How to Avoid or Limit the Need for Peer Review Fair Hearings and Data Bank Reports

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Part 1: Program Objectives

- Provide recommendations regarding best practices, bylaw provisions and other strategies to address and resolve quality and peer review issues without resorting to “investigations” and hearings.
- Discussion on what constitutes an “investigation” for Data Bank purposes.
- Use of collegial intervention.
- What actions are and are not reportable to the Data Bank – when can a physician resign without a report?
- When pursuing a code of conduct/disruptive behavior pathway is more appropriate than peer review/investigation procedures.
- How to manage the peer review process and investigation stages to avoid hearings and litigation.

The Changing Healthcare Landscape

- Consolidation of health care markets
  - Hospital and physician group mergers
  - Practice acquisitions
  - Physicians employment
- Provider margins are under attack
  - Reductions in Medicare/Medicaid reimbursement
  - Higher costs
  - Private payer reductions
- New models of provider integration are emerging
  - Co-management arrangements
  - Patient centered medical home
  - ACOs
  - Insurance company/provider networks
  - Clinically integrated networks
The Changing Healthcare Landscape (cont'd)

- Shift from “Volume to Value” as a basis of reimbursement
  - Pay for performance
  - ACO quality metrics
  - Value Based Purchasing
  - Reduced or denied reimbursement for:
    - Hospital acquired conditions
    - Never events – (Billing Medicare for a never event is considered a false claim)
    - Re-admissions within 30 days

The Changing Healthcare Landscape (cont’d)

- Never Events
  - Surgery on wrong body part
  - Surgery on wrong patient
  - Wrong surgery on a patient
  - Death/disability associated with use of contaminated drugs
  - Patient suicide or attempted suicide resulting in disability
  - Death/disability associated with medication error

The Changing Healthcare Landscape (cont’d)

- Hospital Acquired Conditions
  - Foreign object left in patient after surgery
  - Death/disability associated with intravascular air embolism
  - Death/disability associated with incompatible blood
  - Stage 3 or 4 pressure ulcers after admission
Impact of Changing Landscape

- Existing and future quality metrics and outcome measures need to be incorporated into appointment/reappointment procedures, including privileging and credentialing, quality improvement and utilization standards and studies and OPPE/FPPE monitoring programs.
- Failure to meet standards will result in lower reimbursement, and will increase potential liability under theories of respondent superior, apparent agency and corporate negligence.

Impact of Changing Landscape (cont’d)

- Failure to meet standards could result in:
  - Exclusion from ACO membership
  - Loss of accreditation
  - Loss of managed care contracts
  - Increased insurance premiums
  - Loss of clinical privileges/medical staff/ACO membership
  - Increased governmental investigations/enforcement actions tied to billing for substandard care (“worthless services”)
- These changes will likely increase the volume of peer review quality improvement activity and therefore the possibility of more investigations, hearings and litigation.

Managing the Peer Review Process – Fundamental Principles

- Follow your bylaws and all applicable rules, regs and policies
- Follow applicable state and federal laws
- Address issues immediately – the longer you wait the more difficult it is to act
- Document, document, document
- Always try to resolve issues and adopt solutions at the lowest possible level – concept of “collegial intervention”
- Be transparent and adopt fair procedures – peer review is not a shell game
- Involve physicians early on in the process
Managing the Peer Review Process – Fundamental Principles (cont’d)

- Distinguish your “peer review/quality improvement process” from the investigation/remedial action phase.
- Know what actions are and are not reportable to the state and to the Data Bank and what actions trigger hearings under the Bylaws.
- Avoid conflicts of interest.
- Make sure that your documentation trail is protected under state/federal confidentiality statutes and amend your bylaws and policies accordingly.
- Need to create and promote a “just culture” environment where physicians and other practitioners can acknowledge errors and accept responsibility without fear of reprisal or loss of privileges.

Hypothetical Scenario

Dr. Callahan is a 68 year old orthopedic surgeon at a stand alone suburban community hospital. He leads a large practice group which is loyal to the hospital but it is struggling financially and currently is considering a number of merger/affiliation/acquisition options. Dr. Callahan was a former Department Chair and Chief of Staff and is one of the hospital’s biggest admitters.

