Staff Bylaws provide due process protection for members of the medical staff .

In the instant case, JCMC was obligated to provide for administrative review of the action it initiated in summarily suspending Peyton. This administrative review was effected by providing Peyton the opportunity to have a hearing before the "Fair Hearing" panel. The only charge to this "Fair Hearing" panel was to determine whether or not the summary suspension of Peyton was reasonable under the circumstances. In order for the summary suspension to be reasonable under the circumstances, the panel should have addressed whether or not there was a likelihood of immediate harm and that lesser corrective action steps were not adequate. It is submitted that the Fair Hearing panel made the wrong decision. Regardless, once the decision was made to continue the summary suspension Article IV of the JCMC Medical Staff Bylaws requires that an investigation be conducted which would have provided Peyton with due process as to the allegations made.

In the instant case, JCMC violated its bylaws by failing to follow the procedures as set out in Article IV of the hospital bylaws. There was no peer review prior to the Fair Hearing and the Fair Hearing panel members were not competent to judge Dr. Peyton's medical practice nor was the "Fair Hearing" committee ever intended to judge Peyton's medical practice outside its limited charge. The hospital's position that the "Fair Hearing" provided proper peer review is disingenuous. Only four of seven members of

the hearing panel reviewing the reasonableness of Dr. Peyton's summary suspension were even licensed physicians and none practiced within his very narrow subspecialty, radiation oncology. In addition, there was no expert to educate the panel because a radiation safety officer is not competent to testify as to the standard of care in radiation oncology. No meaningful investigation took place and an attempt to call in the ACR to provide the necessary expertise never materialized because JCMC refused to allow Peyton to participate. It is impossible to perform peer review of a physician without that physician being part of the process. Had the ACR been permitted to review Dr. Peyton's practice and made recommendations, those recommendations would have been made to the Medical Staff pursuant to Article IV, after which some decision would have been made. Assuming Peyton was dissatisfied with the recommendation of the Medical Staff, he would again have had the opportunity to have the decision administratively reviewed by a "Fair Hearing" committee. The scheduled review by the ACR is the only evidence in the record that peer review was ever contemplated under the bylaws.

The Health Care Quality Improvement Act ("HCQIA") provides qualified immunity from money damages to physicians engaging in effective professional peer review provided that a professional review action is taken

> (1) in the reasonable belief that the action was 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 the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)

In order to qualify for immunity, peer review must meet all four standards. There are issues of fact as to whether or not JCMC can meet even one of the requirements, let

alone all four, of either of the professional review actions taken against Peyton, i.e. the summary suspension and the subsequent permanent revocation.

The Health Care Quality Improvement Act ("HCQIA") should not serve to grant JCMC immunity for its conduct in summarily suspending and subsequently revoking the privileges of the Appellant. The Act should also serve to protect physicians who are summarily suspended where no meaningful investigation takes place. The purpose of summary suspension is to prevent the likelihood of immediate harm to patients while an investigation is pending. No corrective action was ever contemplated as required by the JCMC bylaws if it reasonably believed such was needed. Instead JCMC opted for the most drastic action available to it. Under the Bylaws, **only** the Medical Staff can recommend revocation of a physician's privileges after completion of the Corrective Action process defined in Article IV. The physician is then entitled to the "Fair Hearing" and appeal process outlined in the Fair Hearing Plan. In the instant case, the Board of Directors unilaterally voted to "permanently suspend" Dr. Peyton's privileges with no notice or hearing and no investigation by the Medical Staff as required under the Bylaws.

ARGUMENT

I. In Tennessee, a Hospital's Bylaws Are An Integral Part Of Its Contractual Relationship With Its Medical Staff. Therefore JCMC Was Required to Comply With Its Bylaws.

A. There is a mutual responsibility for the hospital and medical staff to act in the best interest of patients and the public.

Tennessee law is abundantly clear that that the JCMC bylaws are an integral part of its contractual relationship with its medical staff. Dr. Peyton was a member of that medical staff. TMA and ACR support Dr. Peyton's prayer to this Court to allow the Appellant to put on proof as to the issues surrounding the JCMC "fair hearing" process

that was utilized to bar him from practicing his profession at its hospital. To so hold would be correct as a matter of law and public policy.

