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An Epidemic of Racism in Peer Review: Killing Access to Black and Brown Physicians

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ABSTRACT: Recently, the medical profession has experienced a significant increase in the number of adverse medical staff actions against physicians of color. This crisis is one of epidemic proportions and impact, threatening the economic, physical, and mental well-being of African American physicians and taking a corresponding toll on the health and lives of Black patients, who are already negatively impacted by the systemic racism in the health care system. This article will explore the history, context, and nature of medical staff actions and corresponding legal challenges; health outcomes and the importance of access to physicians of color; the perversion of the peer review process with underlying themes of economic competition, preservation of power, racism, and unconscious bias; and some suggested actions for tangible reform.

Introduction

Medicine is not immune to the larger societal ills. The past few years have shined a spotlight on racial inequities, leading the American Public Health Association, [1] American Academy of Pediatrics, [2] and the American Medical Association, [3] among others, to publicly declare that racism is a public health crisis and to suggest redress in a myriad of different ways.

Mirroring this national crisis at a focused level, the health law bar and the media [4] have reported a significant increase in the number of adverse medical staff actions against physicians of color—raising a question among some physicians whether this increase is attributable to an increase in medical staff actions motivated by racism or an increase in the number of physicians of color coming forward to challenge some of these actions. Nonetheless, it is a crisis of epidemic proportions and impact, threatening the economic, physical, and mental well-being of African American physicians, often with devastating impacts to the availability of care to many already underserved patients in this country.

History of Medical Staff Membership and Corresponding Legal Challenges

To have a better appreciation of today's crisis and its negative consequences, it is critical to understand the context of medical staff membership, clinical privileges, and the impact that the spike in discipline has for affected health care professionals. As a fundamental baseline, medical staff membership and clinical privileges are a critical component of a physician's medical practice if he/she/they requires access to institutional medical facilities to provide medical services, perform procedures, or admit patients to receive medical services. Thus, the grant, denial, or adverse action taken against a physician's medical staff membership and clinical privileges—decisions that are made by committees of the medical staff of a hospital or health system—have a direct, immediate, and devastating impact on a physician's financial, professional, and mental well-being and, in turn, the well-being of the physician's patients.

To give a better sense of what is at stake, consider the example [5] of Dr. A, an African American physician who resides in a rural but growing community and whose husband is an accomplished physician in his own right. Dr. A and her husband have been active members of the community for over 25 years, where they have built their respective practices, are active in their church, and have raised three children, all of whom have gone on to superior academic achievement in their own fields, including medicine. With an unblemished career in a high-risk specialty, five years ago Dr. A established an outpatient facility to serve a patient population that has clinical needs that neither of the local health

systems either identified or met. As Dr. A's outpatient facility started to succeed economically, Dr. A expressed concerns regarding the risk that a gap in specialty coverage and qualified, trained nursing staff at the hospital was creating for high-risk patients in the community; in turn, the hospital's peer review committee initiated a medical staff investigation against Dr. A based on retaliatory nursing staff complaints but did not address the quality-of-care concerns expressed by Dr. A. Other White, male contemporaries were not subject to the same level of scrutiny or abuse. Because of the impact that a report to the National Practitioner Data Bank (NPDB) would have on Dr. A's medical staff membership and privilege, license, participation in insurance plans, etc., Dr. A had no choice but to invest the significant time, money, and emotional capital to participate in the medical staff process triggered by the retaliatory investigation.

Ultimately, Dr. A prevailed with the support of unimpeachable medical experts, but the trauma of the process of having to defend her patient care had far-reaching consequences in terms of rebuilding her practice, which was constrained in the interim, the impact to the continuity of care for her patients, and the severe anxiety she experienced in re-entering the hospital. That anxiety left this otherwise confident, assertive, dedicated physician so emotionally overcome that she could not speak at the hospital, with her physician husband having to communicate for her. Until one has witnessed or experienced the consequences of peer review, the magnitude of this demoralization and the damage to a physician's career may be hard to imagine. Key to driving change in the medical staff process is for all participants in the medical staff process—from hospital administration to the medical staff leadership, members of the peer review committees, and lawyers representing parties in the process—to have a full and complete appreciation of the significant consequences of their decisions and the impact that their biases can have.

These actions are taken as part of a peer review process that is supposed to include certain due process protections for the affected physician. However, because of the subjective nature of peer review and the "metrics" used in such review, the process is too often replete with unconscious bias and economic, racial, and other improper motivations. Hospitals have a vested interest in the quality of care that physicians on their medical staff provide. Under the operating principle that physicians and health care professionals are best qualified to evaluate the quality of medical care, the governing boards of hospitals delegate this responsibility to the medical staff, [6] although they may not abdicate their responsibility entirely. [7] Peer review is one component of that quality assurance. As its name indicates, this self-regulatory review should be conducted by peers of the affected physician with clinical knowledge in the relevant specialty. However, this term arguably

should be extended beyond "peer" in the clinical sense to include racial and ethnic peers due to concerns regarding implicit bias and micro [8] and macroaggressions discussed herein.

Indeed, hospitals can be held liable under a theory of negligent credentialing if a patient is harmed as a direct result of the hospital's failure to conduct a reasonably rigorous credentialing process to make sure that the physician is appropriately qualified to provide the allegedly negligent services resulting in harm. [9] Hospitals can take action against a physician's medical staff membership and clinical privileges for a variety of reasons including "disruptive" behavior, quality of care and competency concerns, lack of required certifications or other qualifications designated by the medical staff bylaws or privileges delineation, failure to meet record keeping requirements, unprofessional conduct, and geographic proximity of the physician's residence to the hospital, just to name a few. Too often these reasons are a pretext for racism, and concerns regarding "negligent credentialing" become a crutch to justify actions taken against medical staff that are racially motivated.

An illustrative example of this reality is the example of Dr. B, a young African American specialist with impeccable training and credentials. On the basis of his experience and credentials, he was highly recruited to establish service in his specialty at one of the hospitals within a system that previously did not have this specialty. Within six months of joining the hospital, he was outperforming other specialists located at the system's main campus, which caught the attention of the Department Chair, a White physician, who previously held this distinction. Unbeknownst to Dr. B, prior to his recruitment the health system had a pattern of terminating Black physicians by leveraging quality of care or other similar pretextual concerns. When the Department Chair's economic position was threatened, Dr. B suddenly found himself the subject of a case review and quality-of-care complaints for the very first time, and by his own Department Chair, in a manner inconsistent with his White, male colleagues. This case review led to a proposed corrective action plan, which Dr. B was told he could either accept or find himself subject to disciplinary action. He was told that resignation was not an option without the resignation being reportable to the NPDB, creating a problem for his future credentialing. Dr. B completed all of the requirements of the corrective action plan with only a six-week continued observation remaining when he was terminated from the hospital's physician group without cause, leaving him unable to continue to exercise his clinical privileges at the hospital. Despite the absence of any patient morbidity or mortality in any of the patient cases that were the basis for the corrective action plan or any negative external review of these cases by the hospital; the presence of a favorable external review from a Harvard-trained Black surgical specialist affirming the excellent care provided by Dr. B; a

dire physician shortage in the specialty generally and in the throes of COVID; and the absence of any due process for Dr. B, the health system was unwilling to allow Dr. B to complete the remaining six weeks of observation and refused to give Dr. B a "letter of good standing" for future credentialing inquiries. As a direct consequence of the hospital's actions cloaked under the guise of "peer review," Dr. B, a father of two young children, has spent the past two years as an incredibly well-trained, yet unemployable, surgical specialist who would otherwise be in great demand. He continues to suffer from situational depression as a consequence of these unfounded actions.

This type of racially motivated medical staff exclusion is not novel. In fact, as early as 1958, the Eastern District of North Carolina considered a lawsuit brought by "three Negro doctors for themselves and for other Negro doctors, as a class, for the purpose of obtaining admission to practice medicine at James Walker Memorial Hospital on what is known as the 'Courtesy Staff.'" [10] Drs. Hubert Eaton, Daniel Roane, and Samuel Gray properly applied but were denied courtesy medical staff membership solely based on their race. These physicians brought suit under the Fourteenth Amendment of the U.S. Constitution, alleging they were denied equal protection of the laws and under federal civil rights statutes. [11] After a decade, they were granted medical staff membership and privileges at the hospital. [12] Yet, a pattern of discrimination and litigation persisted as a result of state and local medical societies' denial of membership to African American physicians. [13] Often membership in these societies or recommendations of other physicians were necessary to be admitted to local hospitals' medical staffs. The societies justified denial of membership to physicians of color because they were not public entities subject to the federal statutes, had the right of self-governance, [14] and could deny membership to anyone. These decisions had a direct impact on training, professional and business development, hospital admitting privileges, board certification, licensure, and advancement of African American physicians in the profession. It was not until four years after the passage of the Civil Rights Act of 1964 that the American Medical Association (AMA) amended its constitution and bylaws to allow its governing body to investigate state/local society discrimination and to expel them from membership in the AMA. [15] For those who have the false impression that this type of discrimination no longer exists, study findings as recently as 2017 show racial disparities in society membership persist, with data showing that White students were selected for membership in the national Alpha Omega Alpha honor society six times more frequently than Black students. [16]

Physicians, irrespective of race, have taken action against the credentialing institution's adverse action on multiple different legal grounds, including claims based upon antitrust laws, economic credentialing, due process under federal and state laws, defamation, and intentional interference with business relationships. Black and Brown physicians have

brought claims under federal civil rights statutes, many of which are employment focused such as Title VII of the Civil Rights Act of 1964, creating limitations on those claims as discussed below. [17]

Legal Claims

Physicians who have had their medical staff membership and/or clinical privileges denied, terminated, suspended, or otherwise restricted may bring claims against the hospital, medical staff, and those involved in the decision-making based on several different legal theories as described below. However, for the reasons outlined below, these remedies are limited in their ability to hold organizations accountable for their racist actions.

