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Illinois Adopts New Medical Staff Summary Suspension Standard

Effective June 1, 2009, the Hospital Licensing Act was amended in order to impose new standards and requirements before a hospital and medical staff can summarily suspend a physician's medical staff and clinical privileges. In addition, the amendment under [House Bill 0546](#) requires that certain steps be followed and rights be provided to a physician when a decision is made to seek an outside review of a physician's practices. A more detailed discussion of each of these new provisions is set forth below.

I. Summary Suspension Standard

Most would agree that the imposition of a summary suspension has the most significant adverse impact on a physician's career and reputation compared to any other form of disciplinary action. Hospitals and medical staffs typically will shy away from a physician applicant with a summary suspension on his or her record because these decisions are typically reserved for the most egregious situations in which the life or well being of patients and other individuals in the hospital are placed in serious jeopardy by the physician's actions or conduct. Although most medical staff bylaws limit suspensions to this scenario, there are other hospitals which allow, for example, a summary suspension where this is a violation of hospital policy or where the physician's conduct may be disruptive of the medical staff or hospital operations. These and other alternative grounds for a summary suspension are no longer allowed as a result of HB 0546.

A. The Standard and Documentation Requirements

1. A summary suspension of a medical staff member's practice can only be imposed where "continuation of practice...constitutes an immediate danger to the public, including patients, visitors, and hospital employees and staff."
2. Although this language is not new, the fact that a summary suspension cannot be based on any other grounds is made clear by a new requirement which states that: "A summary suspension may not be implemented unless there is actual documentation or other reliable information that an immediate danger exists."
3. Furthermore, "the documentation or information must be available at the time the summary suspension is made...."
4. The intent behind this amendment was to narrow the scope on which a suspension decision is made and to make sure that the information is based on hard evidence rather than rumor or innuendo. For example, an internal and/or external review

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in the form of minutes or a report which establishes that an immediate danger exists in the judgment of those who are empowered to impose the suspension would satisfy this documentation requirement. At times, documentation may not be immediately available. If a physician shows up in the surgical suite in an obviously impaired condition with the intent to proceed with a scheduled case, a phone call to the department chair from the scrub nurse or anesthesiologist regarding the physician's condition would likely qualify as "reliable information that an immediate danger exists." A summary suspension under these circumstances would be permissible.

B. Immediate Review of Suspension Decision by the Medical Executive Committee

1. The Act now requires that when a summary suspension decision is made, "the Medical Executive Committee, or other comparable governance committee of the medical staff as specified in the bylaws, must meet as soon as is reasonably possible to review the suspension and to recommend whether it should be affirmed, lifted, expunged, or modified if the suspended physician requests such review."
2. Although many existing medical staff bylaws already include an expedited review of a summary suspension decision by the MEC, this is now a mandated requirement for all hospitals.
3. Keep in mind that the Act already requires that a physician be given a hearing within 15 days after the suspension is imposed. The amendment does not give a specific time frame for when the suspension decision must be renewed, but, as a practical matter, the MEC or other medical staff governance committee should convene within three or four days at the latest.
4. Another reason for meeting quickly is that if the MEC, for example, decides that the suspension should be "lifted, expunged, or modified," this recommendation must be reviewed and considered by the hospital governing board, or a committee of the board, on an expedited basis. Again, given the 15-day limitation, the act of reviewing and possibly reinstating the suspension by the board all has to take place within a narrow time frame so as to allow the subsequent hearing to commence before the 15-day hearing requirement expires.
5. Recognizing that it may be difficult to convene a hearing within this limited time frame, not to mention the time it takes to prepare for the hearing, the Act also provides that the parties may mutually agree to a delay in the proceedings.
6. If the MEC upholds the suspension, most bylaws provide that the physician's hearing rights are immediately triggered. The Act does not require that this decision go first to the board for review. Although nothing under the Act would preclude such a review, the 15-day hearing requirement must be met unless otherwise waived by the parties.

C. A Hearing Is Not Required if Physician's License to Practice Is Suspended or Revoked

1. Most current bylaws require that a hospital inform a physician of his or her right to request a hearing if their license is suspended or revoked. This is typically viewed as an administrative or automatic suspension. Under the new Act, a hearing is no longer required.

