

# **Memorandum**

**TO:** Division of Practitioner Data Banks,  
Bureau of Health Professions,  
Health Resources and Services  
Administration

**FROM:** NPDB Guidebook Work Group Distribution

**DATE:** January 31, 2014

**SUBJECT:** Comments to Draft NPDB Guidebook

---

## **1. INTRODUCTION**

In response to the invitation from HRSA to comment on the draft revisions to the NPDB Guidebook, we convened a group of healthcare attorneys to review and respond jointly. The comments here are the views of each of us individually, and do not represent an official position of any of our respective firms or employers.

While there were many comments, all of which are provided below, the issue that generated the most attention and concern is the issue of the definition of investigation, when to report the voluntary surrender of privileges, and questions 16 and 17 on page E41 of the draft which suggests that the definition of investigation is somehow linked to the concepts of ongoing professional practice evaluation (OPPE) and focused professional practice evaluation (FPPE). This obviously is a critical issue because if a physician resigns while under investigation or to avoid an investigation, this decision is reportable. This Section is confusing and the stated scope of what qualifies as an investigation is far too broad and finds no support in HCQIA. For this reason we start our comments with this issue.

## **2. VOLUNTARY SURRENDER AND DEFINITION OF INVESTIGATION**

We recognize that the Health Care Quality Improvement Act (HCQIA) requires reporting of the voluntary surrender of medical staff membership or clinical privileges while under investigation or to avoid an investigation. However, we are concerned with the attempt to define an investigation based upon the existence of either OPPE or FPPE for several reasons, as follows:

- I. The incorporation of OPPE and FPPE into the Data Bank itself incorporates concepts developed and defined by the Joint Commission. Not all hospitals are accredited by the Joint Commission and there is no guarantee or expectation that the definitions of the concepts will remain the same, or even remain as part of any accreditation process.
- II. We also believe there should be more than 2 choices with respect to defining ongoing peer review; there should be a continuum or “middle ground”. We believe that hospitals

and other peer review organizations, as well as subject physicians, require the opportunity to evaluate and even correct conduct as part of an ongoing quality improvement process, without the process being labeled an investigation. We do not believe the concept of OPPE should be the only avenue for that, because we believe there are times when an individual physician, or a group of physicians, or hospital departments may need more guidance and improvement than is contemplated by the “ordinary OPPE”, and we do not believe that such quality improvement process should rise to the level of an investigation which would require reporting to the NPDB in the event of the voluntary surrender of any privileges or medical staff membership.

- III. Finally, there is also the significant possibility that the proposal is inconsistent with the existing precedent, as more fully explained below.

We submit that, if HRSA adopts the position in its revised Guidebook that the surrender of privileges while under departmental peer review process such as an FPPE, that this will represent a substantial departure from prevailing interpretation, and will have a chilling effect on efforts to address physician competence and conduct issues in a non-punitive, collegial and proactive manner.

HCQIA requires a hospital to file a report with the NPDB when it:

- (1) takes a professional review action that adversely affects the clinical privileges of a physician for a period longer than 30 days; [or]
- (2) accepts the surrender of clinical privileges of a physician (i) while the physician is **under an investigation by the entity** relating to possible incompetence or improper professional conduct, or (ii) in return for not conducting such an investigation or proceeding.

42 U.S.C. § 11133(a)(1)(A) and (B) (emphasis supplied). The district court for the District of Columbia held, in *Simpkins v. Donna E. Shalala*, 999 F. Supp. 106, 114 (D.C. Cir. 1998) that “this definition, in [HCQIA] itself, indicates that an investigation by individual supervisors of a physician's quality of care does not trigger the reporting provisions of 42 U.S.C. § 11133(1)(A) unless the actions of those supervisors amount to action by the hospital.” The court noted, further that HHS has promulgated its interpretation of “health care entity” at 45 C.F.R. § 60.3 that is “substantially similar to the text of the statute.”<sup>1</sup> Thus, the court concluded that, the text

