



## Commentary

# Process Not Litigation: Dealing with Physician Incompetence and Impairment in a Hospital

*By Stephen Kline, Jeremy Etherington, Joanna Bates*

**S**t. Paul's Hospital is a busy teaching institution in the urban core of Vancouver, British Columbia. Although the standard of care is high, its Medical Advisory Committee (MAC), which assumes responsibility for monitoring the quality of hospital-based physician practice, occasionally becomes embroiled in issues of physician incompetence or impairment. In the absence of a clear and responsible process safeguarding both the privacy and integrity of the individual, on the one hand, and the need to maintain strict standards of care, on the other, concerns brought to the MAC may quickly escalate into legal battles between physicians and the hospital when more reasonable solutions should prevail. Following several incidents of this nature, the MAC charged a subcommittee to develop a policy that would balance the rights and responsibilities of the individual physician against those of the hospital, to try to pre-empt legal action. This policy would apply to all residents and staff.

### BACKGROUND

A literature search was conducted to identify articles and documents to support the development of such a process. (1 - 5) The broad mandate to review physician performance is established by the Province of British Columbia under the Hospital Act, which charges the hospital medical staff to "discipline its own members in such a manner as it thinks fit and, if circumstances warrant, recommend to the board the suspension, restriction, cancellation or non-renewal of the permit of a member to practice within the hospital." As outlined in a joint policy document by the BC Medical Association and the BC Hospitals Association, the criteria for evaluating physicians should be "explicit, objective and developed in conjunction with the medical staff."

In addition, the hospital board "should ensure that the evaluation process and criteria are incorporated into the medical staff bylaws"<sup>(2)</sup> These recommendations imply a duty to evaluate physi-

cian performance through the utilization of specific parameters which are developed collaboratively, and defined clearly in hospital regulations governing medical staff practice. Provincial licensing bodies also have overlapping responsibility for the competency of practice, which has led to formalized competency assessment programs in several jurisdictions. (6 - 8) Many of these programs are described in an expanded literature base which documents experience with performance assessment by physician peers, both inside and outside the hospital environment. (9 - 11)

According to recommendations of the Canadian Medical Association, medical department heads "are responsible for setting standards of care, ensuring that these are known to the members of their departments, and providing evidence to hospital administration and the board of trustees that the care has been reviewed and is within known and established standards." (12)

Briefly, then, the medical staff must discipline its own members. Before discipline can occur, physician evaluation must be undertaken based on well-documented criteria that are both explicit and objective. Department heads must develop the standards from which these criteria derive, and are responsible through the MAC to the board of trustees to ensure that these standards are met. Although hospitals have always reviewed certain aspects of physician performance both formally and informally, few have developed comprehensive mechanisms to ensure that due process occurs (9, 11) nor is this process clearly defined in the medical-staff bylaws of most Canadian hospitals. As a result, it may be difficult for department heads and members of the MAC, when confronted with a physician who is allegedly incompetent or impaired, to ensure that "due process" occurs. If principles of natural justice are denied, however, litigation is likely to ensue.

### INCOMPETENCE VS IMPAIRMENT

For the purposes of this work, incompetence is defined as an

inability or unwillingness to practice within the standards of care prescribed by chairs for their department members; impairment refers to a diminished ability to provide the requisite standard of care owing to a physical or mental illness or disturbance, substance misuse of any kind, or criminal behaviour. The crucial elements in managing such problems involve their early identification and reporting, as well as the development of a patently fair process which recognizes the interests of all concerned.

In the case of the incompetent physician, complaints or concerns may arise from staff physicians, residents, other healthcare staff, patients or their families. No matter what channel these complaints follow, they should, in the case of staff physicians, be directed to the chair of the relevant departments or, in the case of residents, to the director responsible for medical education. Complaints or concerns about impairment may arise from the same sources as those for incompetence; however, the families of physicians and the College of Physicians and Surgeons are more likely to be involved. These complaints should be handled differently from complaints of incompetence, as will be discussed shortly.

Before complaints of incompetence can be addressed in a meaningful manner, three steps must be implemented. First, department heads must develop detailed standards of care in collaboration with hospital quality-of-care and utilization-management groups as well as their own department members. General guidelines are insufficient. Indicators might include resource utilization, length of stay, complication rate or rate of unscheduled readmissions to hospital. Second, the system of physician performance evaluation must derive specifically from these standards and expedite the ready identification of outliers. Finally, the hospital administration must establish a process that facilitates communication of complaints or concerns about physician performance, and revise hospital bylaws and policy as necessary.

Complaints of impairment need to be handled with the utmost discretion. On the one hand, physicians' rights and privacy must be respected; on the other, the department heads and hospital administration must act quickly to safeguard patient care. To achieve this balance, complaints or concerns about physician impairment should be directed simultaneously to the relevant department head, the Vice-President of Medicine, and a permanent designate of the MAC, presumably a physician with expertise in this area. Following a timely investigation, the latter two individuals should make a collaborative decision on whether the facts of the case warrant its being reported to the College or being addressed internally. The department head should be excluded from the initial process of investigation because of medical-staff concerns regarding potential bias; however, the department head should be notified immediately if the issue is reported to the College.