Fair hearing procedures are essential to sound medical policy and must be at the forefront of hospital decision-making. Such procedures are set out in Article IV of the Bylaws. When a hospital seeks to bar physicians from, as in this case, practicing radiation oncology in a hospital, it must do so in accordance with the established bylaws. The Joint Task Force on Hospital-Medical Staff Relationships of the American Medical Association has recognized the relationship between the facility and medical personnel practicing in a hospital:

> There is thus mutual responsibility for the proper performance of the respective obligations of the hospital governing board/administration and the organized medical staff. It is ultimately in the best interest of each to recognize this mutuality and to accommodate the needs and concerns of the other.

American Medical Association and American Hospital Association, The Report of the Joint Task Force on Hospital-Medical Staff Relationships 8 (Feb. 1985).

B. The Board for Licensing Health Care Facilities Requires Hospitals to agree to have a set of bylaws.

The Tennessee Board for Licensing Health Care Facilities has recognized this important relationship and requires in its rules that the medical staff and hospital governing body agree to have a set of bylaws:

> The hospital *shall* have an organized medical staff operating under bylaws adopted by the medical staff and approved by the governing body, to facilitate the medical staff's responsibility in working toward improvement of the quality of patient care.

Emphasis added. Official Compilation of Rules and Regulations of the State of Tennessee, Section 1200-8-1-.06(2)(a). Further, the Board's rules specifically require that all hospital bylaws address privileging (also referred to as credentialing):

> The hospital and medical staff bylaws shall contain procedures, governing decisions or recommendations of appropriate authorities concerning the granting, revocation, suspension, and renewal of medical staff appointments, reappointments, and/or delineation of privileges. At a minimum, such procedures shall include the following elements: A procedure for appeal and hearing by the governing body or other designated committee if the applicant or medical staff feels the decision is unfair or wrong.

Official Compilation of Rules and Regulations of the State of Tennessee, Section 1200-8-1-.06(2)(b). Any contemplated action by a hospital relating to hospital privileges must be referred to the medical staff in the first instance for review and recommendation. Compliance with this requirement is found in Article IV of the bylaws. Therefore, it is inherent in the State's rules that a hospital cannot take away the privileges of a member of its medical staff without a fair hearing process being followed. To do otherwise would be a violation of due process. Tennessee rules ensure that no action that impairs a physician's ability to practice his/her profession will be taken without the expert input of its medical staff. JCMC denied Peyton not only the expert input of its medical staff, but also the expert input the ACR review would have provided.

C. The Tennessee Supreme Court has held that a hospital's bylaws are an integral part of its contractual relationship with its medical staff.

The Tennessee Supreme Court in the case of Lewisburg Community Hospital Inc. v. Alfredson, 805 S.W.2d 756 (Tenn. 1991) was "asked to decide a question of first impression –whether medical staff bylaws constitute a contract between a hospital and a member of the medical staff." The Court answered that question in the affirmative:

> We agree [with the Court of Appeals] and hold that the Hospital's bylaws were an integral part of its contractual relationship with Alfredson, a member of its medical staff, and that he had a contractual right to require the Hospital to follow its bylaws which, in this case, required it to provide hearings to physicians when the Hospital takes action which "significantly reduces a physician's clinical privileges."

Id at 756-757. In Alfredson, David Alfredson, M.D., was an exclusive provider of radiology services through his professional corporation at Lewisburg Community Hospital in Lewisburg, Tennessee. In 1984, the Hospital entered into a contract with another entity that was to provide CAT scan services at Lewisburg Hospital. Almost one year later, the Hospital terminated the contract with Dr. Alfredson and entered into an exclusive contract with another radiology provider. While he technically remained on staff, Dr. Alfredson was prohibited by the hospital from using its equipment and charging fees for interpreting x-rays. Id at 757-758. Since the Tennessee Supreme Court held that hospital staff bylaws are an integral part of the contractual relationship of the medical staff and hospital, JCMC was bound to honor its contractual relationship with the Appellant. In fact, the Alfredson Court saw "no merit" that the medical staff but not a hospital is bound by the bylaws. Id. at 759. As will be pointed out in this brief, JCMC failed to follow the hospital staff bylaws regarding due process, summary suspension and/or revocation and therefore was in breach of its contractual relationship with a member of its medical staff, Dr. Peyton.

