

## **PBLD : You think you work with an incompetent surgeon: so now what?**

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### **Objectives:**

1. Understand the strengths and limitations of how competency is assessed.
2. Understand the medical staff processes that are used when a complaint is lodged against a medical staff member regarding their competence.
3. Understand the balances attempted between protecting the provider, the institution, and the patient when complaints arise alleging medical incompetence.
4. Understand alternative methods to resolving issues regarding medical competence.

### **Case:**

Dr. Jones is an obstetrician gynecologist who is 5 years out from his residency training program and who works at your hospital. Recruiting physicians in general and obstetricians in particular to your hospital is very difficult. Dr. Jones is one of a three-member OB-Gyn group who is the only OB-Gyn group practicing at your hospital. You have witnessed him freeze in the middle of a cesarean section. You have heard him give verbal orders that you believe are contrary to the standard of care. During surgery he is frequently unable to complete simple laparoscopic procedures and routinely calls in his partners to help him finish. OR chatter about Dr. Jones is routinely dismissive of his abilities and he is widely disliked as an individual. You believe that he is incompetent and a danger to your patients.

1. How do you establish whether or not Dr. Jones is competent? What methods can you use to support or refute your belief?
2. Where do you take your concerns about Dr. Jones?
3. What difference would it make if his group is responsible for a significant portion of the revenue generated by your hospital, or if Labor and Delivery is a service line that the hospital administration is committed to?

When you approach Dr. Jones with your concerns he vigorously denies that he has any professional issues and accuses you of having a vendetta against him because you dislike him personally. His partners refuse to discuss the situation with you. You take your concerns to the Chief of the Medical Staff, and insist that she do something to correct the situation.

1. What actions will the CMO take? How does the hospital investigate this question? What are the processes used during this investigation?
2. What resources are available to the hospital to help with this situation?
3. What resources are available to help the physician deal with this situation?
4. What are the potential outcomes of a hospital investigation of Dr. Jones?
5. Under what circumstances must Dr Jones be reported to either the National Practitioner Data Bank or to the State Medical Board?

The investigation done by the hospital is generally supportive of your concerns, and an adverse credentialing action is recommended. Dr. Jones and his lawyer take the hospital to court and are able to force them to back down.

1. What options do you have for dealing with Dr. Jones?

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2. Do you have any liability in bringing forward more concerns about Dr. Jones competence?  
Do you have any liability in not bringing forward concerns about Dr. Jones' competence?
3. Do you have any legal vulnerability in the event Dr. Jones continues to practice and you must provide anesthesia for his patients?

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**Discussion:**

Incompetent physicians are an unfortunate fact of life in medicine. Gone are the days when it is acceptable to “sweep a problem doctor under the rug” or allow them to move to a different institution. In some states (including Wisconsin) you can face liability if you do not report evidence of the incompetence or impairment of a colleague. At the same time, managing an incompetent physician has gotten more difficult. You may be convinced that a physician is incompetent but have difficulty substantiating that. Some of your colleagues may disagree with your opinion; a few may disagree vehemently.

This discussion will not address the disruptive physician, which is a different and often easier problem. However, there is often overlap between these issues; physicians with competence concerns can try to mask their inadequacies by abusive and disruptive behavior to keep colleagues and coworkers on the defensive. A case can be made that a disruptive physician is incompetent along the axes of professionalism and interpersonal relations. However, we will focus instead on the question of competency and the medical staff processes used when questions arise.

**Establishing Incompetence:**

Most incompetent physicians are competent in some or most of their practice; it is unusual to find physicians who are wholly incompetent. There are different kinds of competence often classified as technical, judgment, knowledge, and personal skills competencies. Competence of physicians under ordinary circumstances is documented by external measures: CME completion, board certification or recertification, maintenance of licensure, participation in medical staff governance, and patient complaints. These measures poorly reflect the clinical competence of a provider and instead offer a convenient way to provide legal cover to the institution or group. Somewhat stronger are measures that come from Quality Improvement data such as postoperative complication rates, blood utilization, or unexpected ICU usage. Involvement in adverse and sentinel events or being named in RCA (Root Cause Analysis) findings can also provide evidence related to competence. This type of data should be included with the material in the physician’s OPPE (Ongoing Professional Practice Evaluation) or FPPE (Focused Professional Practice Evaluation) files. However, it is rare to find a real outlier in these measures and most surgeons who you have competence concerns about will lie within 2 standard deviations of the mean of whatever metric you are looking at. This is particularly true of hospitals with small medical staffs, where the concerning physician themselves will contribute relatively greater weight to the mean.

