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AN ANALYSIS OF MEDICAL PEER REVIEW IMMUNITY IN TEXAS:

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AN ANALYSIS OF MEDICAL PEER REVIEW IMMUNITY IN TEXAS:
MALICIOUS CREDENTIALING, A LICENSE TO HARM OR GOOD PUBLIC
POLICY

INTRODUCTION

The physician and hospital share a symbiotic relationship. Most physicians need to have access to the medical equipment, staff and facilities provided by hospitals. Hospitals rely on physicians admitting patients as a primary source of revenue.¹ Notwithstanding this fact, the physician’s ability to utilize the services of the hospital is contingent upon her obtaining medical staff membership and privileges. Prior to being granted privileges, the physician must submit to a process known as medical peer review.² Peer review is a mandatory process that promotes quality of care, facilitates accreditation and is a necessary compliance requirement for hospitals to receive Medicare reimbursements.³

¹ DEAN M. HARRIS, CONTEMPORARY ISSUES IN HEALTHCARE LAW AND ETHICS (3rd ed. 2008)
³ Id.
Although the primary focus of peer review is to ensure quality of care, in some instances its application has had the opposite effect. Moreover, due to the potential for litigation, and the lack of protection that existed prior to the passage of the Health Care Quality Improvement Act (HCQIA), many physicians expressed a reluctance to participate in peer review. However, the HCQIA effectively abated this concern through its immunity protection afforded to those participating in the peer review process. Unfortunately, some states such as Texas appear to have gone overboard in their immunity provisions to the extent that the protection afforded medical peer review is thwarting the primary objective of the HCQIA, which was and remains the enhancement of quality of care.

This article examines medical peer review immunity in Texas in light of the recent legislative review. Specifically, it reviews the impetus for providing immunity in medical peer review. Secondly, it demonstrates how the peer review process has failed the healthcare consumer in Texas by juxtaposing two significant cases, Poliner v. Texas Health System and Romero v. KPH Consolidation, Inc., D/B/A Columbia Kingwood Medical Center. Finally, this article offers a discussion of an alternative approach that the authors believe will protect the peer review process while not adversely impacting quality of care.

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HISTORY OF HEALTH CARE QUALITY IMPROVEMENT ACT (HCQIA) OF 1986

The HCQIA was passed by Congress in 1986 to provide for an effective peer review and interstate monitoring of incompetent physicians. It also granted a qualified immunity from damages for those who participate in peer review activities.\textsuperscript{6} If a “professional review action” satisfies certain reasonableness requirements, then those persons participating in the review “shall not be liable in damages under any law of the United States or of any State…with respect to the action.”\textsuperscript{7}

Persons participating in a professional review action are entitled to immunity if the action is taken:

1. in the reasonable belief that the action was in 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).\textsuperscript{8}

\textsuperscript{6} Austin v. McNamara, 979 F.2d 728, 733 (9th Cir. 1992); 42 U.S.C. § 11101.
\textsuperscript{7} 42 U.S.C. § 11111(a)(1).
\textsuperscript{8} 42 U.S.C. § 11112(a).
Once these preceding standards have been met, the HCQIA offers immunity to:

(A) the professional review body,

(B) any person acting as a member or staff to the body,

(C) any person under a contract or other formal agreement with the body, and

(D) any person who participates with or assists the body with respect to the action.\(^9\)

The term “professional review body” includes a “health care entity and the governing body or any committee of a health care entity which conducts professional review activity.”\(^10\) The HCQIA creates a rebuttable presumption of immunity, forcing a plaintiff to prove that a defendant’s actions did not comply with the relevant standards.\(^11\)

The legislative history of 42 U.S.C. § 11112(a) indicates that its reasonableness requirements were intended to create an objective standard, rather than a subjective good faith standard. The House Report on § 11112(a) stated:

Initially, the Committee considered a “good faith” standard for professional review actions. In response to concerns that “good faith” might be misinterpreted as requiring only a test of the subjective state of mind of the physicians conducting the professional review action, the Committee changed to a more objective “reasonable belief” standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action,

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\(^{9}\) 42 U.S.C. § 11111(a)(1).