---

<sup>1</sup> The court quoted from 45 C.F.R. § 60.3, as follows: “The relevant portion of Section 60.3 provides: “Health care entity means: (a) A hospital, (b) An entity that provides health care services, and engages in professional review activity through a formal peer review process for the purpose of furthering quality health care, or a committee of that entity; or (c) A professional society or a committee or agent thereof, including those at the national, State, or local level, of physicians, dentists, or other health care practitioners that engages in professional review activity through a formal peer review process, for the purpose of furthering quality health care. 45 C.F.R. § 60.3.”

of the relevant statute and regulation signify that “**formal action by the hospital**, as an organization, triggers Section 11133(1)(A)'s reporting provisions, **not individual action.**” *Id.* (Emphasis supplied). In the context of the *Simkins* case, this meant that a departmental review process (now generally referred to as a Focused Professional Practice Evaluation (FPPE), using The Joint Commission (TJC) terminology) was not an investigation “by the entity” for purposes of NPDB reporting.

The FPPE in the *Simkins* case included a review of the impacted physician by the Department Chief, at the Direction of the Department Chair, to determine whether action regarding privileges was warranted and, based on that initial review, a recommendation for six months of monitoring and consultation, with further recommendations to be made at the expiration of six months. This was not an “investigation” for Databank reporting purposes. By contrast, in *Omar v. Jewish Hospital Healthcare Services*, 153 S.W.3d 845 (Ky. App. 2004), the court upheld the report of a surrender of privileges while “under investigation by the entity” because the physician in that case, at the time of his resignation, was undergoing a formal corrective action investigation initiated by the Medical Executive Committee pursuant to its Bylaws.

Based on the judicial guidance offered by the *Simkins* and *Omar* decisions, hospitals have generally understood that an “investigation by the entity” starts when the MEC (or another comparable committee) initiates or directs that an investigation take place, or at a minimum, that the CEO, CMO, or other hospital official directs the initiation of such an investigation. Specifically, investigations within the industry are typically considered to have commenced when there is a request for formal corrective or disciplinary action which may or may not lead to an adverse peer review decision which, affirmed, would be reportable to the Data Bank.

In contrast, the decision by a Department Chair that a specific provider in his or her department may require review or supervision, is not the equivalent of a formal investigation, but rather as part of the routine peer review process. Peer review extends through a continuum of different forms of review and informal intervention. It can include simple evaluations which occur on a random or selected basis centering on internal or external standards of criteria, which is a day-to-day activity or they can be more focused when issues are identified that require further evaluation and interaction with a physician. Based on guidance from The Joint Commission, most Medical Staff Bylaws and peer review policies are designed in a way to promote “collegial intervention” in which informal methods are used to address quality or behavioral issues at an early stage. Even when a committee process is triggered, such as a Surgical Review Committee, the reviews and analyses in any meetings or interactions with the physician which occur thereafter are viewed by the industry as still part of the peer review process. They are not considered to be an investigation for Data Bank purposes. The policy underpinning of the FPPE process is that quality improvement is most effective when it is direct, proactive, immediate, and non-punitive. FPPE is intended to encourage Departmental leaders (and others) to work collaboratively and continuously with the physicians in their departments to improve quality of care and address deficiencies through collegial intervention.

Although a FPPE plan certainly is imposed when issues have been identified it has not reached the stage in which physician privileges are adversely affected which otherwise would trigger a hearing. In other words, if the FPPE plan is not reportable, it makes no sense that a physician's resignation while under the plan, or before its implementation should be reportable either. Moreover, keep in mind that The Joint Commission requires that an FPPE plan being imposed on all physicians for a set period of time usually six to twelve months. These are in place before the physician exercises a single clinical privilege. Is this too an investigation? We would be interested in further discussing or understanding the NPDB's position on this issue.