II. Given the Paramount Importance Of Hospital Medical Staff Membership To A Hospital-Based Physician's Ability To Practice Medicine, A Physician Whose Hospital Privileges Are Summarily Suspended should Be Afforded Due Process Pursuant To The Contractual Obligation Of The Medical Staff Bylaws.

A. The Imposition Of A Summary Suspension Is Devastating To Patients And To The Ability Of The Affected Physician To Practice Medicine

"Summary suspension" of hospital privileges as relevant to this case refers to the action taken by a hospital to immediately and without notice to the affected individual terminate a physician member of the hospital medical staff from caring for patients in the hospital. More importantly, it terminates the physician-patient relationship between the affected physician and any and all patients who have chosen care from that physician in

the hospital. In other words, any patient sick or injured enough to have been hospitalized by their doctor may no longer be treated by their doctor of choice during the course of their hospitalization or treatment.

Summary suspension has devastating impacts on patients. It suddenly and decisively ends established physician-patient relationships. The physician's knowledge of a patient's health built up over the years from continuously treating the patient suddenly is thrust into the hands of someone not familiar with the patient. Studies back the importance of continuity of care for patients who maintain a regular relationship with a physician. Continuity of care leads to fewer and/ or shortened stays in the hospital.[1] In this case, the devastation is even more pronounced because Dr. Peyton is a radiation oncologist and was the only radiation oncologist present at JCMC at the time of his summary suspension.

Radiation oncology is the highly technical medical specialty of radiology that deals with the therapeutic application of radiation in the management of disease, especially cancer. The sudden cessation of the physician-patient relationship to cancer patients can only have severe effects on patients who have not only been treated by their doctor for a deadly disease but have had their hands held by their physician to deal with the emotional trauma of fighting a potentially fatal disease.

The consequences of summary suspension are also severe for the physician. Smith v. Our Lady of the Lake Hospital, Inc., 639 So.2d 630 (La. 1994). Besides not being able to treat patients in a particular hospital, other areas of a doctor's ability to deliver medical care are damaged.

> Summary deprivation of this right amounts to a stigma of medical incompetence. It clearly affects the doctor's ability to maintain his income during the period of time between suspension and a hearing, and because of

[1] *See* Cal. Managed Care Health Improvement Task Force, Rep. To Leg. (December 13, 1999), Recommendations on the Physician-Patient Relationship.

> the loss of reputation attendant to a summary suspension, may affect his earning capacity subsequent to the hearing.

McMillan v. Anchorage Community Hospital, 646 P.2d 857 (summary suspension of physician's privileges not justified under hospital's bylaws since it was not clear that physician's behavior adversely affected patient care or that immediate action of summary suspension was necessary). Dr. Peyton's situation was even more untenable because he was a hospital-based physician (TR Vol. VII, p. 955). Hospital-based physicians have no outside office in which to see patients if they are unable to see patients in a hospital. Radiation oncologists utilize expensive radiation equipment to treat their patients. It is usually not economically feasible for a physician to purchase such equipment. More often, the resources of a hospital are utilized to obtain radiation equipment and therefore a radiation oncologist must practice virtually exclusively in a hospital.

Another arena where an adverse action such as a summary suspension can damage a physician's reputation is the mandatory report to the National Practitioner Data Bank pursuant to the Health Care Quality Improvement Act (HCQIA). Any summary suspension from a hospital that lasts more than 30 days must be reported to the "Data Bank". 42 U.S.C. 11101-11152. This automatic reporting is a departure from the general rule that matters should only be reported once a physician has had an opportunity for a hearing.[2] Negative statements in reports to the Data Bank can cause substantial economic loss for a physician even before he/she has a chance to defend himself/herself. The

[2] The Secretary of the U.S. Department of Health and Human Services has recognized the unusual nature of summary suspensions:
"The requirement to report summary suspensions prior to the exhaustion of all internal administrative appeals may be viewed as an exception to the prior guidance which indicates that adverse actions on clinical privileges are not reportable prior to appeals. Summary suspensions are considered final when they become professional review actions through action of the authorized hospital committee or body, according to the hospital bylaws." (*National Practitioner Data Bank Guidebook,* p. E-17). The *Guidebook* further states: "In establishing this policy on the reporting of summary suspensions, HHS assumes that hospitals use summary suspensions for the purpose stated in Part A of the Act: to protect patients from imminent danger, rather than for reasons that warrant routine professional review actions."