The quality, risk management and medical staff offices and personnel are hard working professionals but are overworked, underpaid and understaffed due to cutbacks. The tendency is to “silo” information and protect turf rather than share and collaborate.

Hypothetical Scenarios (cont’d)

Medical Staff leaders and Department Chairs/Section Chiefs are unpaid volunteers all with busy schedules. Recruitment of new leaders is becoming increasingly more difficult.

Recently, a number of Dr. Callahan’s cases have been “falling out” based on hospital-wide and Department specific quality indicators including a higher incidence of post-op infections, questionable surgical procedures and complications associated with misplaced instrumentation. In addition, his behavior has been described as “odd” including tempermental outbursts and verbally abusive behavior towards nurses and even patients.
Peer Review Phase – Preliminary Assessment

- Hypothetical presents both a quality of care issue as well as a possible impairment problem – how does one proceed?
- Department Chair, Medical Staff President, VPMA/CMO should meet to review available information (although case reviews already should have commenced in accordance with peer review policies).
- Should probably proceed down a dual path rather than just the quality review because “causation” has not been determined. Has Callahan’s possible impairment caused the adverse patient outcomes?
- Also need to decide if you are dealing with a behavioral issue to be addressed under your existing Code of Conduct policy or an impairment problem under your Physician Wellness Committee process.

Quality of Care Review

- Peer review/quality management procedures should be designed to capture adverse outcomes and related information from multiple resources and methods:
  - HAC
  - Never events
  - Medical Staff/Department quality indicators
    - Post-op infections
    - Lawsuits
    - Return to surgery within identified number of days

Quality of Care Review (cont’d)

- Patient complaints
- Over-utilization reports
- Physician periodic quality reports
- Incident reports
- Non-compliance with quality metrics/outcomes
- Committee review of randomly selected cases or cases in which issues have been identified.
- Cases assigned for review should avoid actual conflicts of interest and be based on medical record and any accompanying documentation.
Quality of Care Review (cont’d)

- Where nurses or other non-physicians make the initial judgment on whether cases are forwarded to a committee for review you should occasionally audit their work.

- Cases reviewed by physicians on a committee are compared to indicators or standards. If they “fall out”, they are given a preliminary rating or ranking on an escalating scale of severity.

  - **Best Practice**: Depending on the preliminary ranking, physician should be provided an opportunity to meet with Committee and/or provide written comments to respond to assessments/concerns.

- Report also should evaluate concerns, if any, about judgment, acceptance of responsibility, impairment, etc.

- Report, and any recommendations, should be forwarded to Department Chair, VPPA/CMO, and any Medical Staff and/or hospital-wide Quality or Performance Improvement Committee.

- Department Chair should keep track of all related quality reports and other information in physician’s quality file to determine existence of any patterns of substandard care or related issues – ongoing monitoring is a requirement.

- Information needs to be assessed in order to determine whether an FPPE plan or other remedial measure, which does not trigger a hearing or an investigation is warranted.
Quality of Care Review (cont’d)

- Best Practice: Bylaws should contain a provision which encourages, if not requires, "collegial intervention" as a first step in the process where issues are identified so as to attempt to address issues in a pro-active, supportive manner. Goal is to remediate at lowest level possible. (See example Bylaw provision)

- Best Practice: Department/Section Chairs should be given some latitude in implementing low level remediation measures, i.e., monitoring, proctoring, retrospective/concurrent case reviews, without a formal investigation and without having to recommend remedial/corrective action – can seek MEC support if needed.

Any recommendations, whether by a Department or Medical Staff/Hospital-wide Committee, during this Peer Review phase should follow these guidelines:

- All recommendations should avoid the need for a hearing or Data Bank report.
- Emphasis should be on progressive remedial measures.
- All recommendations and support for the decision needs to be documented.
- Consider allowing the physician to appear before the Committee before a recommendation is made.