Due Process and Equal Protection

The Fourteenth Amendment of the U.S. Constitution's Due Process Clause provides that no state shall ". . . deprive any person of life, liberty, or property without due process of law . . . ." [18] The Fifth Amendment states, "Nor shall any state deprive any person of life, liberty, or property, without due process of law . . . ." [19] Procedural due process generally includes notice and an opportunity to be heard. Although some courts have found that action against existing medical staff membership and clinical privileges impact liberty or property rights, [20] a constitutional challenge based on either Amendment's Due Process Clause requires governmental action, either at the federal or state level. [21] While the Fourteenth Amendment has been used to successfully challenge actions involving a state actor hospital, [22] the "state actor" requirement makes it extremely difficult for physicians of any race to sustain constitutional due process claims against private hospitals and/or health systems. [23]

Immediately following the passage of the Civil Rights Act, Congress passed two statutes to guarantee equal rights under the law and allowing a person to bring civil action for the deprivation of such rights. 42 U.S.C. § 1981 calls for equal rights for all persons in the U.S. in every state and territory in making and enforcing contracts, suing, giving evidence, and the full and equal benefit of all laws and proceedings to secure persons and property as enjoyed by White citizens. In bringing a claim under § 1981, a plaintiff must allege that he/she/they is a member of a protected class and was discriminated against related to those activities set forth in the statute. The Eleventh Circuit has ruled that medical staff membership and privileges do not constitute the contractual rights contemplated by the statute, guided by Georgia state law under which medical staff bylaws give a quasi-contractual cause of action for failure to follow their provisions but do not constitute a contract. [24]

The second statute, 42 U.S.C. § 1983, created claims against the state for deprivation of rights, privileges, or immunities secured by the Constitution and laws, such as the Fourteenth Amendment. Although government-owned health care organizations can be subject to liability under § 1983, private individuals and entities may only be subject to liability if the plaintiff can demonstrate that the private individual or entity acted under the "color of state law." The courts have held that receipt of public funding or being organized under state law does not make a private entity a state actor. [25] This latter component is often an insurmountable hurdle in claims stemming from medical staff matters. Although the courts have found that medical staff membership and clinical privileges for purposes of engaging in an occupation, at least at a public hospital, constitute "a liberty interest subject to procedural due process safeguards," [26] finding that state law nexus is a challenge for cases involving private hospitals. Some of the recommended changes below are aimed at creating this accountability.

Antitrust

A hospital may be found in violation of antitrust laws if it denies or takes action against a physician's medical staff membership for anti-competitive reasons. [27] Typically, these violations are alleged when a hospital uses the credentialing process as a means of restraining trade or eliminating competition. If the hospital's governing body or medical staff has excluded a physician from the medical staff for anti-competitive reasons, this action may have violated the Sherman Act and/or state antitrust laws. [28] To establish a claim under Section 1 of the Sherman Act, a plaintiff must establish four elements: (1) a contract, combination, or a conspiracy, [29] (2) a substantial impact on interstate commerce, (3) an anti-competitive purpose or effect, and (4) an effect on relevant services and markets. [30] Violations of these laws can entail costly litigation, treble damages, and civil or criminal penalties. [31]

Notwithstanding these protections, disenfranchised physicians have rarely been successful in bringing antitrust claims, largely because of the difficulty of proving antitrust violations in this context. [32] Specifically, the antitrust laws were designed to protect competition, as opposed to competitors, and, as noted by the Fourth Circuit, "The fact that a hospital's decision caused a disappointed physician to practice medicine elsewhere does not of itself constitute an antitrust injury." [33] Furthermore, hospitals have a defense against antitrust claims if they can show that they acted for a reason independent of any anti-competitive motivations, such as quality of care. [34] The nexus between the antitrust laws and peer review exists and becomes somewhat of a circular connection under the Health Care

Quality Improvement Act [35] (HCQIA) (as discussed infra), which grants immunity from the potential for treble damages in an antitrust action and other lawsuits. [36] Specifically, this immunity includes treble damage liability under federal antitrust law.

Economic Credentialing

The 1990s saw an increase in the pattern of cases involving economic credentialing in various forms, primarily using the credentialing process to take action against a physician's medical staff membership and privileges under the guise of quality of care, masking anti-competitive conduct and/or motivations. Economic credentialing in its original form involved taking action against a physician's medical staff privileges based on the physician's actions that had a negative financial impact on the hospital. In response to this original line of cases, states adopted various statutes prohibiting hospitals from using credentialing standards that were not related to clinical competency, oftentimes using hallmarks of skill, education, and clinical competence. [37] In turn, this reform has led some decision-makers in the medical staff process to recharacterize actions based on anti-competitive (often coupled with racial) motivations as concerns with clinical competency.

All too often, as described in Dr. B's case above, "substandard quality of care" becomes code for racism. Dr. B's case, sadly, is not an isolated example. Dr. C, who is located in the same rural community as Dr. A, is one of 16 identified Black physicians who, over a period of five years, experienced some sort of peer review action at a rate far surpassing their White counterparts. When Dr. C joined the community, she began reading unassigned diagnostic studies that previously would go days and weeks without professional interpretation by the other specialist on staff, much to the ordering physicians' frustration and to the detriment of patients' care. Unfortunately, as Dr. C encroached on the "territory" of the other specialist, who was a White physician, the medical staff process became a battleground for economic competition disguised as quality-of-care concerns. When Dr. C reported quality issues within the department, including that hospital staff were engaging in the unlicensed practice of medicine and nursing and altering medical records, the hospital summarily suspended Dr. C's privileges on the basis of retaliatory complaints from non-licensed White personnel based on their assessment of quality-of-care concerns in two cases where there was no evidence of any deviation from the standard care or adverse outcomes. When these claims were demonstrated to be without merit, the focus of the "peer review" shifted to the propriety of Dr. C reading the unassigned diagnostic studies. After legal intervention and demonstrating that she was reading those unassigned studies on a timelier basis than her White Department Chair, often at the request of the referring physician, Dr. C's privileges were restored. The discriminatory treatment experienced by Dr. C and raised in the course of these

proceedings to this day remains unaddressed by the health system and, after spending considerable time and resources to reinstate her privileges, Dr. C experienced a second wave of proposed disciplinary action a year later over the same issues with the unassigned studies prompted by her White Department Chair, who was losing revenue as a result of his failure to respond timely to those studies that needed to be read.

Merriam Webster defines "racism" as "a belief that race is a fundamental determinant of human traits and capacities and that racial differences produce an inherent superiority of a particular race." [38] All too often, this definition is embodied very clearly in medical staff matters involving "quality of care" and/or "professionalism" concerns where these terms are code for racist actions. To date, the literature does not include studies providing statistical quantifications of this trend beyond articles discussing the phenomenon of "professionalism" [39] and microaggressions, [40] perhaps, in part, because these claims typically do not make it to litigation (as discussed below) where discovery can identify disparate treatment by numbers. [41] Part of the difficulty for physicians challenging credentialing actions brought under the guise of "quality issues" is medical staff members are required by law and the medical staff bylaws to exhaust their administrative remedies provided under the medical staff bylaws prior to bringing action in court, while hospitals and health systems get legal protections and immunities for actions related to quality-of-care concerns.