Pennsylvania Supreme Court in Hayes v. Mercy Health Corp., 559 Pa. 21, 739 A.2d 114 (1999) indicated that a physician's Data Bank entry may, if left unchallenged, have a deleterious effect on the physician's medical career. That is because the entries in the Data Bank are available to all state medical boards, medical malpractice carriers, and other hospitals.

In addition, hospital chief administrators in licensed Tennessee hospitals are required to notify the Tennessee Board of Medical Examiners when a physician's privileges are summarily suspended.[3] This reporting requirement does not depend on whether or not the reporting hospital has conducted a post-summary suspension hearing of the matter. This string of reporting requires physicians, even before a hearing is held, to defend themselves on a number of fronts. These fronts may include all of the other hospital medical staffs where the physician holds privileges, TennCare, commercial managed care plans in which he/she participates, the local medical society in which the physician belongs, his/her state chapter and national specialty society, national specialty board(s) of which he/she is certified, and perhaps the U.S. Department of Health and Human Services' Office of the Inspector General. Any entity that credentials or investigates doctors potentially has access to the adverse summary suspension report before the physician has a chance to clear his/her name in a hearing.

The HCQIA requires hospitals to check with DHHS before they grant initial hospital privileges and then, once granted, every two years. 42 U.S.C. 11135. Once an adverse action such as a summary suspension is reported, DHHS may, through the Medicare and Medicaid Patient and Program Protection Act, 42 U.S.C. 1320a-7 *et seq.*, and the Peer Review Improvement Act 42 U.S.C. 1320c *et seq.,* to investigate the

[3] *See* T.C.A. Section 68-11-218(a)(1) and (a)(2). Such reports must be in writing and filed within 60 days of the date of the action (a)(3).

affected physician. Such an investigation could lead to exclusion from the Medicare or Medicaid (TennCare) programs.

B. Summary Suspensions of Hospital Medical Staff Privileges Should Only Be Used As A Last Resort

Summary suspensions should be a last resort and used only in rare and extreme cases in which it is absolutely necessary to protect patients from imminent and substantial harm. The Tennessee General Assembly recognized this in making the standard for the Tennessee Board of Medical Examiners, the state agency responsible for licensing and conduct of doctors. It cannot summarily suspend a medical license unless it finds "that public health, safety, or welfare imperatively requires emergency action…" T.C.A. Section 4-5-320(c).

Similarly, the JCMC medical staff bylaws provide for a high standard for summary suspensions:

> Whenever a practitioner willfully disregards these Medical Staff Bylaws or Rules or whenever his conduct requires that *immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage* to the health or safety of any patient, employee or other person present in the hospital, the chairman of the medical executive committee or of a committee of either the medical staff or board shall have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of such practitioner…

Emphasis added. JCMC Medical Staff Bylaws Article IV, Section 2 (Trial Exhibit 15, p. 32). Otherwise, a wide variety of other "corrective action" short of summary suspension was afforded practitioners under the JCMC Bylaws. Such corrective action included the issuance of a warning, letter of admonition, letter of reprimand, probationary period,

required clinical consultation, reduction of privileges, or suspension of privileges.[4] Yet, none of these avenues short of summary suspension was utilized by JCMC.

Congress, in the process of enacting the Health Care Quality Improvement Act provisions allowing for summary suspensions of medical staff privileges, ensured that there were safeguards for subsequent notice and hearing on the summary suspension issues. It noted the abuses that could occur with respect to summary suspensions and urged that they not be used to harass physicians by leading to "interminable investigations". According to the Committee on Energy and Commerce House Report No. 99-903:

> The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection during an investigation, and to allow quick action where it would be reasonable to conclude that someone's health might otherwise suffer. Nevertheless, these exceptions are not meant to provide a backdoor for harassment of physicians through repeated short-term suspensions or interminable investigations never leading to a professional review action. Such actions could not meet the "reasonable belief" tests in subsection 101(a). *See* 1986 U.S. Code Cong. And Admin. News, p. 6394.