\(^{10}\) 42 U.S.C. § 11151(11).

\(^{11}\) 42 U.S.C. § 11112(a).
would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.\textsuperscript{12}

The case that arguably precipitated the creation of HCQIA and its subsequent enactment was a case originally out of Oregon captioned \textit{Patrick v. Burget}.\textsuperscript{13} In this case the plaintiff, general and vascular surgeon, Dr. Timothy Patrick, sued the partners in the Astoria Medical Clinic (Clinic), alleging that they engaged in unlawful monopolization and conspiracy. Dr. Patrick worked at the Clinic under a one-year contract but declined to join the partnership at the end of the contract and, instead, opened up a competing practice, independent of the Clinic.\textsuperscript{14}

The defendants refused to enter into cross-coverage agreements with Dr. Patrick or to provide consultations to his patients, and they generally referred their own patients to hospitals located 50 or more miles away rather than to Dr. Patrick. At the same time, Clinic physicians repeatedly criticized Dr. Patrick for failing to obtain outside consultations and adequate backup coverage. The most pertinent aspect of this case with regard to the topic of this paper is that several defendants allegedly acted in bad faith in connection with peer review proceedings that triggered disciplinary action against Dr. Patrick.\textsuperscript{15}

In 1979, one of the defendants, Dr. Gary Boelling, a partner at the Clinic, complained to the executive committee of the Columbia Memorial Hospital’s (CMH) executive committee.

\textsuperscript{13} \textit{Patrick v. Burget}, 800 F.2d 1498(9\textsuperscript{th} Cir. 1986), rev’d, 486 U.S. 94 (1988).  
\textsuperscript{14} Id.  
\textsuperscript{15} Id.
medical staff about an incident in which petitioner had left a patient in the care of a recently hired associate, who then left the patient unattended. CMH was the only hospital in Astoria, Oregon at that time. The executive committee decided to refer this complaint, along with information about other cases handled by Dr. Patrick, to the State Board of Medical Examiners (BOME). Another defendant, Dr. Franklin Russell, another partner at the Clinic, chaired the committee of the BOME that investigated these matters. The members of the BOME committee criticized Dr. Patrick’s medical practices to the full BOME, which then issued a letter of reprimand that had been drafted by Russell. The BOME retracted this letter in its entirety after Dr. Patrick sought judicial review of the BOME proceedings.16

Two years later in 1981, at the request of defendant Richard Harris, a Clinic surgeon, the executive committee of the CMH's medical staff initiated a review of Dr. Patrick’s hospital privileges. The committee voted to recommend the termination of Dr. Patrick’s privileges on the ground that his care of his patients was below the standards of the hospital. Dr. Patrick demanded a hearing, as provided by hospital bylaws, and a five-member ad hoc committee, chaired by defendant Boelling, heard the charges and defense. Dr. Patrick requested that the members of the committee testify as to their personal bias against him, but they refused to accommodate this request. Before the committee rendered its decision, Dr. Patrick resigned from the hospital staff rather than risk termination. His lawsuit is what followed.17

16 Id.
17 Id.
A jury awarded Dr. Patrick $650,000 for antitrust damages, which the court trebled, plus $228,600 in attorney’s fees. The Ninth Circuit reversed on the grounds that the trial court failed to properly instruct the jury with respect to the applicability of the state-action of antitrust immunity to peer review activities. The United States Supreme Court reversed, holding that Oregon’s peer review statute did not provide for active supervision as necessary to establish antitrust immunity under the state-action doctrine.\(^\text{18}\)

From this case, The HCQIA was passed to provide for an effective peer review and interstate monitoring of incompetent physicians.

