



**Avoiding Career-
Threatening Landmines:
A Physician's Guide to
Credentialing,
Peer Review,
Malpractice, and
Disciplinary Matters**

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For physicians, serious professional risks often begin quietly: a vague peer-review inquiry, a credentialing question, a malpractice settlement discussion, a request for a “voluntary” evaluation, or a contract clause that seems routine until it limits future practice. These issues can quickly affect clinical privileges, licensure, employment, malpractice reporting, hospital relationships, and National Practitioner Data Bank ([NPDB](#)) reporting.

This article is a practical issue-spotting guide. It identifies recurring warning signs—situations where early legal advice may preserve options, prevent avoidable reporting consequences, and protect the physician's ability to continue practicing. The same principle runs throughout: the earlier a physician recognizes the risk, documents the facts, and seeks guidance from counsel experienced in these matters, the more control the physician usually has over the outcome.

Employment Contracts: Review Restrictive Terms Before They Become Career Barriers

A physician employment agreement is not just a compensation document. It can determine where the physician may practice, how quickly the employer may

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terminate the relationship, whether the physician receives adequate process before suspension or termination, and whether future disputes trigger credentialing or reporting consequences. Before signing or renewing an agreement, physicians should review provisions that affect clinical autonomy, mobility, and reputation.

- **Call coverage obligations**—The agreement should specify the expected number of call days, how additional call is assigned, and whether (and how) providing excess call coverage is compensated.
- **Productivity compensation**—If the agreement includes a productivity-based compensation model, the formula should be clear, measurable, and protected from unilateral revision or discretionary interpretation.
- **Non-compete and non-solicitation clauses**—Because federal non-compete rules remain unsettled and state law varies, physicians should evaluate whether any restriction is enforceable, avoidable, or negotiable before signing.
- **Termination and suspension provisions**—Physicians should understand what constitutes “cause,” whether notice and cure rights exist, and whether termination could affect privileges, credentialing, or board disclosures.

A lawyer can often identify risks that are not obvious from the compensation package alone, including overbroad restrictions, vague conduct standards, one-sided termination rights, and provisions that intersect with medical staff bylaws or credentialing obligations. Physicians should be especially cautious about signing an agreement after a dispute has started, because settlement, resignation, or separation terms may later shape what must be disclosed to hospitals, payers, licensing boards, or the NPDB.

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Malpractice Lawsuits: Watch for Conflicts and Reporting Consequences

Medical malpractice litigation can create professional consequences beyond the lawsuit itself. According to the American Medical Association (AMA), nearly one in three physicians has been sued during their career.¹ The risk is particularly high for surgeons, especially neurosurgeons and orthopaedic surgeons.² When a malpractice claim names both a physician and an affiliated hospital, practice group, or other entity, the insurer may appoint one lawyer to defend multiple insureds. That arrangement may be appropriate in some cases, but physicians should watch for conflicts between their own professional interests and the institution's interests.

- The hospital or group has incentives to shift fault to the physician.
- The insurer favors a settlement structure that may create avoidable NPDB consequences.
- The physician's name, conduct description, payment allocation, or settlement language could affect future credentialing, licensing, employment, or privilege applications.

In some circumstances, when an actual or potential conflict exists, physicians

¹ See AMERICAN MEDICAL ASSOCIATION: [One in Three Physicians Previously Sued in Their Career](#) (May 10, 2023).

² *Id.*; see also Elsamadicy A.A., Sergesketter A.R., Frakes M.D., & Lad S.P., Review of Neurosurgery Medical Professional Liability Claims in the United States, 83 Neurosurgery 997 (2018) (finding that neurosurgery malpractice claims are among the most prevalent and costly of all specialties).