As stated in the House Report, "interminable investigations" are inherently unfair. Investigations *before* corrective actions, even if "interminable", still allow the physician to practice medicine, albeit handcuffed, during the investigation. Similarly unfair is the situation where there is virtually no investigation prior to a summary suspension and a subsequent reporting to the Data Bank occurs. Albeit unfair, the targeted physician is then allowed to participate in a reasonable investigation with due process safeguards. Because Peyton was never given this opportunity, the hospital is not entitled to immunity.

C. In Order To Protect The Affected Physician and Patients, The Issue Of Whether A Summary Suspension Is Actually Warranted Should Be Resolved Prior To The Hearing On The Merits Of The Underlying Charges

[4] JCMC Bylaws Article IV, Section 1E (Trial Exhibit 15, p. 31).

As shown above, because of the nature of the summary suspension action, it should only be used as a last resort due to "the failure to take such action may result in an immediate danger to the health of any individual". 42 U.S.C. 11112(c)(2). If taken, the affected physician should be afforded an expedited hearing on the issue as to whether the summary suspension was warranted at all. The JCMC Bylaws contemplate such a hearing:

> Medical Executive Committee Action. As soon as possible after such summary suspension (not to exceed ten working days), a meeting of the medical executive committee shall be convened to review and consider the action taken. The medical executive committee may recommend modification, continuation or termination of the terms of the summary suspension.

JCMC Medical Staff Bylaws Article IV, Section 2(B) (Trial Exhibit 15). First, the Bylaws provision contemplates a review of the *"action taken"*. The action taken is a summary suspension which, by the term of the Bylaws, is limited to "protect the life of any patient(s)" or "reduce or substantially likelihood of immediate injury or damage to the health or safety of any patient…"[5] In other words, it is a review of whether a summary suspension should have taken place at all. Second, there is no mention of a hearing in Article IV, Section 2(B) of the JCMC Bylaws. Finally, the next section of the Bylaws, Article 2, Section 2(C), grants additional procedural rights to a summarily suspended physician. Thus, the JCMC Bylaws contemplate a bifurcated review process.

The meeting of the medical executive committee after the summary suspension is for the purpose of reviewing the exigent circumstances that purportedly led to the summary suspension. The issue would be whether immediate action was required. No finding of fact was ever made that the summary suspension of Peyton's privileges was necessary to prevent the likelihood of immediate harm to any individual. Later, the

summarily suspended physician is afforded a fair hearing under Article V to review the recommendation of the Medical Executive Committee.[6] He is still entitled to the full Corrective Action procedures required under Article IV which specify how an investigation is to be conducted.

The Tennessee General Assembly adopted a bifurcated hearing process in regards to the summary suspension of a physician's medical license that should be illustrative as to how the JCMC Bylaws work because the Bylaws employ the same bifurcated model. T.C.A. 4-5-320(c) grants an agency the right to summarily suspend a license upon a finding of imminent danger.[7] However, it also affords the affected license holder, say physician, to receive an informal review before the agency to determine if the summary suspension was required under the law. Even if such summary suspension is not warranted under Tennessee law, the agency can still issue a notice of charges for "proceedings for revocation or other action".[8]