Again, the goal is to design a remedial action plan that provides education and support to the health care practitioner while not in any way limiting the exercise of their clinical privileges. As you know, monitoring and proctoring are not reportable to the Data Bank. If a physician decides to resign while being monitored or proctored during a routine peer review process in which the Medical Staff never envisioned imposing a reportable action on the physician why should his or her resignation at that time be considered reportable? Such a position is inherently unfair to the physician and, more importantly, will significantly hamper proactive and supportive methods and other means by which to assist and educate physicians and to improve patient care outcomes and patient safety.

Moreover, we suggest that the concern that FPPE and/or other informal peer review intervention intervention could trigger Databank reporting requirements could have a significant chilling impact on this type of informal activity, and, potentially, turn the clock back to a time when most of the peer intervention occurred in a highly formalistic way.

We cannot ignore the reality that a Databank report for quality/competence reasons can have significant negative professional consequences for physicians, and, for that reason, is often regarded by physicians as a "death-knell" to professional advancement. Therefore, super-imposing Databank reporting obligations on informal FPPE or on mandatory FPPE for all new applicants and applicants for new privileges (by way of the "surrender of privileges" reporting requirement) could, in our opinion, reduce cooperation and create adversity and thereby undermine and chill the very activity that TJC and others promote and endorse as highly effective method for improving quality and safety.

### **3. OTHER COMMENTS**

Set forth below are our comments, observations and questions regarding the draft NPDB Guidebook.

#### **I. Chapter B: Eligible Entities (B-1)**

The Data Bank Work Group at one point in time sent a letter to the NPDB asking whether an ACO can be considered a healthcare entity for purposes of immunity protections and querying the Data Bank. We received a letter over a year ago indicating that an ACO could qualify as a health care entity. As a result of that determination, we would recommend that an ACO be referenced either in this Section dealing with Eligible Entities or, for example, in the Table B-1 which also lists eligible entities.

Yet another option is to list in Table B-3 and referencing same. At B-8 which provides additional examples of health care entities such as HMOs, PPOs, etc.

**A. Table B-3: Examples of Entities That May Qualify as Multiple Eligible Entity Types (B-12)**

This Table states that “a managed care organization that provides health care services and performs peer review for the purpose of furthering quality health care...must report certain clinical privileges actions.” It has always been our understanding that even if a managed care entity followed a peer review process and all of the hearing procedures under HCQIA, it still has the option of determining whether it wishes to be considered a health care entity for Data Bank purposes. If it does not opt in then it has no obligation to query or report. This chart states that the health care entity “must report”.

Another important issue is the continued reference to “peer review process”, “professional review activity” and “professional review action” and the different explanation and references to these terms and how it affects reporting requirements or the interpretations of “investigation”. In our opinion, as will be pointed out in these comments, the Guidebook uses and applications of these terms goes beyond the intent of HCQIA and current industry practices and interpretations.

**B. Q &A: Eligible Entities (B-17)**

1. Question 4 (B-17).

A question and issue which arises throughout the Guidebook involves reporting and querying requirements for health care systems with multiple hospital and other health care entities. For antitrust and other related purposes, these systems are viewed as a single entity particularly if there is a common corporate parent and therefore peer review, price and other information can be and should be freely shared throughout this system. The NPDB restricts the matter in which Data Bank reports can be shared if the hospitals have separate medical staffs or have separate credentialing procedures even if a physician, by applying, is given membership on multiple medical staffs.

In answer to Question 4 as to whether merged hospitals with separate medical staff offices have to query separately, the NPDB response is that if a practitioner is allowed to practice at both institutions even if it only applies to one, then only one query is required. However, there are hospital systems where there may be a single application with the expectation that the practitioner will practice at multiple entities but with different credentialing procedures. Health care systems, even with separate credentialing procedures, should be able to make a single query which information can be shared with other owned or controlled health

care entities, including non-hospital health care entities. It is redundant for multiple facilities within the same unified system to make multiple queries to obtain the same information. Needless to say, each entity would have to document that they received the appropriate information so as to qualify as a “query” for regulatory purposes and that copies of any reports be included in the separate credentials files, to the extent that separate files are maintained.

