

Sham Peer Review: Litigation Hurdles

Lawrence R. Huntoon, M.D., Ph.D.

Physicians who litigate against those who subject them to sham peer review suffer multiple stresses.

Severe professional reputation, career, and livelihood damage, and emotional and financial stress all add to the stress of litigation itself. Even physicians who can practice medicine after it all face the daily uncertainty of financial survival in a strictly outpatient practice. If they try to hold the shammers legally accountable, that lawsuit presents more hurdles to overcome. Anticipating those hurdles may help physicians overcome them by better understanding the legal process.

I present this information based on my study and experience, and it is not intended as legal advice or legal opinion. Physicians should consult their own attorneys for legal advice and opinion. Cases in state courts are discussed with the recognition that details of state statutes pertaining to questions of immunity, privilege, and defamation vary across the states.

HCQIA: Qualified and Limited Immunity

The Health Care Quality Improvement Act of 1986 (HCQIA), the federal law that governs peer review, provides qualified and limited immunity to hospitals and peer reviewers (42 U.S.C. §§ 11101-11152). The immunity is qualified by the reasonableness standards of HCQIA for professional review actions which provide:

(a) In general

For purposes of the protection set forth in section 11111 (a) of this title, a professional review action must be 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).

(42 U.S.C. §11112(a)(1-4)).

These reasonableness standards have been further modified by case law, where courts have held that these standards are subject to an objective test, and that subjective bias and animus against the physician under review are irrelevant.¹

The fourth prong of the reasonableness standards also provides:

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111 (a) of this title unless the presumption is rebutted by a preponderance of the evidence.

The effect of this provision is that the accused physician under review is presumed “guilty” of the charges against him, by virtue of the fact that the adverse action taken against the physician was presumed reasonable and warranted unless the physician can show, by a preponderance of the evidence (slightly greater than 50 percent chance; more likely than not) that the hospital did not comply with one or more of the reasonableness standards.

The immunity provided to hospitals and peer reviewers under HCQIA is also limited to monetary damages (42 U.S.C. §11111(a)). HCQIA does not provide immunity for declarative or injunctive relief. Some physicians have been successful in obtaining a preliminary injunction to prevent, at least temporarily, a hospital from reporting a physician to the National Practitioner Data Bank (NPDB) based on an abusive peer review process. In one case, the Court acted to prevent further adverse action against the physician and also ordered the hospital to reinstate his privileges.²

Although HCQIA does not provide immunity from injunctive relief, certain states, notably Florida (Fla Stat. § 395.0191 (7), (2019) and Minnesota (Minn. Stat. § 145.63, subd.1., “relief in any action”), have state laws that extend immunity to include injunctive relief absent a showing of intentional fraud (Florida) or malice (Minnesota).

In order to establish intentional fraud so as to overcome immunity for injunctive relief in Florida, the plaintiff must plead fraud with particularity. “The factual basis of a claim of fraud must be pled with particularity and must specifically identify misrepresentations or omissions of fact, as well as time, place or manner in which they were made.”³ Given the secrecy and closed-door meetings that occur in peer review, this is a particularly difficult requirement for physicians to meet.

The legal standard for a preliminary injunction, in general, requires that the applicant show (1) a substantial likelihood of success on the merits of the claim; (2) a substantial threat of irreparable injury or harm for which there is no adequate remedy by law; (3) that the threatened injury to the applicant outweighs any harm that the injunction might cause to the defendant; (4) that the injunction will not disserve the public interest.⁴

In one case, the court found that once an Adverse Action report in the NPDB is disseminated, it represents a “bell that cannot be unrung.”⁵ The court also found that a remedy at law for this irreparable harm was insufficient.

No Private Cause of Action Created by HCQIA

It may come as a shock to physicians who have been victimized by a sham peer review, but there is no private cause of action created by HCQIA. A physician cannot sue a hospital and peer reviewers for conducting a sham peer review. The physician is typically left with a claim of breach of contract (for which punitive damages do not apply) and intentional tort claims.

An intentional tort is basically an intentional wrongful act that injures another or infringes upon the rights of another. Claims of intentional torts in sham peer review cases typically include such acts as defamation, tortious interference with contracts and/or business relationships, fraud/misrepresentation, and intentional infliction of emotional distress.