---

[5] JCMC Medical Staff Bylaws Article IV, Section 2(A) (Trial Exhibit 15).
[6] *See* JCMC Medical Staff Bylaws Article IV, Section 2(c) (Trial Exhibit 15).
[7] No revocation, suspension, or withdrawal of any license is lawful unless, prior to the institution of agency proceedings, the agency gave notice by mail to the licensee of the facts or conduct which warrant the intended action, and the licensee was given an opportunity to show compliance with all lawful requirements for the retention of the license. If the agency finds that public health, safety, or welfare imperatively requires emergency action, and incorporates a finding to that effect in its order, summary suspension of a license may be ordered pending proceedings for revocation or other action. These proceedings shall be promptly instituted and determined.
(d)(1) Notwithstanding the provisions of subsection (c), in issuing an order of summary suspension of a license the agency shall use one (1) of the following procedures:
(A) The agency shall issue a notice to the licensee providing an opportunity for a prompt *informal hearing, review or conference* before the agency prior to the issuance of an order of summary suspension; or
(B) (b) The agency shall proceed with the summary suspension and notify the licensee of the opportunity for an *informal hearing, review or conference* before the agency within seven (7) business days of the issuance of the order of summary suspension.
(2) The notice provided to the licensee may be provided by any reasonable means and shall inform the licensee of the reasons for the action or intended action of the agency and of the opportunity for an informal hearing, review or conference before the agency. The informal hearing, review or conference described by this subsection shall *not be required to be held under the contested case provisions of this chapter.* The hearing, review or conference is intended to provide an informal, reasonable opportunity for the licensee to present the licensee's version of the situation to the person or entity authorized by law to summarily suspend the license involved. *Whether the informal hearing, review or conference is held before or after an order of summary suspension, the sole issue to be considered is whether the public health, safety or welfare imperatively required emergency action by the agency.* [Emphasis added]. T.C.A. 4-5-320(c) and (d).
[8] T.C.A. 4-5-320. (a).

As stated by the Plaintiff-Appellant in his brief before this Court, the gravamen of his complaint is that JCMC failed to follow its Bylaws and afford Dr. Peyton proper peer review. The record of this case shows that Dr. Peyton's hospital privileges were summarily suspended on April 29, 1994 (TR Vol. X, p. 1599) and a "Fair Hearing" was conducted on June 14, 15, 16, 1994. (TR Vol. I, p. 104-105). After the "Fair Hearing" was an appellate review. (TR Vol. I, pp. 8-9, p. 360-361). A year later the Board affirmed the reasonableness of the summary suspension, which was the only issue before it, and then voted to "permanently suspend", i.e. revoke Dr. Peyton's privileges. (TR Vol. I, p. 9; p. 361). Because there was only one hearing, that ostensibly to determine the reasonableness of the summary suspension, the Bylaws were not followed. JCMC provided no notice or hearing prior to revoking Peyton's privileges, nor was any investigation ever conducted. There was never a bifurcated review process as contemplated by the Medical Staff Bylaws Article IV, Section 2(c) and Article V. The Plaintiff-Appellant argues, and the TMA and ACR concur, that no fair hearing actually took place. If the issue at the so-called "Fair Hearing" was merely whether the summary suspension should have taken place at all, then the fair hearing provisions of the Bylaws were ignored by JCMC and JCMC breached its contractual obligation to Dr. Peyton to follow its own Bylaws.

III. The Plaintiff-Appellant Was Not Afforded Proper Peer Review Under The Law So That JCMC Cannot Be Entitled To Immunity Under The HCQIA.

A. Adequate Peer Review Does Not Take Place Where A Summary Suspension Takes Place Before Any Meaningful Investigation

The "Fair Hearing" given to Dr. Peyton on June 14, 15, 16, 1994, did not rise to the level of proper peer review. Because JCMC violated its own Bylaws by not giving

Dr. Peyton a fair hearing under Article IV, it should not be able to claim immunity under the HCQIA. 42 U.S.C. 111101 *et. seq.*

One of the requirements for a health care entity to be immune from liability for one of its decisions under HCQIA is that the peer review action was taken after a reasonable effort to ascertain the facts of the matter. Dr. Peyton maintains that in this case JCMC did not make a reasonable effort to ascertain the facts of the matter *before* the "Fair Hearing", and made no effort whatsoever to provide notice and hearing prior to revoking his privileges. Therefore, under HCQIA, the immunity claimed by JCMC cannot attach because immunity only attaches *after* a reasonable effort is made to ascertain the facts. 42 U.S.C. 11112(a).

