Defending Doctors in Disciplinary Proceedings

BY FRED M. ZEDER
Discipline Proceedings

Medical discipline essentially consists of two different types of proceedings: those that are carried out by hospital quality assurance committees under the auspices of peer review, and proceedings before the Arizona Medical Board. The total number of investigations in both venues is difficult to determine because the hospital process is strictly confidential. The Arizona Medical Board is one of the most active boards in the country, currently processing 605 investigations. Since the beginning of fiscal year 2003, it has handed out 120 disciplinary orders. Similar investigations are carried out by other Arizona licensing boards, including those responsible for overseeing our state’s dentists, chiropractors, nurses, naturopaths, podiatrists and psychologists.

Although investigations and proceedings by the board and by hospitals occur in different venues, they are similar and interrelated. Generally, the proceedings in both purport to follow an inquisitional rather than an adversarial format. This means that both usually begin with one or more information-gathering interviews designed to clarify the events giving rise to the investigation. In both venues, doctors under investigation are entitled to elemental due process under rules applicable to administrative proceedings or as spelled out in hospital bylaws. Discipline in either venue can set in motion a cascade of events that will have a far-reaching negative impact on the physician’s practice.

A doctor who is disciplined in one venue may face consequences in another. For example, hospital peer review committees are required to report findings of unprofessional conduct to the Medical Board. Federal law requires that discipline in either forum be reported to the National Practitioner Data Bank. Hospitals, regulatory agencies and professional associations access this bank more than 3.5 million times a year. By contract, doctors are required to report disciplinary actions to their own professional liability carriers and to their patients’ health insurance plans.

License revocation or loss of hospital privileges has obvious ramifications. But even less severe discipline can have serious economic consequences, as well. Doctors who are placed on probation, issued letters of reprimand or censure or who have their licenses or hospital privileges restricted may find that they are ineligible for reimbursement for services provided to health plan patients, or they may lose their malpractice insurance. If a doctor loses his
malpractice insurance and can’t find or afford a replacement carrier, he will find himself ineligible to hold hospital privileges.

The Path of a Case

The successful resolution of a disciplinary case is always easiest to achieve if the case is properly handled right from the beginning. In a state licensing case, the beginning is easier to determine because the state is required to give the doctor timely notice of a complaint. In the hospital setting the doctor can often identify a brewing problem from a series of hostile encounters with other members of the hospital’s medical or nursing staff.

Any time a peer review committee reviews a series of a doctor’s cases or any time a single case proceeds beyond the lowest committee echelon, a corrective action proceeding may be in the offing. If the hospital sends a doctor’s case for outside review, that means that the hospital’s own staff committees already have decided there is a serious problem and are intent on gathering “unbiased” expert opinion evidence in preparation for a corrective action hearing.

In both forums, there is usually a period in which the disciplinary authority investigates and gathers information before deciding whether discipline is warranted. In both forums, the doctor will be required to respond, often in writing or through interviews, to specific questions about patient care. This is the time that good legal advice can be most helpful. The content and tone of the doctor’s initial and subsequent responses can have significant impact on the matter’s future course.

Because the response may become important evidence, when contacted by an investigator or a review committee, the doctor should be both cooperative and defensive. Great care should be taken to be sure that any oral or written explanation is accurate and complete. Before responding, the doctor should insist on seeing any patient statements obtained by the board or the hospital. Explanations should never be offered until the doctor has had a chance to examine medical records and any other materials that may assist in recalling precisely what occurred.

If the disciplinary authority has already had the case reviewed by an expert, a copy of that review should be requested. It is important that the doctor’s response be well reasoned and knowledgeable in both the medicine and the law applicable to the case. Invariably, it will be closely scrutinized by the authorities’ reviewing experts and may serve as a basis for their opinions on the case. Having an attorney with experience in disciplinary proceedings review the response before submission can sometimes avoid serious problems down the line.

Even with a strong case, winning a disciplinary hearing is difficult.

When a death or serious injury is involved, the doctor should get his or her own early independent expert evaluation to determine how the case should be handled. To claim protection from later discovery, it must be clear that you are seeking these reports as the doctor’s attorney in anticipation of litigation. Whenever possible, this should be done before the doctor responds to queries. Doctors often think that the complaint is without merit, so they do not pay much attention to the investigation. They are often reluctant to foot the costs for their own expert’s review, believing that their peers or the Board will ultimately have to acknowledge the correctness of their position.
Addressing the Charges

Some physicians have a fundamental misperception that their state medical boards are favorably inclined toward them. What they don’t understand is that boards have to justify their existence. They do this by disciplining as many physicians as they can—and by putting some of them out of business. Until they experience it firsthand, many doctors don’t realize that as the disciplinary authority invests time and effort in an investigation, a momentum builds toward rather than away from a finding that discipline is warranted. Simply denying any wrongdoing is often not enough to close the investigation. Sometimes being sure that the disciplinary authority is aware of all exculpatory evidence or supplying the authority with a favorable and credible expert opinion can reverse the momentum.

As a general rule, investigations don’t fall out of the sky on a totally blameless practitioner. In the vast majority of instances, the doctor has done something to justify scrutiny. On the other hand, a reason for scrutiny or even criticism is not necessarily justification for discipline.

With this in mind, one important step to successful resolution of many disciplinary charges is often a cautious acknowledgment by the doctor that there is room for improvement. Medical boards and hospital committees are charged with protecting patients. If your client gives them reason to think that she is unwilling or unable to learn from her adverse outcomes, it will encourage them to take action to protect patients from her. The doctor’s willingness to acknowledge room for improvement demonstrates that the doctor is reasonable and will cooperate, as long as the disciplining authority acts reasonably. When the doctor indicates a willingness to cooperate, the disciplinary authority is more likely to be willing to explore creative solutions.