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confronting a malpractice claim should consider asking their carrier to assign [independent counsel](#). Independent counsel may also help negotiate settlement wording, payment allocation, and NPDB reporting language if a settlement occurs. Because NPDB reports may be reviewed by hospitals, licensing boards, and other credentialing bodies, physicians should not assume that a “small” or “routine” settlement has no future consequences.³

Peer Review: Treat Early Inquiries as Potentially Significant

Peer review is an important quality-assurance tool, but for the physician under review it can also become a career-defining process. The AMA recognizes peer review as a means of promoting professionalism and maintaining trust, while emphasizing that fairness is essential when a physician’s reputation, status, or livelihood may be affected.⁴ The [HCQIA](#) likewise ties federal peer-review immunity to basic fairness standards, including a reasonable effort to obtain the facts, adequate notice and hearing procedures, or other procedures that are fair under the circumstances.⁵

³ See 45 C.F.R. § 60.7 and 60.12 (requiring the reporting of certain medical malpractice payments and adverse professional review actions to the NPDB); U.S. Dep’t of Health & Hum. Servs., NPDB Guidebook, ch. E, [Reporting Medical Malpractice Payments](#), and [Reporting Adverse Clinical Privileges Actions](#).

⁴ See [AMA Code of Medical Ethics Opinion 9.4.1](#).

⁵ See 42 U.S.C. § 11112(a)–(b) (establishing fairness standards for professional review action, including fact-finding, notice, and hearing requirements).

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Because hospitals and medical staffs often rely on bylaws, rules, policies, and accreditation standards, physicians should obtain and review the governing documents early. For example, physicians who maintain privileges at a health care facility should know:

- What process applies before the matter becomes a formal investigation or corrective action?
- What rights does the physician have to submit a response, meet with the committee, review records, or request a hearing?
- Which committee or officer is taking action or proposing to take action, and does anyone involved have a conflict, competitive interest, or prior involvement in the dispute?

Physicians should not dismiss informal peer-review communications as harmless. A hallway conversation, request for a written explanation, email from a department chair, or “collegial intervention” may later become part of an investigatory file. Physicians should preserve key communications, maintain a chronology, and ensure any clinical response is accurate, concise, and consistent with the medical record. Legal input is especially important before submitting written statements that may later be used against the physician in subsequent proceedings.

Peer Review Warning Signs: When to Slow Down and Get Advice

Certain developments indicate that a matter may be moving from routine quality review toward formal discipline, reporting, or employment action. Physicians should consider contacting counsel when any of the following occurs:

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- **Performance Improvement Plans (PIPs)**—A PIP may be presented as remedial or educational, but it can become evidence that the institution viewed the physician as deficient.
- **Focused Professional Practice Evaluation (FPPE)**—The Joint Commission describes [FPPE](#) as a process for evaluating privilege-specific competence, including when a question arises about a currently privileged practitioner’s ability to provide safe, high-quality patient care. FPPE should be predefined, consistently implemented, privilege-specific, and supported by qualitative and quantitative information where appropriate.⁶
- **Shortened reappointment or conditional privileges**—A reduction from the usual credentialing cycle, new conditions on privileges, or repeated requests for follow-up information may signal escalating concern.

Other red flags include requests to resign, take a leave of absence, voluntarily restrict privileges, attend a meeting on short notice, waive hearing rights, sign a corrective action agreement, or undergo an evaluation before the physician understands who ordered it and why. Certain adverse clinical privilege actions lasting more than 30 days, and certain surrenders or restrictions of privileges while under investigation, must be reported to the NPDB.⁷

⁶ See THE JOINT COMMISSION, FPPE—Understanding the Requirements; Hospital Accreditation Standards, Medical Staff Chapter, MS.08.01.01.

⁷ See 45 C.F.R. § 60.12(a)(1)(i)-(ii); 42 U.S.C. § 11133(a)(1)(A)-(B) (requiring health care entities to report certain adverse clinical privilege actions lasting longer than 30 days and certain surrenders or restrictions of clinical privileges while under investigation to the NPDB); [NPDB Guidebook](#), ch. E, at E-31.