Courts have refused to attach HCQIA immunity in situations where peer review committees failed to give appropriate fair notice and procedures as required by U.S.C 11112(a)(3). *See* Islami v. Covenant Medical Center, Inc. 822 F. Supp. 1361 (N.D.Iowa 1992) where the Court found that a genuine fact existed as to whether the peer review committee had followed its own bylaws and the provisions of HCQIA. Id. at 1379. *See also* LeMasters v. Christ Hospital, 791 F. Supp. 188 (S.D. Ohio 1991). In Simpkins v. Shalala, 999 F. Supp. 106, the Court found that Dr. Simpkins name should be removed from the National Practioner Data Bank because the investigation conducted by the hospital did not qualify as an investigation to trigger the reporting requirements under HCQIA finding the hospital did not follow its Bylaws in conducting an investigation. The provisions in D.C.'s Bylaws governing investigations were very similar to those specified in Article IV of JCMC's Medical Staff Bylaws. The Court noted:

> The "review" of Dr. Simpkins did not follow this D.C. General procedure. D.C. General provided no documentation to HHS that a complaint of any kind was ever submitted to the Medical Director of D.C. General. As a result, the specified investigatory procedures mandated by D.C. General's Bylaws were never initiated. No complaint was delivered to the accused

> staff member, Dr. Simpkins, nor was "an investigating committee" appointed as required by the Bylaws. These deviations from the By-laws were not minor but rather fundamental in nature and indicate that these actions cannot be reasonably found to constitute an investigation by D.C. General.

Id. At 116. In the instant case, JCMC did not appoint an investigating committee as require under the Bylaws, Article IV.

In Brown v. Presbyterian Healthcare Services, 101 F.3d 1324 (10th Cir. 1996), the Court found that HCQIA immunity did not attach where a reasonable jury could find that the peer review committee in question did not make a reasonable effort to ascertain the facts of the matter. Id. at 1333. The peer review committee in the Brown case made a finding that a physician had breached an agreement with the facility to seek consultation for high-risk obstetric patients. The Court found that a reasonable jury could have found that the peer review committee did not make a reasonable effort to obtain the facts. Id. at 1334. The testimony revealed that the peer review panel only reviewed two charts and that Dr. Brown had appropriately treated her high-risk patients for the previous six months. Id. at 1333-1334. Thus, the TMA and ACR submit that a thorough investigation is required *before* immunity may attach. To do otherwise would not be a reasonable effort to ascertain the facts of the case. The TMA and ACR concur that the "Fair Hearing" provided to Peyton was not peer review and that JCMC did not make a reasonable attempt to obtain the facts. Therefore, JCMC can not claim immunity under HCQIA.

B. Proper Peer Review Must Be performed By Qualified Physicians.

In order for proper peer review to take place, the peer review committees undertaking actual peer review should be competent to truly provide *peer* review. Every committee involved in the professional review process is not competent to provide peer review of a targeted physician. During the June 14-16, 1994, hearing for Dr. Peyton, only

four of the seven committee members were physicians. The Tennessee General Assembly recognized the importance of having peer review committees capable of truly performing peer review when it enacted the Tennessee Peer Review Law of 1967. It provides in pertinent part:

> In conjunction with the applicable policies of the Health Care Quality Improvement Act of 1986 (42 U.S.C. 11101-11152), it is the stated policy of Tennessee to encourage *committees made up of Tennessee's licensed physicians* to candidly, conscientiously, and objectively evaluate and review their peer's professional conduct, competence, and ability to practice medicine.

Emphasis added. T.C.A. 63-2-219(b)(1). The stated policy of Tennessee, therefore, is for peer review committees to be made up of physicians. Had the conduct complained of in the instant case been based on sexual harassment, theft, or even chemical impairment, laymen serving on the committee might have understood the underlying issues that prompted a summary suspension. In Dr. Peyton's case, the issues were of a very complex medical and scientific nature. The record shows that the American College of Radiology was scheduled to conduct the peer review of Dr. Peyton's practice of radiation oncology on May 9-10, 1994. (TR Vol. VI, p. 936; Vol. VII, pp. 982-983). However, the ACR declined to come because it could not conduct adequate on-site peer review without Dr. Peyton's involvement. (TR Vol. I, p. 97; Vol. V, p.10). JCMC denied him the chance to participate in any objective peer review. (TR Vol. V, p. 774).