In cases where discrimination in conducting peer review is alleged, the automatic protection from damages that HCQIA provides to professional review bodies, which meet the reasonableness standards, does not apply (42 U.S.C. § 11111(a)(1)(D)). This includes violation of the Civil Rights Act of 1964 (42 U.S.C. 2000e, et seq.) and the Civil Rights Act of 1866 (1981 Action) (42 U.S.C. 1981 et seq.). A claim of discrimination requires the plaintiff to provide comparators—similarly situated physicians of a non-protected class who are not treated as harshly as the targeted physician in peer review matters.

Violation of federal and state constitutions (e.g., 1st Amendment, due process) may also be claimed in some cases, where a governmental entity (e.g., county) owns the hospital involved in the action.

Motion to Dismiss

On occasion, plaintiff physicians may encounter a motion to dismiss. This generally occurs early on in litigation and is usually based on the plaintiff's failure to state a claim upon which relief can be granted (failure to state the necessary elements of the claim) or expiration of the statute of limitation for the claim or claims.

In one case, the physician had a firm belief that he would prevail in the internal hospital peer review/appeals process based on the truth and the facts. "[H]e felt that he could resolve his issues without having to seek monetary damages."⁶ Counsel argued that "if [Plaintiff] could have a successful result at the end of the peer review proceeding and not feel the need to move forward with any claims, then that would avoid the issue of having to bring any of these issues forward in the court."^{6, p.38} Because he believed that he provided excellent medical care and colleagues participating in his peer review would clearly see that and would fully exonerate him, he did not file a lawsuit against the hospital and peer reviewers until after the hospital peer review/appeals process had been completed. The physician was subjected to an indefinite suspension from the emergency/trauma call schedule at the hospital, an action that was upheld by the Board of the hospital, and the adverse action was reported to the NPDB.

By the time the physician filed a lawsuit, four years after the hospital filed an Adverse Action Report to the NPDB, the statute of limitation on his defamation claim (2 years in this case, and typically only 1 year) had expired, and the Court found, therefore, that his claim was time-barred, and dismissed it.

A motion to dismiss may also include arguments that the physician failed to exhaust administrative remedies prior to filing a lawsuit and that there was a privilege protecting the defamation by the hospital.

Motion for Summary Judgment

A motion for summary judgment is the most consistent and formidable hurdle that a physician must overcome in

order to continue to pursue his lawsuit. The motion is typically based on a claim of immunity by defendants based on HCQIA and/or state law.

According to a well-known law firm that provides courses to hospitals on peer review, gives advice in drafting medical staff bylaws, and defends hospitals in lawsuits, in 2011 "only seventeen (12.8%) were successful in vacating immunity."⁷

In our legal system, judges decide matters of law and juries decide issues of material fact. The evaluation of whether a hospital has failed to meet the reasonableness standards of HCQIA involves a little of both—issues of law and issues of material fact.

In a motion for summary judgment, the Court must view the evidence in a light most favorable to the plaintiff physician (non-moving party) in determining whether the evidence is sufficient for a reasonable jury to find that the hospital failed, by a preponderance of the evidence, to meet one or more of the reasonableness standards of HCQIA.^{8,9} Sufficiency is the key term as the Court must not usurp the role of the jury by evaluating the weight of the evidence to determine which side is most persuasive or which witnesses are most credible.

Thus, "in determining whether a peer review participant is immune under [HCQIA], the proper inquiry for the court is whether [the physician] has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity under 42 U.S.C. § 11112(a) [i.e. the reasonableness standards]. Courts apply an objective standard in determining whether a peer review action was reasonable under 42 U.S.C. 11112(a)."¹⁰

Once a physician plaintiff overcomes the motion for summary judgment, the matter can proceed to trial to determine whether a jury will "find, by a preponderance of the evidence, the peer review action was not reasonable" [did not meet one or more of the reasonableness standards of HCQIA].¹⁰

Federal vs. State Immunity

Federal immunity provided by HCQIA differs from immunity provided by states in that HCQIA does not require that peer review be conducted in good faith in order to obtain immunity. State peer review immunity statutes generally require that peer review be conducted absent bad faith or malice.