Furthermore, even with "due process" protections afforded by law, the standards provided create such a low bar and the opportunity for subjectivity is so great that the affected physician has little recourse, and the health system and medical staff leadership have very limited accountability, rendering the whole process nothing more than an expensive exercise. By claiming quality-of-care issues, the health system and other health care professionals manipulating the process for racist and/or economic reasons often hide behind "quality-of-care" concerns where they receive greater protection for their actions and have little accountability. In most of the cases described in this article, the affected Black physician is a highly trained, highly credentialed, highly accomplished physician with an established, unblemished record whose cases at issue in the medical staff matter have been reviewed by external, preeminent, nationally recognized, excessively credentialed, independent physicians who have concluded that no credible quality issue exists, the complaints were absolutely unfounded, and to take any credentialing action would be baseless and contrary to medical standards. Although the affected physician is affirmed and vindicated on a personal level with these types of reviews, unfortunately the physician's pursuit to rectify these wrongs often becomes a war of attrition based on financial and psychological resources inflamed by the shame and stigma of being criticized for substandard quality of care. Even if or when a physician reaches the courtroom in this

marathon, courts give great deference to the medical staff process and generally will not substitute their judgment for the hospital's judgment in a credentialing matter, which makes legal accountability for these racial biases and motivations virtually unattainable. [42]

Discrimination Claims

Other claims can be brought under Title VII of the Civil Rights Act of 1964, which provides a private cause of action for employment discrimination based on race, among other things. [43] However, the medical staff status of physicians often does not afford them the separate employment relationship to support these claims. [44] Federal courts have held with some consistency that a plaintiff physician could not sustain a Title VII claim in the absence of a direct or indirect employment relationship between the hospital and the medical staff physician. [45] The rationale in a number of these cases is that the hospital's peer review procedures do not constitute control over the manner and means by which a physician performs his/her/their job. Some courts, however, have used an "economic realities" test coupled with other theories to sustain a Title VII claim. Those courts have found that, even though the credentialing hospital did not pay the physician a salary or benefits, it exercised such economic control over the physician by preventing him/her/they from using the hospital's facilities and influencing hospitals across the country to hire/not hire the affected physician that an employment relationship existed for purposes of Title VII. [46]

In situations where a physician is employed by the hospital, a trend that has accelerated over the past five to ten years, [47] the physician may more easily pursue the remedies afforded by Title VII based on his/her/their employee status. However, the physician has the same challenges as any plaintiff bringing such a suit, including making a *prima facie* showing that others similarly situated (whose job situation is almost identical to the affected employee) were treated more favorably or not subjected to the same or similar adverse treatment, and rebutting the employer's claim that it had a "legitimate, non-discriminatory reason" for its action by proving that the employer's reason was merely pretext for discrimination. The challenge of showing that the employer's stated reason for the adverse employment action is pretextual is heightened in the health care setting where the employer identifies quality of patient care as the reason for its action. The physician also has the practical dilemmas created by an intertwined medical staff status and employment agreement that may allow the employer to circumvent the medical staff due process and other rights and protections by terminating the physician's employment pursuant to that agreement. All of this is done with the club of filing a report against the physician with the NPDB under the HCQIA, as discussed below.

The Challenges of the Health Care Quality Improvement Act and Peer Review Immunities

Originally passed to "restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance," [48] the HCQIA also creates a potentially devastating professional impact for physicians who are the subject of a hospital's report of an adverse action to HCQIA's NPDB. Far from its original goal, however, the HCQIA has institutionalized a process to perpetuate racism by reducing health systems' accountability for their improperly motivated adverse credentialing actions while tying the hands (and professional careers) of the individual physicians credentialed through the system. While the HCQIA also sets due process standards for hospitals and other entities taking and reporting adverse actions, it does not provide a private cause of action for a physician impacted by the hospital's failure to follow HCQIA's due process standards. In addition to state law immunities afforded to peer review committees and activities, [49] HCQIA also grants limited immunity to reporting entities from suits for money damages to participants in peer review actions so as to encourage participation in peer review. [50] For the immunity to attach, the professional review action must meet certain standards. [51] However, the action of the professional review entity is presumed to meet these standards unless the plaintiff physician rebuts the presumption by a preponderance of evidence. [52] The courts have consistently found that because the test is an objective one based on the sufficiency of the basis for the defendant's actions, bad faith is immaterial, [53] making these issues ripe for determination at summary judgment. [54] Further, the courts examine the reasonableness of the decision in light of the facts known at the time the decision was made, not in light of facts later discovered. [55] These standards make it nearly impossible for a plaintiff physician to prevail on allegations against the hospital because, even if the doctor could show that the peer review committee reached an incorrect conclusion based on lack of understanding or other reasons, he/she/they cannot meet the burden of contradicting the existence of the hospital/peer review committee's reasonable belief that they were acting in furtherance of health care. [56] This problem is amplified in cases involving a summary suspension under medical staff bylaws where the timetable to avoid a report to the NPDB is so tight given the need for external review and written opinion from highly regarded, actively practicing physicians and where limited due process does not occur until *after* imposition of the summary suspension.

A notable exception to HCQIA's immunities is for damages under any law of the United States or any state relating to the civil rights of any person(s); [57] however, this protection, as currently applied, becomes somewhat of a circular problem because, as noted above,

physician plaintiffs are effectively and largely foreclosed from holding private hospitals accountable for their discriminatory acts.

Similar to the federal legislation, most states have created peer review statutes to encourage activities designed to promote the quality of care by (1) protecting documents and review materials generated during such evaluations from discovery by plaintiffs' lawyers in medical malpractice claims and (2) protecting participants in peer review from suits by affected practitioners. [58] However, unlike HCQIA, these state statutes often do not contain exceptions for discrimination claims. [59] Georgia's peer review statute, for example, provides immunities from liability for peer review activities, but it does not include an exception for discrimination. It does include an exception if a participant was "motivated by malice" or the information provided was "false and the person providing it knew that such information was false." [60] However, the malice standard has proven to be a difficult one to meet. [61]

Additionally, legitimate peer review and quality improvement activities are essential to improving the delivery of quality health care. In their present form, however, these activities are flawed because they lack the goal of health equity as a critical component. [62] Consequently, they often become a means for perpetuating racism. Authors Malika Fair and Sherese Johnson highlight the need for quality improvement activities, including peer review, to collect and stratify data by racial and ethnic categories and to make the data transparent to physician leaders and administrators to address system-level changes that incorporate differences in care due to bias. [63] These efforts must be coupled with education and training of the members of the committees that conduct quality improvement and peer review—not only for the patients and the data they review and the actions and direction that these initiatives need to take, but also to mitigate, if not eliminate, bias and to serve the specific physician providers whose data and quality of care that they may be reviewing.

The "Disruptive" Physician Label

Professionalism standards in this nation have developed through a White-dominant culture and professional associations whose leadership composition is disproportionately unrepresentative of people of color. Consequently, American professionalism standards generally favor majority-White, Western values and have "become coded language for White favoritism in workplace practices that more often than not privilege the values of White and Western employees and leave behind people of color." [64] This bias is borne out in the challenges created by The Joint Commission standards and medical staff bylaws provisions, policies, and procedures designed to address "disruptive" behavior.

White-led and majority-member medical staffs and organizations have drafted and implemented the medical staff bylaws, including credentialing and peer review policies, The Joint Commission standards that govern and/or accredit most hospitals in this country, and they typically track Conditions of Participation developed by the Centers for Medicare and Medicaid Services (CMS). In fact, in 2018, *Modern Healthcare* commented that "[d]iversity among hospital leadership teams is lacking and in some cases worsening." [65] It noted that although 32% of hospital patients were racial minorities, racial minorities held only 11% of executive leadership positions at hospitals, and minority representation in every C-suite position had either decreased or remained flat since 2013 except, not surprisingly, for the chief diversity officer position. [66] Others estimate that 98% of senior management in health care organizations is White. [67] Therefore, not surprisingly, standards for accountability being established at these levels do not set fundamental, baseline requirements that include diversity, equity, and inclusion. [68]

Effective January 1, 2009, The Joint Commission overhauled its "Leadership Standards," including adding standards to address "Disruptive Behavior" under its standards for culture and system performance. [69] These changes followed the Institute of Medicine's report on patient safety, published in 2000, which noted that a culture of intimidation that accompanies disruptive behavior by physicians and other health care personnel implicitly contributes to mistakes. [70] Leadership Standard 03.01.01 requires that hospitals have a "code of conduct that defines acceptable and disruptive and inappropriate behaviors" and that "[l]eaders create and implement a process for managing disruptive and inappropriate behaviors." [71] Disruptive behavior is described as "a style of interaction by physicians with others, including hospital personnel, patients, and family members, that interferes with patient care . . . that adversely affects morale, focus and concentration, collaboration, and communication and information transfer, all of which can lead to substandard patient care." [72] Racist conduct is not included in the list of examples of "behaviors that undermine a culture of safety" that includes reluctance or refusal to answer questions, return phone calls or pages; condescending language or voice intonation; and impatience with questions. [73] This terminology subsequently was relabeled in 2012 as behavior that "undermines a culture of safety" due, at least in part, to objections that strong advocacy for improvements in patient care can be characterized as disruptive behavior. [74]

As borne out in the years following implementation of The Joint Commission's Leadership Standards 03.01.01 (LD 03.01.01), the "Disruptive Physician" label can and has been subjectively and discriminatorily assigned with severe consequences to the physician. As projected by physicians in the community, the label has been misused "by those in positions of power in a hospital to weed out physicians felt to represent an economic threat to more favored medical staff (a phenomenon known as 'economic

credentialing') [75] or who were perceived to be whistleblowers . . . ." [76] In fact, it has extended beyond economic competition into racial discrimination. As noted, "there is no question that unpopular or outspoken members of a medical staff run a real risk of significant disciplinary action if charges of disruptive behavior are affirmed," [77] usually by a process implemented by a White-majority medical staff.

