

Editorial

Sham Peer Review: The 'Voluntary' Abeyance

Lawrence R. Huntoon, M.D., Ph.D.

Hospitals introduced the concept of “voluntary abeyance” years ago and have been using it as an alternative to a summary suspension ever since. A physician is typically asked to sign an agreement whereby he agrees not to practice in the hospital or not to perform a procedure or surgery until an investigation can be completed.

A “voluntary” abeyance, however, is always presented with an “or else.” The physician is typically told that if he does not agree to the “voluntary” abeyance, a summary suspension will immediately be imposed. In the case of a “voluntary” abeyance with respect to specific procedures or surgeries, he may be told that he will either be summarily suspended or a corrective action will be initiated against him if he does not agree.

In some cases, the physician is told that he must decide on the spot whether to sign the “voluntary” agreement during a meeting with hospital leaders/officials, and he will not be allowed to call to consult with his attorney prior to making his decision. This tactic is unambiguous evidence of a bad-faith peer review and represents an egregious violation of due process and fundamental fairness.

The “voluntary” abeyance, therefore, is never voluntary. The physician is always coerced to sign the abeyance agreement, under duress, with the threat of immediate summary suspension or other adverse action if he does not sign it.

The information presented below is based on my study and observations. I am not an attorney and do not provide legal advice or opinion. Physicians are encouraged to consult with their attorneys for legal advice and opinion.

A Rose by Any Other Name

In an article in *Data Bank News* in January 2010, “Summary Suspension or Precautionary Suspension: ‘A Rose By Any Other Name,’” the National Practitioner Data Bank stated:

Some in the healthcare community have introduced the concept of a “precautionary suspension” and/or “abeyance” and have put forth the argument that these actions are not reportable....

The Data Bank’s position is that the reportability of any particular action is based upon whether it satisfies the reporting elements [restriction or reduction of privileges] of the NPDB not the name affixed to the action. Renaming a summary suspension as “precautionary suspension” and/or “abeyance” does not remove the requirements to report the action to the NPDB [National Practitioner Data Bank] as an adverse action against clinical privileges if the factors listed above are present....

Consequently, in the scenario stated above, if a

hospital suspects but has not confirmed a risk to an individual and imposes a suspension as a precaution and the suspension remains in effect for more than 30 days, it is reportable to the NPDB.¹

Some hospitals use the “voluntary” abeyance to set a trap for unsuspecting physicians. As with the tactic whereby a hospital tells a physician that it will be better for him if he just resigns so he will not have to go through the lengthy and uncomfortable peer-review proceedings in the hospital after which he will be reported to the NPDB if an adverse action is upheld, physicians may be advised that a voluntary abeyance, unlike a summary suspension, is not reportable to the NPDB. After all, it is just “voluntary.” At the 31-day mark, the physician is then shocked to learn that the hospital has reported him to the NPDB, and his career is either ruined or ended. As one judge put it: “An adverse report to the Data Bank is akin to a ‘scarlet letter’ that could permanently harm a physician’s professional reputation.”²

If the hospital is successful in misleading a physician into believing that resigning while under investigation rather than going through the formal peer-review process in the hospital is not reportable, it results in a big win for the hospital. The hospital is able to ruin the physician’s reputation by filing an Adverse Action report with the NPDB (resigning while under or to avoid investigation), without having to provide the physician with any due process or appeal under the medical staff bylaws since the physician has resigned from the medical staff.

In cases where the hospital does not put in writing that it will not report the voluntary abeyance to the NPDB, it is recommended that the physician use a covert recorder, where legal to do so, to record the hospital’s verbal assurances of not reporting an abeyance to the NPDB. Written or recorded evidence can then be used in litigation to support a claim that the hospital conducted a peer review in bad faith, breached the implied covenant of good faith and fair dealing, and acted with actual malice or actual fraud. This can additionally be used to support a motion for temporary restraining order and preliminary injunction to prohibit the hospital from reporting to the NPDB.