With the exception of California, Nevada, New Hampshire, and Oregon, all states have peer review immunity statutes (as of 2016).¹¹ According to a law review article, "Many states provide greater immunity than the HCQIA with respect to state-law claims because they do not require the peer review process to satisfy all prerequisites set forth in the HCQIA."¹¹ The same law review article noted that "HCQIA immunity applies to damages claims arising under state law as well as federal law."¹¹

According to the Cornell Law School Legal Information Institute, bad faith is "a term that generally describes dishonest dealing. Depending on the exact setting, bad faith may mean a dishonest belief or purpose, untrustworthy performance of duties, neglect of fair dealing standards, or a fraudulent intent."¹² In the context of sham peer review, the underlying purpose has no true nexus to competence or professional conduct, and, therefore is not taken in the reasonable belief the action is in the furtherance of quality health care, but rather has an improper underlying motive that has nothing

to do with professional competence or conduct. An attempt on the part of those conducting a sham peer review to make it look as if they are conducting a legitimate good faith peer review may be evidence of fraudulent intent.

According to USLegal, "Malice in law is the intent, without justification excuse or reason, to commit a wrongful act that will result in harm to another.... Legally speaking any act done with a wrong intention is done maliciously."¹³ Malice "can be inferred from a person's conduct."¹³

The Minnesota Court of Appeals found: "Hospital acted willfully in violating its own peer review procedures. That willfulness is malice. *See Rico*, 472 N.W.2d at 107 (defining malice in similar context as 'the intentional doing of a wrongful act without legal justification.')." ¹⁴ The appeals court agreed that the findings cited by the district court demonstrated malice on the part of the hospital. These findings referenced actions that may be applicable to other similar cases, especially those involving a charge of "disruptive" physician. The appeals court stated:

The district court reached its conclusion of malice based on six findings: (1) Hospital's peer-review process began outside Hospital's normal channels; (2) Hospital began its investigation in contravention of the Hearing policy, which required that Hospital leadership meet with Physician to discuss his behavior before seeking discipline; (3) Hospital conducted the investigation in a manner contrary to the DAB [disruptive/ abusive behavior] policy, which required Hospital to give Physician an opportunity to correct his behavior before imposing discipline; (4) in charging Physician, Hospital cited incidents that were unfairly old; (5) Hospital treated Physician disparately as compared to other physicians subjected to discipline; and (6) Hospital improperly applied its power to punish Physician to "make a public statement [i.e. NPDB report]."¹⁴

In determining whether a professional review body is entitled to immunity under HCQIA, courts often look at the objective reasonableness tests (42 U.S.C. 11112(a)1-4) in the light of the totality of the circumstances. One court stated:

[W]e disagree with [defendants'] theory that retaliatory animus by the hospital is entirely irrelevant to HCQIA immunity. As our cases indicate, the "objective reasonableness test" looks to the "totality of the circumstances" to determine whether a defendant has met the standards for immunity set forth in HCQIA. *Goodwich*, 343 Md. At 208, 213, 680 A.2d at 1079, 1081. Therefore, any evidence is relevant if it could lead a rational trier of fact to conclude that the immunity standards were not met. This includes evidence that retaliatory animus prevented the defendant from making "a reasonable effort to obtain the facts" or supplanted the required "reasonable belief that the professional review action was 'warranted by the facts' and 'in furtherance of quality health care.'" See 42 U.S.C. § 11112(a)1-4. It also includes evidence that the action was "primarily based on...any...matter that does not relate to the competence or professional conduct of a physician," and therefore cannot qualify for immunity. See 42 U.S.C. §11151(9).... [E]vidence of retaliation is simply one of the several factors to be considered when determining whether, in the totality of the circumstances, the professional review action satisfied the standards of immunity set forth in HCQIA.¹⁵

As perpetrators of sham peer review rarely confess their misdeed(s), the evidence of bad faith is often circumstantial, but circumstantial evidence may be sufficient to demonstrate bad faith. One Court stated:

In a disciplined doctor's action against peer review committee members, like this one, the doctor will seldom, if ever, be able to uncover direct evidence of the peer review committee members' improper motive or intent. Instead, the disciplined doctor's proof will consist of a broad array of circumstantial evidence regarding alleged defects in the peer review process, the committee members' knowledge, and the reasons touted for the disciplinary action taken.¹⁶

Another Appeals Court in another state came to the same conclusion:

[A] subjective state of mind will rarely be susceptible of direct proof; usually the trial court will be required to infer it from circumstantial evidence.¹⁷

The Supreme Court of Michigan found that the defamation definition of actual malice applies in making determinations about immunity:

However, peer review immunity is not absolute. A person, organization, or entity that has acted with malice when engaging in a peer review function is not protected from liability.¹⁸

The Supreme Court of Michigan adopted the actual malice definition as stated in another case:

Similarly, a review entity is not immune from liability if it acts with knowledge of the falsity, or with reckless disregard of the truth or falsity, of information or data which communicates or upon which it acts.¹⁹ The Supreme Court of Michigan further explained:

Although this definition originated in the context of defamation, this definition is uniquely appropriate to Michigan's peer review scheme [MCL 331.531], as peer review immunity is based on the communication of information about professional activities and standards....The defamation definition of "malice" promotes the goals of peer review because peer review participants are not protected if they are not performing evaluations with a focus on improving patient care, but rather on the basis of false extraneous factors unrelated to patient care.¹⁸

Although statutes vary from state to state, the Michigan Supreme Court provided a well-reasoned approach to defining and evaluating malice as it applies to immunity.

A hospital's failure to follow its own policies and procedures (e.g. disruptive behavior policy) in peer review can also lead to a finding of malice and loss of immunity under state law. In affirming a district court's decision to grant a temporary injunction to prevent the hospital from disciplining a physician, the Minnesota Court of Appeals stated:

A hospital's peer-review action is motivated by malice, for the purposes of Minn. Stat. § 145.63 (2006), when a hospital disregards its own policies and intentionally and repeatedly violates a physician's procedural rights when disciplining a physician through a peer-review process....

The district court granted the temporary injunction after determining that Hospital's peer review action leading to discipline of Physician was taken in malice and, therefore, Hospital was not entitled to immunity.¹⁴

The hospital in this case also tried to have the physician's lawsuit dismissed based on the grounds that the physician

had signed an agree-not-to-sue statement, something that many physicians throughout the nation are required to sign as a condition of obtaining medical staff privileges. The Court rejected that argument noting that the hospital was motivated by malice and finding that “a contract cannot limit liability for malicious acts.”¹⁴

A law review article noted that federal and state immunity for peer review has made it easier to conduct bad faith, sham peer review with little fear of being held accountable in a court of law. In addition to immunity laws, peer review privilege and confidentiality statutes have undermined quality assurance in hospitals:

The immunity in the HCQIA, and in parallel state statutes, allows peer review bodies to impose discipline without much fear of litigation, even though this immunity makes it easier to conduct sham peer review. The NPDB system spreads reports of discipline nationwide, even though this reporting system magnifies the effect of sham peer review and may drive good doctors out of the profession....

The immunity granted to the peer review process by the Healthcare Quality Improvement Act of 1986, together with state protections of immunity, privilege, and confidentiality, have the paradoxical effect of undermining the quality assurance function of peer review. These protections produce both improper severity and improper leniency.... One serious problem of the current system is bad-faith, or “sham” peer review....

Direct competitors also can have influence on the peer review process even when they do not serve as reviewers themselves, such as where hospital bylaws prevent direct competitors from participating in a review committee or a fair hearing panel, but do not prohibit them from participating in the peer review process in a different capacity....

[W]e are convinced, from reviewing the various reports and from our own anecdotal experience, that sham peer review is indeed a serious problem. Simple common sense dictates that if people have a motive and ability to get rid of an unwanted coworker for illegitimate reasons, with little expectation of being called to account, they will sometimes do so.¹¹

Thus, it is obvious that bad faith, sham peer review does not serve the public interest.

Failure to Exhaust Administrative Remedies

If a physician victim of sham peer review files a lawsuit prior to the completion of the peer review process in a hospital, the hospital may file a motion to dismiss the lawsuit based on the doctrine of failure to exhaust administrative remedies.