2. Question 5.

We have a similar response to Question 5 with respect to different departments within the same hospital making multiple queries to the NPDB. The Guidebook proposes a rather simple solution by creating multiple user accounts under 1 DBID. Perhaps this approach could be used as a solution to Question 4.

3. Question 7.

The response to the question of whether PCMHs are eligible to participate as a health care entity seems to conflict with the charts and other statements in the Guidebook. Table B-3 states that such health care entities which do provide formal peer review must report as a health care entity yet the last paragraph in this Section states that such entities would be “eligible to participate.” Again, we also need to obtain clarification as to what is intended by “formal peer review to further the quality of health care.”

**II. Chapter C: Subject of Reports**

**A. Cables C-2: Examples of Health Care Entities**

List should include ACOs.

**III. Chapter D: Queries**

**A. Hospitals (D-4)**

Many hospitals have created a Medical Staff membership category in which physicians exercise absolutely no clinical privileges. Under the Medicare Conditions of Participation and accreditation standards, hospitals and medical staffs are not required to go through the typical appointment and reappointment process or the related privileging/credentialing decisions regarding this category of physicians. If not providing health care services or treating patients why does the hospital need to query the Data Bank regarding these practitioners? The text under this Section states a query must take place when a practitioner applies for medical staff appointment or for clinical privileges. This should be modified.

**B. Residents and Interns (D-5)**

If a resident or intern is still being supervised while “moonlighting” or if these services are being factored into a resident or intern’s evaluation must the Hospital still query the Data Bank?

**C. Summary of When Hospitals Must Query the NPDB (D-5)**

Again, it is our position that hospitals should be not required to query the Data Bank regarding physicians and other practitioners who are members of the Medical Staff in name only but hold no clinical privileges. Other examples would include physicians who serve on the emeritus or honorary staff who are in this category because of their long years of service but do not admit, treat, or provide patient consultations.

**D. Attorney Access (D-8)**

A plaintiff’s attorney can obtain access to a Data Bank report if it can be established that the Hospital failed to query the Data Bank. When the attorney submits required documentation to obtain this information, does the hospital have an opportunity to respond? If not, hospitals should be given this right.

**E. Centralized Credentialing (D-9)**

A number of health care systems do have a centralized credentialing process which credentials the individual practitioners across the system but which might allow technical approval of membership at each facility. As previously stated, if hospitals are part of a single system with a common corporate parent we question the need for each hospital to make a separate query to the Data Bank.

**F. Delegating Credentialing (D-10)**

This Section states that if a PPO delegates its credentialing responsibilities to a health care entity such as the Hospital, it is prohibited from receiving Data Bank query results. Because the PPO is still legally liable for its appointment and reappointment decisions under different theories, i.e., corporate negligence, apparent agency, it should be entitled to receive this information.

**G. Querying Through an Authorization (D-11)**

This Section states that an authorized agent cannot make a query response on behalf of more than one entity. What if the entity has a centralized credentialing process and the agent is making a query on behalf of several entities within the same integrated system? The Guidebook previously stated that if a query is being made about a particular physician who is automatically given privileges at multiple facilities then it would seem that the agent should be allowed to make a single query request for each health care entity within the system. Appropriate documentation obviously would be required.

**H. Question No. 10**

The health care system is expected, if not required, to know all peer review related information regarding a physician who has privileges at multiple hospitals within the system. Physicians typically sign an authorization or consent form that allows this information to be shared with affiliated hospitals within the system so that consistent decisions regarding privileges and credentials can be made. The hospital and the system should be able to share this information with its affiliated health care entities without having to make multiple queries to obtain identical reports.

**IV. Chapter E: Reports**

**A. Revision-To-Action Report (E-9)**

This Section gives examples of when a Revision-to-Action Report should be submitted and includes as an example when a “probationary period has ended”. Probations are not reportable and therefore making reference to this term will be confusing. We would recommend that this reference be deleted.