II. A TALE OF TWO CASES

In 2005 and 2006, the Texas courts rendered decisions in two cases involving the application of the immunity provisions of the Texas Medical Peer Review statutes that advocates of quality healthcare could find quite troubling. Although both cases involved peer review immunity, one decision seemed to promote good public policy and advance quality of care while the other arguably established a license to harm.

A. \textit{Poliner v. Texas Health System}

Dr. Lawrence Poliner received his medical degree from Cornell University School of Medicine in 1969, and completed his residency in Internal Medicine at the University of Colorado in 1972.\(^\text{19}\) He became board certified in internal medicine in 1972 and in

\(^{18}\) \textit{Id.}

cardiovascular diseases in 1977. He first applied for privileges at Presbyterian Hospital of Dallas (PHD) in May 1996. He was granted temporary privileges in June 1996, and formally appointed to the hospital staff in January 1997. The first year of Dr. Poliner’s appointment to the medical staff at PHD was provisional, and in July 1997, Dr. Poliner applied for reappointment to the medical staff. He was granted reappointment at PHD in October 1997.

On September 29, 1997, allegations began to surface regarding Dr. Poliner’s medical practices. A nurse in the Cardiac Catheterization Lab filled out a Committee Event Report Form (CERF) on Dr. Poliner with respect to a patient that had died following a cath procedure. Several more CERFs were filed on patients that had adverse outcomes after undergoing cath procedures performed by Dr. Poliner. In addition, the director of PHD’s cardiac cath lab reviewed an emergency angioplasty Dr Poliner had performed and concluded that it was performed on the wrong artery and that he had missed a totally occluded left anterior descending coronary artery. The investigation further disclosed that several nurses had filed complaints regarding Dr. Poliner’s lack of attention to the needs of patients. As a result of these findings, and without being afforded due process, Dr. Poliner was asked to sign an abeyance letter in which he agreed

20 Id.
21 Id.
22 Id.
23 Id.
24 Id.
25 Id.
26 Id.
to suspend all of his cath practices until an ad hoc committee could review all of his cath lab cases.\textsuperscript{27}

These incidents were referred to PHD’s Clinical Risk Review Committee (CRRC). The CRRC formed an Internal Medicine Advisory Committee (IMAC) to conduct an investigation into Dr. Poliner’s practices.\textsuperscript{28} During this period of time, an ad hoc committee (AHC) was formed consisting of six cardiologists to review forty-four randomly selected cases of Dr. Poliner.\textsuperscript{29} The AHC concluded that substandard care was rendered in twenty-nine of the cases. Based on the AHC findings, the IMAC voted unanimously to recommend suspension of Dr. Poliner’s cath lab and echocardiography privileges, expressing concerns regarding his clinical judgment, clinical skills in the performance of angio cardiography and echocardiography, unsatisfactory documentation of medical records, and substandard medical care.\textsuperscript{30}

Dr. Poliner requested and was granted a hearing concerning the suspension of his privileges. Although the Hearing Committee recommended that Dr. Poliner’s privileges be restored, they upheld the summary suspension of his privileges.\textsuperscript{31} Concerned that the presence of the summary suspension would be harmful to him, Dr. Poliner filed a lawsuit alleging inter alia, slander and libel against the physicians that served on the AHC, IMAC and the hospital.\textsuperscript{32}

\textsuperscript{27} Id.
\textsuperscript{28} Id.
\textsuperscript{29} Id.
\textsuperscript{30} Id.
\textsuperscript{31} Id.
\textsuperscript{32} Id.
Texas Peer Review Immunity Statutes require a showing of *actual malice* to prevail in a lawsuit against the peer review community or hospital for negligent credentialing.\(^{33}\) Moreover, Texas statutes and case law limit discovery of peer review information. However, the court held in favor of Poliner and required that the review information be produced.\(^{34}\) In granting discovery to Poliner and not granting immunity to the defendants, the court seemed most troubled by the abeyance letter stating that it was “…a complete failure to investigate and to gather all of the facts from both sides before Dr. Knochel summarily suspended plaintiffs privileges by telling the plaintiff to sign the abeyance letter or face immediate suspension.”\(^{35}\)

On March 27, 2006, Dr. Poliner was awarded $366 million by a Texas jury. Although the award was reduced on appeal, one could argue that the malice requirement served its purpose. Although it provides protection for those who voluntarily serve on peer review committees and make decisions in good faith, it does not protect those that deny medical staff privileges in bad-faith, as the court reasoned was the case in Poliner. In this case one could effectively argue that the malice requirement of the Texas Medical Practice Act served a good public policy.