‘Voluntary’ Abeyance—Uncertain Imminent Danger

The Health Care Quality Improvement Act (HCQIA) addresses adequate procedures in investigations or health emergencies. Section 11112(c) states:

(c) Adequate procedures in investigations or health emergencies

For purposes of section 411(a) [42USCS § 11111(a)] of this title, nothing in this section shall be construed as—

(1) requiring the procedures referred to in subsection (a)(3) of this section—

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

Hospitals have the burden of putting forth sufficient evidence to show that the 11112(c)(2) exception, imminent danger, for summary suspension applies.³ As noted in the *Lo v. Provena Covenant Medical Center* case, “Of course, the danger to patients must be genuine and imminent. Otherwise, the summary suspension would be arbitrary and capricious.... The summary suspension must be an informed decision....”⁴

Moreover, a summary suspension/voluntary abeyance cannot be based on a subjective belief or concern that the physician may pose a risk of imminent danger to patients if such action is not taken. Like the objective test that applies to the HCQIA reasonableness standards (Sec. 11112(a)1-4),⁵⁻¹¹ an objective test also applies to the imminent danger standard.¹² Certain fundamental principles of due process apply. As the Court stated in the *Kiester v. Humana Hospital Alaska, Inc.*, case:

However, basic principles of due process of law require that criteria established for granting or denying privileges not be vague and ambiguous, and that as established, they be applied objectively. See *Williams v. Kleveland*, 534 F. Supp. 912, 917 (W.D. Mich. 1981) (holding that rules established by hospitals to regulate the conduct of doctors must be capable of objective application); *Miller v. Eisenhower Medical Ctr.*, 27 Cal. 3d 614, 614 P.2d 258, 265, 166 Cal. Rptr. 826 (Cal. 1980) (finding that rules governing the admission of physicians cannot stand if the standard is unreasonably susceptible of arbitrary or discriminatory application); *Martino v. Concord Community Hosp. Dist.*, 233 Cal. App. 2d 51, 43 Cal. Rptr. 255, 260 (Cal. App. 1965) (stating a hospital must set up standards which are clear, not vague, ambiguous or uncertain); *Wyatt v. Tahoe Forest Hosp.*, 174 Cal. App. 2d 709, 345 P.2d 93, 97 (Cal. Dist. App. 1959) (noting that the standard set up was so vague and uncertain “that admission to the staff can depend on the whim and caprice of the directors”).¹³

A summary suspension/voluntary abeyance must be based on objective evidence that the physician poses a realistic, recognizable threat to patient safety, which requires immediate action by the hospital.¹⁴ The finding of imminent danger by a professional review body must also be based on documented contemporaneous evidence of imminent danger to patients, not on a speculative possibility, nor based on post hoc rationalization.¹⁴

HCQIA did not create freestanding immunity for summary

suspension/voluntary abeyance. A summary suspension/voluntary abeyance is subject to reasonableness standards 1 and 2 and partially to 4 (42 U.S.C. Sec. 11112(a)). There must be an objectively reasonable belief that the action was in the furtherance of quality healthcare; there must be an objectively reasonable effort to obtain the facts of the matter (which includes getting the physician’s side of the story); and there must be an objectively reasonable belief that the action was warranted based on the facts known at the time, after an objectively reasonable effort was made to obtain the facts of the matter. The presumption that a hospital met the reasonableness standards of HCQIA can be rebutted by a preponderance of the evidence—42 U.S.C. §11112(a)(4).

When a hospital implements a summary suspension or coerces a voluntary abeyance prior to providing an opportunity for the physician to explain his care or rebut the charges, they are failing to make an objectively reasonable effort to obtain the facts of the matter (42 U.S.C. §11112(a)(2)). This should result in loss of immunity for the hospital under HCQIA.

As the 2010 *Data Bank News* article indicates, hospitals often reserve the term “voluntary abeyance” “where an investigation has not yet established whether a restriction on privileges is necessary or not.... In these instances, the hospital suspects, but has not confirmed, a risk to individuals and imposes the suspension or abeyance as a precaution.”¹ Therefore, the existence of imminent danger is often in question and not yet established by objective facts.

Voluntary Abeyance and Violation of Medical Staff Bylaws

Hospitals that conduct sham peer reviews often view a voluntary abeyance as an opportunity and excuse to deprive the accused physician of due process and fundamental fairness that the physician would otherwise be entitled to for a summary suspension under the medical staff bylaws. They argue that the physician has no due process rights under the bylaws specifically for a “voluntary” abeyance.