In the case of *Raymond H. Pierson, III, and Joanne R. Werntz v. Orlando Regional Healthcare Systems et al.*, the Court stated:

Generally, judicial power should not be invoked or exercised until administrative remedies are exhausted. See, e.g., *Gamma Phi Chapter of Sigma Chi Fraternity v. Univ. of Miami* 718 So. 2d 910, 911 (Fla. 3d DCA 1998).⁶

However, the remedy sought from the peer review process is very different from the remedy sought in a court of law, and when the administrative remedy is not available or not adequate, then a plaintiff is not required to complete the peer review process before filing a lawsuit.

The Court made this clear in the Pierson case:

Here, however, the relief being sought in court—money damages—is different from the relief sought through the peer review process. Money damages were not even available through the administrative process; the only remedy Plaintiff sought in that process was restoration to call.⁶

Another court arrived at the same finding:

[A] plaintiff is not required to pursue administrative remedies where they are not available and adequate. Therefore, where, as here, a plaintiff seeks money damages for breach of contract, which an administrative body is not empowered to award, the administrative remedy is not considered adequate and the plaintiff is not bound to exhaust it before seeking relief in court.²⁰

A potential pitfall for physicians who decide not to file a lawsuit prior to completion of the hospital peer review process is that the statute of limitation may expire before the peer review process is completed. In *Long v. Houston Northwest Medical Center*, the Court found:

[T]he appellant could have sought judicial redress for intentional infliction of emotional distress and tortious interference with business relations when his surgical privileges were suspended, on April 13, 1983. The later review of the suspension of his privileges and subsequent denial of reinstatement of his privileges did not affect the accrual of the causes of action. Thus, in order to avoid the bar of the statute of limitations, the appellant was required to file suit...within two years of April 13, 1983....Therefore, as a matter of law, the appellant's [claims]...are barred by the statute of limitations.²¹

Peer Review Privilege

Peer review privilege refers to the protection provided to peer review information from discovery and admissibility in court proceedings. HCQIA does not provide any peer review privilege. Peer review privilege is provided by state laws.

Every state except New Jersey provides peer review privilege.¹¹ As noted in a law review article, “The main significance of the state-level privilege statutes is to prevent medical malpractice plaintiffs from using evidence generated by the peer review process.”¹¹

California and New York have created exemptions to peer review privilege for any statements made by a party to the lawsuit at peer review committee meetings.²² The peer review privilege may also be deemed to be waived if someone refers to peer review committee reports during deposition.²²

States also have confidentiality statutes, which differ from privilege statutes in that the former bars release of peer review information to third parties outside of the peer review process.

Some hospitals have attempted to use state peer review privilege law to prevent a physician from obtaining the evidence needed to demonstrate an abusive peer review process, defamation, and other wrongful acts committed in the course of peer review. Absent the evidence the physician needs to prove his claims, a hospital will then argue that the case should be dismissed.

Fortunately, courts have typically rejected that argument, noting that to do otherwise would likely violate provisions in the state's constitution.

An appeals court in Florida found that the legislature expressly intended to allow a plaintiff physician access to peer

review records needed to support a claim of defamation:

[C]ertain policy considerations influenced the legislature to grant a limited immunity, not including actions involving malice or fraud. Our decision today is consistent with the expressed intent of the legislature to provide meaningful access to the courts for those asserting a cause of action outside this limited immunity. To do otherwise would raise serious constitutional issues.²³

Some states have an exception to peer review privilege for an action brought by a doctor for wrongful termination.

[I]f a physician were denied information relating the reason for his dismissal, he would be unable to challenge an adverse decision. In recognition of the physician's need for this information, the [Illinois] legislature drafted this exception. Indeed, if the legislature had not so provided, the statute's validity might well be questioned under the due process clause.²⁴

One law review article summarized the situation as follows:

[N]o plaintiff should be completely foreclosed from bringing a legally recognized claim to a court of law. Our traditional sense of justice, sound public policy, and the constitution in every state demand no less. In addition, medical treatment may be adversely affected if review committees are permitted to operate maliciously to damage the careers of competent medical professionals. If committee members act with wrongful intent in the review process, the privilege should not apply, and plaintiffs are entitled to full discovery of all information that will enable them to present their claim....