**B. Romero v. KPH Consolidation, Inc., D/B/A Columbia Kingwood Medical Center**


\(^{34}\) See Spevak, *supra* note 7

\(^{35}\) Poliner. 2003 U.S. Dist. Lexis 17162 at 43.
In February 1993, Dr. Merrimon Baker applied to Columbia Kingwood Medical Center for privileges to practice there as an orthopedic surgeon. Columbia is an acute care facility located on the northeast side of Houston, with 155 beds and 360 doctors on the medical staff. In addition to applying for privileges, Dr. Baker also was a member of the medical staff at Cleveland Regional Hospital located just north of Kingwood. Columbia granted Dr. Baker provisional privileges in February 1994. This was done notwithstanding the fact that Dr. Baker had a significant history of medical malpractice.

After Dr. Baker was granted privileges at Columbia several allegations began to surface regarding possible substance abuse. Allegations were made by former employees, colleagues, and at some point even his wife confronted him about his substance abuse. Ultimately, Cleveland Regional Hospital (CRH) suspended Dr. Baker from practicing there after he operated on the wrong leg of a patient. Although the chief of staff at Cleveland also served on the peer review committee at Columbia, the record does not reflect that Columbia knew of the action taken by Cleveland.

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36 Romero v. KPH Consolidation, Inc., D/B/A Columbia Kingwood Medical Center, 166 S.W.3d 212, 48 Tex. Sup. J. 752.
37 Id.
38 Id. at 217. Dr. Baker had been sued ten times from for malpractice between the period of 1988 to 1993. According to the record, while some of the suits were resolved favorably to Dr. Baker one lawsuit alleged that in 1990 while at Cleveland he had operated on the wrong hip of a patient. That suit was settled and dismissed six months after it was filed.
39 Id. at 218. Dr. Baker’s office manager told a physician associated with Dr. Baker that she suspected he was abusing hydrocodone. Cleveland Regional Hospital allegedly had ordered Dr. Bake to submit to random drug testing. Baker’s wife confronted him about his drug abuse and he voluntarily entered a treatment program. Baker was subsequently reported to the Board of Medical Examiners by is form office manager and the Board notified Baker that it was initiating an investigation into his alleged substance abuse.
40 Id.
41 Id.
On July 15, Dr. Baker performed elective back surgery on Ricardo Romero, a 40 year old longshoreman, whom Baker had been treating for about a year. During the surgery, Romero lost a lot of blood before Baker or anyone else noticed, and in the 45 minutes it took to prepare a transfusion, he lost almost all of the blood in his body. Consequently, Romero went into cardiac arrest and ultimately suffered severe and permanent brain damage that has left him profoundly disabled and unable to care for himself. Dr. Baker’s privileges were subsequently suspended by Columbia and permanently suspended by Cleveland. Mr. Romero’s wife sued Dr. Baker and others and settled with all of the defendants except Columbia. She alleged in her lawsuit that Columbia’s negligence resulted in a delayed blood transfusion for Romero during surgery, and that it acted with malice in credentialing Baker to practice in the hospital. On appeal, the Texas Supreme Court held that “there was no evidence of malice as required by Tex. Occ. Code Ann. § 160.010(b).” Moreover, the court noted “that because the hospital invoked its confidentiality privilege under Tex. Occ. Code Ann. § 160.007 (a) as to credentialing and peer review, the record was silent as to what information the hospital had about the surgeon and what steps it took in response to the information.” Therefore, the Texas Supreme Court affirmed the court of appeals ruling, reversing the trial courts decision in favor of the plaintiffs. Through its ruling, one could argue that the Court in essence granted a license to harm.