Consider the example of Dr. X, whose colleagues gave her that moniker because her White colleagues find her East African last name difficult to pronounce. If she sees and raises a quality-of-care issue that she has observed in the course of providing patient care at a hospital, she likely will draw the ire of those (mostly White) providers about whom she complained—sometimes physician colleagues and sometimes nursing staff who are not completing assigned tasks to the detriment of patient care. [78] If a nurse reports Dr. X under the hospital's policies implementing LD 03.01.01 for being "disruptive," the medical staff leadership's focus oftentimes turns to the doctor's interpersonal behavior rather than the nurse's dereliction of duty. If Dr. X has not previously reported her concerns, then any response to the nursing staff's report may be viewed as retaliatory, leaving her between the proverbial rock and a hard place. Dr. X must tread lightly in her defense because if she appears too defensive, she only adds credence to the accusations about her behavior. Indeed, her attempts to draw attention back to the nurse's failures may be perceived as defensive posturing. Proving the adage that no good deed goes unpunished, Dr. X now has the emotional and financial cost of defending a medical staff investigation that may, at best, be driven by racial insensitivity and at worst by racism—neither of which is excusable.

Dr. X also recalls that a colleague, Dr. G, the only Black physician in a very lucrative specialty and new to a hospital environment, found himself in the middle of a medical staff investigation into claims under its "professionalism policy" for inconsequential items when he expressed concerns regarding nursing issues impacting patient safety and quality of care. When a nurse alleged that he spoke to her in a curt manner, he was ordered to attend anger management therapy—being labelled as the quintessential "angry Black man" —and could not return to practice until completion of the therapy. Dr. G refused to accept this stereotype, which dates back to slavery. As described by LaMills Garrett, Criminal Justice and Political Action Chair for the National Association for the Advancement of Colored People (NAACP), "If they could paint a picture of black people, in general, being angry, hostile and otherwise, then they could then justify any behavior that came towards them." [79] The pejorative label, noted by Mr. Garrett as a defense strategy in the Derek Chauvin trial to characterize George Floyd, often occurs in scenarios like Dr. G's where a Black man or woman seeks to hold employees or other people accountable. [80] Rejecting this stereotype, Dr. G obtained at his own expense an independent psychiatric evaluation

from a prominent African American physician at an urban academic medical center in the state who, not surprisingly, assessed that Dr. G was not unbalanced, predisposed to psychological or behavioral issues, or a threat to patient care. Indeed, as the psychiatrist assessed, Dr. G, a former military serviceman, was experiencing professional stress at levels that surpassed his high-level military service and was handling the same with extraordinary calm, grace, and minimal levels of frustration that far exceeded any reasonable expectation. The bias of professionalism standards and manipulation of these standards for racially motivated purposes is another area that is ripe for redress, as proposed below.

Breach of Medical Staff Bylaws

It is not uncommon to see language in medical staff bylaws that is usually referenced as the medical staff's "Non-Discrimination Policy," but is very narrow in its scope, reading something like the following: "No individual shall be denied permission to practice at the Hospital on the basis of sex, race, religion, national origin, gender expression or identity, sexual orientation or any other status protected by applicable state or federal law." (Note: This language is separate from the Office for Civil Rights' mandatory language under Section 1557 of the Patient Protection and Affordable Care Act (PPACA), 42 U.S.C. § 18116, [81] which is focused on anti-discrimination related to program beneficiaries and ripe for extension to anti-discrimination to physicians and other providers.). This language, although helpful to provider applicants for medical staff membership and clinical privileges, does not hold a hospital and its medical staff leadership accountable for their actions impacting a physician's medical staff membership and clinical privileges following the admission of the physician to the staff.

Many jurisdictions have established that medical staff bylaws constitute a binding contract between the medical staff and the physician/provider-member. [82] Therefore, if the hospital takes action affecting a physician's privileges without following the provisions of its own bylaws, the physician has a cause of action against the hospital for breach of contract, which is particularly helpful to the affected physician holding private hospitals accountable for their actions. In jurisdictions where a contractual or quasi-contractual cause of action is available, if the medical staff bylaws were to include anti-discrimination provisions that are broader in scope—in other words, that prohibit discrimination for the entirety of the relationship between the hospital, the medical staff, and its members, not just on the initial application—then these provisions could be an effective tool for holding hospitals, their medical staffs, and their leadership accountable for discriminatory acts. Further, if hospitals and their medical staffs were required—as a function of The Joint Commission standards, state licensure requirements, Medicare Conditions of

Participation, and/or the Office for Civil Rights—to include this language protecting physicians and other health care professionals in their bylaws, these changes could begin to move the needle on accountability.

Breach of Fiduciary Duties

The Board of Directors or Trustees of hospitals (referred to herein as the Board) have certain duties established by law. A hospital's Board has the ultimate authority and responsibility for the operations and governance of the hospital, and the medical staff is viewed as carrying out the delegated function of providing patient care on behalf of the Board. Additionally, the Board has statutory obligations under state corporate codes, state public hospital acts, state licensure acts, and the federal Internal Revenue Code. Hospital Boards, as creatures of state corporate law, also have duties established at common law, generally including the duty of care, duty of loyalty, duty of obedience, and duty of confidentiality. These duties, specifically, the fiduciary duties of loyalty, compel Boards to pay attention to diversity and to take affirmative steps to make sure that corporations comply with civil rights and anti-discrimination laws. An in-depth discussion of these obligations is beyond the scope of this article, and we refer the reader to the in-depth article authored by Almeta E. Cooper and Michael W. Peregrine that is part of this publication. [83] However, we would be remiss not to mention the application of these legal requirements to medical staff matters where hospital Boards are vested with the ultimate responsibility for medical staff decisions. Given the fiduciary obligations of the Board to ensure compliance with applicable laws as part of its duty of loyalty, the Board cannot ignore discrimination in this context without running the risks of derivative suits and other liability as established under the *Caremark* decision. [84] Recent litigation in the Delaware courts has expanded *Caremark* a step further to require Boards to identify major risks (including violation of anti-discrimination laws) and put systems in place to mitigate them, [85] including implementing and adhering to compliance programs that include compliance with anti-discrimination laws.

Health Outcomes and THE Importance of Access to Physicians of Color

Data documenting disparate health outcomes for patients of color is well chronicled across multiple medical and surgical specialties. For example, Black patients are much less likely to be given pain medications in the emergency room than White patients with the same presentation. [86] Black women are four to five times more likely to die from pregnancy

related complications than White women. [87] These bleak realities persist across educational levels and socio-economic status such that Black persons doing well from a financial or educational standpoint are not protected from these disparate outcomes.

Bearing the statistical evidence of these outcomes in mind, the harsh statistical realities around the lack of Black physicians in the training pipeline and workforce are even more concerning, particularly with studies documenting the markedly improved outcomes for Black patients being treated by Black physicians. [88] In 1931, only 2 out of 25,000 specialists in the United States were African American—surgeon Daniel Hale Williams and otolaryngologist William Harry Barnes. [89] "In 1978, there were 542 black male matriculants to M.D.- granting institutions. In 2014, that number was 515." [90] Or, looking at it another way, at 13.17 % of the total U.S. population in 2018, [91] only 5% of active physicians were identified as Black or African American, [92] an increase of only 2.5% from 1910. [93] Black and Brown medical students are more likely than White students to report that their race or ethnicity affected their medical school experience. [94] Physician influencers are demanding a formal study of the observation that Black physician trainees are up to 31-fold more likely to be expelled from post-graduate training programs than White trainees. [95] Once training is complete, physicians of color experience racism in their workplace and while providing care. [96] These statistical deficits are a call to action to reimagine affirmative action programs to incentivize the recruitment, employment, and retention of diverse talent to achieve a representative health care workforce. The same mandate holds true for enrollment in professional/doctorate level programs. However, if once these statistical odds are overcome and the health care system is unable to retain Black physicians because of unchecked discriminatory actions in the profession, any efforts to build talent in the front end are eradicated. In light of the slim number of Black physicians who make it to the active practice of medicine, the profession must do more to increase the pipeline, and it is imperative to ensure that those practicing Black physicians are not driven out of the practice of medicine by inadequate protections in the medical staff setting.

Retention of Black physicians is even more critical when considering its role in combatting disparately poor outcomes for Black patients. The disproportionate limitation of practicing physicians with cultural competence through the medical staff process is directly at odds with the delivery of care to the underserved. A wealth of research data exists supporting the positive link between access to Black health professionals and/or cultural competence and the quality of care and health outcomes for Black patients. [97] For example, a sentinel study of the outcomes of newborns in the intensive care unit showed that the mortality indices for Black newborns were cut in half when Black physicians cared for them. [98] Other studies have demonstrated that Black male patients received more life-

saving screenings and tests when working with Black physicians and health care providers, decreasing the cardiovascular gap with White men by up to 19%; [99] Black patients were more receptive to surgical recommendations from Black physicians; [100] Black patients experienced an improved awareness of lung cancer through Black physicians; [101] and Black patients had higher adherence to cardiovascular medicines when under the care of Black physicians, [102] just to name a few. Therefore, plans for improved health outcomes must include expanding access to such practitioners, rather than limiting representative access through the medical staff process.