If handled properly, admitting room for improvement is not the same as pleading guilty. But be careful: The line...
between an expression of honest humility and an admission that will be used against your client is often difficult to draw and harder to walk.

Resolving One Case

Take, for example, the case of a young obstetrician who made a series of arguably poor judgment calls during the course of three complicated forceps deliveries. After the hospital’s obstetrics committee reviewed the cases, it passed the matter to an ad hoc committee to determine whether the hospital should submit the matter for independent expert review. At that point, the case could have gone two ways.

One way would be for the doctor to deny there is a problem. The hospital would then obtain the review, which probably would have resulted in a finding of substandard care. That in turn would have led to the issuance of a “Corrective Action Notice,” the first step down the road to a hospital hearing and the ultimate imposition of some sort of restriction on the doctor’s staff privileges. The restriction would be reported to the Medical Board, the Data Bank and so on.

Another more constructive resolution was used. Before the review, the doctor proactively proposed an arrangement with a mutually approved mentor to review the medical records of her complicated delivery cases with her and consult before any future forceps delivery was attempted for a period of one year. The doctor agreed to pay the mentor for this in-service training exercise and authorized the mentor to report any problems directly to the chief of the obstetrics committee. The committee acknowledged that this mentoring agreement was a form of voluntary in-service training as opposed to an imposed restriction on the doctor’s privileges.

If, at the end of the year, the mentor and the committee deemed the doctor’s performance acceptable, the mentoring was to be over and the past cases could not serve as a basis for any future disciplinary action. If her performance was unacceptable, the past cases and any substandard cases occurring during the year were to be submitted for independent review.

In this solution, the hospital and patients were protected from a quality of care standpoint, and the doctor did not have a mark on her public record. So long as the year passed without incident, the doctor and the hospital were spared the considerable time, expense and anguish of a corrective action proceeding, which could have been more arduous than a malpractice trial.

The line between an expression of humility and an admission is difficult to draw and harder to walk.

This solution was only reached because both sides were willing to be flexible and cooperate early on, before the case became a disciplinary proceeding under the hospital’s bylaws and before the hospital obtained an expert opinion putting it on notice that the doctor had committed unprofessional conduct—malpractice—requiring a report to the Medical Board.

Therefore, a successful resolution to a disciplinary proceeding is one that assures quality of care and corrects the problem giving rise to the charge against the physician with a minimum of interference to the doctor’s practice and damage to her pocketbook. Under the best of circumstances, the resolution is one that does not constitute corrective action by the hospital or discipline by the state and therefore does not require a Data Bank report.

Prognosis of the Doctor’s Case

There are cases in which a creative solution is impossible because the disciplinary authority is unable to act reasonably—or just not interested in doing so. Medical boards are concerned with the public’s perception of their effectiveness. Occasionally a situation comes along in which publicity compels the board to undertake an investigation or take the investigation further than otherwise warranted by the medical facts.

Hospital peer review may be used for ulterior motives. For example, the review may be inspired and conducted by those with an economic incentive to exclude the investigated doctor from the medical marketplace. When the hospital acts in bad faith, those involved are subject to counter-suit for damages. Otherwise hospitals, their committee members and the Medical Board are immune from damage suits under state and federal law. The only remedy is to appeal the authority’s action and obtain an injunction. On appeal, the court will not retry the case. The authority will only be reversed if the court finds its action was illegal, arbitrary or capricious.

There are cases in which the doctor is right and the disciplining authority is just plain wrong. It may be that the authority is wrong on the facts or is misinterpreting the appropriate standard of medical care. These cases must be prepared for hearing with the skill and thoroughness that good medical malpractice lawyers use in preparing their civil cases for trial. They also must be prepared with the understanding that mastery of the medicine is more likely to carry the day than courtroom theatrics. Boards are not totally unmoved by a gallery packed with the your client’s supporters. Unfortunately, they are not moved very far.

Both board and hospital proceedings must be conducted in a manner that affords the doctor basic legal fairness pro-
This does not mean that disciplinary hearings are held on an even playing field. They are held before panels comprised mostly of other doctors who are familiar with the system. The panel members know that before a case ever gets to a hearing, other medical professionals, during the investigation or committee reviews, already have decided that the doctor has provided sub-standard care or committed unprofessional conduct. This creates a predisposition to find against the doctor.

How far this predisposition goes will depend on the forum involved and who sits on that panel. Bottom line, this predisposition means that even with a strong case, winning a disciplinary hearing is difficult.

How difficult is it? That always depends on the circumstances, but some generalizations can be made.

• Winning may require you to enlist the services of world-class experts with reputations that the panel will have to acknowledge.
• Winning will require the effective preparation and presentation of all defense witnesses and, in particular, your client.
• Winning will require you, in effect, to carry the burden of convincing the panel that your client is clearly right on the facts and the medicine.
• Winning a disciplinary hearing is possible but is always an uphill battle where just being right may not be enough.

For these reasons, a good disciplinary lawyer should think long and hard before counseling a doctor to roll the dice. And in those cases where the dice must be rolled, you must be prepared to give 110 percent effort to your client’s defense.

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endnotes

1. See the Board’s Web site: www.bomex.org.
2. ARS § 32-1451(A).
3. 42 USC §§ 11132,11133.
4. Once the hospital has obtained an expert opinion indicating that the doctor is guilty of unprofessional conduct—malpractice—a report to the Medical Board is required. ARS § 32-1451(A).
5. The Board can issue an advisory letter, which is a nondisciplinary action. ARS § 32-1401.3.