42 Id.
43 Id. at 219. Dr Baker’s privileges at Columbia were for a period of two years, and after being suspended, he did not apply to have them renewed. Cleveland chose to permanently suspend his privileges because of violations that included “numerous delinquent medical charts, failure to make daily rounds for all patients as required…, and failure to enter timely progress notes for all patients.”
44 Id.
45 Id. at 1. See Lexis case summary
46 Id. at 1. See Lexis case summary
C. Analyzing Poliner and Romero in the context of the Texas Medical Practice Act

The Texas medical peer view requirements have been codified in the Texas Medical Practice Act (TMPA), which provides among other things, immunity to members that serve on a peer review committees and more importantly through its confidentiality provisions makes it more difficult for injured patients to sue for negligent credentialing.\textsuperscript{47} In essence, the Texas medical peer review statutes have had the practical effect of negating the tort of negligent credentialing in Texas and replacing it with a more difficult cause of action, malicious credentialing.\textsuperscript{48} The current statutes and the interpretation of those statutes by the Texas courts impedes the promotion of quality of care due to three key provisions: (1) the malice requirement as it pertains to all complainants, (2) the limited discovery and (3) the specific intent requirement recently promulgated by the Texas legislature.\textsuperscript{49}

Although the malice requirement may be appropriate to protect peer review committee members from lawsuits by physicians that disagree with the decisions of the committee, it is problematic when the plaintiff is a patient as in \textit{Romero}. The malice requirement bode well for \textit{Poliner}, notwithstanding the fact that “physicians challenging

\begin{itemize}
  \item \textsuperscript{47}TEX. OCC. CODE § 160.0079(a) (2007).
  \item \textsuperscript{48}See Strama T. B., Texas supreme court essentially negates tort of negligence credentialing against health care entities, http://www.texhealthlaw.org/Public/archive/s7txsupct.htm
  \item \textsuperscript{49}TEX. HEALTH & SAFETY CODE § 161.0329(a). “The records and proceedings of a medical committee are confidential and are not subject to court subpoena.” see also TEX. CIV. PRAC. & REM. CODE § 41.001 (7). “Malice means a specific intent by the defendant to cause substantial injury or harm to the claimant.”
\end{itemize}
peer review win only in the most egregious cases.” However, as previously stated, the primary intent behind medical peer review is to protect patients from incompetent physicians. According to Logan, “peer review is a common method for exercising self regulation…the purpose of this system is to improve quality of health care and reflects a widespread belief that the medical profession, in most cases, is best qualified to police its own.” It is the second aspect of peer review that is the cause of much concern by some. That is, the assertion that the medical profession is the best qualified to police its own. While generally this may be true, the Romero case is just one example of the significant harm that can occur when physicians fail to police their own.

Unlike Poliner, the peer review statutes did not benefit Romero. In fact, due to the malice and confidentiality requirements, one can make a strong argument that the statutes had an adverse affect on quality of care. Mr. Romero’s situation is the epitome of what the HCQIA and ultimately the TMPA was intended to prevent. As stated by Dr. Josie Williams during her testimony before the Joint Select Committee to study the medical peer review process in Texas, the purpose of a peer review process is to assess, “How can we do it better? How can we make it happen never again…How can we fix it so that we do it right the first time, every time?”

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51 Manion v. Evans, 986 F.2d 1036, 1037 (6th Cir. 1993).
52 Michael Logan, Peer Review: How to Avoid the Poliner Result, Presentation before the American Bar Association, Health Law Section, Chicago (2005) at i.
53 See Joint Select Committee to Study the Medical Peer Review Process, Interim Report to the 80th Legislature (2007), http://www.tlrl.state.tx.us/scanned/interim/79/M468.pdf, Dr. Josie Williams is the Director for the Texas A&M University System Health Science Center, Rural and Community Health Institute.
process failed him. It was as though the medical peer review committee had granted Dr. Baker a license to harm.