Medical staff bylaws typically provide that a physician whose privileges have been suspended has the right to meet with the Medical Executive Committee (MEC) within 14 days of the suspension. This requirement, which is found in HCQIA (42 U.S.C. §11112(c)(1)(B)), exists to give the accused physician an opportunity to tell his side of the story and explain his care (as required under HCQIA §11112(a)(2)), and it allows the MEC to decide, based on objective facts, whether to continue or terminate the suspension/abeyance before it reaches the 31-day mark of reportability.

When hospitals fail to provide the physician with an opportunity to explain his care and rebut the accusations made against him within 14 days following a voluntary abeyance, they are blatantly violating their own medical staff bylaws.

The 2010 *Data Bank News* article clearly indicates that a voluntary abeyance is to be treated exactly the same as a summary suspension. Medical staff bylaws by legal necessity mirror HCQIA requirements. Section 11112(c)(1)(B) of HCQIA states in part: “in the case of a suspension or *restriction*

of clinical privileges..." (emphasis added). A voluntary abeyance is unquestionably a restriction of clinical privileges. Therefore, a physician who has been coerced to sign a "voluntary" abeyance agreement is entitled to the same due process protections under the bylaws as a physician who has been subject to a summary suspension.

Some FPPEs May Pose a Risk to a Physician Similar to a Voluntary Abeyance

In 2007, The Joint Commission introduced two new terms—the Ongoing Professional Practice Evaluation (OPPE) and the Focused Professional Practice Evaluation (FPPE)—as tools to help hospitals make privileging decisions.¹⁵ The Joint Commission provided the following explanation:

- **OPPE** is a screening tool to evaluate all practitioners who have been granted privileges and to identify those clinicians who might be delivering an unacceptable quality of care. It is important to emphasize that OPPE is not designed to identify clinicians who are delivering good or excellent care. Therefore, the criteria used for OPPE may also identify some clinicians who have no quality of care issues (i.e., identifications of situations that turn out to be false positives). As with all screening tests, a positive finding must be followed up with a more specific diagnostic test, one that should have high specificity for poor care.
- **FPPE** is the follow up process to determine the validity of any positives (whether true or false) found through OPPE. This process is applied only to the small number of clinicians who were identified by OPPE.

Since the outcome of the FPPE is so important, the review, decision and follow-up process developed by the hospital—usually at the department level—must be objective and capable of accurately determining when a clinician's performance is falling below an acceptable norm. To accomplish this goal, it is important that a thorough and thoughtful process be developed by each department with substantial input from peers.

Essentially, the "Joint Commission terminology for peer review is Focused Professional Practice Evaluation (FPPE)" (John Herringer, Associate Director, Standards Interpretation Group, The Joint Commission, personal communication, 2011).

An FPPE, however, does not always arise from an OPPE. Some hospitals use an FPPE to address a specific complaint lodged by someone against a specific physician. In practice, the FPPE often functions like a Star Chamber proceeding. A committee meets behind closed doors, reviews information related to a specific complaint against a physician, determines whether the physician is "guilty" or not, and administers "punishment" to the accused physician, all without asking the physician for his side of the story. Not only is the accused physician not given an opportunity to explain his care or rebut the charges, but there is typically no appeal to the "verdict" and "punishment" mandated by the "Star Chamber" committee. Physicians may be asked to "voluntarily" sign an

FPPE decree, implicitly agreeing to the terms. Typically, no alternative to the FPPE is offered to the physician. In some cases, some hospitals use successive FPPE requirements as a form of harassment against the targeted physician.

