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Understanding the Disciplinary Process: Hospital Bylaws, Reporting Adverse Actions, and Legal Considerations

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Possessing thorough knowledge of legal and administrative procedures underlying hospital-based adverse actions is essential for hospital in-house counsel and attorneys who represent health care providers. Significant changes have occurred within the hospital and health care environment that have shifted the balance of power among hospital leadership, physicians, residents, nurses, and other ancillary staff over the last decade. All of these factors have rendered hospital-based peer review and adverse action proceedings more challenging for health care attorneys who must navigate and grasp the nuances of the hospital bylaws, the regulatory requirements for reporting of hospital adverse actions, and the political environment of the hospital medical staff.

Significant Changes in Health Care

Two paradigm shifts within health care have profoundly affected the conduct of adverse actions in hospitals. The first is the trend over the last decade toward the gradual corporate consolidation of hospitals and hospital systems nationwide. The second is the decreasing tolerance for disruptive behavior in the clinical workplace. Both shifts have greatly influenced how hospital adverse actions are adjudicated.

Health Care and Hospital Consolidation

One significant effect of hospital consolidation is that what happens in one system hospital may impact one's status in all the system hospitals. In addition, due to the consolidation of health care systems, the clear delineation between members of the hospital medical staff who participate in peer review committees and corporate hospital leadership at the administrative and board level has blurred considerably. The movement of hospitals toward corporate consolidation is often accompanied by hospitals purchasing local independent medical practices and absorbing them into the larger hospital system. Accordingly, it is now more common to find members of hospital medical staff committees assigned to adjudicate peer review actions who are also affiliated in some way (including through employment) with the hospital. This creates a peer review system that may favor the hospital over the physician facing an adverse action, as the organizational and administrative wall that once existed between the medical staff and hospital leadership and governing bodies is gradually dissolving.

Evolving Workplace Conduct Standards

In the realm of workplace civility and communication, most lawyers whose practices involve labor and employment law are familiar with the current climate of zero tolerance for toxic behavior in the workplace. The sweeping changes in workplace culture brought by the #MeToo movement, have shifted the standard for acceptable conduct among health care clinical staff at every level.

Many physicians who experienced life as a first-year medical resident 25 or 30 years ago will recall the crucible of arduous workplace conditions that were akin to military basic training; long work hours and physical exhaustion, sometimes coupled with verbal abuse from their precepting physicians. These conditions would now be considered a hostile work environment under contemporary legal standards. However, over the past ten years, there has been a noticeable shift in the balance of power between residents and precepting physicians. Thirty years ago, a precepting physician with an abrasive teaching style would rarely be investigated, much less disciplined. Today, adverse actions against such precepting physicians are increasingly common. A new generation with markedly different attitudes about professionalism, authority, and overall workplace conduct has emerged and is here to stay. As a result, all hospital bylaws should address "disruptive" behavior by physicians and recognize its linkage to the overall

quality of clinical care. For hospital medical staff leadership today, poor civility and communication are treated as quality of care issues or, depending on the circumstances, even impairment issues. Such behavior, if unchecked, can readily result in a summary suspension of a physician's medical privileges. Abusive or disruptive behavior is no longer tolerated; it will be reported and the physician will be investigated and disciplined.

Authority to discipline physicians for disruptive behavior has been recognized by the courts. For example, in *Nanavati v. Burdette Tomlin Mem'l Hosp.,* 107 N.J. 240 (1987), the New Jersey Supreme Court held that hospital privileges can be revoked because of a physician's inability to work with others where the hospital can show that such behavior will probably have an adverse impact on patient care. Likewise, the Wyoming Supreme Court in *Guier v. Teton Cty. Hosp. Dist.*, 248 P.3d 623 (Wyo. 2011), as well as the Delaware Supreme Court in *Sternberg v. Nanticoke Mem'l Hosp., Inc.,* 15 A.3d 1225 (Del. 2011), upheld revocation or suspension of medical staff privileges based on inappropriate behavior of physicians.

Hospital Bylaws and Peer Review Procedures

The ultimate guideline that has remained virtually unchanged over the years is a hospital's medical staff bylaws, which contain the same standard provisions found at hospitals nationwide. The bylaws contain standard policies relating to the leadership structure of the medical staff, qualifications required for medical staff membership, delineation of clinical privileges, and the role of the individual hospital committees. One shortcoming in almost all medical staff bylaws is a process for progressive disciplinary action. Most bylaws only include the "nuclear option"; i.e., once a problem is identified a physician can be suspended or privileges revoked, even though there is potential for corrective action short of such severe disciplinary action. This is an evolving area and probably should be addressed through medical staff policies and procedures as opposed to the bylaws since amending bylaws can often be a cumbersome and time-consuming process.

Most importantly, the bylaws outline the procedures for investigations and adverse actions by the medical staff related to quality of care, misconduct, or impairment issues. Adhering to these peer review procedures outlined by the hospital bylaws is crucial for several reasons. First, it ensures the physician member facing an investigation and/or adverse action receives a "Fair Hearing," but also provides the hospital the benefit from the immunity granted under the Health Care Quality Improvement Act of 1986 (HCQIA). 42 U.S. Code § 11101. Given the inclination of medical staff members to sue the hospital medical staff and hospitals after being subjected to peer review, preserving this statutory immunity is important for the hospital.

The National Practitioner Data Bank (NPDP)

Overall, the most significant consideration for any physician facing an adverse action at the hospital level is whether the action will be reported to the National Practitioner Data Bank, the web-based clearinghouse established by the HCQIA, which contains adverse action reports concerning a health care provider. Any health care entity that provides health care services and engages in a formal peer review process for the purpose of improving quality health care, or a committee within that entity, is authorized to report adverse actions to the NPDB.

NPDB Reports are Permanent

Adverse Action reports on the NPDB are permanent and can be accessed by all health care, regulatory, and law enforcement entities with a need to know of the physician's disciplinary history. The negative impact that an NPDB report can have upon a physician's credentials—licensure, certifications, accreditation, hospital privileges, and third-party payer contracts—cannot be overstated. Consequently, an NPDB report will create a "domino effect" which can jeopardize a provider's medical licensure, privileges at other health care facilities, DEA registration for prescribing privileges, contracts with third party payers, and specialty board certification.

Conclusion

The landscape of hospital-based disciplinary actions has evolved significantly, influenced by health care consolidation and changing workplace norms. Understanding the intricacies of hospital bylaws, peer review procedures, and the far-reaching implications of NPDB reports is crucial for health care providers. As the stakes continue to rise, up to and including damage to a physician's career by an adverse NPDB report, it is crucial for medical staff members to seek prompt health care legal counsel as soon as they have been targeted for discipline.

Likewise, hospital and medical staff counsel should be consulted prior to instituting corrective action to explore progressive discipline as an alternative to suspension and/or revocation of privileges and to ensure that the processes are fair and in compliance with the HCQIA. By doing so, both the affected individual physician as well as the hospital and medical staffs can better navigate these complex processes in an increasingly challenging health care environment. Since the enactment of the HCQIA, the stakes for both the health care provider facing an adverse action as well as the hospital and medical staff are higher than ever.