Once a recommendation is made and implemented, physician compliance with recommendation must be carefully tracked, and reports made and submitted to Department Chair and other appropriate personnel.

- Compliance and non-compliance need to be documented and shared with physician.
- If Physician is non-compliant there should be a face-to-face meeting where he needs to be told that repeated violations or any adverse events may require escalation of review and imposition of additional remedial measures.
Quality of Care Review (cont’d)

- Keep in mind that if physician resigns at any point during the Peer Review Phase, it is not reportable to the Data Bank because he is not under investigation nor is he resigning in lieu of corrective/remedial action.
  - “Investigation” is not a defined term under the statute or Data Bank Guidebook.
  - The New Guidebook, issued in April, 2015, adopts a broad interpretation of what constitutes an investigation. (E-34)
  - If a formal targeted process is used and relates to a specific practitioner’s professional competence or conduct, such a review which could include an FPPE is considered an investigation by the Data Bank.
  - Investigations are not reportable – “only the surrender or restriction of clinical privileges while under investigation or to avoid investigation is reportable.” (E-19)
  - “A routine review of a particular practitioner is not an investigation.” (E-19)

- An investigation, once triggered, remains in effect until final decision is made. (E 45 at Q&A No. 19)
- “Investigations” should only be triggered at the time of a formal written request for remedial/corrective action where the result could be a reportable action.

Behavioral Assessment Phase

- Need to determine whether aberrant behavior should be addressed under the Code of Conduct process or the Physician Wellness Committee process.
  - Decision will be based largely on how behavior compares with past conduct, the details contained in incident/occurrence reports and any follow up interviews which may be necessary.
  - Once a path is chosen, you generally will be expected to follow the process until the end but either option should allow for ability to trigger remedial action if necessary to protect patients.
Best Practice: Bylaws should require all credentialed practitioners to report to a Department Chair or Medical Staff officer any behavior where there is any “reasonable suspicion” of impairment. If documentation supports this assessment, physician should be required to consent to an internal evaluation by the Physician Wellness Committee to determine whether a formal assessment should be conducted. Failure to meet with the Committee or abide by its recommendation can be grounds for remedial action.

If a physician is placed in a rehab or similar program while on a leave of absence and returns with full privileges, no report to the Data Bank is required.
- Check state law because you may be required to advise the state if physician is found to be impaired.
- If privileges are voluntarily reduced, action may be reportable and could trigger hearing rights.
- Physicians who were in a rehab program and return to the hospital with privileges should be placed on an action plan which must be monitored for compliance.

Plan should describe consequences for non-compliance.
- Need to determine how to respond to third party inquiries.
How to Manage an Investigation

- Investigation triggered by a formal written request from designated Medical Staff Officer, Department/Section/Committee Chair or member of senior management.
- Should only be made if other non-reportable measures have failed or if clearly inadequate to address identified problem.
- Written request should contain sufficient detail so that MEC can determine whether an investigation should be triggered.
- Request should contain accompanying documentation.
  - Best Practice: Request should not specify action sought, i.e., reduction or cessation of privileges. Investigation and recommendation should be left to ad hoc committee.

Better to use an independent or ad hoc investigating committee when remedial/corrective action is requested instead of full MEC that can be appointed by either the Department Chair or the MEC.
  - Best Practice:
    - Need at least one or more members on the Committee who are of the same specialty and ideally are not a direct competitor.
    - Use physicians who are knowledgeable, respected and who will "do the job".

Prior to Committee’s recommendation, all relevant information should be shared with physician in advance and physician should have the right to an informal meeting with Committee to discuss identified problems.
- Meetings are informal – attorneys not allowed.
- Committee should prepare a report with findings to support recommendation to the MEC which are linked to existing standards/requirements under applicable Bylaws, Rules, Regs and policies – physician’s comments should be reflected in report.
- If some kind of remedial action is recommended, try to find a balance between protecting patients while avoiding decisions that will trigger hearing rights – hearings should be limited to what is reportable.
How to Manage an Investigation (cont'd)

- If using outside reviewers, make sure you develop a paper trail to maximize confidentiality protections under state/federal peer review statutes. Also, reviewers should not make any recommendations on what remedial action, if any, to take.
  - Reviewers should agree in advance to serve as a witness in case a hearing is required in the future; otherwise, report may be useless.
  - Outside review should be used on a limited basis and only when actual conflicts of interest exist, or the physician is already claiming bias or where an expertise not otherwise available on the medical staff is needed.