D. Comparing Texas Civil Immunity Statute to Other States

All of the states and the District of Columbia have enacted some type of immunity statutes limiting the liability for certain types of medical peer review participants.54 Each state varies in the amount of immunity protection provided.55 In Texas, records and proceedings of a medical peer review are confidential and any records or determinations of, or communications to, a medical peer review committee are privileged.56 A record or determination of or a communication to a medical peer review committee is not subject to subpoena or discovery and is not admissible as evidence in any civil judicial or administrative proceeding without a waiver of the privilege of confidentiality executed in writing by the committee, with limited exceptions as authorized by law.57 The Texas Supreme Court has held, however, that a party may be entitled to in camera review to determine whether the documents from a medical peer review committee proceedings would be discoverable.58 In other words, the judge may review the documents produced by the peer review committee to determine whether the court believes that the actions taken by the committee were malicious, and if so, may then enter the documents into the record. This means in Texas that individual members of the committees, as well as

55 Id.
56 TEX. OCC. CODE § 160.007 (a) (2006).
57 TEX. OCC. CODE § 160.007 (e) (2006).
58 In re Living Ctrs. Of Texas, Inc., 175 S.W.3d at 255.
hospitals and the committee itself generally are immune from credentialing suits by patients, if the patient plaintiff cannot show that the actions taken were malicious.

As a comparison, in Ohio individual members of peer review committees, hospitals and the committee itself are generally immune from credentialing suits by patients, as in Texas. However, Ohio requires not only a showing of malice to pierce the confidentiality of peer review records but also that the committee acted without reasonable belief that the action taken was warranted and that the committee acted without the scope of function, duty or activity. This appears to set up a much more onerous situation for a patient plaintiff, or physician plaintiff for that matter, to have records from peer review proceedings disclosed, as not only would they have to show that the actions were taken maliciously, but that they were also unreasonable and outside the scope of the function of the committee.

New York has provided a situation similar to Ohio regarding the additional requirements for immunity. However, the immunity protection applies only to individual committee members who have “taken action or made recommendations within the scope of his function and without malice, and in the reasonable belief after reasonable investigation that the act or recommendation was warranted”. This means that while individual members of committees are generally immune from credentialing suits by patients, New York law does not extend that same protection to hospitals or the committee itself. However, unlike Texas, the law has been drafted to allow for a piercing

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60 Ohio Rev. Code Ann. §§ 2305.28 (B)
61 N.Y. Educ. Law § 6527 (3)
of the immunity statute *without* the need to establish the additional requirements of
malice, unreasonableness and without the scope of function of the committee or hospital.
Thus, when comparing Texas law to Ohio or New York, a plaintiff in Texas need only to
show that the actions of the peer review committee were done maliciously and they
would be able to have records of those proceedings disclosed.

Although the immunity statues in Texas, Ohio and New York all impose a malice
standard to some degree, the authors believe that imposing such a standard is not in the
best interest of the healthcare consumer, nor should it be applied when the plaintiff is a
patient. In the remainder of this paper, the authors offer an alternative approach that we
believe protects the integrity of the peer review process while promoting quality of care.

III. AN ALTERNATIVE APPROACH THAT PRESERVES THE PROCESS AND
PROMOTES QUALITY CARE

As result of *Poliner*, the Texas legislature formed a Joint Select Committee (JSC)
to Study the Medical Peer Review Process.\(^62\) In January 2007, the JSC submitted its
interim report, including recommendations for consideration by the Eightieth
Legislature.\(^63\) Unfortunately, the interim report does not adequately address the lingering
problems created by the TMPA as it pertains to negligent credentialing and more
specifically the adverse impact the specific intent requirement has on the quality of care.
The JCS acknowledges that “patients may find the malice standard required in such cases

\(^{62}\) See Joint Select Committee to Study the Medical Peer Review Process, Interim Report to the 80\(^{th}\)
Legislature (2007), [http://www.lrl.state.tx.us/scanned/interim/79/M468.pdf](http://www.lrl.state.tx.us/scanned/interim/79/M468.pdf), Dr. Josie Williams is the
Director for the Texas A&M University System Health Science Center, Rural and Community Health
Institute.

