Avoiding the legal pitfalls of suspending physician privileges

Suspensions vary, but hospitals must follow right steps to ensure fairness and legality

SUSPENDING a physician’s privileges can be a tricky procedure, although it’s a situation that every medical executive committee (MEC) faces at one point or another. Suspending physicians for impairment is typically very straightforward, but suspensions that result from behavioral or quality issues tend to land in particularly gray areas, which means your hospital’s bylaws and procedures relating to suspensions need to be airtight.

There are two key points to remember regarding physician suspensions, says Lisa Carson, a partner at Buerger, Moseley, and Carson, PLC, in Franklin, Tenn. They particularly apply to summary suspensions, which occur because of clinical, quality, or other concerns that may create a danger to the safety of patients or others:

➤ If you have to suspend a physician to protect patients, don’t hesitate. It’s easier to defend a case involving a suspension than a case in which an intoxicated surgeon was allowed to do a surgery because no one would confront the physician.

➤ Don’t use suspensions as a way to get rid of a physician you don’t like. If summary suspension is being considered, the hospital should look to see whether there are any other options available to protect patients. If there are, the MEC needs to exhaust those options first.

There are protections afforded to hospitals in the Healthcare Quality and Improvement Act (HCQIA) regarding physician suspensions, but failure to provide legitimate reasoning as well as fair due process can get hospitals into hot water, says Anne Roberts, CPMSM, CPCS, a senior director of medical affairs at Children’s Medical Center in Dallas.

“Any time corrective action is taken, medical staff leadership should ensure that they are following the processes outlined in their bylaws.”

—Anne Roberts, CPMSM, CPCS

Three categories of suspensions

There are generally three types of physician suspensions, and each can be used during different circumstances:

➤ Automatic suspension: This is usually used during drastic scenarios when a physician fails to meet basic staff requirements (e.g., maintain a valid license or liability insurance coverage, provide documented immunization information, or complete required education training), Roberts says. This type of suspension does not entitle the provider to fair hearing or due
process, and should include provisions so if requirements aren’t met within a certain time frame, the physician voluntarily relinquishes clinical privileges.

➤ **Administrative/disciplinary suspension:** This is most often used as punishment for physicians with behavioral problems, Carson says. Suspensions of this nature that continue for less than 30 days are not reportable to the NPDB. Generally, the provider is afforded the right to due process before the suspension takes effect.

➤ **Summary suspension:** When an investigation of any kind occurs, medical staff leaders need to quickly determine whether there is an immediate risk to patients. If so, a summary suspension may be implemented until the medical staff has the chance to complete a full investigation. These investigations are typically reportable, but that report can be voided or modified if the investigation later clears the provider, Roberts says.

### Determining imminent danger

Of the three types of suspensions, a summary suspension is by far the murkiest in terms of having definitive cause. Automatic and administrative suspensions are usually based on the findings of a full investigation or a clear-cut violation of medical staff requirements. A summary suspension often deals with quality of care issues or behavioral alterations, both of which can be highly subjective.

“When you’re dealing with quality of care issues that are less obvious, again you have to make that imminent danger analysis, and so I would be very hesitant to make that determination based on subjective quality of care issues without having a peer look at whatever patient record was in question,” Carson says.

Although many procedures are black and white in terms of what the physician should or should not do, others can be incredibly complicated. Surgeons need to make split-second decisions, many of which do not involve a well-defined standard of care.

Behavioral issues come in varying degrees as well. If a physician pushes or physically assaults an employee, that may be grounds for summary suspension, but if there is a pattern of seemingly rude behavior or a string of outbursts during stressful situations, you may need to wait until a full investigation is completed before initiating a suspension, unless of course patient safety is being immediately compromised and there is no other way to protect patients.

Carson suggests that her clients implement a written provision in their bylaws that calls for a quick MEC review of any summary suspension. A summary suspension can be imposed by the CEO in conjunction with at least one medical staff leader, whether it’s the chief of staff or the department chair. However, a quick MEC review provides added legal protection for the hospital, and the facility is offered immunity under the HCQIA once a professional review action is ratified by a professional review body.

“Some hospitals have a time frame as tight as 72 hours, and some are five business days, but I certainly don’t think...
it should be longer than five business days before you pull the MEC together and have the medical staff committee review the action, interview the practitioner, and then decide whether to continue the suspension,” Carson says.

**The 14-day rule**

Hospitals should remember that HCQIA offers them a 14-day grace period that acts as a “get out of jail free card” for summary suspensions, Carson says.