How to Manage an Investigation (cont'd)

- Outside reports are double-edge swords because they really cannot be ignored.
- Physician should be given a copy of the report as well as the opportunity to respond before the ad hoc committee makes its recommendation.
- Should attempt to perfectly comply with Bylaw procedures although only "substantial compliance" is required.

How to Manage an Investigation (cont'd)

- Investigation and recommendations need to be fair, reasonable and consistent. Questions to ask include “how did we handle these issues or problems in the past?” and “do we have enough information on which to base an informed decision?”
- Some hospitals and medical staffs attempt to get the adversely affected physician to come up with an acceptable action plan which they must follow.
Collegial Intervention

It is the policy of the Medical Staff leadership of the Medical Center to work collegially with Medical Staff members to assist them in delivering high quality and safe medical care, to continually improve their clinical skills, to comply with Medical Staff and Medical Center policies, and to meet all performance expectations as established from time to time by the Medical Staff. Medical Staff policies, including those on Peer Review, performance improvement, conduct, and Physician health and impairment describe some of the collegial interventions available to Medical Staff leaders in working with colleagues whose clinical performance or professional conduct is problematic. Collegial intervention may include letters of warning/concern, a reprimand, a notice that the Physician’s conduct will be monitored for a period of time and/or that similar conduct in the future will result in remedial action, including but not limited to, termination from the Medical Staff; a voluntary agreement to attend meetings, CME courses, obtain consultations, or other appropriate action. Collegial intervention shall not entitle a member to a hearing or appeal under the fair hearing rights outlined in Article VIII.
Questions & Answers

1. Do the procedures and recommendations discussed during the presentation apply to large group practices which may be more difficult to manage than hospital medical staffs?

Response: Without commenting on which organization is more difficult to manage, we believe that many of the principles discussed have direct application to group practices. For example, the concepts of “just culture” and fundamental fairness in addressing quality of care and behavioral issues are or can be universal concepts applied in any setting. That being said, group practices are not obligated to follow the multi-tiered peer review process which includes required investigations, hearings and appeals utilized by hospitals and medical staffs and are dictated by accreditation standards as well as state and federal law. Instead, like employed physicians, group practices have the ability to hire and fire at will subject only to their employment agreements and whatever internal policies they have adopted. One would hope that in order to attract and keep good physicians there is a fair process that has been incorporated into a group practice to address quality and behavioral issues.

2. What about a reportable process for employed physicians?

Response: I touched on this subject during the presentation but it deserves further comment and, as I mentioned, probably a separate program. We all know that hospitals and health care systems are employing more and more physicians. Employers in most states are allowed to “terminate at will”, meaning they can fire employees with and without cause and are not required to provide hearings and appeals. Most hospitals take advantage of this legal option. Similarly, hospitals typically include what we call “clean sweep” provisions in their exclusive provider contracts with hospital-based practices such as anesthesia, radiology and pathology which allows them to terminate the group contract and group members without a hearing, employed physicians usually are not given the formal hearing and appeal rights under these contracts even though they are also members of the medical staffs.

Because peer review investigations, hearings and appeals are time intensive and expensive exercises we do not expect that hospitals will change this practice. Instead, they are likely to provide some limited process as set forth in existing Human Resource or Employment Policies.
As I mentioned during the presentation, The Joint Commission takes the position that employed physicians who are terminated for quality of care, behavioral or other issues that would require a hearing for independent medical staff members should have the same hearing rights. This is not an explicit standard but implicit in the sense that the Medical Staff Standards on physician hearing rights makes no distinction between employed and non-employed physicians on a medical staff.