**B. Notice of Appeal (E-10)**

If a hospital’s decision to terminate a physician is based on licensure action must they also file a report of the notice of appeal if the physician appeals this decision?

**C. Narrative Descriptions (E-11)**

This Section states that the narrative descriptions should summarize the official findings or statement of the facts of the case and include a description of the circumstances that led to action taken. Is this a new standard? Does NPDB ever send back a report because it does not contain sufficient information?

**D. Question No. 2 (E-14)**

If the subject of an NPDB report has already received such a report as per NPDB policy, why does identifying information need to be redacted, removed or obscured before a copy is provided to the individual by the reporting organization? We realize the reports are confidential but what if the reporting entities are within the same health care system?

**E. Reporting Adverse Clinical Privileges Actions (E-28)**

The Guidebook states that “adverse clinical privileges” actions involving censures, reprimands, or admonishments should not be reported to the NPDB unless they adversely affect the practitioner’s clinical privileges for a period longer than thirty (30) days.” It is important to clarify what is meant by “adversely affect”. Our position would be that if a physician is still able to exercise clinical privileges without any restrictions then the privileges are not adversely affected. For example, if a physician is being monitored or proctored or is required to obtain a mandatory consultation from a Department Chair who does not have veto authority over a treatment decision, then privileges are not being

adversely affected even though the physician may not welcome this form of remedial action. Censures, reprimands and admonishments do not have the effect of taking away privileges and therefore these decisions should never result in a Data Bank report.

**F. Multiple Adverse Actions (E-29)**

The Guidebook states that if multiple actions are imposed only one needs to be reported. The example given is a 12 month suspension followed by a five-month probation. Probations do not adversely affect a physician's clinical privileges and therefore inclusion of this reference could suggest that a five-month probation or one that last more than days would be reportable which is not the case. Another example should be used such as the imposition of a mandatory consultation which would require prior approval of the Department Chair for a period exceeding thirty days.

This being said it is interesting that the NPDB takes the position that both actions need not be reported. Hospitals would be very interested in knowing that two forms of disciplinary action were imposed because this would be important information to factor into an appointment and reappointment decision. What is the NPDB's rationale for taking this position?

**G. Denials or Restrictions (E-29)**

The Guidebook should clarify that a request for clinical privileges either at the time of appointment or reappointment, should not trigger a Data Bank report if the decision is based on technical qualifications or whether the practitioner has current competency and experience to exercise these privileges as opposed to being based on concerns of sub-standard care or practices. In other words, if the hospital requires that a physician only be granted cardiac cath procedures if they have performed 50 procedures in the previous year, the denial of a physician's request for such privileges based on the fact he only conducted 40 in the previous years should not be reportable. This is another way of saying that he is not qualified or sufficiently competent to obtain the privileges. No hospital would ever report a physician under these circumstances.

**H. Withdrawal of Applications (E-30)**

This Section provides that a physician can be reported to the Data Bank if he or she withdraws an application from consideration irregardless of whether the practitioner knew they were under investigation. We believe that this position is inherently unfair to the physician. The hospital should be required to advise this physician so that he or she can make an informed decision of whether or not to withdraw the application. Our position applies to any circumstances in which a physician could be reported while "under investigation".

**I. Investigations (E-31)**

Our concerns regarding this section are addressed in our initial comments.

**J. Temporary Clinical Privileges (E-32)**

This Section states that if temporary privileges are denied with no opportunity for renewal which would be less than 30 days and the action terminates temporary privileges, even if based on quality of care concerns, is not reportable. What if the termination was based on conduct or competence that did or could adversely affect patients? If the hospital felt compelled to report the physician in order to protect patients are you saying that this action is either not reportable or the report would not be accepted by the NPDB?

**K. Proctors (E-34)**

This Section reflects the industry's understanding of when a decision to require proctor is or is not reportable. The NPDB may want to include other examples such as monitoring re-education, retrospective review of cases, etc.