“Certainly there still has to be a good faith belief and a factual basis for the action, but the Healthcare Quality and Improvement Act allows up to a 14-day period of suspension while an investigation is ongoing in order to determine if imminent danger does exist.” For example, if there was a sudden string of surgical complications identified with a surgeon, the chief of staff and CEO could suspend all privileges or those related to a specific procedure and would then have 14 days to obtain an expedited external review of that physician’s chart for a final decision.

“So there would be some solid documentation then for the committee to review and make a decision in that 14-day time frame whether to continue the suspension,” Carson says. “By the end of that 14-day time frame, they should have a strong factual basis for imminent danger before they continue the suspension.”

**External versus internal reviews**

One issue that may arise during the review process is whether to use an internal or external reviewer, particularly when the suspension is based on quality of care.

This is one of the most common legal pitfalls, Carson says. Although external reviews can be costly, especially ones that require a quick turnaround, they are much more objective from a legal standpoint, making it difficult for a physician to make claims of an unfair hearing.

This is particularly true among facilities with smaller medical staffs, says **Dean White, DDS, MS**, a medical staff consultant based in Granbury, Texas.

“If you have one cardiologist that reviewed cases of another cardiologist and there are only two in town, and you use all his feedback to suspend the other guy, you are going to be sued, even if he’s right,” he says. “That’s where the external review comes into play.”

But there are two potential downsides to external reviews: One, they can be expensive, and two, the external reviewer’s final determination may not provide definitive answers. “Sometimes they get wishy-washy,” White says. “Physicians hate to suspend fellow physicians.”

Internal reviews can work if you have a large medical staff or the cases in question allow for a multi-specialty review team. However, if there is any question as to whether a review could be perceived as unfair, it’s best to reach to an outside source to review a physician’s records.

“It’s not absolutely mandatory under the law, but it just protects everybody because it removes any issue with someone who has ulterior motives for identifying a quality of care issue, particularly when you’re dealing with summary suspension and the standard is so high to sustain it,” Carson says. “Larger medical staffs in some markets can handle these things well internally, but even on large medical staffs, you are still leaving yourself open to that challenge that someone is trying to run a competitor out of town.”

**Dealing with behavioral issues**

Suspending a physician for behavioral issues is highly subjective. Although disruptive physicians should not be tolerated, there are a lot of gray areas in terms of defining disruptive physicians and whether they have committed an offense that warrants a suspension.

Typically behavior-related suspensions occur after a string of incidents, particularly if the behavior begins to affect patient care, or if the physician has a history of volatile behavior and previous warnings. If a medical staff is considering suspending a physician for this reason, it should have clear documentation of incidents as told by other staff members, and any prior discussions with the physician. Additionally, hospitals need to take a hard look at their own procedures—if a physician is acting out, the problem may be with the processes rather than the behavior.

“Our problem is not just bopping these guys on the head and saying, ‘Don’t do that anymore.’ We need to fix the system that caused them to have a problem,” White
says. “If they went ballistic because someone wasn’t get-
ging them what they needed, we need to figure out how to
get them what they need. If lack of training and proctoring
and education or mentoring is the reason they messed up,
we need to fix the system so they get trained or mentored
so they don’t mess up again.”

Addressing quality issues

The other gray area involving physician suspensions
is anything related to quality of care. Although patient
safety should always be the foremost concern, many
adverse outcomes may have extenuating circumstances,
and isolated incidents likely won’t warrant a suspension
unless a physician is truly a danger to patient health.

For this reason, White recommends implementing
a grading or scaling system to evaluate adverse outcomes:
A physician’s case should undergo a simple peer review
with someone from a similar specialty and then be as-
signed a grade on a four-point scale. A grade of 1 denotes
an event that, although it shouldn’t happen, involves
extenuating circumstances out of the physician’s control,
or does not involve clinical actions below the standard
of care. A grade of 4 denotes an event that should never
happen and could potentially harm another patient. The
medical staff can use these grades to determine whether
the severity or the frequency of a physician’s quality of
care issues warrants a suspension.

“If everyone else only has a couple 2s in a whole year,
but one physician has four or five 2s, that’s a frequency
problem,” White says. “If he or she has a 4, that’s severe,
and you probably only need just one of those to take
action.”

Reporting requirements

Everyone is familiar with the NPDB’s suspension
requirements that say a suspension is not reportable if it
is under 30 days. For that reason, medical staffs often sus-
pend physicians for as many as 29 days to take disciplinary
action without affecting their future employment.

However, hospitals should also pay attention to their
state’s reporting requirements for physician suspensions, as
they can vary widely, Carson says.