Tools for Reform

The following are just a few suggested tools for reform in this area of discriminatory activity that has such a devastating impact on the professional futures of minority physicians and treatment outcomes for minority patients, including reforms in the "due process" protections, education and training, and expansion of federal laws and agencies' prohibitions against discrimination to licensed professionals.

Reform of Due Process

As discussed above, the HCQIA established some baseline due process protections for physicians who are the subject of professional review actions that may lead to reporting to the NPDB. The discretion this law leaves to reporting entities beyond these fundamental principles is unfettered, however, and should include provisions designed to prevent abuse of the peer review process, specifically on grounds of race-based discrimination. Too often, we see hospitals, health systems, and medical staffs checking the boxes to satisfy procedural due process requirements but either providing incomplete procedural due process or not providing substantive due process. In order to afford affected physicians true due process, the following measures are just a few to standardize and incorporate:

1. **Requiring Diverse Leadership and Peer Review Committee Representation**. The leadership and committees that are responsible for and essential to quality and peer review must include diverse representation and have more than a perfunctory understanding of the importance and value of different perspectives. The July 2020 Bulletin for the Office for Civil Rights referenced below [103] provides an excellent basis for these initiatives.
2. **Mandating Meaningful Training at the Leadership and Peer Review Level**. The standards at the HCQIA level and at The Joint Commission (the latter discussed in more detail below) need to include a mandate for clinical and legal training to focus solely on critical issues in racism, including structural racism, implicit bias, and cultural

competency. While a number of for-profit organizations and companies in the marketplace focus on medical staff leadership and hospital executive training to protect facilities from claims related to breach of medical staff bylaws and other related laws, it is imperative that facilities recognize that (1) their failure to require that their committees function without bias creates liability for which they can be held accountable (see below), and (2) by failing to have a diverse perspective on quality-of-care and related issues, they are creating a disadvantage to the patients they serve and their staff that provides such care.

3. **Ensuring Diverse and Informed Representation at Each Phase of Due Process**. The standards for facilities should include checks and balances to ensure diverse representation at each phase of due process—from the peer review committee and leadership initially reviewing complaints and initiating action, to the composition of and training of hearing panel members that will be conducting hearings related to professional review actions, to making certain that the Board of each health care facility includes diverse representation and has received implicit bias and related training and understands the importance of this imperative in fulfilling Board duties. [104]
4. **Calibrating Data and Information Utilized in Peer Review and Professional Review Action Considerations**. More affirmative obligations on peer review and related committees to make sure that information and data before the committee related to an affected provider are both substantiated and not reflective of implicit or explicit biases are critical. Technology, if used properly, may be one method to counter bias and disparities. An ability to identify, filter, and act against bias and discrimination in information presented before or involved in the peer review process is key to ensuring true due process.
5. **Reviewing and Revising Peer Review Standards, Policies, and Procedures Through an Equity Lens**. Health care facilities must engage in a multidisciplinary push to prioritize examination of their peer review policies and procedures and bylaws through an equity lens. Given the variation of demographics across facilities nationwide, it may be that a national task force should be created to lead this charge and could conceivably work with The Joint Commission to drive change to the standards created by this accreditation body to hold facilities accountable in a meaningful way. Of course, this dual-pronged approach will require similar examination at the level of The Joint Commission, whose Chief Medical Officer also serves as its Chief Diversity, Equality, and Inclusion Officer, but where Black physicians are not fully represented at the officer and Board levels.

The AMA has adopted guidelines for the health care workplace which, although employment-focused, provide a starting point for this review of an organization's policies and procedures to address systemic racism in a health care setting: [105]

- Clearly define discrimination, systemic racism, explicit and implicit bias, and microaggressions in the health care setting.
- Ensure the policy is prominently displayed and easily accessible.
- Describe the management's commitment to providing a safe and healthy environment that actively seeks to prevent and address systemic racism, explicit and implicit bias, and microaggressions.
- Establish training requirements for systemic racism, explicit and implicit bias, and microaggressions for all members of the health care system.
- Prioritize safety in both reporting and corrective actions related to discrimination, systemic racism, explicit and implicit bias, and microaggressions.
- Create anti-discrimination policies that:
  - Specify to whom the policy applies (i.e., medical staff, students, trainees, administration, patients, employees, contractors, vendors, etc.).
  - Define expected and prohibited behavior.
  - Outline steps for individuals to take when they feel they have experienced discrimination, including racism, explicit and implicit bias, and microaggressions.
  - Ensure privacy and confidentiality to the reporter.
  - Provide a confidential method for documenting and reporting incidents.
  - Outline policies and procedures for investigating and addressing complaints and determining necessary interventions or action.
- These policies should include:
  - Taking every complaint seriously.
  - Acting upon every complaint immediately.
  - Developing appropriate resources to resolve complaints.
  - Creating a procedure to ensure a healthy work environment is maintained for complainants, and prohibit and penalize retaliation for reporting.
  - Communicating decisions and actions taken by the organization following a complaint to all affected parties.
  - Document training requirements to all the members of the health care system and establish clear expectations about the training objectives. [106]

Other providers, such as Boston's Brigham and Women's Hospital, are taking this necessary exercise a step further by intentionally seeking to identify institutional racism. [107] In the course of its work, the Brigham and Women's Hospital's Health Equity Committee identified that Black and Latino heart failure patients admitted to the hospital

during a certain period of time were far more likely to be admitted to the general medicine service versus the cardiology service, and heart failure patients admitted to general medicine service were more likely to have unplanned hospital readmissions in the 30 days following discharge. The Committee determined that, by identifying the concrete examples within its own institution of different access to services and different opportunities by race, the concept of institutional racism was no longer abstract and consequently, "no longer someone else's problem," as described by its former Co-Chair, Dr. Michelle Morse. [108]

Affording Focused Legal Protections for Black Physicians

Discrimination in the medical staff context reflects a double whammy of structural racism in law and medicine. Health care and the judicial system are two of many systems in the United States whose origins include elements of institutional racism. [109] As a consequence, institutional racism in these two sectors beget racial disparities in health care delivery and outcomes. [110] Although these inequities have been observed and studied, and the subject of discussion, research, policies, and even laws, [111] we have yet to create effective change. In short, the focus on the end result, rather than the institutional racism in the health care system, has amped up the epidemic of discrimination rather than treat the problem.

Historically, legal protections in health care against discrimination based on race have focused almost exclusively on patients. Specifically, Title VI of the Civil Rights Act protects patients from ". . . on the ground of race, color, or national origin, be[ing] excluded from participation in, be[ing] denied the benefits of, or be[ing] subjected to discrimination under any program or activity receiving Federal financial assistance." [112] According to Title VI's implementing regulations, providers who receive federal funds cannot discriminate against federal health care patients based on race, color, or national origin either intentionally or through policies or practices that disproportionately and adversely affect patients on the basis of those traits. [113] The regulations further explain providers' obligations to provide care free of discrimination: "[Providers who receive Federal health care funds] may not, directly or through contractual or other arrangements, utilize criteria or methods of administration which have the effect of subjecting individuals to discrimination because of their race, color, or national origin, or have the effect of defeating or substantially impairing accomplishment of the objectives of the program as respect to individuals of a particular race, color, or national origin." [114] A "recipient" is also defined to include any private agency, organization, or individual who receives federal financial assistance, such as Medicare payments. [115] Title VI of the Public Health Service Act originally required health facilities that receive Hill-Burton funds to provide services

on a non-discriminatory basis. [116] In addition, Section 1557 of the PPACA protects individuals from being excluded from participation in, being denied the benefits of, or being subjected to discrimination on the basis of race, color, and national origin, among other things. [117] Interestingly, in 2019, CMS declined to extend these protections as part of its Conditions of Participation for hospitals, instead relying on Section 1557 for this protection and perhaps denying patients the one remedy that captures the attention of hospitals: Medicare participation.

Other federal laws prohibit discrimination on the basis of race or color in specific programs or activities funded by federal dollars. [118] On July 20, 2020, the Office for Civil Rights issued a bulletin for hospitals, other health care providers, and state and local agencies that receive federal financial assistance to address "Civil Rights Protections Prohibiting Race, Color and National Origin Discrimination During COVID-19." [119] In sum, the bulletin is a reminder for its recipients that they must comply with Title VI, and also includes specific recommendations addressing this compliance through providers' policies and procedures, assignment of staff and resources, internal governance, and patients' access to care. [120] Notably, following the Civil Rights Act, the then-Department of Health, Education, and Welfare adopted regulations that required physicians receiving federal funds to sign statements of compliance, swearing against racially discriminatory practices. [121] This requirement was abandoned in 1996, leaving physicians' services unaccountable to civil rights legislation, much as hospitals have very little accountability to physicians today.