Evaluations, Monitoring, and Fitness-for-Duty Requests

Physicians may be asked to participate in 360-degree reviews, professionalism coaching, behavioral assessments, substance-use evaluations, neuropsychological testing, or fitness-for-duty examinations. Some requests are appropriate and patient-safety focused; others may be overbroad, poorly defined, or used to pressure a physician into concessions. Before agreeing, physicians should clarify the purpose, scope, confidentiality, evaluator qualifications, reporting pathway, and consequences of nonparticipation.

- **Who is requiring the evaluation**—The physician should know whether the request comes from an employer, medical staff committee, physician health program, licensing board, or third-party vendor.
- **What the evaluator will receive and report**—Physicians should understand what records will be reviewed, whether the report will include diagnoses or recommendations, and who will receive the final report.
- **Whether the request is proportional**—A narrow competency concern may not justify an expansive psychological, substance-use, or monitoring process without a clear factual basis.

The AMA's ethics guidance recognizes that physician impairment issues should be handled in a way that protects patients while also promoting appropriate assistance, treatment, accommodations, and return to safe practice when possible.⁸ Physicians should seek legal advice before signing releases, monitoring contracts, consent forms,

⁸ See [AMA Code of Medical Ethics Opinion 9.3.2](#).



or agreements allowing broad disclosure to hospitals, boards, employers, physician health programs, or credentialing entities. The practical question is not only whether an evaluation is justified, but also who receives the results, how they may be used, and whether confidentiality protections are clearly defined.

Sham Peer Review: Recognizing the Peer Review Ambush and Protecting the Record

Legitimate peer review advances patient safety. But bad-faith peer review—often called [sham peer review](#)—can be used to retaliate against a physician, suppress competition, punish whistleblowing, or force a physician out without ordinary employment protections. Physicians should be alert when the process appears driven more by politics, economics, or personality conflict than by objective patient-care concerns.

Common warning signs include:

- Multiple complaints appearing suddenly after a business, employment, whistleblower, or leadership dispute.
- Allegations framed in vague or subjective terms rather than objective clinical standards.
- Accusations of “[disruptive behavior](#)” without clear notice, consistent standards, patient-safety evidence, or an opportunity to respond.
- Requests to attend an “informal” meeting with a department chair, committee, Medical Executive Committee, or similar body without sufficient notice or disclosure of the specific concerns.
- Being asked to resign, accept restrictions on privileges, enter monitoring, or

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agree to corrective action before fully understanding the consequences.

The danger is not merely the meeting itself, but also the record created before, during, and after the meeting. Physicians should ask for the specific concerns in writing, review the bylaws, preserve communications, avoid off-the-cuff admissions, and seek advice before agreeing to “voluntary” restrictions or resignation. Joint Commission standards recognize that bylaws and related policies should address suspension or termination of privileges, fair hearings, and appeals.⁹

Hospitals and peer-review participants may seek immunity under the Health Care Quality Improvement Act ([HCQIA](#)), but that protection depends on standards such as a reasonable belief that the action furthered quality health care, a reasonable effort to obtain the facts, adequate notice and hearing procedures or other fair procedures, and a reasonable belief that the action was warranted.¹⁰ Physicians facing potentially retaliatory or irregular peer review should involve counsel before waiving rights, resigning privileges, or submitting statements that may become part of the record.

⁹ See THE JOINT COMMISSION, Hospital Accreditation Standards, Medical Staff Chapter, MS.01.01.01.

¹⁰ See 42 U.S.C. § 11111 (providing immunity for qualifying professional review actions); 42 U.S.C. § 11112 (establishing the standards that a professional review action must satisfy for review immunity under the HCQIA).