**L. Residents and Interns (E-34)**

Although NPDB makes a distinction between a resident and intern who participating in residency or similar program as distinguished from moonlighting in terms of reportability, the fact remains that any sub-standard care provided by these interns or residents at any point in time in their training should be identified so that hospitals and medical staff residency programs can be placed on notice about potential problem practitioners. We have seen situations where hospitals have taken on new residents without the knowledge of significant behavioral problems or substandard practices before obtaining staff privileges. Although we can appreciate the NPDB's goal of not wishing to unnecessarily penalize these individuals, perhaps any reports in the Data Bank made during an internship or residency could be redacted or eliminated once the individual becomes a fully licensed physician.

**M. Confidentiality Laws Related to Drug and Alcohol Treatment (E-34)**

This Section is too vague. Most medical staff bylaws make reference to a Physician Wellness Committee. These committees are set up to evaluate practitioners who may be suffering from some form of physical or psychological impairment. Sometimes these meetings with the committee are voluntary and sometimes they are "suggested". Typically, there is no real "clinical privileges action taken" although we are not sure what this means. If privileges are unaffected and the practitioner goes into a rehab program, then there has been no adverse action and therefore we would submit there is nothing to report. On the other hand, if clinical privileges are effectively reduced or suspended, that is a different matter. Typically, physicians go on a leave of absence during this rehab period. We are assuming that such a leave of absence would not be considered a clinical privileges action, although clarification on this point would be helpful.

**N. Table E-6: Determining if Clinical Privileges Actions Must Be Reported (E-36)**

According to this Table, a physician or dentist who voluntarily restricts or surrenders clinical privileges is considered to be under investigation and therefore the decision is

reportable because it is considered to have occurred “while under investigation”. This is not always the case. For example, it is quite common at time of reappointment for a department chair to sit down with a physician who may have accumulated privileges over a long career and suggest to him or her that because they no longer doing particular procedures or performing particular invasive tests that it might be wiser to voluntarily relinquish those privileges. That is simply good management. It does not necessarily mean that the physician is a substandard physician or a current risk to patients. There is another way to say that because they have not performed a sufficient number within recent history that it is probably better that they avoid potential problems by voluntarily giving up certain privileges. Under no circumstances would any hospital or medical staff consider this to be a reportable event.

Similarly, the Table states that a decision to voluntary restrict or surrender clinical privileges in return for not conducting an investigation relating to competence and conduct is reportable. Again, there is the issue with how the term “investigation” is defined. If the physician in the example above is told by the Chair that he or she is inclined to keep privileges, that they would need to conduct a more thorough review of his past practices to determine whether privileges should be maintained, is this considered an investigation? Most would view this as normal peer review well before any decision is made to trigger a more thorough investigation preliminary to a professional review action.

What about the circumstance in which issues are identified and the physician decides to “voluntarily” relinquish privileges which last for a period of more than thirty (30) days, but after the review all of the physician’s clinical privileges remain intact. Is this voluntary reduction reportable? In the interest of protecting patients, and to avoid an unnecessary hearing, sometimes a “cooling off period” is appropriate. In this way patients are actually or potentially protected, a more thorough review can take place, and if the physician’s privileges are unaffected, it would seem unnecessary to have to report the physician under these circumstances and then immediately submit a Revision to Report form.

## **O. Q&A: Reporting Clinical Privileges Actions**

### **1. Question 2 (E-37).**

As previously stated, the fact that a physician does not have the clinical competency to qualify for expanded privileges does not mean they are not competent. For example, many hospitals and medical staffs grant a set of “core privileges” to physicians in any particular department if they have the appropriate background, training and experience. In order to exercise certain specialized privileges, additional background and training and experience is required. These standards are typically fairly black and white. If a physician requests such expanded privileges hoping to obtain them, even if he or she did not meet the qualifying criteria, technically the determination is being made that they are not competent because they have not had enough experience but not because they are incompetent or are a substandard physician. This response needs to be clarified because

we are assuming that the decision not to expand the privileges based on this hypothetical would not be reportable.