[S]tate constitutions consistently contain clauses guaranteeing access to the states' courts and allowing every person in the state a remedy for any legally recognized injury. If a state recognizes a doctor's claim for wrongful denial of hospital privileges, therefore, can the state also deny the doctor access to the records of the hospital's credentials committee if those records contain the only evidence of the alleged wrongful acts? The doctor's entire case may be contained in the committee records; to deny such a plaintiff access may be a de facto abrogation of the doctor's claim and denial of legal remedy.²²

Peer review privilege statutes pose an additional hurdle in cases in which a physician alleges discrimination and needs the peer review records of other physicians at the hospital to prove disparate treatment. Federal courts have refused to bar discovery of peer review records of other physicians, citing the Virmani case: "To prove his allegations of disparate treatment, [the plaintiff] must compare the proceedings in his case against those involving similarly situated physicians. The interest in facilitating the eradication of discrimination by providing perhaps the only evidence that can establish its occurrence outweighs the interest in promoting candor in the medical peer review process."²⁵

Privileged Defamation

A physician, who brings a claim of defamation against a hospital and unethical physicians who conducted a sham peer review against him, at times may encounter a qualified common law privilege known as privileged defamation. Privileged defamation, and exceptions thereto, are defined

by state law. It applies to statements made within the closed confines of peer review.

A U.S. District Court in Florida explained:

"One who publishes defamatory matter concerning another is not liable for the publication if (a) the matter is published upon an occasion that makes it conditionally privileged and (b) the privilege is not abused." *Nodar v. Galbreath*, 462 So.2d 803, 809 (Fla. 1984) (quoting Restatement (Second) of Torts § 593 (1976)). "The law of Florida embraces a broad range of the privileged occasions that have come to be recognized under the common law." *Id.* "A communication made in good faith on any subject matter by one having an interest therein, or in reference to which he has a duty, is privileged if made to a person having a corresponding interest or duty, even though it contains matter which would otherwise be actionable, and though the duty is not a legal one but only a moral or social obligation." *Id.* (quoting 19 Fla. Jur. 2d Defamation and Privacy § 58 (1980)).

This common law privilege has been recognized in communications between doctors at a hospital regarding another doctor and in statements concerning an employee's fitness. See *Magre v. Charles*, 729 So. 2d 440, 443 (Fla. 5th DCA 1999) ("Here [*Pierson and Werntz vs. Orlando Regional Healthcare Systems et al.*] the letter was distributed to fellow physicians who clearly had an interest in the substance of the communication. Thus the defamatory statements were qualifiedly privileged."); *Nodar*, 462 So. 2d at 809 ("Under the common law of Florida, a communication to an employer regarding his employee's performance is conditionally privileged...."). The privilege is overcome, however, by a showing of express malice. See *Nodar*, 462 So. 2d at 810 ("If the statements were made without express malice...then there can be no recovery."); accord *Magre*, 729 So. 2d at 443....

"Express malice" has been defined as "ill will, hostility, and evil intention to injure or defame." *Denby v. English*, 667 So. 2d 350, 353 (Fla. 1st DCA 1995).^{6, pp 19-21}

It should be noted that common law malice is different from the definition of malice applicable to defamation claims.²⁶ Common law malice, which means ill will, hostility, evil intent to injure and defame, is often required to support a claim for punitive damages.²⁶

Actual malice, in the context of a defamation claim, means that the defamer knowingly provided false statements or acted with reckless disregard of the truth or falsity of the statements. So, the fact that the defamer harbors ill will toward the plaintiff physician or otherwise dislikes the physician is not sufficient to demonstrate that the defamer acted with actual malice.²⁶ Evidence of ill will toward the plaintiff physician may be used to support a claim of actual malice, but by itself is not sufficient to demonstrate actual malice.²⁶

Therefore, in order to overcome a hospital's claim of privileged defamation, the plaintiff physician must show that the defamer acted knowing that the defamatory statements were false or had serious doubts about the truth of his statements²⁶ or acted with a high degree of awareness of the probable falsity of the statements.

