

How A Physician Gets Reported to the National Practitioner Data Bank*BY KAREN C. DUNCAN*

Part 1 of this series of peer review articles examined the fundamentals of how hospital medical staff monitor and regulate the quality of the physician staff member's care. Hospital physician quality management is structured through a semiautonomous, self-governing group, the Medical Staff Organization, whose members evaluate their peers through formal evaluations in various committees. When the Medical Staff Organization finds that a physician staff member has provided inadequate patient care, the Medical Staff may suspend the affected practitioner or limit his or her right (or privilege) to practice certain procedures within the hospital.

In Part 2, the Peer Review Primer examined the organization of the Medical Staff and how hospital physicians acquire the privilege to treat patients in a hospital. A prospective staff physician formally requests membership in the Medical Staff Organization, requesting to perform delineated medical procedures. The Medical Staff Organization has the authority to approve the application and recommend the physician to the hospital board. Only the hospital itself, however, has the ultimate authority to approve and accept a member of the hospital medical staff.

This Peer Review Primer, Part 3, describes the formal process by which a hospital suspends or restricts a doctor's privileges to practice. Medical staff committees are organized by function (e.g. quality, physician wellness, and risk management committees) or by departmental role (e.g. surgery, medicine, obstetrics). All hospital committees govern themselves through a formal set of bylaws. Medical staff committees, as part of their routine practice, survey the care provided by its physician members through the use of statistical data and other information gathering methods. In some cases, individual concerns are brought to the attention of the committee through patient or staff complaints. When a matter is brought to the attention of a committee, the committee investigates and determines whether the physician has delivered care appropriate to set standards. If a problem is detected, the matter may be referred to several successively more senior committees, eventually ending in a Medical Staff management or executive committee with authority to act. Members of these senior medical executive committees are typically elected physicians who rotate every one or two years.

When a medical quality concern is brought before a medical executive committee, the committee may make several choices. The medical executive committee may resolve the investigation in the favor of the practitioner, immediately suspend the practitioner from practice while an investigation continues, or allow

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Interestingly, the Third Circuit's opinion is set forth in a decision written by then-Judge Alito. *See United States ex rel. Mistick PBT v. Housing Authority of the City of Pittsburgh*, 186 F.3d 376 (3rd Cir. 1999).

the practitioner to continue to practice while the investigation continues. Some investigations require evaluation by a specialist, who may be an economic competitor of the investigated physician. In those cases, in order to avoid the appearance of any anti-competitive interests, the records may be sent to experts outside the hospital staff for evaluation.

If a decision is made to restrict a staff member's clinical privileges in any way, the affected physician is usually entitled to due process through a hearing. The process requirements are set out in detail by the Health Care Quality Improvement Act (HCQIA) and generally culminates in a trial-like "Fair Hearing" hospital administrative process consisting of three or more physician members forming a panel who will hear witnesses testimony and receive evidence. In many cases, the affected physician is represented by legal counsel, as is the hospital and, in some cases, the Medical Staff Organization itself. The Fair Hearing panel will issue a recommendation to the hospital board either supporting the restriction of clinical privileges or recommending that the restriction be terminated. The decision whether to uphold or reverse the restriction is ultimately a responsibility of the hospital board. The medical staff bylaws typically allow both the hospital and the affected physician a right of appeal to the hospital board. The entire peer review process is highly confidential and information about the proceedings may not be acquired by most third parties, in particular medical malpractice plaintiffs.

The HCQIA requires hospitals to report to the National Practitioner Data Bank through the State Medical Board whenever a physician's clinical privileges are restricted for more than 30 days. A report must also be made if a hospital accepts a physician's surrender of all or part of a medical staff member's clinical privileges while the member is under investigation. Even if the physician member was unaware that he or she was under investigation, the HCQIA mandates that such surrender must trigger a report. Additionally, a hospital may not agree to forego or stop an investigation about a staff member's incompetence or improper professional conduct in exchange for the surrender of clinical privileges.

Some of the National Practitioner Data Bank requirements for reporting clinical adverse actions are subject to interpretation. There are therefore sometimes disagreements between the reported physician and the hospital about whether a report should be filed. Hospitals may ask for advisory opinions from the Data Bank, or a reported physician may dispute an adverse action report by completing a Data Bank dispute form. The Secretary of the Department of Health and Human Resources will make a determination with respect to the appropriateness. If the Secretary concludes that a filed report was appropriate, the reported practitioner may request that the basis for his or her disagreement be included in any subsequent Data Bank report to other hospitals.

The HCQIA protects with immunity from damages, the participants in the committee process leading to the report and the reporting itself. Significantly, the protection is immunity from damages, but it is not immunity from a lawsuit itself. Despite those HCQIA immunities, the reported physician often sues the hospital and the members of

the committees for damages. Legal theories typically include antitrust, defamation, interference with contractual rights and intentional infliction of emotional distress. The vast majority of these claims are dismissed on motions for summary judgment. The HCQIA provides that the defendant hospital may collect its attorney's fees under some circumstances.

Reports to the National Practitioner Data Bank may have long term and deleterious effects on a physician's career, as the reported physician must explain the report to every subsequent hospital from which he or she requests privileges. For that reason, hospital medical staff committees are reluctant to report colleagues to the National Practitioner Data Bank unless it is absolutely necessary. Any attempt by the medical staff or hospital to negotiate around the HCQIA Data Bank reporting requirements, however, is perilous and can expose the hospital to damages and to loss of HCQIA immunity. Legal counsel experienced in this area of the law should always be consulted early in the committee process and whenever a formal or informal limitation of clinical privileges is contemplated.

Karen C. Duncan is an attorney with the New Orleans office of Frilot Partridge, L.C..