An underlying concern is that some hospitals are terminating physicians who should be reported but are not. This is sometimes part of a “deal” which might include a severance package and a good reference so long as the physician goes away quietly. Most of us would be concerned if these physicians are simply moving on to their next position and hospitals are not providing truthful and objective responses to third party inquiries received from prospective employers, hospitals and medical staffs.

One complication is that if a hospital reports an employed physician without a hearing and the physician sues the hospital, they will not be able to access the immunity protections under the Health Care Quality Improvement Act (“HCQIA”). I have advised clients that under these circumstances a medical staff hearing and appeal should be offered to the physician. If the physician waives this offer the immunity protections would still apply. HCQIA allows for alternative processes as opposed to the full hearing and appeals procedures although there is no “bright line” standard as to what would be sufficient in order to still be eligible for these protections.

These issues require serious debate to find a balance between an employer’s legal right to hire and fire at will and the employee’s right to fundamental fairness while taking into consideration the need to report terminated physicians to the state or Data Bank or otherwise put third parties on notice when they present an objective threat to patients. Stay tuned.

3. Should we keep separate Peer Review files and are they purged after a certain number of years?

Response: Most hospitals and medical staffs have two files for physicians. There is the credentials file, which includes appointment/reappointment applications and related materials, and a peer review or quality file which contains protected or confidential information regarding quality of care issues that have been collected during the course of a physician’s medical staff tenure. Their might even be a third file relating to impairment issues although this information is probably included in the peer review file.

The peer review files need to be maintained for a stated period of time for a number of reasons. First, because a single adverse event rarely should result in a decision which triggers a hearing or state/Data Bank report, we typically collect information over a period of years to determine whether the data reflects patterns of substandard practices or behavior. For that reason alone we need to maintain files for a number of years. Second, we need to be mindful of the relevant statute of limitations in each state in case a malpractice or corporate negligence claim is brought against the physician and hospital. These statutes vary from state to state but are usually between 2 and 4 years. You need to consult with your local or in-house counsel on this point.
Third, some states have mandatory record keeping requirements which may apply. Again, you need to consult with counsel.

Taking these standards into consideration I believe most hospitals and medical staffs maintain these peer review records for between 5 and 10 years but then purge them, particularly if dealing with “clean” records which probably applies to the majority of physicians.

4. **Should an investigation be done under the direction of a peer review committee so that the confidentiality/immunity protections afforded under state/federal law apply?**

Response: Absolutely. But remember, you need to look to your state law to determine how the protections apply. Each state is somewhat different and you need to follow not only the statute but also the case law which has interpreted the statute. Therefore consult with your in-house our outside legal counsel to make sure you are following the law AND that your bylaws and policies also are in compliance with the law and that you follow your bylaws/policies.

5. **To what extent and how much information should non-physician reviewers (such as a PI Director) be able to review before it is provided to a physician?**

Response: Each hospital has its own procedures and policies with respect to how peer review information, reports, complaints, etc., are reviewed and processed before it is shared with the physician in question. There is no clear rule on how much information can be shared and by whom, although we always need to be mindful about the confidentiality and sensitivity of this information. It should only be reviewed by those individuals who need access in order to fulfill a job and/or committee function. Always keep in mind HIPAA and other confidentiality statutes.

6. **If during the course of ongoing monitoring of a practitioner we find out that the physician resigned from another hospital while under investigation by that facility for quality of care concerns, is it best to seek further information from this practitioner through a collegial discussion with the physician with the Chief of Staff and Medical Director, should this go the Credentials Committee?**

Response: First of all, it is important to point out that whenever you are put on notice of some adverse event, lawsuit, disciplinary action, etc., involving a practitioner you have a legal duty to obtain as much information as possible in order to make an informed judgment on what remedial action, if any, may be required. Second, it is my view that you should confirm the accuracy of the information. All too often decisions are made and actions taken based on rumor, innuendo and inaccurate information. It is better to go to the source. Here, if the information is accurate and was obtained from the hospital, the next step would be to set up a meeting with the physician. There are always two if not three sides to the story and the physician should be given a collegial opportunity to respond to the information you have obtained. This meeting might require a follow-up with the other hospital, which may or may not want to give you all of the details. Remember that a physician should have a continuing obligation to provide you with whatever information you need at time of appointment, reappointment and all times in between.