C. Cases Deciding The Issue Of Immunity Under HCQIA

The TMA and ACR acknowledge that most courts asked to decide the issue of immunity under the HCQIA have granted the health care institution or peer review committee immunity. In every single case where immunity was granted, the physician had received peer review by medical colleagues and, in many cases, objective review by

outside reviewers in the same specialty. By way of example: (1) in Austin v. McNamara, 979 F.2d 728 (9th Cir. 1994) the target physician, a neurosurgeon, had review by a surgical audit committee involving a second neurosurgeon; the medical executive committee appointed an ad hoc committee with a third neurosurgeon; and additional external review with two other neurosurgeons appointed by the California Medical Association; (2) in Bryan v. James E. Holmes Regional Medical Center, 33 F.3d 1318 (11th Cir. 1994) the target physician had review by the chief of the medical staff, the head of surgery, an ad hoc committee appointed by the executive committee, review by a board certified doctor in his specialty, and panel of seven physicians; (3) in Matthews v. Lancaster General Hospital, 87 F.3d 624 (3d Cir. 1996) this orthopaedic surgeon was reviewed by another orthopaedist, and an ad hoc committee of physicians; (4) in Manzetti v. Mercy Hospital of Pittsburgh, 565 Pa. 471, (776 A.2d 938) the target physician, a surgeon who performed some cardiac surgery, had review by several cardiac surgeons and eight anesthesiologists who worked with him, all of whom presented testimony to a panel of three physicians as a result of an investigation by the medical executive committee; (5) in Sugarbaker v. SSM Health Care, 190 F.3d 905 (8th Cir. 1999), the target physician, a general surgeon, had review by the medical executive committee, four surgeons, the surgery review committee and an ad hoc committee of independent physicians. In enacting the HCQIA, Congress sought to balance its concern for protecting physicians improperly subjected to disciplinary action with its concern over the chilling effect the fear of civil lawsuits would have on peer review. Meyer v. Sunrise Hospital, 22 P.3d 1142, 1149 (Nev. 2001). The Act presumes that a professional review action meets the requirements set out in SEC. 412. (11112) to qualify for protection against money damages unless rebutted by a preponderance of the evidence. The TMA and ACR submit that Appellant has produced ample evidence that JCMC has failed to meet all four

of the standards necessary to qualify for immunity from damages under HCQIA as to the first professional review action of summary suspension and certainly met none of the requirements as to the second professional review action of revocation.

IV. Conclusion

The TMA and ACR and their member physicians are committed to the quality of patient care and an effective peer review process with which to maintain that high level of care. Patient quality and peer review is not maintained when a hospital fails to follow its bylaws. Physicians accused of practicing poor medicine should be afforded a fair opportunity to defend themselves under the protection of the medical staff bylaws and peer review laws. It is respectfully submitted that Peyton is entitled to a finding that JCMC is not entitled to immunity under the HCQIA under the facts or at least a holding that the facts taken in Peyton's best light and any inferences to be drawn therefrom prevent the trial court from granting JCMC immunity from damages under HCQIA at the Summary Judgment stage.

Respectfully submitted this the _____ day of _____, 2002.

TENNESSEE MEDICAL ASSOCIATION

By: _____

A. Yarnell Beatty, Esq. (#13712)
General Counsel
Tennessee Medical Association
2301 21st Avenue South
Nashville, Tennessee 37212-0909
(615) 385-2100

Attorney for Amicus Curiae
Tennessee Medical Association

CERTIFICATE OF SERVICE

I hereby certify pursuant to Rule 20 of the Tennessee Rules of Appellate Procedure that a true and exact copy of the foregoing **Motion for Leave to Appear and File Brief as Amicus Curie** has been forwarded by first-class mail, postage prepaid to the following counsel of record on this the _____ day of _____, 2002.

Howell H. Sherrod, Esq.
SHERROD, GOLDSTEIN & LEE
249 East Main Street
Johnson City, TN 37604

Ronald T. Hill
EGERTON, McAFEE, ARMISTEAD & DAVIS, P.C.
500 First American Center
P.O. Box 2047
Knoxville, TN 37901

_____
A. Yarnell Beatty (#13712)
Tennessee Medical Association