Often the strongest support for a contention of incompetence comes from the review of specific cases where the care is alleged to be below standard, particularly if associated with a bad outcome.

Case review should begin internally as part of the institutional QI or Peer Review processes, well before the question of competency is raised at the medical staff level. The more clear the deviation from standard occurs and the more often these types of events occur the stronger the case is that the provider has competency issues. Case reviews are most often performed by other members of the surgical group but may also be done by other medical staff, particularly from associated specialties. These reviews often involve discussions with other individuals involved in the care of the patient and focus on some of the same areas as do competency concerns: the medical assessment of and care for the patient (medical knowledge), the appropriateness of the procedure (judgment), the technical skill with which the procedure was performed, and appropriate use of consultants, medications, blood, and hospital resources (systems-based practice). Cases that come through this process with unanswered questions or unresolved controversies may be submitted for external peer review, where a physician in that specialty from another institution who is mutually agreed upon by the surgeon, the group, and the hospital does a case review and renders an opinion as to the care provided.

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**Investigating a Complaint; Medical Staff Processes**

When questions arise as to the competency of a member of the medical staff, usually a significant amount of the preceding activities have already occurred. They have usually been on staff for some time and have accrued at least some track record of cases, outcomes, metrics, and case reviews. It is from this activity (and OR staff and Medical Staff scuttlebutt) that the questions about the provider emerge. The earlier problems can be identified and remedial measures taken generally the easier it is to manage the situation.

You have several avenues available to raise concerns about another provider. If your relationship with them is good enough it may be possible to approach them directly. Alternatively, work through their group, Department Chair, or an affiliated group to find a peer they trust who can approach them respectfully. If not those, then you can work within your hospital's Medical Staff structure. The route you take will depend on the organization of your Medical Staff and the Hospital Bylaws but could include talking to members of the Credentials or Physician Wellness Committees, Hospital QI or Peer Review, or the Chief or Vice-Chief of your Medical Staff. Choose the route that you think will give you the best chance to be heard, but you must provide data to support your contention that there is a competency issue. Unsubstantiated allegations may support the perception of a vendetta on your part.

Merely "firing" a provider is rarely a good solution for the issue and should not be your goal when raising these issues. It raises the problem of recruiting a replacement (will they be better or worse?), service coverage issues, and revenue issues for the group and the hospital. Remediation is almost always preferable to punitive action. Threatening a physician's self-esteem and livelihood will provoke a much stronger negative reaction than will addressing issues from a genuine desire to help your colleague. Every opportunity should be made available to the physician to assist with life stressors, psychological problems, or substance issues whether or not they are perceived to contribute to questions of competency. If such assistance is provided to the physician, their confidentiality must be respected and you are well-advised to be perceived as supportive of the effort. Personal animosity will undermine your credibility, as will participating in OR gossip and backstabbing. You must maintain a professional, non-confrontational relationship with the physician. You and your colleagues almost certainly discuss this physician in private but once you decide to take some sort of action you must treat everything subsequent to that as confidential. Continuing to discuss the issues except under the auspices of a Hospital Review may leave you and your group open to allegations of a vendetta.

When questions are initially raised, most situations are addressed in an informal and ad-hoc manner, with some documentation. Often the provider will realize or can be made to see that they have problems, particularly if they are offered some concrete steps that they can take to improve the situation. Early intervention can be nonthreatening and non-punitive, confidential, and protective of the provider and their livelihood as well as their patients. Early intervention can use the same avenues as routine case review and QI but can be supplemented with observation and mentoring or proctoring to help the provider in areas where they are weak.

It is unfortunate but true that revenue, service coverage, and recruiting issues will play a role in the evaluation of the physician. A lower level of competence will be accepted in institutions that have difficulty recruiting, simply because the alternative to this person practicing may be an inability to offer the service. It may be perceived that interruptions to service lines that are very profitable or very important to the hospital cannot be tolerated.

If a provider refuses or is unable to see that there are problems there will likely be steadily escalating steps, discussion, and documentation. With each step higher levels of hospital administration may be involved and the data on which the provider is being questioned must be stronger. As this progresses the Chief of the Medical Staff, if they are convinced that there is likely to be merit to the concerns about the provider, can institute more rigorous reviews, can mandate that the Department conduct a FPPE, and can send cases for external review without the consent of the provider.