Before examining the deficit of these current laws in protecting Black physicians in America, it is important to consider that these laws arguably, while well intentioned, place a band-aid on discrimination and racism in health care. They do not address the bleed because they do not go back and address the underlying institutional racism in the judicial and legislative branches. In the parallel sector of education, this phenomenon is reflected in *Brown v. Board of Education,* [122] which is cited as the seminal case for desegregation. While this decision banned government-sponsored segregation and laid a foundation for equal access to a quality public education, it was woefully deficient in preventing continued structural inequity in educational access and outcomes, which, in turn, have been clinically documented to increase the development of chronic disease and reduce overall life expect ancy. [123] Moreover, many schools are still segregated today, and seminal studies document that Black children are more likely to have in-school behavior criminalized. [124] That said, because true reform geared at the level of structural racism requires a rebuild of the system, in the interim, changes in current laws, regulations, and

economic incentives may be a viable tool for protection as we work our way back to the bottom of reform and start rebuilding. In this vein, the authors offer several proposed areas of interim legal protections.

1. **Expansion of Employment Discrimination to Recognize the Medical Staff Relationship**. Under current law, the courts are divided as to whether an employer-employee relationship exists between a hospital and a staff physician to support a claim for discrimination under Title VII, making it difficult to hold health systems and others accountable for wrongful, discriminatory acts in the medical staff and peer review context. This stumbling block may continue to erode since, as of January 2021, 70% of physicians in the United States were employed by hospital systems or other corporate entities, including private equity firms and health insurers. [125] However, in the interim, accountability can be recognized by considering the medical staff relationship on par with employment for this limited purpose or creating a separate class that has equivalent rights as an employment relationship.
2. **Amend HCQIA Requirements to Incorporate a True Waiver of Immunity Based on Title VII**. As discussed above, HCQIA provides immunity from damages to members of professional review bodies in medical staff cases, except in discrimination cases. Theoretically, this makes it possible for a physician member of a protected class to recover damages from a health system where the physician can prove discrimination by the hospital in its action affecting the physician's medical staff membership and/or clinical privileges. However, the reality is that the physician must first prove the employment relationship with the hospital, which is a significant, if not insurmountable, hurdle under present law. In order for this exception to have any meaning then, Title VII claims must be extended to include medical staff matters, particularly regarding HCQIA immunities for systems that have so blurred the lines between employment and independence through their own corporate structures, policies, and procedures.
3. **Accessible Accountability Under State Peer Review Law**. Hand in hand with federal law change is the need for state law reform. Specifically, to protect against the biases and discrimination that occur in this setting, state law standards for accountability of the institution and participants in peer review must require that their activities are driven solely by legitimate quality-of-care concerns rather than racial or other improper motivations. This change will require an adjustment to the currently insurmountable bar of absolute malice under common law, to create a deterrent for abuse of the peer review process, and to hold institutions and their participants legally accountable for failure to conduct their proceedings in a manner that does not perpetuate racial bias, discrimination, and conduct.
4. **Changes to CMS Conditions of Participation for Participating Providers**. CMS has

taken some measures to curtail discrimination against beneficiaries. However, despite the protective measures for beneficiaries included in Section 1557 of PPACA and the more recent July 2020 OCR Bulletin described above, CMS has not extended these protections to physicians and other providers as a Condition of Participation in a way that would hold hospitals' participation status accountable on par with HCQIA's leverage over physicians.

5. **Additions to The Joint Commission Standards for Accredited Organizations**. Similarly, The Joint Commission standards, which form the basis for hospitals' accreditation status—and, consequently, any potential threat to accreditation status captures the attention of hospitals and their leadership—do not require anti-discriminatory structures, processes, and training on the part of the hospital or prohibit discriminatory acts on the part of hospital leadership. These baseline measures should be a fundamental standard and should incorporate the training and attestations referenced below, as well as accountability, by fining institutions and their participants who initiate, instigate, or participate in improperly motivated peer review and disciplinary actions.
6. **State Peer Review & Hospital Licensure Reform**. State statute reform, both at the peer review immunity levels and with respect to hospital licensure requirements, could create accountability for discriminatory acts by hospitals and medical staffs in a meaningful way. For the former, reform might include a parallel state law exception for discrimination claims if the medical staff relationship is recognized on par with the employment status. For states like Georgia that have an exception from peer review immunity for individuals acting with malice, [126] recognizing discriminatory acts as acting with malice per se could accomplish this goal without change to existing law that does not place medical staff status on par with employment for discrimination claims. Both seem achievable goals, particularly in light of the number of states that have enacted economic credentialing bans [127] that seem more complex than preserving basic employment rights that have been thoroughly litigated for nearly 60 years.
7. **Bias Training**. As a "best case scenario," many physicians and health care leadership do not realize the biases they are bringing to the table; however, particularly in light of the patient harm being inflicted by perpetuating ignorance and racism, those who deliver care and are responsible for the delivery of care can no longer rely on the privilege of ignorance or tolerate racism. White colleagues need to have a better understanding of the biases of the lens of privilege through which their perspective is formed. They need to listen and to not be dismissive of the impact of these credentialing decisions on the professional careers of their peers who have earned the right to practice medicine the same way they have but, in most situations, have had to work at least twice as hard for the same accomplishments. This training should include modules on the history of bias

in medicine, with an attestation that removes willful or intentional ignorance of these realities as a defense against accountability. Many do not appreciate that the lack of Black doctors with hospital privileges is not accidental, but the result of restrictive and intentional covenants enforced within our current lifetime. This training should be incorporated in training programs at medical schools and academic medical centers as a Joint Commission requirement, and into model medical staff bylaws. It should extend not only to patients and patient communications, as has occurred and is occurring at some level, but also to colleagues and the health care provider community at large. *Furthermore, such training should not be perfunctory and limited—it is merely a steppingstone.*

Conclusion

"First, do no harm" is the most often quoted and fundamental precept in the Hippocratic Oath. Although referring to patient care, the intrusion of racism into the peer review process in this country inflicts significant harm to the professional careers, personal lives, health, integrity, and well-being of physicians of color, which in turn results in negative patient outcomes for patients of color, including premature deaths—the ultimate patient harm. "Quality-of-care concerns" are too often code words that are used to mask efforts motivated by economic competition or outright racial animus to damage the careers of physicians of color, perverting the peer review process designed to protect patients into an instrumentality of institutional racism that instead harms patients of color.

In reality, the peer review process in this country that is supposed to protect patients while affording physicians due process protections is fundamentally flawed, outdated, and ill-suited to accomplish those goals, and the participants in peer review are either not equipped to recognize and remedy racism's poisonous intrusion into the process or are unwilling to do so. The HCQIA and the peer review process undoubtedly protect the public from bad actors and physicians who lack the skill and competence to safely treat patients, but regrettably, peer review resources are too often weaponized against physicians of color who do not demonstrate legitimate quality-of-care issues.

To keep the faith with Hippocrates, the medical profession is obligated to respond to this crisis, and we must all do our parts—attorneys, medical professionals, administrators, lawmakers, and regulators. The authors have provided several concrete recommendations of reforms that are first steps towards driving racism from the peer review process, including implementing meaningful unconscious bias training, increasing minority representation in all stages of the peer review process, and revising bylaws, policies, procedures, statutes, and regulations through an equity lens. The time to act is now. The

cost of doing nothing is an unknown number of lives unnecessarily lost and too often irretrievably damaged, breaking the basic tenet of the Hippocratic Oath that physicians have been swearing to uphold for 1,750 years and inflicting the utmost harm.

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1 *Racism is a Public Health Crisis*, Am. Pub. Health Ass'n, https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations (last visited Apr. 22, 2022).

2 Maria Trent et al., *The Impact of Racism on Child and Adolescent Health*, 144 Pediatrics (2019), https://publications.aap.org/pediatrics/article/144/2/e20191765/38466/The-Impact-of-Racism-on-Child-and-Adolescent.

3 For the American Public Health Association's statement: *Racism is a Public Health Crisis*, APHA, https://www.apha.org/topics-and-issues/health-equity/racism-and-health/racism-declarations (last visited Apr. 22, 2022); for the American Academy of Pediatrics' statement: Maria Trent et al., *The Impact of Racism on Child and Adolescent Health*, 144 Pediatrics 1 (2019), https://pediatrics.aappublications.org/content/144/2/e20191765 (last visited Apr. 22, 2022); for the American Medical Association's Statement: Press Release, Am. Med. Ass'n, New AMA Policy Recognizes Racism as a Public Health Threat (Nov. 16, 2020), https://www.ama-assn.org/press-center/press-releases/new-ama-policy-recognizes-racism-public-health-threat (last visited Apr. 22, 2022).

4 For example, this observation is discussed in the media at Earl Ofari Hutchinson, *Black Doctors Charge Medical Racial Profiling*, HuffPost, https://www.huffpost.com/entry/black-doctors-medical-racial-profiling_b_12454232 (last updated Oct. 13, 2017).

5 All the examples described in this paper are anonymized examples derived from representative matters from the health law bar.

6 This delegation is supported by The Joint Commission standards.

7 Johnson v. Misericordia Cmty. Hosp., 294 N.W.2d 501 (Wis. Ct. App. 1980) (noting that at this time, Boards primarily consisted of businessman, bankers, and community representatives).

