Discipline

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Many physicians go their whole careers without ever facing a credentialing, privileging, or licensing issue.

Those physicians are fortunate.

However, other physicians who are not so lucky often fail to appreciate the seriousness of their situation and take action too late in the proceedings, thereby jeopardizing their livelihoods.

Background

When physicians are granted medical staff privileges at a hospital, they are governed by the terms and conditions of both the hospital bylaws and medical staff bylaws.

The medical staff bylaws include provisions, in some form or another, for corrective disciplinary action to be taken against physicians for events broadly described as "disruptive conduct" or "posing a threat of harm to a patient or hospital operations." Such actions are generally initiated through an "investigation," which can result from a negative patient outcome or a statistically significant number of negative outcomes, or from a patient or peer complaint.

While hospital investigations of negative patient outcomes and complaints are necessary, unfortunately, there are times when such investigations are triggered by personal animosity, anti-competitive behavior, or economic motivations, under the guise of protecting "patient welfare and safety."

Most, if not all, bylaws also contain provisions allowing for the immediate or "summary" suspension of a physician before and pending an investigation. Many physicians erroneously believe that a summary suspension is only used in the most serious of cases, such as a physician reporting to work under the influence of drugs or alcohol. In reality, that's not the requirement of most bylaws or in practice.

Regardless of the underlying reasons for an investigation or other review, it is important that physicians act swiftly to assess the situation and obtain legal counsel. Often, physicians fail to respond promptly because they are not aware of the potential outcomes of hospital investigations and corrective disciplinary action, such as being reported to the State Licensing Board (SLB) and/or the National Practitioner Data Bank (NPDB).

These physicians are often left scrambling after their privileges have been suspended, revoked, or denied, and/or a report is made to the SLB or NPDB. Significantly, in Michigan, suspensions of more than 15 days are reportable to the SLB, thus, prompt action is critical once a suspension has been imposed.

Step 1 — Where am I?

It is crucial to immediately determine whether the disciplinary or credentialing proceedings initiated by a hospital qualify as an "investigation."

While seemingly innocuous, this distinction is important because both SLB and NPBD guidelines require physicians (including dentists) to be reported if they resign during an "investigation."

Many times, resignation seems like a reasonable alternative during the proceedings, and unwitting physicians resign (without challenging the substance of the charges against them) only to discover later that the resignation itself is reportable.

What constitutes an "investigation" and how these investigations are conducted are usually defined in some manner in the bylaws. However, some bylaws are poorly written, vague (intentionally or unintentionally) and fail to properly define an investigation, or how the investigation, review, and appeals process should be conducted.

Vague procedures for the investigation/review and appeal processes favor the hospital and can do a great disservice to the physician.

In situations where "investigations" are not clearly defined under the bylaws, the NPDB Handbook and case law provides guidance to determine if an "investigation" is present. Generally, an "investigation" must meet the following criteria: formal notice of the investigation must be given to the physician; an investigation must be carried out by a health care entity, not an individual.

Thus, just because a lone individual has raised concerns about a physician's quality of care, this does not mean an investigation is present. Generally during an "investigation," a physician's files are reviewed by an ad-hoc committee or submitted for outside, independent review.

A routine or general review of cases is not considered an investigation; generally, in cases where courts uphold NPDB reports arising from resignations during "investigations," the investigation is triggered by a specific complaint or incident.

The investigation must be related to issues directly pertaining to patient care, not documentation or administrative issues.

Step 2 — What are my rights?

Regardless of whether a physician is subject to a formal investigation or a more casual review, it is important that physicians know and understand their rights under the bylaws.

For example, do they have the right to be advised of the charges being made against them? Do they have the right to respond to the charges? Can they appear at review meetings or present expert testimony in defense of their actions? Do they have the right to bring legal counsel?

If these topics are not addressed in either the hospital or medical staff bylaws, clarification should be sought through appropriate channels (i.e., chief of the medical staff, hospital legal counsel, etc.), preferably in writing.