For example, Tennessee state laws mirror the NPDB
reporting requirements, but Arizona requires even a one-
day suspension to be reported to the state medical board.

“And then there is everything in between,” she says. “In
some states it’s triggered by the basis for the suspension.
If the suspension was because the practitioner was grossly
outside the standard of care, it might be reportable. If the
suspension is because of a behavioral issue that didn’t rise
to the level of impairment, it might not be reportable until it
reaches a certain threshold.”

Conditional suspensions

Finally, all suspensions—whether related to behavior or
quality—should have some kind of conditions attached to
them as soon as they are handed down, White says.

Often the physician is required to take continuing
education or go through a behavior modification program
geared specifically for physicians. If the suspension was
quality related, the physician may also be assigned a pro-
tor to observe a certain number of cases when he or she
returns.

“Whenever a provider has been placed on suspension,
medical staff leaders often will implement a focused pro-
fessional practice evaluation [FPPE] prior to allowing the
provider to return to practice,” Roberts says. “The FPPE
can range from requiring continuing medical education,
proctoring for specific privilege, to implementation of a
performance monitoring plan.”

Hospitals often draw up contracts upon the physician’s
return that include a list of those conditions, which the
physician can review and sign to signify he or she under-
stands them. This is particularly applicable to behavioral
issues where the hospital may need to take additional
action if disruptive behavior persists.

“It’s really nothing more than spelling out that we
expect you to do what every other human in the profes-
sional environment is expected to do, but it actually kind
of forces the physician to digest and acknowledge that
there is a playbook and everyone is on the same page,”
Carson says. ■
Understanding the nuances of enterprise liability

Enterprise liability is utilized by some healthcare organizations, offering more leverage in credentialing decisions and quality control

Enterprise liability is a legal tort and a form of secondary liability in which an entire organization is held liable for actions of its agents or constituents. In the corporate world, enterprise liability is commonly used to hold corporations at least partially responsible for what happens within their organizations.

The healthcare sector has been slow to adopt enterprise liability; some have argued this has compounded current problems with the medical malpractice legal system, forced physicians to practice “defensive medicine,” and contributed to high liability insurance premiums.

Under an enterprise liability system, hospitals would bear the brunt of malpractice claims, incentivizing them to reduce medical errors through open communication and standards-based practices. It would also provide an incentive for meaningful peer review and enforcement of institutional guidelines, while spreading the cost of insurance premiums. Physicians would be considered employees of the healthcare organization and would contribute to the insurance costs of the hospital, but would not be personally on the line for high-risk coverage.

A position paper published by the American Association of Orthopedic Surgeons (AAOS), revised in 2009, calls for medical liability reform, including a shift toward enterprise liability. The AAOS argues that the current system interferes with the patient-physician relationship, prevents analysis of medical errors, and forces physicians into defensive medicine where they order “excessive or unnecessary tests, procedures, visits, or consultations solely for reducing liability risk for the physician.” Adoption of enterprise liability would “encourage shared responsibility and system-wide improvement, and eliminate blame and shame.”

Although few healthcare organizations employ this approach, most teaching hospitals have adopted enterprise liability because physicians are usually considered employees of the hospital. Veterans Administration (VA) hospitals have also adopted enterprise liability after a proposal from the Clinton administration to lower healthcare costs and improve quality. When a patient of the VA brings a claim against a hospital or physician, he or she is essentially bringing that claim against the Department of Health and Human Services.


“Traditionally, hospitals are run where all the doctors who work there are independent contractors, so it requires changing the complete business model to go to an enterprise liability situation, and we’re probably moving in that direction anyway because of the economic move by large hospital chains to acquire physician groups and make them employees of the hospital.”

However, a transition to enterprise liability is not all that simple since healthcare organizations are handcuffed by state laws, says Michelle Mello, JD, PhD, professor of law and public health with the Department of Health Policy and Management at the Harvard School of Public Health in Boston. “It’s not generally up to the institution to determine their own scope of liability unless they voluntarily accept liability,” she says. “Most states have what’s called a corporate medicine doctrine that is basically ‘people practice medicine, corporations don’t.’ Liability will fall on the corporation in a limited set of circumstances, but for the most part it’s going to rest on

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individual practitioners within those organizations.”

**The advantages of enterprise liability**

One of the reasons enterprise liability is attractive to physicians is because the hospital absorbs the administrative headaches that go along with medical malpractice, while also reducing some of the costs associated with liability insurance. “Healthcare organizations go to physicians and say, ‘We will relieve you of the paperwork that drives you crazy currently in your private practice,’ and one aspect of that is medical malpractice,” Malone says.