As defamers will likely never confess to knowingly making false statements or acting with reckless disregard for the truth or falsity of statements, circumstantial evidence will always be needed to demonstrate malice.

Motion in Limine to Exclude the Testimony of a Plaintiff Expert—Daubert Challenge

Finally, plaintiff physicians may encounter a Motion in Limine to strike and/or exclude the testimony of plaintiff's expert. Courts have a gatekeeping role in determining the admissibility of expert testimony. The motion will most often involve a Daubert (pronounced "Dow-burt")²⁷ challenge, although the Frye standard ("generally accepted" in the relevant scientific community) is used in some states for state actions.

The U.S. Supreme Court case, *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. (1993), is the case that prominently established the court's role as gatekeeper for the admissibility of expert opinion based on scientific evidence.²⁸ It replaced the Frye standard, although one of the Daubert factors incorporates the Frye standard—factor 4, that the method is generally accepted in the relevant scientific community.

There are certain subjects, however, like sham peer review, which are based on specialized knowledge and experience, which cannot be tested scientifically.

Noting that the Daubert inquiry is a "flexible one," not governed by a "definitive checklist or test," another Supreme Court case in 1999, established admissibility of expert testimony in cases based on technical and other specialized knowledge.²⁹ Such experts are considered experiential witnesses of the Kumho Tire type.

A State appeals court in Louisiana, for example, found:

The Daubert factors are "not a list of requirements that must be met in each instance of proposed expert testimony or even a list of factors that are necessarily applicable to all types of expert testimony.... Since the expert testimony to be offered by [expert in sham peer review] regarding sham peer review does not constitute traditional scientific evidence, we find the Daubert requirement of strict compliance with scientific methodology unnecessary."³⁰

As such, the Motion in Limine to exclude the sham peer review expert's testimony was denied.³⁰

In some cases an actual Daubert hearing may be required where the expert is present and may be required to testify.

Conclusions

Physicians who file lawsuits against hospitals, and against those in hospitals who conduct sham peer review and harm good physicians as a result, face a steep uphill battle due to laws that place the physician at great disadvantage. These lawsuits are often costly, prolonged, and extremely stressful for the plaintiff physician. Hospitals, enjoying a great advantage in available resources, will often adopt the strategy of attempting to "spend down" the physician by engaging in delays and a plethora of motions, such that the physician may no longer have the resources to continue the battle.

Based on the formidable litigation hurdles the physician faces, it is imperative that the physician choose an attorney who has the knowledge and experience in litigation involving sham peer review.

Knowing the roadmap of litigation hurdles the plaintiff physician may face will hopefully be helpful to the physician victim in understanding the legal process and planning for the future.

Lawrence R. Huntoon, M.D., Ph.D., is editor-in-chief of the *Journal of American Physicians and Surgeons*. Contact: editor@jpands.org.