Credentialing Applications: Accuracy, Consistency, and Context Matter

Credentialing applications are legal and professional representations. Incomplete answers, inconsistent disclosures, or unexplained gaps can create problems even when the underlying issue is defensible. Physicians should read every question carefully because hospitals, payors, licensing boards, and insurers may ask about malpractice history, investigations, privilege restrictions, resignations, board matters, employment gaps, health issues affecting practice, and prior corrective actions. Joint Commission credentialing and privileging standards address verification of credentials, criteria for privileging, scope of privileges, and ongoing professional practice evaluation.¹¹

- The applicant has a prior denial, restriction, suspension, revocation, or nonrenewal of clinical privileges.
- The applicant resigned, withdrew, or allowed an application to lapse while quality, conduct, competence, or health concerns were pending.
- The applicant must disclose prior malpractice payments, board actions, peer-review matters, monitoring agreements, or adverse employment actions.

The goal is not to over-disclose, under-disclose, or provide unnecessary narrative. The goal is to answer accurately, consistently, and with appropriate context. If a

¹¹ *Id.*, Medical Staff Chapter, *e.g.*, MS.03.01.01 (Oversight of Practitioners), MS.06.01.03 (Credentialing), MS.06.01.05 (Privileging) and MS.08.01.03 (Ongoing Professional Practice Evaluation).

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question could reasonably be read more than one way, or if the answer may trigger follow-up about an NPDB report, peer-review matter, resignation, or board investigation, physicians should obtain legal advice before submitting the application. Clinical privilege actions and surrenders while under investigation may have mandatory reporting consequences, and hospitals must query the NPDB when physicians apply for medical staff appointment or clinical privileges and every two years thereafter.¹²

Rights and Remedies Are State-Specific

Federal law, NPDB regulations, HCQIA, AMA ethics guidance, and Joint Commission standards provide important national frameworks. But the specific rights and remedies available to physicians in licensing, credentialing, employment, and peer-review matters often depend on state law, hospital bylaws, medical staff rules, contractual language, and the forum involved. State law may affect hearing rights, deadlines, confidentiality protections, peer-review privilege, judicial review, administrative procedures, whistleblower protections, contract remedies, and

¹² See 45 C.F.R. § 60.12(a)(1)(i)-(ii) (requiring reporting of adverse clinical privilege actions and certain surrenders of privileges while under investigation); NPDB Guidebook, ch. E, Reporting Clinical Privileges Actions (explaining reportable clinical privileges actions and surrenders during investigations); 42 U.S.C. § 11135(a)(1)-(2) (requiring hospitals to “request NPDB information upon application for medical staff membership or clinical privileges and every two years thereafter), *see also* 45 C.F.R. § 60.17(a)(1)-(2) (requiring hospitals to request information from the NPDB concerning a health care practitioner, “[a]t the time a health care practitioner applies for a position on its medical staff ... or for clinical privileges at the hospital and [e]very 2 years” thereafter for practitioners on the hospital’s medical staff).

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practical options before or after an adverse action.

For that reason, physicians should not rely on general guidance alone when responding to a licensing-board inquiry, credentialing question, peer-review notice, corrective-action recommendation, privilege restriction, or resignation request. A physician facing a specific issue should consult an attorney licensed in the relevant state who understands physician disciplinary, credentialing, employment, and peer-review matters.

When Physicians Should Contact a Lawyer

Physicians should consider contacting counsel before signing a restrictive employment agreement, responding to a peer-review inquiry, attending a committee meeting involving competence, conduct, impairment, or professionalism, resigning or restricting privileges, agreeing to monitoring or evaluation, submitting a credentialing application with a complicated history, settling a malpractice claim that may generate NPDB issues, or responding to a licensing-board inquiry. Early legal involvement does not mean the physician is “being difficult.” It means the physician is protecting the record, understanding the rules, and making informed decisions before consequences become difficult to undo.

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[Athan Papailiou](#) advises physicians in complex employment and regulatory issues, including governmental investigations, peer review inquiries, and medical board disputes. If you are facing one of these issues—or if something feels “informal” but potentially consequential—getting advice early can protect your license, reputation, and future practice options.

Disclaimer: This article is for educational purposes only and does not constitute legal advice. Every situation is fact-specific, and physicians should consult a licensed attorney before taking action in any credentialing, peer review, malpractice, employment, or disciplinary matter. Reading this article does not create an attorney-client relationship.

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