8 The term "microaggressions" was coined by Harvard University professor Dr. Chester Middlebrook Pierce in 1970 to describe insults and dismissals by non-Black Americans on African Americans. The term has been expanded to include degradation of any socially marginalized group and described by psychologist Derald Wing Sue as "brief, everyday exchanges that send denigrating messages to certain individuals because of their group membership." The term "macroaggressions," on the other hand, is defined as persecution of an entire group of people —*e.g.,* African Americans as a whole.

9 Seminal negligent credentialing cases include Darling v. Charleston Cmty. Mem. Hosp., 211 N.E.2d 253 (Ill. 1965), *cert. denied*, 388 U.S. 946 (1966); Johnson v. Misericordia Cmty. Hosp., 301 N.W.2d 156 (Wis. 1981); Kadlec Med. Ctr. v. Lakeview Anesthesia Assocs., No. 04-0997 Section I/3 (E.D. La. May. 19, 2005).

10 Eaton v. Bd. Of Mgrs. of James Walker Mem. Hosp., 164 F. Supp. 191 (E.D.N.C. 1958), affirmed 261 F.2d 521 (4th Cir. 1958), *cert. denied,* 359 U.S. 984*; see also* Cypress v. Newport News Gen. & Nonsectarian Hosp. Assoc., 375 F.2d 648 (4th Cir. 1967); Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959 (4th Cir. 1963); Eaton v. Grubbs, 379 F. 2d 710 (4th Cir. 1964).

11 42 U.S.C. §§ 1981, 1983.

12 Robert B. Baker et al., *African American Physicians and Organized Medicine, 1846-1968: Origins of a Racial Divide*, 300 J. Am. Med. Ass'n. 306 (2008); P. Preston Reynolds, *Professional and Hospital DISCRIMINATION and the US Court of Appeals Fourth Circuit 1956-1967*, 94 Am. J. Pub. Health 710 (2004), https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448322/. Dr. Reynolds gives an extensive case history of the *Eaton* case, which ultimately resulted in Dr. Eaton refiling his case against James Walker Memorial Hospital in 1961, relying on the Fourth Circuit decision in Simkins v. Moses H. Cone Mem'l Hosp., 323 F.2d 959 (4th Cir. 1963). Using the *Simkins* decision, Dr. Eaton argued that state action existed because the city and county owned the hospital, which was required to be maintained as a public facility; the hospital was tax-exempt

and received money from the county to expand the facility; the hospital accepted money under the federal Defense Public Works Act, which required it to follow nondiscrimination provisions; and the hospital participated in the Hill-Burton statewide plan for hospital funds. Although the District Court dismissed the case in 1963, on appeal, the Fourth Circuit reversed the lower court ruling relying on the *Simkins* decision.

13 *E.g.,* Foster v. Mobile Cnty. Hosp. Bd., 398 F.2d 227 (5th Cir. 1968); Ware v. Benedikt, 280 S.W.2d 234 (Ark. 1955); Hamilton Cnty. Hosp. v. Andrews, 84 N.E.2d 469, 85 N.E.2d 365 (Ind. 1949).

14 *E.g.,* Hawkins v. N.C. Dental Soc'y, 230 F. Supp. 805 (W.D.N.C. 1964), *petition for reh'g denied*, 85 N.E.2d 365 (Ind. 1949). The Fourth Circuit reversed the judgment granted to the dental societies in the dentist's action under the Fourteenth Amendment. Hawkins v. N.C. Dental Soc'y, 355 F.2d 718 (4th Cir. 1955).

15 *Id.* at 312.

16 Dowin Boatright et al., *Racial Disparities in Medical Student Membership in the Alpha Omega Alpha Honor Society*, 177 JAMA Internal Med. 659 (2017).

17 42 U.S.C. §§ 2000e–2000e-17 (2021).

18 U.S. Const. amend. XIV, § 1.

19 U.S. Const., amend. V.

20 *E.g.,* Lew v. Kona Hosp., 754 F.2d 1420, 1424 (9th Cir. 1985); Darlak v. Bobear, 814 F.2d 1055 (5th Cir. 1987); *cf.* Engelstad v. Va. Mun. Hosp., 718 F.2d 262, 266 (8th Cir. 1983); Daly v. Sprague, 675 F.2d 716, 727 (5th Cir. 1982); Suckle v. Madison Gen. Hosp., 499 F.2d 1364, 1366 (7th Cir. 1974); Shaw v. Hosp. Auth. of Cobb Cnty., 507 F.2d 625 (5th Cir. 1975); Stidham v. Tex. Comm'n on Priv. Sec., 418 F.3d 486 (5th Cir. 2005).

21 *E.g.,* Stretten v. Wadsworth Veterans Hosp., 537 F.2d 361 (9th Cir. 1976); Schlein v. Milford Hosp., 423 F. Supp. 541 (D. Conn. 1976).

22 *E.g.,* Foster v. Mobile Cnty. Hosp. Bd., 398 F.2d 227 (5th Cir. 1968) (finding no evidence of racial discrimination).

23 Scott v. Sisters of St. Francis Health Svcs., Inc., 645 F. Supp. 1465 (N.D. Ill. 1986).

24 Jimenez v. WellStar Health Sys., 596 F.3d 1304 (11th Cir. 2010).

25 Blum v. Yaretsky, 457 U.S. 991 (1982) (holding hospital's acceptance of Medicaid payments did not render it a state actor for Section 1983 purposes).

26 Shaw v. Hosp. Auth. of Cobb Cnty., 507 F.2d 627 (5th Cir. 1975); *e.g.*, Stidham v. Tex. Comm'n on Priv. Sec., 418 F.3d 486, 491 (5th Cir. 2005).

27 *See* 15 U.S.C. §§ 1, 2 (2021). Section 1 states that "[every] contract . . . or conspiracy, in restraint of trade or commerce . . . is hereby declared to be illegal." Section 2 states: "Every person who shall monopolize, or attempt to monopolize, or combine or conspire with any other person or persons, to monopolize any part of the trade or commerce . . . shall be deemed guilty of a felony"; *see also* 15 U.S.C. § 45 (1988) (deeming unfair methods of competition unlawful).

28 *E.g.,* Alaska. Stat. § 45.50.564 (2021); Del. Code. Ann., tit. 6 §§ 2101-14 (2022); Mich. Comp. Laws §§ 445.771–.788 (2021).

29 Legal authority is divided on whether the medical staff is a separate legal entity for purposes of conspiring with the hospital. *E.g.,* Wallace v. Garden City Hosp. Osteopathic, 330 N.W.2d 850 (Mich. 1983); *cf.* Oltz v. St. Peter's Cmty. Hosp., 861 F.2d 1440 (9th Cir. 1988); Weiss v. York Hosp., 745 F.2d 786 (3d Cir. 1984); Bolt v. Halifax Hosp. Med. Ctr., 851 F.2d 1273 (11th Cir. 1988).

30 *See, e.g.,* Bus. Elecs. Corp. v. Sharp Elecs. Corp., 485 U.S. 717 (1988).

31 15 U.S.C. § 15(a). Additionally, because violation of the Sherman Act is considered a felony, it is grounds for mandatory exclusion from participation in Medicare and state health care programs—a death knell for most providers. 42 U.S. C. § 1320a-7(a)(1).

32 *E.g.,* Novak v. Somerset Hosp., 625 F. App'x 65 (3d Cir. 2015); Patel v. Midland Mem'l Hosp. & Med. Ctr., 298 F.3d 333 (5th Cir. 2002); BCB Anesthesia Care v. Passavant Mem'l Area Hosp. Ass'n, 36 F. 3d 664 (7th Cir. 1994); Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992).

33 Brown Shoe Co. v. United States, 370 U.S. 294 (1962); *see also* Oksanen v. Page Mem'l Hosp., 945 F.2d 696 (4th Cir. 1991) (en banc); Todorov v. DCH Healthcare Auth., 921 F.2d 1438 (11th Cir. 1991).

34 *E.g.,* Matthews v. Lancaster Gen. Hosp., 87 F.3d 624 (3d Cir. 1996); Robinson v. Magovun, 688 F.2d 824 (3d Cir. 1982).

35 42 U.S.C. §§ 11101–11152.

36 *Id.* § 11101(4); Singh v. Blue Cross/Blue Shield of Mass., Inc., 308 F.3d 25 (1st Cir. 2002).

37 *E.g.,* Ohio Rev. Code § 3701.351(B) (2021).

38 *See racism*, Merriam-Webster, https://www.merriam-webster.com/dictionary/racism (last visited Apr. 22, 2022).

39 Aysa Gray, *The Bias of 'Professionalism' Standards,* Stanford Soc. Innovation Rev. (June 4, 2019), https://ssir.org/articles/entry/the_bias_of_professionalism_standards (discussing the work of Tema Okun and Keith Jones, *see* Dismantling Racism Works, *White Supremacy Culture in Organizations,* Ctr. for Cmty. Orgs., https://coco-net.org/wp-content/uploads/2019/11/Coco-WhiteSupCulture-ENG4.pdf).

40 Derald Wing Sue et al., *Racial microaggressions in everyday life: Implications for Clinical Practice*, 62 Am. Psych. 271 (2007).