Enterprise liability also eliminates the blame game of identifying the responsible party. Some medical errors are physician-based, others are system-based, and some are a combination of both. Enterprise liability identifies one responsible party so that less time is devoted toward deciding how liability should be allocated to multiple defendants, Mello says. It also reduces the legal costs of multiple legal teams representing multiple defendants.

The best way to approach enterprise liability is not to have the hospital take responsibility for all of its practitioners’ actions, but to use a shared system where both hold some liability for quality patient care. “That probably makes more sense, and it is closer to concepts of just culture that are permeating the patient safety world right now,” Mello says. “Just culture is not one where we write off every injury as a systems failure and don’t look at the role of individuals; just culture is one in which we try to understand the portion of responsibility among individuals and institutions.”

**Effect on peer review and negligent credentialing**

In theory, enterprise liability would have a positive effect on peer review and quality control, Malone says, since the current malpractice system does not always promote objective review. For example, a hospital may be aware of a surgeon credentialed at the facility with subpar quality metrics, but since the surgeon is an independent contractor, he or she is not legally responsible for the practice. Terminating or suspending privileges is an option, but this eliminates a source of income. Sometimes, if the surgeon brings in a lot of capital for the hospital, quality issues are ignored.

“[Enterprise liability] lines up the interests better,” Malone says. “Economists call it internalizing your costs as opposed to externalizing costs. When you internalize the costs of the malpractice inside the hospital and not delegate it out to independent contractors and private insurance companies, then the incentives are lined up for better and safer patient care.”

Enterprise liability incentivizes more rigorous peer review and thorough credentialing and privileging since the hospital is on the line for the physician’s actions. It would also eliminate claims of negligent credentialing, he says.

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**California appellate court upholds judgment on peer review hearing process**

The California Court of Appeals, First Appellate District, affirmed a district court’s judgment regarding a physician’s claim that his peer review hearing violated his due process and his subsequent suspension was not supported by substantial evidence. The court concluded there was no evidence of financial bias on the part of the hospital board or hearing panel members.

Hamid Safari, MD, was board-certified in obstetrics and gynecology and maternal fetal medicine (perinatology) and was privileged at KFH Medical Center in Fresno (Kaiser). On April 22, 2005, Safari was the delivering physician for the birth of two twins. Safari elected to induce delivery because the mother’s “fasting sugars were all elevated and because she had two prior successful deliveries.” The first twin was delivered successfully, but Safari elected to use a vacuum extractor to facilitate the delivery of the second twin, who was not progressing down the birth canal. In addition to the vacuum, multiple attempts...
by the physician assistant to manually rotate the baby’s head failed, and the child died during the delivery.

In July 2005, the medical executive committee (MEC) concluded that a vacuum delivery was not appropriate and recommended that Safari’s privileges to perform vaginal deliveries should be restricted. Safari requested a fair hearing and a judicial review committee (JRC) to hear his appeal. The Medical Board of California also conducted an investigation of the incident and concluded that although the delivery of a second twin is subject to much debate, it may have been more appropriate to proceed with a cesarean section rather than the vacuum. The JRC later unanimously voted to uphold the MEC recommendation to terminate Safari’s clinical privileges.

In December 2006, following the JRC decision, Safari underwent training at the Physician Assessment and Clinical Education program at the University of California, San Diego. A senior program representative of the program determined that although Safari’s medical knowledge was impressive, he could benefit from behavioral counseling. Safari was later referred to a psychologist who determined that defensiveness and self-righteousness had led to Safari’s difficulties with other staff members.

In April 2007, the quality and health improvement committee (QHIC) approved the termination of Safari’s vaginal delivery privileges and set up a practitioner review and oversight committee (PROC) for further review of his clinical privileges. The PROC concluded that Safari should be able to treat patients, but only as a consultative perinatologist at the request of obstetricians.

Safari requested a hearing after being informed that the QHIC would adopt the PROC recommendation. At that point Safari was also offered a $2 million buyout, provided he resign from the hospital, but he rejected the offer.

In 2008, Kaiser conducted an external peer review and found Safari’s obstetrical care to be unacceptable and a deviation from accepted standards. The MEC then conducted a focused practice review for Safari’s cases after 2006 and determined there were still concerns with his clinical judgment; it asked the PROC to reconvene for a recommendation on additional action. The PROC recommended that Safari’s participation with Kaiser Foundation Health Plan (KFHP) be terminated, a recommendation that was adopted. Safari requested a hearing, which was consolidated with the appeal on the 2007 QHIC decision.