Step 3 — What should I do?

Some physicians think they should just wait for the Fair Hearing (if things get that far) before seeking legal advice. However, waiting can be a devastating mistake.

A Fair Hearing is conducted like a "mini-trial," often with lay and expert witnesses, and can be an exhausting and extremely expensive endeavor. Additionally, by the time a Fair Hearing arrives, due process rights may have already been waived, giving way to biased and one-sided conclusions regarding the physician's conduct.

Further, a physician may accidentally miss the deadline to request a Fair Hearing; fail to properly follow request procedures; unwittingly waive the right to a Fair Hearing; or not be entitled to a Fair Hearing on all of the adverse actions they would otherwise be entitled.

Waiting until a Fair Hearing can also mean that a physician has already faced a suspension or other restriction on his/her privileges, resulting in the loss of valuable income, a loss of good will, and a report to the NPDB or SLB.

Thrown away: Rite Aid settlement underscores the importance of personal information disposal

On July 27, 2010, it was reported that Rite Aid Corp. agreed to pay $1 million to the Department of Health and Human Services (HHS) to settle potential violations of the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Rule.

The settlement follows a joint investigation by the HHS Office for Civil Rights (OCR) and the Federal Trade Commission (FTC).

An investigation of Rite Aid was initiated by OCR after pharmacies were videotaped disposing of prescriptions and labeled pill bottles containing individuals' PHI into open trash dumpsters that were accessible by the public. According to reports, this practice occurred in a variety of cities across the United States.

In the investigation, OCR and the FTC found that Rite Aid: failed to implement adequate policies and procedures to ensure the privacy of PHI during the disposal process; failed to adequately train employees on the proper disposal of PHI; failed to maintain a sanctions policy for members of its workforce who improperly disposed of patient information; and failed to assess compliance with its disposal policies and procedures.

In addition to paying the settlement amount, Rite Aid signed a consent order with the FTC to settle potential violations of the FTC Act. The retailer also agreed to take corrective action to improve its policies and procedures to safeguard the privacy of its customers.

These actions will include: revising and distributing their policies and procedures regarding the disposal of PHI; adequately training workforce members on these new requirements; conducting internal monitoring; sanctioning workers who do not follow the policies and procedures; and engaging a qualified, independent third-party assessor to conduct compliance reviews and render reports to HHS.

Document Disposal

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More information on proper disposal methods can be found in the frequently asked questions about the HIPAA Privacy and Security Rules requirements for disposal of PHI on the OCR website: www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/disposalfaqs.pdf

The HHS Resolution Agreement and Corrective Action Plan can be found at: www.hhs.gov/ocr/privacy/hipaa/enforcement/examples/riteaidres.pdf

The Rite Aid case is the second reported joint investigation by OCR and the FTC. A similar case involving another drug store chain, CVS Caremark, was settled in February 2009.

Disposing of individual health information into a trash container without proper destruction methods could violate several requirements of the HIPAA Privacy Rule. The Rule requires health plans, health care clearinghouses and most health care providers (covered entities) to safeguard the privacy of patient information. This practice extends to protecting information during its disposal.

Although the HIPAA Privacy and Security Rules do not require a particular disposal method, covered entities are responsible for determining what policies and procedures are reasonable for their institution.

In making this determination, institutions should consider the form, type and amount of PHI to be disposed. Sensitive information, such as social security number, driver's license number, credit card number, or diagnosis and treatment information will warrant more care due to the risk of identity theft, discrimination, or other harm to the individual's reputation. PHI should be rendered unreadable, indecipherable, aand unable to be reconstructed before its disposal.

Examples of proper disposal methods include: shredding, burning, pulping, or otherwise pulverizing paper records containing PHI; maintaining labeled prescription bottles in an opaque bag in a secure storage area; clearing, purging, or destroying any electronic media containing PHI; and using a disposal vendor as a business associate to pick up and destroy PHI.