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A formal investigation or review of a provider's competence is generally initiated by someone in the C-Suite (often the Chief Medical Officer), or perhaps a Department Chair or Service Chair. Once a formal investigation is begun it usually can't be stopped before its conclusion. Generally the CMO either runs the investigation or has a Medical Staff Subcommittee perform it and report to him / her. Individuals are chosen who have had no role prior regarding questions about the practitioner and who preferably have some expertise related to the specialty of the provider. Alternatively, the CMO can refer an investigation for external review.

The report of the investigation is sent to the CMO and the C-Suite. The provider must have the opportunity to see and rebut the report; exactly how and when will depend on the processes described in your Medical Staff Bylaws.

Ancillary issues:

Two other issues are worth noting briefly. One is that it is a time honored practice to allow a questionable provider to move to another institution to avoid the consequences of a competency review. This practice is no longer acceptable \*unless the receiving institution is informed as to the questions that have arisen regarding the provider's competence\*. This is a very murky area legally, as reporting unsubstantiated allegations may lead to liability for restraint of trade or for libel or slander. A very rough rule of thumb is that anything that may be considered rumor or OR chatter should not be reported to the new institution, but any unusual review of the provider's practice (and definitely if a formal investigation has begun) must be communicated to their new institution.

The second topic worth a quick review is the possibility of a Summary Suspension. Most Medical Staff Bylaws permit this if there is an immediate risk to patient safety. It is done by the CEO with the advice and approval of the Chief of the Medical Staff. Immediate written notification must be received by the provider and constitutes a request for corrective action. The practitioner has 10 days to request suspension of suspension of privileges while corrective action hearing proceeds, and if not lifted a Summary Suspension must be reported to the Wi Medical Examining Board (MEB) and the National Practitioner Databank (NPDB) within 30 days.

**Possible Outcomes of a Medical Staff Investigation**

A formal inquiry which documents problems in part or all of a provider's practice can include several different types of recommendations. Providers can receive a verbal warning; a letter of reprimand; probation; or a requirement for consultation. Providers can retrain (either voluntarily or involuntarily) in certain areas of practice. They can also voluntarily relinquish parts of their practice and / or credentials. This does not require a report to either the Wi MEB or the NPDB when it happens. Involuntary limitation of credentials is also another viable option, if the provider's incompetence is limited to specific areas or procedures. Most onerous is a complete suspension of privileges. Recommendations for involuntary suspension or revocation of part or all of a Provider's privileges and Medical Staff membership must be reviewed by and approved by your Medical Executive Committee or equivalent. Your Bylaws must specify the procedures for due process: formal notice to the provider, an adequate amount of time for the provider to review the report and recommendations, the right to challenge those before a Fair Hearing of the Executive Committee, and the right to appeal an adverse action. Ultimately a decision to restrict credentials will be made by the C-Suite and the Hospital Board. The Hospital Board is the ultimate "decider" for this process. Once again the provider has all the rights of due process when dealing with the Hospital Board, with the exception that a Fair Hearing may not be granted if one has already taken place at the Executive Committee. Any involuntary adverse action regarding a provider's credentials must be reported in 30 days after it occurs to the Wi MEB and the NPDB.

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There is a likelihood that any such decision will result in a legal challenge by the physician and their attorney. This lawsuit would seek an injunction to prevent reports to the MEB and NPDB, and would seek to overturn restrictions on the provider's practice due to allegations of procedural or due process errors, factual errors in the investigation, or other errors in the investigation such as bias or an anticompetitive agenda on the part of the investigating body. The ultimate outcome of that lawsuit will depend on the strength of each case and negotiations between the physician's attorney and the hospital's and may very well result in a physician's return to practice, although perhaps with some restrictions or caveats. The hospital is allowed to void MEB and NPDB reports if the facts of the case change (for example, if the lawsuit brought by the provider is lost by the hospital).

**Longer Term Outcomes**

An adverse credentialing or medical staff membership decision, particularly if it lasts more than 30 days, involves loss of all privileges, or results in NPDB and MEB reports, makes it very difficult for a provider to find employment in their field. They may be able to find work at institutions that are desperate for staff, or they may be able to segue into related fields such as insurance or disability evaluations, but often they are forced out of medicine entirely.