REFERENCES

1. Huntoon LR. Sham peer review: the unjust 'objective test.' *J Am Phys Surg* 2007;12:100-101. Available at: <http://www.jpands.org/vol12no4/huntoon.pdf>. Accessed Oct 27, 2020.
2. *Cole v. St. James Healthcare*, 2008 MT 453, 348 Mont. 68, 199 P.3d 810 (affirming decision of District Court of the Second Judicial District of Montana).
3. *Cedars Healthcare Group, Ltd. v. Mehta* 16 So. 3d 914, 917 (Fla 3d DCA 2009).
4. *D.S.C. Commc'ns Corp. v. DGI Techs, Inc.*, 81 F.3d 597, 600 (5th Cir 1996).
5. *Frank S. Walker, M.D., v. Memorial Health System of East Texas et al.*, 231 Supp.3d 210 (E.D. Tex. 2017).
6. *Raymond H. Pierson, III, and Joanne R. Wernt vs. Orlando Regional Healthcare Systems et al.*, No. 6:08-cv-466-Orl-28GJK, at 37 (M.D. Fla. Apr 6, 2010).
7. Lapenta S, Horthy Springer Mattern. Peer review protections: lessons learned from battles lost. Presentation at the American College of Obstetrics and Gynecologists' Quality and Safety for Leaders in Women's Health Care Course; Jun 9-11, 2011. In: Benson MD, Benson JB, Stein MS. Hospital quality improvement: are peer review immunity, privilege and confidentiality in the public interest? *Northwestern J Law Social Policy* 2016;11(1):1-27. Available at: <https://scholarlycommons.law.northwestern.edu/njlspl/vol11/iss1/1/>. Accessed Oct 28, 2020.
8. *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1334 (11th Cir. 1994).
9. *Brader v. Allegheny General Hospital.*, 167 F.3d 832, 839 (3rd Cir. 1999).
10. *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1333 (10th Cir. 1996).
11. Benson MD, Benson JB, Stein MD. Hospital quality improvement: are peer review immunity, privilege, and confidentiality in the public interest? *Northwestern J Law Social Policy* 2016;11(1):1-27. Available at: <https://scholarlycommons.law.northwestern.edu/cgi/viewcontent.cgi?referer=&httpsredir=1&article=1131&context=njlspl>. Accessed Oct 28, 2020.
12. Definition of bad faith. Cornell Law School Legal Information Institute. Available at: https://www.law.cornell.edu/wex/bad_faith. Accessed Oct 29, 2020.
13. Malice Law and Legal Definition. USLegal. Available at: <https://definitions.uslegal.com/m/malice/>. Accessed Oct 29, 2020.
14. *In re Peer Review Action*, 749 N.W.2d 822, 828 (Minn. Ct. App. 2008).
15. *Freilich v. Upper Chesapeake Health Systems, Inc., et al.*, 423 Md. 690, 33 A.3d 932 (2011).
16. *Smith v. Our Lady of the Lake Hospital*, 639 So.2d 730, 753 (La. July 5, 1994).
17. *Knight v. City of Capitola*, 4 Cal.App.4th 918, 932 (1992).
18. *Bruce B. Feyz, M.D. v. Mercy Memorial Hospital, et al.*, 475 Mich. 663, 719 N.W.2d 1 (Mich. Sup. Ct. 2006).
19. *Veldhuis v. Allan*, 164 Mich. App. 131, 416 N.W.2d 347 (1987).
20. *Winter Springs Dev. Corp. v. Fla. Power Corp.*, 402 So.2d 1225, 1228 (Fla. 5th DCA 1981).
21. *Long v. Houston Northwest Medical Center, Inc.* No. 01-90-00284-CV, 1991 WL 19837 (Tex. App. Feb 14, 1991).
22. Creech CD. The medical review committee privilege: a jurisdictional survey. *NC Law Rev* 1988;67(1):179-231 Available at: <http://scholarship.law.unc.edu/nclr/vol67/iss1/15>. Accessed Oct 29, 2020.
23. *Good Samaritan Hospital Association v. Simon*, 370 So.2d 1174 (Fla. Dist. Ct. App. 1979).
24. Illinois Supreme Court (in dictum) in *Jenkins v. Wu*, 102 Ill. 2d 468, 479, 468 N.E. 2d 1162, 1168 (1984).
25. *Virmani v. Novant Health, Inc.*, 259 F.3d 284, 289 (4th Cir. 2001).
26. Belik LE. 'Actual malice' is not actually malice. The Virginia Defamation Law Blog; Sep 9, 2013. Available at: <https://www.virginiadefamationlawyer.com/actual-malice-is-not-actually-malice/#:~:text=%E2%80%9CActual%20Malice%E2%80%9D%20Is%20Not%20Actually%20Malice%20by%20Lee,showing%20that%20the%20defendant%20acted%20with%20actual%20malice>. Accessed Oct 29, 2020.
27. Gottesman MH. Admissibility of expert testimony after Daubert: The 'prestige' factor. *Emory Law J* 1994;867-868.
28. *Daubert v. Merrell Dow Pharmaceuticals, Inc.*, 509 U.S. at 593, (1993).
29. *Kumho Tire Co. v. Carmichael*, 526 U.S. 137 (1999).
30. *Marcus L. Pitmann, M.D. v. Howard M. Rigg, M.D., et al.*, State of Louisiana Court of Appeal, Third Circuit, No: CW 08-00410 (Apr 11, 2008).