To implement this strategy for addressing impairment, three steps are necessary. First, the hospital must develop and implement a hospital-wide educational process for early identification

of physician impairment. Second, an open communication process must be established. Finally, the MAC must identify and support an appropriate physician as a permanent designate of the MAC to deal with matters of physician impairment.

### **INTERVENTION**

The process of intervention must achieve solutions in a fair and even-handed manner, based on principles of natural justice, in order to avoid dispute resolution through litigation.

In the case of incompetent practice, minor issues should be recorded and addressed directly by the department chair. Major outliers, identified by measuring physician performance against departmental standards of care, should be referred by the department chair directly to the MAC for consideration and possible intervention. The physician concerned must be notified at the same time as the referral is made to the MAC, and provided with a copy of the complaint.

In the event of a formal complaint to the MAC by the department chair, the MAC should appoint an ad-hoc committee to make recommendations for action regarding the quality-of-care issue in question. Since issues of neutrality and potential conflict of interest are paramount in determining the make-up of the subcommittee, it should include an impartial department chair, a physician representative from the hospital's Quality Council or similar body, and a representative from the medical staff executive.

On receipt of the complaint and upon the advice of the MAC, a subcommittee should convene immediately with a mandate to recommend one or more of the following outcomes: status quo; change of privileges; remediation or education; notification to the College of Physicians and Surgeons; appointment of an external reviewer; or, if impairment is subsequently identified, referral to the physician trained to deal with cases of physician impairment. The subcommittee must have access to all records pertinent to the investigation and must complete its investigation in a timely manner. The individual involved must have full access to the report of the subcommittee. Active psychological support for the physician named in the complaint is imperative.

In the event of a complaint about physician impairment, the MAC designate and the Vice-President, Medicine, may conduct interviews with individuals or staff prior to intervention. The affected physician must be notified that such a process is taking place.

### **DISCUSSION AND CONCLUSIONS**

The process as described has not yet been tested. It attempts to accommodate the often-competing interests of the hospital administration, the department head and the individual physician. Timeliness is critical to an effective process. Moving from a legal framework to a peer-review structure should expedite a solution and minimize harm to individuals and departments

alike. In addition, the hospital must agree to, and actively support, an education policy regarding impairment, including a widely understood confidential reporting system. The principles of natural justice should prevail over a tedious and often unnecessary legal process. A process which is timely, fair and trusted by members of the medical staff will boost morale, save money and ensure less polarization between physicians and administration. In the current environment, the health of institutions can only be fostered by open communication, due process and balanced judgement in lieu of litigation and the breach of trust. ❧

*Steven Kline is the Head of Psychiatry at St. Paul's Hospital, University of British Columbia.*

*Jeremy Etherington is Head of Emergency Medicine and Chair of the Medical Advisory Committee at St. Paul's Hospital, University of British Columbia.*

*Joanna Bates is Director of Postgraduate Education and the Dean of Admissions, Faculty of Medicine, University of British Columbia.*

*The authors would like to thank Mr. Phil Hassen for his advice and support.*

#### REFERENCES

1. *Hospital Act*, British Columbia, 1995
2. *Granting of Privileges: Guidelines for Hospital Trustees, Administration and Medical Staff: Part III, Appointment/Reappointment Process*. BC Medical Association, College of Physicians and Surgeons of BC and BC Hospitals Association, joint publication, June 1991
3. *Medical Practitioners Act*, British Columbia, 1979.
4. *Employment Guidelines: Workplace Harassment*, St. Paul's Hospital, Vancouver, BC
5. *Report of the Task Force on Alcohol and Drug Abuse in the Workplace*. British Columbia, September 1987.
6. Bates J, Page GG, and Dyer VS. The Assessment and Enhancement of Clinical Competence in British Columbia, Canada. Proceedings, *Sixth Ottawa Conference on Medical Education, Certification, Licensure and CME*, 1995.
7. Page GG, Bates J et al. Physician Assessment and Physician Enhancement Programs in Canada. *CMAJ* 1995; 153: 1723-8.
8. McCauley RG and Henderson HW. Results of the Peer Assessment Program of the College of Physicians and Surgeons of Ontario. *CMAJ* 1984; 131: 557-61.
9. Nash DB, Markson LE et al. Evaluating the Competence of Physicians in Practice: From Peer Review to Performance Assessment. *Academic Medicine* 1993; 68 (Feb. Suppl.): 519-22.
10. Ramsey PG, Wenrich MD et al. Use of Peer Ratings to Evaluate Physician Performance. *JAMA* 1993; 269: 1655-60
11. Langsley DF. Medical Competence and Performance Assessment. *JAMA* 1991; 266: 977-80.
12. Cruess SR. Medical Department Heads *CMA Guide to Medical Administration in Canadian Hospitals* (DD Gelman, ed.) Ottawa, 1996: E 3.3-3.4

The process described in this article has not been tested. Readers are invited to comment and introduce evidence-based best practices. Fax your notes to: The Editor 416 368-6292 or by email to [dkent@longwoods.com](mailto:dkent@longwoods.com).