FPPEs that require only monitoring of charts, or that require the physician to take certain coursework, are not reportable to the NPDB. However, FPPEs that restrict or reduce clinical privileges in some manner are reportable to the NPDB if they are in place for more than 30 days. One example is an FPPE that requires proctoring when a proctor must be present in order for the physician to exercise his clinical privileges. This is explained in the National Practitioner Data Bank Guidebook as follows:

Proctors

If, as a result of a professional review action related to professional competence or conduct, a proctor is required in order for a physician or dentist to proceed in freely exercising clinical privileges, and the period lasts longer than 30 days, the action must be reported to the NPDB. In other words, if, for a period lasting more than 30 days, the physician or dentist cannot perform certain procedures without proctor approval or without the proctor being present and watching the physician or dentist, the action constitutes a restriction of clinical privileges and must be reported. However, if the proctor is not required to be present for or approve the procedures (for example, if the proctoring consists of the proctor reviewing the physician's or dentist's records or procedures after they occur), the action is not considered a restriction of clinical privileges and should not be reported to the NPDB.¹⁶

Hospitals may not be familiar with all the intricacies concerning NPDB reportability in the NPDB Guidebook, especially those pertaining to FPPEs that pose a restriction of clinical practice. In some cases, the hospital may advise the physician, in writing, that the FPPE resulting in a restriction of clinical privileges is not reportable to the NPDB. In those situations, a judgment must be made as to whether the hospital is conducting a good-faith or bad-faith peer review. If the physician believes that the FPPE is being administered in good faith, then the risk of being reported to the NPDB may be minimal. If instead, the physician believes the hospital is conducting the FPPE in bad faith, then at least the physician has it in writing that the hospital deliberately misled him about the reportability of the action if the hospital subsequently files a report with the Data Bank. Also, it is important to remember that an NPDB investigation for failure to report a reportable action is a complaint-driven process in which neither the hospital nor affected physician has any incentive to complain.

Leave of Absence

In some cases, the physician's attorney may be able to negotiate a leave of absence (not related to professional competence or conduct) as an alternative to a summary suspension/ voluntary abeyance or to an FPPE requiring real-time proctoring. A leave of absence may entail taking

specific coursework or may require an evaluation of clinical judgment, which some universities provide.

The leave of absence should be contemporaneous and implemented in lieu of a summary suspension/voluntary abeyance, and any ongoing investigation should be closed prior to implementing the leave of absence. A leave of absence taken while an investigation is open or ongoing is immediately reportable to the NPDB.¹⁷ If a hospital is satisfied with coursework/evaluation the physician completed during his leave of absence, an investigation may not be needed on termination of the leave of absence. If the hospital is not satisfied, then an investigation can be opened on termination of the leave of absence.

Some hospitals, recognizing that they violated requirements of HCQIA and their own medical staff bylaws by not providing the physician with the opportunity to be heard by the MEC within 14 days of an abeyance, may, once they are beyond the 14-day mark, seek to retroactively implement a leave of absence in an attempt to deprive the physician of due process to which he was entitled. This is also done in an attempt to absolve themselves of any violation of HCQIA or the medical staff bylaws.

Conclusion

In practice, there is no such thing as a truly voluntary abeyance. Physicians are typically coerced to sign a “voluntary” abeyance under threat of an adverse action against their privileges if they refuse. According to HCQIA and its implementing regulations, including the NPDB Guidebook, a voluntary abeyance is exactly the same as a summary suspension. A voluntary abeyance should, in all circumstances, be treated exactly the same as a summary suspension—both involve a restriction of clinical privileges. Some FPPEs that contain a clinically-restricting proctor provision, which the physician may be asked to “voluntarily” sign, implicitly agreeing to its terms, are also reportable to the NPDB if they are in effect for more than 30 days. The successful negotiation of a leave of absence early on, as an alternative to a summary suspension/voluntary abeyance or certain FPPEs, may prevent irreparable damage to the physician’s career caused by an Adverse Action report to the NPDB.

Lawrence R. Huntoon, M.D., Ph.D., is editor-in-chief of the *Journal of American Physicians and Surgeons*. Contact: editor@jpands.org.

REFERENCES

1. Anon. Summary Suspension or Precautionary Suspension: ‘A Rose By Any Other Name.’ *Data Bank News*, January 2010:6. Available at: <https://bit.ly/databanknews>. Accessed Apr 24, 2022.
2. *Jesse A. Cole, M.D. vs. St. James Healthcare*. Memorandum and Order. Montana Second Judicial District Court, Silver Bow County, Cause No. DV-07-44, Order #15 Jun 1, 2007:16. Available at: <https://bit.ly/newmanorder>. Accessed Apr 24, 2022.
3. *Smigaj v. Yakima Valley Memorial Hospital Association*, 165 Wash. App. 837, 269 R3d 323, rev. denied, 174 Wash. 2d 1006, 278P.3d 1112 (2012). Available at: <https://caselaw.findlaw.com/wa-court-of-appeals/1595374.html>. Accessed Apr 24, 2022.
4. *Lo v. Provena Covenant Medical Center*, 342 Ill. App. 3d 975, 985 (Ill. App. Ct. 2003). Available at: <https://casetext.com/case/lo-v-provena-covenant-medical-center-2>. Accessed Apr 24, 2022.

