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Credentialing & Peer Review
LEGAL INSIDER

Adopt proper procedures to ensure fair use of precautionary suspensions

Suspending a physician's privileges is a complicated and disruptive undertaking—for both the hospital and the physician. If not handled carefully and judiciously, a suspension could cause dissension among the medical staff members, interfere with the smooth operations of the hospital, and cause the hospital to incur significant legal costs. And of course, suspended physicians suffer financial losses and damaged reputations, and face potential consequences from licensing authorities, third-party payers, and other healthcare providers.

As a result, some hospitals see precautionary suspensions as a nonpunitive way of temporarily limiting the privileges of a physician that is more collegial than the traditional summary suspension. In essence, a precautionary suspension is an immediate limitation or denial of privileges prior to the completion of a professional review action. It is intended to last for a short duration.

The idea behind a precautionary suspension is to make the peer review process more flexible and impose a measure that protects patient safety but does not require a disciplinary measure and, in particular, avoids a summary suspension, says **Michael Eisner, Esq.,** a partner with Eisner & Lugli in New Haven, CT.

Further, a precautionary suspension, unlike a summary suspension, may alleviate the immediate need for a report to the National Practitioner Data Bank (NPDB). Used properly, a precautionary suspension can protect a physician's reputation and practice while protecting patients. But proper use of a precautionary suspension requires considerable advance thought and planning, specific bylaws provisions, and exacting compliance with procedures and regulations.

> **"Most problems with physician competence can be handled in a less confrontational way"**
> *—Todd Sagin, MD, JD*

Avoid suspensions when possible

Many hospitals overuse suspensions, says **Todd Sagin, MD, JD,** national medical director of The Greeley Company, a division of HCPro, Inc., in Marblehead, MA. Naturally—and appropriately—hospitals react quickly to protect patients when there is an indication that a physician's clinical skills or interactions with others may adversely affect patient care. A suspension of the physician is a remedy that protects patients from harm. But most problems with physician competence or demeanor can be handled in a less confrontational and less disruptive way, Sagin says, even as the hospital keeps patient safety concerns at the forefront.

As part of its peer review procedures, hospitals can

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Use caution when negotiating NPDB and other reports

When a physician agrees to relinquish privileges or resigns from the medical staff to avoid an investigation or corrective action, his or her attorney often will try to negotiate a settlement that includes an agreement not to make a report to the National Practitioner Data Bank (NPDB)—or at least to limit the information in the report.

Similarly, the physician may hope to influence the hospital's response to any inquiry that another healthcare provider makes about the physician.

Hospitals often are willing to consider physician requests regarding these issues but can properly engage in negotiations about required reports only in limited circumstances. However, through careful drafting of bylaws and by engaging in appropriate, educational forums of ongoing peer review, a hospital can take steps to ensure that it meets its reporting requirements while at the same time preserving a competent physician's ability to practice medicine.

Reports required if action results from, or is taken to avoid, investigation

Hospitals and other healthcare entities must make reports to the NPDB whenever a professional review action, based on reasons related to professional competence or conduct, adversely affects the clinical privileges of a physician or dentist for a period exceeding 30 days, says **Michael Callahan, Esq.,** an attorney with the law firm of Katten Muchin Rosenman, LLP**,** in Chicago. Hospital and healthcare entities also must report any voluntary surrender or restriction of clinical privileges that takes place while the physician is under investigation or to avoid investigation.

Reports must be made to the NPDB within 15 days of the action.

Hospitals also must be aware of state reporting requirements, which may be broader than the requirements established under federal law, cautions **Brian Foley, Esq.,** of Schenk, Price, Smith & King in Morristown, NJ.

For example, in New Jersey, a hospital must report to the State Board of Medical Examiners and the State Board of Health any employed, contracted, or privileged physician who "voluntarily resigns from staff or relinquishes any partial privileges to perform a specific procedure while a hospital is reviewing the practitioner's conduct or patient care or has through any member of the medical staff or administrative staff expressed an intention to do so."

Thus, in New Jersey, even a threatened investigation is reportable to state authorities. Although New Jersey's statute is particularly broad, many other states require more extensive reporting than the federal government does, Foley says.

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NPDB

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Reportable actions should be a last resort

As a matter of practice, hospitals should impose actions that require a report to the NPDB only as a last resort, Callahan says. Except in the rare case in which a serious problem arises and there was no prior warning regarding the practitioner, hospitals should impose suspensions and privilege restrictions only after all other attempts to modify physician behavior—such as meetings to discuss clinical issues, proctoring, or other appropriate interventions—have failed, he says.

Ideally, when a situation has come to the point that requires the hospital to move toward corrective action, the physician's mentor, department head, or other colleague can offer him or her the opportunity to avoid a situation that requires a NPDB report.

Timing, procedure affect NPDB requirements

Hospitals hoping to avoid situations in which NPDB reports are mandatory can develop their peer review and disciplinary procedures with this in mind without "gaming" the system or disregarding their responsibility to report, says Callahan.

For example, hospitals are accumulating tremendous amounts of data about physicians through pay-for-performance programs, ongoing monitoring in accordance with Joint Commission requirements, outcomes profiling, etc. Reviews of physician performance using those data are ongoing in many institutions, and such reviews are not based on a concern about a physician's competence or conduct—although the review itself may raise such concerns.