Once you are comfortable that all relevant information has been obtained, it should be forwarded to the appropriate Medical Staff Committee and certainly the Department Chair who is likely the one responsible for the ongoing monitoring. I would not provide this information to a
Committee before sharing with the physician. The physician also should be given the opportunity to appear before the Committee before any further action is taken.

7. Was the Dr. Callahan hypothetical a “normal” peer review process?

Response: The “hypothetical” scenario we described was a composite profile of a number of peer review situations we have faced in working with hospitals and medical staffs. I expect that most people have had to address similar situations. We purposefully provided a profile that raised quality of care and behavioral issues so that we could discuss both a quality and a behavioral assessment pathway as part of the presentation.

If the question being raised is whether the process we described was typical or normal, I would say yes, keeping in mind that there is no single way to conduct these reviews. We did not have enough time to fully explore each pathway with respect to how to deal with a disruptive, impaired or aging physician.

8. Please define “investigation” versus “peer review”. When does peer review become an investigation?

Response: The reason we distinguished the Peer Review Phase from the Investigation Phase is because one of the Data Bank reporting events is resignation while under investigation. As a general matter, the term “Peer Review” is all encompassing and actually begins during the appointment process up through and including a disciplinary hearing if ever required. An “Investigation” is a component of peer review but should be distinguished and specifically described or defined in your Bylaws so that you know when an investigation is triggered. There is no set definition for an investigation. You get to decide when an investigation commences and how it is defined, although the Data Bank has taken the position that it is the final arbiter if there is a question or dispute on when the investigation commenced. The starting point of such a review is your bylaws and related policies. My suggestion is that the initial review process of tracking cases and sending them to a Committee for review, meeting with the physician, engaging in collegial intervention, implementing remedial measures that do not require a hearing should NOT be a part of your investigation phase because if so defined in your Bylaws then a resignation at any time during this process arguably is reportable. Therefore, the investigation phase under the Bylaws should occur only if collegial intervention, FPPE and other non-reportable remedial measures have failed and you are therefore forced to request formal corrective/remedial action. This step typically requires the appointment of an ad hoc committee, if deemed appropriate by the MEC, to respond to the written request by conducting an internal investigation. We hope this helps to clarify the point I was trying to make.
9. By the time our Medical Staff Peer Review Committee reviewed a case the physician was already off the staff. We sent the case to external review but the Peer Review Policy requires that the physician be given an opportunity to respond to the review. The physician was sent the report and did respond but wanted a copy of the medical records in order to prepare a final response. Because we had the final decision from the external reviewer, do we need to give the physician the records and prolong the issue?

Response: First of all, because the physician resigned I am not sure why you continued with the outside review unless he resigned while under investigation and you might need to report the resignation IF the report was adverse AND you would have taken an action that triggered a hearing requirement if he had not resigned. Otherwise the decision to proceed with the review anyway seems unnecessary.

Second, if you are inclined to proceed with the review, especially if it could result in a Data Bank report, out of fairness to the physician and consistent with your policy you definitely should be giving the records to the physician or making arrangements for him to see the records on site.

Third, keep in mind that a reviewer NEVER makes a final decision with respect to what action is taken. They compare the record to standards of care but the report needs to be reviewed by committees and shared with the physician for comment before there is a final recommendation. The Committee might agree or disagree with the reviewer; it never totally abdicates its independent judgment to make the final recommendation or decision.

10. If a physician is deemed to need proctoring in order to continue his/her practice, isn’t that a corrective action that requires reporting?

Response: In the Final Guidebook, the NPBD takes the position that proctoring which lasts more than 30 days in which the proctor is physically present is reportable. This has never been the approach of hospitals and medical staffs. There are obvious ways of getting around this outcome, such as not requiring the proctor’s physical presence, but there has been push back from the industry with the goal of changing their stance. Proctoring should be considered an option and component of your peer review process.