5. *Austin v. McNamara*, 979F.2d 728 (9th Cir. 1992). Available at: <https://law.justia.com/cases/federal/appellate-courts/F2/979/728/383317/>. Accessed Apr 24, 2022.
6. *Bender v. Suburban Hospital, Inc.*, 134 Md. App. 7, 758 A.2d 1090; cert. denied, 362 Md. 34, 762 A.2d 968 (2000). Available at: <https://cases.justia.com/maryland/court-of-special-appeals/2000s99-0.pdf?ts=1462360223>. Accessed Apr 24, 2022.
7. *Cowett v. TCH Pediatrics, Inc.*, 2006 Ohio 5269 (Ohio Ct. App., Mahoning County 2006), 2007 Ohio 724 (2007). Available at: <https://cases.justia.com/ohio/seventh-district-court-of-appeals/2006-ohio-5269.pdf?ts=1396138796>. Accessed Apr 24, 2022.
8. *Fox v. Parma Community Hospital*, 160 Ohio App. 3d 409, 419, 2005 Ohio 1665 (Ohio Ct. App., Cuyahoga County 2005). Available at: <https://cases.justia.com/ohio/eighth-district-court-of-appeals/2005-ohio-1665.pdf?ts=1396138574>. Accessed Apr 24, 2022.
9. *Pamiantuan v. Naticoke Memorial Hospital*, 192 F.3d 378, 389 (3rd Cir. 1999). Available at: <https://caselaw.findlaw.com/us-3rd-circuit/1367145.html>. Accessed Apr 24, 2022.
10. *Sugarbaker v. SSN Health Care*, 190 F.3d 905, 914 (8th Cir. 1999). Available at: <https://law.justia.com/cases/federal/appellate-courts/F3/190/905/516693/>. Accessed Apr 24, 2022.
11. *Zisk v. Quincy Hospital*, 834 N.E. 2d 287, 295 Mass. App. (2005). Available at: <https://caselaw.findlaw.com/ma-court-of-appeals/1206129.html>. Accessed Apr 24, 2022.
12. *Brandner v. Providence Health and Services*, Sup. Ct. Alaska, No. S-15933, No. 7172 (2017), p. 9. Available at: <https://bit.ly/brandnervphs>. Accessed Apr 24, 2022.
13. *Kiester v. Humana Hospital Alaska, Inc.* 843 P.2d 1219, 1225 (1992). Available at: <https://law.justia.com/cases/alaska/supreme-court/1992/s-4361-1.html>. Accessed Apr 24, 2022.
14. *Brandner v. Providence Health and Services*, Sup. Ct. Alaska, No. S-15933, No. 7172 (2017), p. 8. Available at: <https://bit.ly/brandnervphs>. Accessed Apr 24, 2022.
15. Wise, R.A. OPPE and FPPE: Tools to help make privileging decisions. The Joint Commission Blog, Aug 21, 2013. Available at: <https://bit.ly/jcoppe>. Accessed Apr 24, 2022.
16. National Practitioner Data Bank. NPDB Guidebook. Health Resources and Services Administration; October 2018:E41. Available at: <https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp>. Accessed Apr 24, 2022.
17. National Practitioner Data Bank. Q&A: reporting clinical privileges actions. In: NPDB Guidebook. Health Resources and Services Administration; October 2018:E49-E50. Available at: <https://www.npdb.hrsa.gov/resources/aboutGuidebooks.jsp>. Accessed Apr 24, 2022.

A Guide to Home-Based COVID Treatment

Step-By-Step Doctors’ Plan
That Could Save Your Life

Editors: Jane M. Orient, M.D. &
Elizabeth Lee Vliet, M.D.

Download your
free copy today:
CovidPatientGuide.com