\(^{63}\) *Id.*
more burdensome since they must prove that a health care entity willfully intended to harm a patient by credentialing a questionable provider."  

This statement by the committee pails in comparison to the actual burden the plaintiff will face. The Texas appellate court in *Rose v. Garland Community Hospital* clearly recognized the importance of the credentialing process in promoting quality of care and acknowledged that the credentialing process is a separate and distinct process that takes place long before the patient engages the healthcare system. In other words, it is a pre-medical treatment review that is intended to ensure medical treatment is being provided by competent physicians. Although, on appeal the Texas Supreme Court reversed and remanded, finding that the credentialing process was an inseparable part of the treatment provided to the patient, we believe that whether the credentialing process is viewed as separable or inseparable, as most recently determined by the Texas Supreme Court, the fact remains that establishing that a medical peer review committee made its decision with malicious intent creates a substantial burden on the plaintiff and borders on the absurdity.

The burden of proving malice in a malicious credentialing case when the complainant is a patient creates an insurmountable legal hurdle. The malice standard contains a subjective and an objective component. The objective component is based on determining that the “conduct in granting or maintaining surgical privileges for a doctor who abuses drugs involved an extreme degree of risk.” In order to establish the subjective component, the plaintiff must demonstrate that the hospital (1) have actual,
subjective awareness that the physician posed an extreme risk to patients, and (2) act with conscious indifference to the rights of its patients.\(^{67}\)

Moreover, the subjective component has been further restricted by the revised statutory definition of malice to mean only “specific intent by the defendant to cause substantial injury or harm to the claimant.”\(^{68}\) This revised standard makes it even more difficult for a patient complainant to prevail in a malicious credentialing case. This challenge is clearly illustrated in Chief Justice Phillips’ dissenting opinion in \textit{St Luke’s Episcopal Hospital v. Comfort and Kingsley Agbor}, where he stated, “I find it difficult to conceive that a hospital would credential its doctors with either the intent to harm patients or with such reckless disregard for their welfare as to establish malice. Even if such a case were to exist, however, a plaintiff would not be able to prove it because another part of the TMPA prevents discovery of the peer review committee’s records.\(^{69}\) Former Justice and now U.S. Senator John Cornyn also dissented, noting in part that “it is as clear as such things get that by enacting the Texas Medical Practice Act (TMPA) the Legislature did not intend to lower then prevailing standards of patient care by insulating hospitals from their own negligence in credentialing physicians. But the Court’s irregular construction of the TMPA does exactly that.”\(^{70}\) Both Justices Phillips and Cornyn in their dissent raised the purpose of the TMPA and how the application of the immunity and discovery provisions of the statute thwarts that purpose. Justice Cornyn goes further, exploring the reasons Congress enacted the Health Care Quality Act, stating that its

\(^{67}\) \textit{Id.}

\(^{68}\) See \textit{supra} note 31.

\(^{69}\) \textit{St. Luke’s Episcopal Hospital v. Comfort and Kingsley Agbor,} 952 S.W.2d at 512.

\(^{70}\) \textit{Id.} at 513.
purpose was “to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.”71 With this purpose in mind, the authors propose an alternative approach that will promote the purpose of both the HCQIA and TPMA without concomitantly having a chilling effect on the willingness of physicians to serve on peer review committees.