2. Question 3 (E-37).

What if denial was simply based on the Department Chairman's decision because the physician did not meet the qualifications requirement without the review of the Credentials Committee and the Board of Directors? Would this make any difference to the NPDB?

3. Question 6 (E-38).

The question here is whether a PPO which terminates a physician's contract for poor patient care resulting in termination as a network participant requires one or more NPDB report.

First of all, the question assumes that the PPO has opted to be treated as a health care entity for querying and reporting purposes. Second, under what circumstances would it be considered a "professional review action by the PPO"? Does the PPO make this determination? Is the NPDB saying that if the physician was simply terminated by a director without any process that the decision it is not reportable? In previous questions and answers the NPDB has described certain processes as a professional review action rather than deferring to the entity to determine whether it so qualifies. What exactly is the standard? In our experience, PPO hearing panels can include a majority of PPO-employed individuals (including medical directors) and may even include individuals who are not physicians. While these individuals may not have anticipated in the initial decision regarding the physician, direct employees of the PPO can hardly be considered impartial. Moreover, how can a decision made by a panel that includes non-physicians be considered a "professional review action"?

The answer to this question also has important implications with respect to hospital employment of physicians. More and more physicians are being employed by hospitals. The employment agreements typically include a provision which states that membership and clinical privileges are automatically relinquished upon termination and further that the physician waives any hearing and appeal right under the Medical Staff Bylaws. Because these decisions are not usually made pursuant to a peer review process or a professional review action, these decisions are not reported to the NPDB.

4. Question 11 (E-40)

Aside from the issue of what does or does not constitute an investigation, which is limited to where the entity is looking into possible incompetence or improper professional conduct as opposed to normal peer review procedures, is the concern that a physician's failure to renew, as opposed to a proactive decision not to renew, requires a report to the Data Bank even if there were less than thirty (30) days remaining on his or her appointment. As previously stated, we believe it is inherently unfair for a report to be made under the circumstances of this question without advising the physician of the consequences and particularly because it is highly unlikely he will even understand what

does or does not qualify as an investigation. Advising the physician of this possibility could affect whether the physician decides to reapply. Moreover, what if the medical staff determines that had the investigation proceeded, there never would have been a decision that would have resulted in a reportable event?

5. Question 22 (E-43).

The answer to this question should be expanded. For example, what if the physician returns from the rehab program and his privileges are fully restored? Wouldn't the hospital have to prepare a revision to action report indicating this reinstatement decision? Also, we would suggest that you indicate whether the physician in this example did or did not enter a rehab program. Why cannot this be considered a voluntary leave of absence? Again, the goal should be attempting to work with physicians to get back on track rather than to penalize them or report them to the Data Bank. It seems wholly counterproductive to report a physician who, irrespective of the fact that there was some cajoling involved, ultimately decided to go into the rehab program to get help in order to return to become a productive physician.

6. Question 23 (E-42).

When concerns regarding possible impairment arise, many bylaws impose a duty on medical staff members and others to notify a medical staff officer, department chair or hospital official. The bylaws again typically require that if a physician is requested to be evaluated by a Physician Wellness Committee to determine whether an evaluation is appropriate, most physicians will agree to meet with the Committee. If after this meeting a physician voluntarily agrees to enter into a rehab program, no one in the industry would consider this a reportable event. Would the NPDB agree with this assessment?

Respectfully submitted,

Michael R. Callahan  
Katten Muchin Rosenman, LLC

Harry Schulman  
Hooper, Lundy & Bookman, P.C.

Michael A. Cassidy  
Tucker Arensberg, P.C.

Mary Holloway Richard  
Integrus

Robin Locke Nagele  
Post & Schell, P.C.

Robert R. Harrison  
The Johns Hopkins Health System

Barbara Blackmond  
Horty, Springer & Mattern, P.C.

Beth Anne Jackson  
Beth Ann Jackson, Esq., P.C.