41 Virmani v. Novant Health Inc., 259 F.3d 284 (4th Cir. 2001).

42 *E.g.,* Khan v. Suburban Cmty. Hosp., 340 N.E. 2d 398 (Ohio 1976); Duffield v. Mem'l Hosp. Ass'n, 361 F. Supp. 398 (S.D. W. Va. 1973); Mauer v. Highland Park Hosp. Found., 232 N.E.2d 776 (Ill. App. Ct. 1967); Richards v. Emanuel Cnty. Hosp. Auth., 603 F. Supp. 81, 85 (S.D. Ga. 1984); Truly v. Madison Gen. Hosp., 673 F.2d 763, 765 (5th Cir. 1982); Kaplan v. Carney, 404 F. Supp. 161, 165 (E.D. Mo. 1975); Sosa v. Bd. of Managers of Val Verde Mem'l Hosp, 437 F.2d 173, 177 (5th Cir. 1971) ("The evaluation of professional proficiency of doctors is best left to the specialized expertise of their peers, subject only to limited judicial surveillance.").

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44 At least one court has suggested that under § 2000e-5, the language "a person claiming to be aggrieved" could expand the provisions of § 2000e-2 and § 2000e-3, which are limited to "employment practices." *See, e.g.,* Sibley Mem'l Hosp. v. Wilson, 488 F.2d 1338, 1341 (D.C. Cir. 1973). The court in *Sibley* observed: The Act, in providing for the filing of complaints with EEOC and of eventual actions in the District Court, does not use the term "employee." The phrase is, rather, the "person aggrieved;" and that term can certainly be taken as comprehending individuals who do not stand in a direct employment relationship with an employer. The fact that the Act purports to provide remedies for a class broader than direct employees is a strong indication that the proscriptions contemplated.

45 *See, e.g.,* Diggs v. Harris Hosp.-Methodist, Inc., 847 F.2d 270 (5th Cir. 1988); Johnson v. Greater Southeast Cmty. Hosp. Corp., 903 F. Supp. 140 (D.D.C. 1995); Todros v. Coleman, 717 F. Supp. 996 (S.D.N.Y. 1989); Beverley v. Douglas, 591 F. Supp. 1321 (S.D.N.Y. 1984).

46 Amro v. St. Luke's Hosp., No. 84-1355 (E.D. Pa. Jan. 13, 1986); Mallare v. St. Luke's Hosp., 699 F. Supp. 1127 (E.D. Pa. 1988); Mousavi v. Beebe Hosp. of Sussex Cnty., Inc., 853 F. 2d 919 (3d Cir. 1988); Doe *ex rel* Doe v. St. Joseph's Hosp., 788 F.2d 411 (7th Cir. 1986); Christopher v. Stouder Mem'l Hosp., 936 F.2d 870 (6th Cir.), *cert. denied,* 502 U.S. 1013 (1991); Salamon v. Our Lady of Victory Hosp., 514 F.3d 217 (2d Cir. 2008); Stremple v. Nicholson, 289 Fed. App'x 571 (3d Cir. Aug. 27, 2008); Nassar v. Univ. of Tex. Sw. Med. Ctr., No. 3-08-CV-1337-B (N.D. Tex. 2010) (jury verdict); Pardazi v. Cullman Med. Ctr., 838 F.2d 1155 (11th Cir. 1988).

47 This rate is up to 70% by the end of 2020. *See* Laura Dyrda, *70% of physicians are now employed by hospitals or corporations*, Becker's ASC Rev., https://www.beckersasc.com/asc-transactions-and-valuation-issues/70-of-physicians-are-now-employed-by-hospitals-or-corporations.html.

48 42 U.S.C. § 11101(1), (2).

49 *E.g.,* Ala. Code § 6-5-333 (2021); Colo Rev. Stat. § 12-30-207 (2021); Idaho Code § 39-1392c; Kan. Stat. § 65-442 (2021); Minn. Stat. § 145.63 (2021); N.M. Stat. § 41-9-4 (2021); Okla. Stat. tit. 63, §1-1709 (2021); Tenn. Code § 63-1-150 (2021); Wis. Stat. § 146.37 (2021).

50 H.R. Rep. No. 903 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6287, 6384, 6384; 42 U.S.C. §§ 11101(5), 11111(a). HCQIA also includes a possible antitrust exception; however, as discussed *infra*, those claims (and therefore the exception) are difficult to sustain.

51 42 U.S.C. § 11112(a).

52 *Id.*; *see, e.g.,* Matthews v. Lancaster Gen. Hosp.*,* 87 F. 3d 624 (3d Cir. 1996).

53 *See, e.g.,* Bryan v. James E. Holmes Reg'l Med. Ctr., 33 F.3d 1318 (11th Cir. 1994); Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992); Brader v. Allegheny Gen. Hosp., 167 F.3d 832 (3d Cir. 1999).

54 *Matthews.,* 87 F. 3d at 635.

55 Poliner v. Tex. Health Sys., 537 F.3d 368 (5th Cir. 2008); Singh v. Blue Cross/Blue Shield of Mass., Inc., 308 F.3d (1st Cir. 2002). Surviving summary judgment is difficult for the physician, as demonstrated in three reported federal cases, Brown v. Presbyterian Healthcare Servs., 101 F.3d 1324 (10th Cir. 1996); Islami v. Covenant Med. Ctr., Inc., 822 F. Supp. 1361 (N.D. Iowa 1992); LeMasters v. Christ Hosp., 791 F. Supp. 188 (S.D. Ohio 1991).

56 Imperial v. Suburban Hosp. Ass'n, Inc., 37 F.3d 1026 (4th Cir. 1994).

57 42 U.S.C. § 11111(a)(1)(D) (2021).

58 *E.g.,* Ga. Code § 31-7-133(a) (2021); 735 Ill. Comp. Stat. 5/8-2101 (2021); Mass. Gen. Laws ch. 111, § 204 (2021).

59 *E.g.,* Ga. Code § 31-7-132.

60 *Id.* § 31-7-132 (a)–(b).

61 *See, e.g.,* Freeman v. Piedmont Hosp., 444 S.E.2d 706 (Ga. 1994) (finding bare allegations of malice could not eliminate the statutory protection of peer review materials from discovery despite fairly significant facts to the contrary). However, Justice Hunstein noted in her special concurrence, "Because the Court of Appeals found sufficient evidence for a jury to infer that Butler maliciously used his 'positional privilege' as a person charged with reporting nurses' concerns about doctors to Piedmont Hospital's peer review organization to interfere intentionally with appellant's business relations, . . . I would apply the exception in OCGA § 31-7-133(a) to the instant case and would find that appellants were entitled to the discovery sought." *Id.* at 799 (J. Hunstein, concurring).

62 For purposes of this paper, the authors use the term "health equity" consistent with the definition employed by the Robert Wood Johnson Foundation: "Health equity means that everyone has a fair and just opportunity to be as healthy as possible. This requires removing obstacles to health such as poverty, discrimination, and their consequences, including powerlessness and lack of access to good jobs with fair pay, quality education and housing, safe environments, and health care." Paula Braveman et al., *What is Health Equity?*, Robert Wood Johnson Found. (May 1, 2017), https://www.rwjf.org/en/library/research/2017/05/what-is-health-equity-.html.

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74 Joint Comm'n, Revision to LD.03.01.01, EPs 4 and 5 (July 1, 2012).

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81 This law provides that an individual shall not, on the ground prohibited under title VI of the Civil Rights Act of 1964 (42 U.S.C. 2000d *et seq.*), title IX of the Education Amendments of 1972 (20 U.S.C. 1681 *et seq.*), the Age Discrimination Act of 1975 (42 U.S.C. 6101 *et seq.*), or section 794 of title 29, be excluded from participation in, be denied the benefits of, or be subjected to discrimination under, any health program or activity, any part of which is receiving Federal financial assistance, including credits, subsidies, or contracts of insurance, or under any program or activity that is administered by an Executive Agency or any entity established under this title [1] (or amendments).

82 *E.g.,* AK, AL, AR, AZ, CA, DC, FL, IA, IL, IN, MD, ME, MN, NE, NJ, NY, NC, PA, SD, TN, TX, UT, WV.

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104 The authors anticipate challenges from facilities asserting that it may be difficult to impossible for them to obtain such diverse representation, perpetuating the shortage of Black talent to serve in these roles. Such responses should not be a plausible excuse for failure to identify, recruit, and retain talented Black physicians.

105 At its 2021 Annual Meeting, the AMA adopted a resolution to help health care organizations adopt workplace policies to address the root cause of racial health inequities. Specifically, the AMA will recommend that health care organizations and systems use the new guidelines to establish institutional policies that promote positive cultural change and ensure a safe, discrimination-free work environment.

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127 *E.g.*, Cal. Welf. & Inst. Code § 14087.28 (2021); Ga. Code § 31-7-7; La. Stat. § 37:1301 (2021); N.Y. Pub. Health Law § 2801-b (2022); Tenn. Code § 68-11-205 (2021).

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