What if the hospital ignores or whitewashes your concerns? Alternatively, what if the provider returns to practice as a result of legal proceedings which restore his credentials? If after the review is complete the physician returns to practice and in your view continues to practice incompetently, you are placed in a severe dilemma. Participating in the care of his patients could expose you to liability in the event he has more poor outcomes. On the other hand, refusing to care for his patients may be seen as evidence of unprofessional behavior or dereliction of duty on your part. You are in a much stronger position if you are not alone in refusing to care for this physician's patients. However, even if your entire group refuses to provide care the group may be subject to a lawsuit by the surgeon. Sometimes a portion of your medical staff will elect to "vote with their feet" and attempt to find employment in an institution away from this problem provider. Your best course of action may be to continue to document objective evidence of incompetence, obtain legal advice to protect yourself, and consider your own options.

There is an ethical imperative to report incompetent colleagues both from patient safety and from professionalism perspectives. Many state medical boards (including Wisconsin) require providers to report colleagues that they have evidence are committing malpractice. According to the Wisconsin Medical Examining Board: "The duty to report codifies ethical obligations which exist in policy statements of the Wisconsin Medical Society and American Medical Association and creates a duty similar to what exists in the laws of many other states. It was written with the knowledge that physicians are in the best position to be aware of colleagues who may engage in a pattern of unprofessional conduct; engage in acts creating an immediate or continuing danger to patients or the public; may be medically incompetent; or may be mentally or physically unable to safely practice medicine. Failure to report such physicians may lead to discipline by the MEB."

The triggers that require a report to the MEB are knowledge of a colleague who: 1. Engages in a pattern of unprofessional conduct, 2) Creates an immediate or continuing danger to one or more patients or to the public, 3) May be medically incompetent or 4) May be mentally or physically unable to safely engage in the practice of medicine or surgery. Note that you are not required to file an MEB report while there is an institutional review in progress; that institutional review is considered to be the first step in addressing a potential problem physician. However, if a review has been completed and in your *\*strong\** opinion a danger to patients still exists, then you may be obligated to file a report with the MEB. Reporting an incompetent colleague may leave you open to reprisals from the physician, their group, or the hospital. The Hospital Board that for whatever reason readmitted this physician to

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practice may not respond favorably to an MEB report. If the perception arises that you are conducting a campaign against the provider your colleagues and the hospital may rally around them and line up against you.

**Conclusions:**

Addressing a colleague who you believe to be incompetent sucks you into murky areas of defining competence, helping colleagues with difficulties, and Medical Staff processes. The best approach is generally data or example-driven, supported by the consensus of your medical staff leaders, and intended to help the provider address their difficulties. Once the process has moved into a formal review the likelihood increases that someone will get hurt and someone (everyone?) will be dissatisfied with the outcome. Your best route is to approach the issues and the provider dispassionately and constructively, document thoroughly, follow Medical Staff Bylaws to the letter, and trust and hope that your institution will help the provider come to a productive solution.

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Appendix A: Wisconsin Medical Examining Board regarding reporting requirements

The Physician's Duty to Report – 2009 Wisconsin Act 382 On May 18th, 2009, the Physician's Duty to Report Act was signed into law. 2009 Wisconsin Act 382 places a legal duty upon all licensed physicians (MDs and DOs) to report the unsafe practice of other physicians to the Medical Examining Board (MEB) under circumstances detailed in the law. This bill was initiated by the MEB in an effort to improve its ability to protect the public from physicians who may pose a threat to their patients. The duty to report codifies ethical obligations which exist in policy statements of the Wisconsin Medical Society and American Medical Association and creates a duty similar to what exists in the laws of many other states. It was written with the knowledge that physicians are in the best position to be aware of colleagues who may engage in a pattern of unprofessional conduct; engage in acts creating an immediate or continuing danger to patients or the public; may be medically incompetent; or may be mentally or physically unable to safely practice medicine. Failure to report such physicians may lead to discipline by the MEB. A summary of the law is available in the July 2010 MEB Newsletter.

This law applies to all licensed physicians without exclusion and thus may in some instances create a conflict for some physicians, particularly those engaged in medical management/peer review and those physicians treating other physicians for psychiatric and substance abuse problems. Additional guidance about possible conflicts can be located in the March 2011 MEB Newsletter.

Reports from physicians about unsafe practice should be made to the Wisconsin Department of Safety and Professional Services (DPS) in writing and contain sufficient detail to allow appropriate investigation. Note that the filing of a complaint does not automatically result in a disciplinary action. Actions by the MEB are judicial in nature and respondents (those reported) have full rights to due process before any adverse action may be taken against them.