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National Practitioner Data Bank
P.O. Box 10832
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Attention: Pamela

Dear Pamela:

First of all, let me express my appreciation for the willingness of NPDB personnel to address the question I have set forth below relating to an interpretation of Data Bank reporting requirements. This question arose out of an exchange between health care attorneys who participate in the Medical Staff, Credentialing and Peer Review List Serve sponsored by the American Health Lawyers Association and who commented on a "hypothetical" scenario as to whether the hospital was required to report a physician if privileges were terminated because of misinformation provided on his reappointment form as well as a purposeful failure to disclose a reduction of insurance coverage in violation of the medical staff bylaws.

In reading the various comments and opinions expressed by these attorneys, it became clear that they had conflicting views as to whether a reporting obligation existed. More specifically, the issue boiled down to whether the physician's competence or conduct which triggered the adverse credentialing decision must or could adversely affect patient health or welfare before it can be reported. Stated differently, is conduct or competence which does not adversely affect patient health or welfare reportable?

So as to give some context to the question, I would like to offer the following background especially in light of a recent publication by Public Citizen which strongly criticizes hospitals and accuses them of under reporting disciplined physicians in violation of Data Bank requirements. Most hospitals and medical staffs are fairly familiar with what actions do and do not require a NPDB report. In fact, this knowledge does affect the type of action imposed or decision made when addressing quality of care issues. Although there certainly might be some under-reporting taking place, one important positive impact which this legislation has had is that it has forced hospitals and medical staffs to consider other remedial measures which do not trigger hearing requirements or NPDB reports while still protecting patients. For example, because most physicians will challenge actions which may result in a report, such as a termination, suspension or reduction in clinical privileges, hospitals and medical staffs now consider the implementation of monitoring, proctoring, consultation requirements, re-education, concurrent and retrospective case reviews and other forms of evaluation as alternative

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approaches. These measures are usually quite effective and send a positive message to physicians because it reflects a willingness to work with physicians in order to get them back on track so as to help improve their performance as well as the quality of their patient care services. The goal, therefore, has been to limit the use of reportable decisions to situations in which the threat to patient care is clearly real and imminent, such as a summary suspension, or where repeated efforts to work with the physician have failed thus leaving the medical staff with no other alternative but to reduce or terminate privileges.

I would also point out that knowing what is and is not reportable is particularly important in light of industry developments relating to Pay for Performance expectations which require certain outcomes or compliance with specific protocols as a condition of additional reimbursement, the increasing list of identified "never effects" by HHS, the imposition of ongoing and focused physician monitoring requirements by the Joint Commission and other similar developments. This ever increasing focus on quality and evidence-based medicine has led to the implementation of physician profiling protocols which compare a physician's performance with his or her peers. Although used principally for educational purposes, hospitals are now generating a substantial amount of quality data about a physician's practice. In addition, there is the recent development of Patient Safety Organizations and the concept of "just culture" which encourages all health care providers to report errors and acknowledge their need for improvement when necessary in return for the protection that such data and information collected and reported to a PSO cannot be used against them in a disciplinary action. These developments only reinforce the need to truly understand what decisions are and are not reportable to the Data Bank in order to encourage physicians to become actively engaged in this collective and industry wide effort to improve patient care.

Focusing now on the relevant portion of The Health Care Quality Improvement Act of 1986 and related regulations (the "Act"), it is clear to me that a physician's conduct or competence leading to, for example, a termination or suspension of privileges, is only reportable if linked to an actual or potential adverse affect on patient health or welfare. There are a number of provisions which support this conclusion. First, under the standard for professional review actions (42 USC Sec. 11112), the immunity protections afforded under the Act "must be taken (1) in the reasonable belief that the action was in furtherance of quality health care...."

In other words, the decision to discipline a physician must be linked or related to protecting patients or furthering interests in providing quality care. This is why terminating a physician for failure to pay dues, or to carry the appropriate amounts of insurance, or violating similar administrative requirements are not reportable. Similarly, if a physician voluntarily relinquishes certain privileges which he has accumulated over time, not because there have been identified problems, but because he is no longer qualified to exercise these privileges is not reportable

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either. Also, if the decision is not related to quality, a hospital and medical staff cannot seek the immunity protections offered under the Act.

The provision of the Act which is directly on point is Section 11151(9) which provides in pertinent part:

The term "professional review action" means an action or recommendation of a professional review body which is taken or made in the conduct of a professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges ...of the physician...."

The NPDB Guidebook is also instructive here. At Page E-17, under the heading "Reporting Adverse Clinical Privileges Actions", it states that: "Reportable adverse clinical privilege actions are based on a physician's or dentist's professional competence or conduct that adversely affects or could adversely affect, the health or welfare of a patient. "On Pages E-21 through E-23, a number of examples of reportable and non-reportable examples are given. Example 4 describes a 31 day suspension for failure to complete medical records. This is a useful example because medical record suspensions are typically automatic and almost never result in a NPDB report even though one can clearly make the argument that such failures can adversely affect patient care. The response as to whether a suspension as described in Example 4 is reportable states:

"Such a suspension would be reportable to the NPDB if the failure to complete medical records related to the physician's professional competence or conduct and adversely affects or could adversely affect a patient's health or welfare."

These provisions would seem to make very clear that a hospital and medical staff must reasonably conclude that a physician's conduct or competence which led to a final decision to adversely affect his clinical privileges, as defined under the Act, was adversely affecting or could adversely affect the health or welfare of patients before reporting to the NPDB. If not, the decision is not reportable.

I realize that the requirement of "affects or could affect adversely" is subject to interpretation and that reasonable people may differ as to whether the conduct or competence in question is reportable. Needless to say, if the reporting party is making a Data Bank report, they would want to create a very clear record as to the link between the physician's conduct and an adverse impact on patient care if they are seeking the immunity protections under the Act.

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The scenario described in the AHLA List Serve exchange, which I have attached here without the names of the corresponding attorneys, focuses on a physician who violated a number of bylaws based on his purposeful failure to disclose, among other things, a reduction in his professional liability insurance coverage, the fact that he was previously suspended for losing his insurance on a prior occasion, as well as the fact that he was the subject of a licensure investigation. This same physician, however, has had absolutely no identified quality of care issues at the hospital over the course of his 20 years as a medical staff member. The remaining details are in the List Serve exchange and will not be repeated here but this discussion brought to a head the question of whether a violation of hospital bylaws and truthful completion of a reappointment form, although clearly grounds for disciplinary action, is reportable if he is terminated and member of attorneys felt it was not.

Again, I appreciate your willingness to address the question posed in this letter and look forward to your response. If you have any questions, please feel free to contact me directly.

Very truly yours,



Michael R. Callahan

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