During the hearing, Safari objected to having Harry Shulman, Esq., as a hearing officer—as well as the panel members that were appointed—on the grounds of bias. Both of those objections were rejected by Shulman. The hearing panel later found that the QHIC had met its burden of proof, and the decision was reasonable and warranted. On September 23, 2010, the board at Kaiser unanimously upheld the recommendation to terminate Safari’s staff membership and clinical privileges with KFH Fresno and KFHP.

In July 2011, Safari filed a writ of administrative mandate claiming the staff administrative hearing was procedurally unfair and that the selection of the hearing officer was unfair since he was one of Kaiser’s own attorneys. Safari also claimed that Shulman had secret communication with Kaiser’s corporate attorneys and that the hearing panel was not a neutral party. A superior court denied Safari’s petition for writ of mandate, which he appealed.

The appellate court determined that Safari was only entitled to a fair procedure, not constitutional due process, since Kaiser is privately owned and peer review decisions based on medical judgments made by private parties do not constitute state action.

The court further determined that Safari received a fair procedure, concluding that there was no appearance of financial bias since the hearing panel members had no substantial financial interest in the outcome.

Additionally, the selection of Shulman as the hearing officer complied with the appropriate requirements, and the court determined there were no secretive communications with Kaiser’s corporate lawyers. Finally, Safari failed to provide evidence to prove the hearing panelist members had a bias against him.

Illinois Appellate Court: Doc’s statements did not violate state confidentiality provisions

The Appellate Court of Illinois, First Judicial District, upheld a trial court’s decision to grant summary judgment for a physician on an action against him alleging that he violated the confidentiality provisions of the Medical Studies Act when he made statements to other doctors relating to the plaintiff’s medical performance during a surgery. Josh Tunca, MD, a specialist in gynecological oncology at Northwest Community Hospital, brought a claim against his colleague, Thomas Painter, MD, a vascular surgeon, after Painter made statements to several other doctors at the hospital regarding Tunca’s performance in a case, which allegedly led to a substantial decrease in Tunca’s income.

On June 24, 2006, Tunca removed an ovarian tumor from a patient; shortly after the surgery, the patient lost pulse in her left leg due to a clot in her femoral artery. Painter was called to perform a femoral-femoral bypass to restore blood flow. According to the complaint, Painter told the vice-president and medical affairs director of the hospital that Tunca had severed the patient’s left iliac artery. The complaint says Painter also told numerous other doctors and medical personnel that Tunca had negligently and inadvertently severed the patient’s artery.

Tunca claimed that Painter’s statements became widely disseminated throughout the hospital, leading to a decrease in the number of referrals he received and a substantial decrease in his income. This appeal dealt exclusively with the issues of whether Painter’s statements about Tunca’s medical performance violated the confidentiality provisions of the act and whether Tunca had a private right of action under the act.

To answer the first question, the court analyzed the text of the act. It looked to common law precedent to support the established interpretation that the act does not protect against the disclosure of information generated before or after a peer review process. In this case, Painter’s statements were made one week after the surgery, and the incident was not reviewed in a peer review committee meeting until February 2007.

The court concluded that because Painter’s statements were made prior to the committee meeting, the confidentiality provisions of the act did not apply to them; since there were no genuine issues of material fact regarding the timing of the statements and the committee meeting, the issue could be resolved as a matter of law and the lower court’s summary judgment ruling was appropriate.

The court noted the act does not give a peer-reviewed physician a private right of action for an alleged violation of the act’s confidentiality provisions. It reasoned the act contains no express language granting a private right of action. The court noted that “the purpose of the Act is to ensure that members of the medical profession will effectively engage in self-evaluation of their peers in the interest of advancing healthcare,” and the act was intended to benefit the general public and designed to prevent increased rates of death and illness that may be more likely in the absence of candid self-evaluation. The court stated that the act was not designed or intended to mitigate the loss of referrals a doctor may experience as a result of statements made about his medical performance, and any benefit a physician may derive from those confidentiality provisions in the act are incidental. The court concluded that the statute does not imply a private right of action. The appellate court affirmed the trial court’s decision to grant summary judgment in favor of the defendant.


The cases were reviewed by Bruce D. Armon, Esq. (barmon@saul.com) and Dawn Crowder, Esq. (dcrowder@saul.com) of Saul Ewing, LLP, in its Philadelphia office. Case summaries are prepared for informational purposes only and should not be considered legal advice.