To reflect the reality of these "routine" reviews, many hospital bylaws provide for something called an administrative review or a preinvestigative review. The provisions establish that reviews of physicians are conducted on an ongoing or intermittent routine basis for specified purposes. If such a routine review raises a red flag about a physician, and interventions fail, Callahan says that a physician who voluntarily resigns or reduces his or her privileges in that circumstance has not done so as a consequence of, or to avoid, an investigation. This is true because the bylaws specifically define such reviews as routine and not initiated in response to concerns about the physician's competence or conduct. Therefore, the hospital need not report the action to the NPDB (although some states may require a report, Foley notes).

Similarly, according to the *NPDB Guidebook* , an investigation must be carried out by the healthcare entity, not an individual member of the medical staff. A focused chart review by the physician's department head would not be considered an investigation by the healthcare entity, but such a review undertaken by the hospital MEC would constitute a NPDB-reportable investigation, should the physician voluntarily resign or limit his or her privileges as a result.

Thus, physicians can submit a voluntary resignation, relinquishment, or reduction in privileges when a review

Serious consequences for delays, failures in reporting data to the NPDB

The National Practitioner Data Bank (NPDB) requires hospitals and healthcare entities to file reports within 15 days of an adverse action or a relevant voluntary surrender. A hospital or healthcare entity that fails to make timely reports is subject to fines and may lose its immunity under the Health Care Quality Improvement Act, says **Brian Foley, Esq.,** of Schenk, Price, Smith & King in Morristown, NJ. In addition, delays in submitting required reports also bring consequences. In recent months, several large healthcare systems have received letters from the U.S. Department of Health and Human Services (HHS) asking them to explain delays in reporting adverse actions. These letters may signal increased HHS attention to this issue, Foley says.

States also react strongly to delays in required reports. Foley notes that a delayed report to the New Jersey Board of Health resulted in substantial fines and even a threat to suspend the hospital's license to operate. He suggests that hospitals work closely with legal counsel to ensure that all required reports are made timely and appropriately.

is being conducted by an individual—rather than a hospital peer review body—and such an action is not reportable to the NPDB, Callahan says. However, again, hospitals must consult their state laws to determine whether such an event is reportable to local authorities.

Content of NPDB report depends on timing

In the event that the hospital chooses to make a report, or must make one under the law, the contents of the report sometimes can be negotiated. Again, timing is a critical element in this decision, with flexibility on these issues diminishing as the process moves forward.

Callahan presents the example of a physician who is under investigation for failing to complete charts in a timely manner. If the physician resigns his or her privileges during an ongoing investigation, the NPDB report might simply read that the physician resigned while under investigation for failing to comply with charting requirements. This assessment is accurate and truthful, and puts on notice any healthcare organizations to which the physician may apply in the future that the physician has a pattern of poor record-keeping.

However, if the physician proceeds to a hearing on the issue, the hearing committee may make a finding of fact that the physician's failure to complete discharge summaries on time led directly to a fatal error on the patient's subsequent admission to the emergency department. Such a finding may appear in the NPDB report, making the incident far more difficult for the physician to overcome as he or she seeks employment elsewhere.

Use caution if MD seeks negotiated disclosure

There is another aspect to the NPDB reporting issue: How will the hospital respond when other healthcare facilities seek information about a physician? Recognizing that there is not much flexibility in the hospital's NPDB reporting obligations, many physicians' attorneys will attempt to negotiate a response to these inquiries that puts the physician client in the best light possible.

In the past, hospitals may have agreed to respond simply by verifying the dates of the physician's association with the facility. But Callahan points out that the decision in the recent Kadlec case has made hospitals wary of failing to reveal pertinent details about their experience with a physician.

Note: In 2006, a jury awarded more than $4 million to Kadlec Medical Center in Richmond, VA, after finding that two practitioners at a New Orleans hospital made intentional misrepresentations to Kadlec in their recommendations for a former partner.

Foley notes that hospitals lose their immunity from liability for accounts of peer review actions only if the disclosure was made in bad faith or with malice. Thus, a truthful recounting of the events that led to the physician's departure or limitation of privileges is protected. However, as the Kadlec case indicates, hospitals risk substantial findings of liability if they fail to provide pertinent information that subsequently leads to the harm of a patient at another institution.

Thus, the more prudent course is to err on the side of disclosure. Callahan suggests that facilities shift the burden of disclosure to physicians by requiring an absolute waiver from them when they apply and reapply for privileges. Such a waiver permits a facility to make a full good-faith disclosure of any relevant incident or pattern when queried by another healthcare entity. In the event that such a waiver was not obtained as part of the original privileging process, hospitals should attempt to get an absolute waiver when they receive an inquiry from a third party after the physician departs.

This is an option that can work regardless of whether the physician agrees to sign, Callahan explains. If the physician provides the waiver, then the hospital can explain the circumstances truthfully without fear of liability to the subject physician. If the physician refuses to give a waiver, a hospital can indicate to the querying facility that it will not provide additional information in the absence of an absolute waiver—and it can reveal that the physician has refused to provide one.

This puts the querying facility on notice that there is a problem and shifts the burden to the physician to provide the information. ■