11. What if Dr. Callahan hires a lawyer before you can begin an investigation and states all communication must go through counsel?

Response: When a physician retains legal counsel he can only require that attorneys need to communicate with attorneys. In other words, the physician’s attorney should not be communicating directly with the hospital but with hospital counsel and hospital counsel cannot be communicating directly with the physician. Hospital representatives, however, can communicate directly with the physician but would want to copy the physician’s attorney on all communications. If you choose to honor the attorney’s request you would first want to have the physician confirm. Personally, because you are at the investigation stage and not the hearing stage of the process and all communications would be coming from a Committee Chair or the MEC, I would politely decline the request but copy the attorney on all communications.

12. If a physician had quality issues and the MEC met and recommended full focused review on 100% of his cases going forward and he then resigned, is this reportable? If
the physician resigned in order to avoid being reappointed for three months versus 1 year, is this reportable?

Response: The key to determining whether an action is reportable is whether you are involuntarily taking away a physician’s privileges. While physicians may not like to be placed under a focused review, or monitoring or proctoring privileges have not been taken away. The same applies to the three month versus one year reappointment. The NPDB does require a report that imposes mandatory consultation that gives another physician, typically the Department Chair, the right to veto the treatment decision of the physician. To avoid this we simply tell the physician under a mandatory consultation that he needs to adhere to the “recommendation” of the Department Chair because if he does not, it might be changed to giving the Chair veto authority. They usually get the message. Of course, if that action is taken the physician is entitled to a hearing.

13. If a medical staff member is employed by the School of Medicine, which has a contract with the Hospital, and the School places the physician in an assistance program for behavioral reasons what does the hospital do?

Response: Because the hospital is on notice that the physician is in a program, your Bylaws should require that the physician report this action to the hospital. Even if not in your Bylaws, you need to obtain information from the School regarding the basis for this decision and then share it with the physician to get his/her perspective in order to decide if the hospital needs to take independent action. We rarely should be taking action based solely on events that occur at a different facility not under the hospital’s control. For example, if the physician’s behavioral problems occurred exclusively in the School and not at the hospital, and there is no similar problem at the hospital, you might just want to track the physician’s progress in the program after you have obtained his authorization. You need the information before making an informed decision on what steps, if any, should be taken.

14. Under the same scenario in No. 13, can the hospital share information with the School?

Response: You need to look at your Bylaws and policies as to whether the physician is required to disclose this information himself. This is not an appointment/reappointment situation where the physician authorizes such a release and even if it was, I doubt it would cover the hospital’s release to the school. But the release of information might be covered under the physician’s employment contract with the School. The better practice is to have the physician agree in writing to the release. If he does not and if not otherwise addressed in any bylaw, policy or agreement, I would not give out the information.

15. What if a physician resigns due to “health reasons” and we later find out that he had a substance abuse problem and his license was revoked?

Response: Assuming you had no knowledge about his problem, you have no obligation to report. The state will be reporting the license revocation to the NPDB and he will not be practicing anymore anyway.

16. Do medical groups have to follow the same procedures as do Hospitals in terms of peer review, reporting, etc.
Response: No. They are not considered “health care entities” under the statute and therefore have no Data Bank reporting obligations. One would hope that the potential loss of employment or partnership will motivate a group member to abide by internal policies and standards of care. One would also hope that collegial intervention and policies based on fairness and transparency are also followed. They are not required.

17. If all of the physicians of the same specialty in a community are competitors can they still participate in an investigation if given no vote?

Response: The standard of not having competitors serve on a hearing committee, which is a requirement under HCQIA and most state statutes and Bylaws, does not technically apply at the investigative stage. That being said, avoiding the use of competitors even at this stage is a best practice and one you should try to follow. Where you really need someone from the same specialty involved I would first try to get someone from a different community who does not compete OR consider obtaining an outside reviewer. The reality is that even if the physician does not formally vote it is likely that his or her views will be heavily relied on by the others, and so the fact that he or she did not vote will not protect you from a claimed conflict of interest.