As previously stated in this article, conventional wisdom suggests that the medical profession, in most cases, is best qualified to police its own.72 However while this may generally be true, the egregious examples of medical negligence cited herein illustrate the fact that sometimes physicians fail to effectively execute this responsibility. Historically, physicians have been reluctant to fulfill this role and participate in peer review. This reluctance in part was based on fear of litigation from a colleague that may have been denied privileges and the fact that physicians who serve on peer review committees “make neither money nor friends.”73 Therefore, in order to ensure physicians are willing to serve on peer review committees, they must be afforded some protection.74 However, the authors believe that the TMPA with its malice standard and discovery restrictions adequately protects physicians that serve on peer review committees, but these same provisions have an adverse affect on quality of care. Cases like Romero, Agbor and Rose illustrate the harm that the malice standard can cause. Therefore an alternative approach is necessary to protect those participating in peer review without harming the patient

71 Id. at 514.
72 See supra note 36.
73 See Cate, supra note 2, and Warner, Understanding and Defending Against Medical Professional Peer Review Antitrust Claims, 22 U. Balt. L. Rev. 269,270 (1994).
74 Id.
complainant. One way to achieve this objective is to adopt an approach similar to that which is used in defamation cases. For example, in a defamation cause of action, the standard of review is based on the status of the complainant. If the complainant is a public figure or public official, the actual malice standard is applied. However, if the complainant is not a public figure or public official general negligence may be sufficient to establish liability.\(^7^5\)

A. *Physician Complainant*

When the complainant is a physician, as in *Poliner*, the malice standard seems most appropriate. The physician most likely will sue because she disagrees with the decisions of the committee and believes that she is being wrongfully denied an opportunity to practice her profession. A malice standard precludes the frivolous lawsuits that can result from a disgruntled physician who feels she has been wronged by the actions of the board. It protects the good-faith actions of those attempting to police their own. However, it does not afford protection to those that act maliciously, nor those that fail to properly investigate claims before denying a physician the right to practice her profession. The malice standard, when the complainant is a physician properly serves the public interest and as such is good public policy.

B. *Patient Complainant*

\(^7^5\) Roger Leroy Miller and Frank B. Cross, *The Legal Environment Today* (5\(^{th}\) ed. 2007).
When the complainant is a patient, as in *Romero*, the malice standard is most inappropriate and should not be applied because it has the potential to negatively impact quality of care. In such cases, a heightened standard of negligence such as willful and wanton behavior would be most appropriate. This would enable the patient complainant, who will rarely ever be the victim of a specific intent to cause harm, a remedy when harm occurs as a result of peer review committee malfeasance. The prospect of being held liable for willful or wanton negligence in the peer review process may serve as an incentive to encourage committee members to do a better job of policing their own. It may deter behavior such as that exhibited by Columbia Hospital in their failure to stop Dr Baker and in essence granting him a license to harm. Justice O’Neill, vehemently reprimanded Columbia’s actions in credentialing Baker, noting that she was "deeply troubled by the head-in-the-sand approach the various hospitals and health-care professionals in this case appeared to take in dealing with a drug-impaired physician."\(^{76}\)

She declared that the purposes underlying the existence of a peer-review privilege are commendable, but accused Columbia of not using the privilege for its intended purpose.\(^ {77}\) Moreover, she opined that a failure by doctors and hospitals to conduct effective peer review and engage in the free exchange of information that the privilege was designed to promote, thwarts the purpose of the privilege.\(^ {78}\) Adopting a status of complainant approach will preserve the privilege, yet make accountable those that abuse the privilege and ultimately grant a license to harm.

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\(^{76}\) See Casey L. Moore, *“In the Wake of the Rose” and “Life After Romero”: The Viability of a Cause of Action for Negligent Credentialing in Texas in Light of Recent Texas Supreme Court Decisions*, 58 Baylor L. Rev. 549, 585-586 (2006) (discussing the purpose of the privilege and the impact that Columbia Hospital’s action could have if such actions continue).

\(^{77}\) *Id.* at 586.

\(^{78}\) *Id.*