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Ask the expert: What would you consider or define as a privilege restriction and who can or should be able to impose such a restriction?

This is an interesting question because it highlights a common error that I see in medical staff bylaws. Whether a decision is considered a "restriction" is sometimes in the eye of the beholder. The more relevant question is probably whether the imposition of any action that is considered a restriction triggers a fair hearing or similar right.

For example, I commonly recommend that the medical staff give department and committee chairs fairly broad latitude to use lesser forms of remedial measures, such as probations, monitoring, proctoring and required consultations, as a way to assist their colleagues when the medical staff identifies quality and utilization patterns. The goal is to use proactive and supportive means to get the physician back on track and to trigger a dialogue that is beneficial to all parties. That being said, there is no question that physicians would probably view even these actions as a "restriction," although there is no limitation on their clinical privileges.

If this approach makes sense, the key becomes how the term "restriction" is defined in the medical staff bylaws and whether any form of restriction will entitle a physician to a fair hearing and appeal. In my practice, I still see bylaws that give physicians hearing rights if their privileges are restricted but do not define restrictions. Suspensions, terminations, and reductions typically trigger hearing rights and, if affirmed, will likely require a report to the National Practitioner Data Bank.

If the bylaws do not define "restrictions," then the physician in question could argue that actions such as monitoring or proctoring trigger a hearing. In such cases, actions that are not reportable and are used to assist physicians will never be imposed because no one will want to go through an elaborate and expensive hearing process. As a consequence, patient care will suffer because the hands of department and committee chairs will be tied.

For this reason, the hospital and the medical staff should both define what is and is not considered a restriction. In addition, the bylaws should clearly spell out who within the organization has the authority to impose these measures and whether these decisions can be made unilaterally or in consultation with the medical executive committee.

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