II. New Standard for External Reviews

It is becoming more prevalent for medical staffs and hospitals to consider using third party reviewers to evaluate patient medical records where questionable care has been provided. The reasons for doing so include conflicts of interest, evaluation of a medical specialist for which there may not be a comparable peer, or to promote the goal of being fair and objective when evaluating quality of care issues. Under HB 0546, a hospital and medical staff must now adhere to new standards for obtaining and relying on these reports when taking some form of remedial or disciplinary action against a physician.

A. All Peer Review Must Be Conducted in Accordance with Medical Staff Bylaws

1. The Amendments make clear that any and all peer review activity affecting “credentialing, privileging, disciplinary action, or other recommendations affecting medical staff membership or exercise of clinical privileges, whether relying in whole or in part on internal or external reviews, shall be conducted in accordance with the medical staff bylaws and applicable rules, regulations, or policies of the medical staff.”
2. Stated differently, such activity cannot be conducted in accordance with only the hospital corporate bylaws or policies unless somehow incorporated or referenced in the medical staff bylaws.

B. Standards for External Reviews

1. Any “adverse” external review report that is “utilized” by the hospital or medical staff “shall be in writing and shall be made a part of the internal peer review process under the bylaws.”
2. Such report “shall also be shared with a medical staff peer review committee and the individual under review.”
3. Although the hospital and medical staff are only required to share these reports with a physician if “adverse” and if “utilized” by the hospital, a better practice is to make the report available to the physician under all circumstances on the basis of fairness and full disclosure.
4. If the committee or the physician under review prepares a written response to the report within 30 days after receipt, the board must take this response into consideration before implementing any final action on the matter if the action would “affect” the physician’s membership or clinical privileges.

III. Recommendations

1. Most likely, given the new standards, all medical staff bylaws/policies will need to be reviewed and amended in order to comply with HB 0546.
 2. Because the law became effective on June 1, 2009, you must comply with all of the suspension and external review requirements immediately even if your bylaws have not yet been amended.
 3. Summary suspensions must be based on the “immediate danger” standard. Although most courts will likely to defer to the judgment of medical staffs and hospitals as to what constitutes an “immediate danger,” the documentation or other reliable information on which the decision is based should fairly and reasonably support the existence of such danger in order to avoid or limit legal challenges.
 4. As a way to guard against a precipitous decision to summarily suspend a physician, we would recommend that at least two authorized individuals, as identified in the bylaws, be required to agree with this decision. Ideally, this should be a clinician, such as the president of the medical staff or department chair, and a layperson, such as the CEO. Others could be added to the list of eligible decision makers as long as there are two who are in agreement. If no agreement, then no suspension. This allows for a more balanced dialogue that should focus on whether immediate danger exists and if there are any other remedial measures available that will effectively protect patients, the public and hospital personnel other than a suspension.
 5. Develop suggested timing guidelines for review of a suspension decision by the MEC. Although a medical staff governance committee other than the MEC can be utilized, which may make sense if the suspension is initially imposed by the MEC, we would recommend that the review be provided by the MEC. Similarly, if the MEC lifts, expunges or modifies the summary suspension, you should define or suggest a specific time frame so that you have enough time to hold a hearing within 15 days if the board reinstates the suspension.
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6. When seeking a third party external review, remember to enter into an appropriate agreement that reflects the fact that this evaluation is part of a protected peer review assessment under the Illinois Medical Studies Act. Other suggestions include the following:

- Advise the reviewer that he or she is not to make any recommendations on what specific action, if any, to take. The reviewer should simply be providing an expert opinion about patient cases.
- Make sure that the reviewer will agree to serve as a witness to a possible hearing or litigation in advance of retaining him or her. If the reviewer will not agree, get a different one.
- Agree to the cost of the review up front.
- Specify the time frame in which the review must be conducted.
- Determine what role, if any, the affected physician will have in terms of preparing case summaries as part of the review and/or allowing the reviewer to contact the physician if there are any questions.

7. Share all reviews with the affected physician irrespective of whether the report is positive or negative.

8. The report should be made a part of the peer review record and taken into consideration before any final recommendation or decision is made by the board so as to maximize confidentiality and privilege protections.

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