

National Practitioner Data Bank Revisited -- The Lessons of Michael Swango, M.D.

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Much attention has been paid in recent months to the story of Michael Swango, M.D., set forth in detail in a book by James B. Stewart, Blind Eye: How The Medical Establishment Let a Doctor Get Away With Murder. At its most basic level, Blind Eye is a story about an apparent serial killer³--a physician who, obsessed with death, used his access to hospitalized patients to inject them with potentially lethal substances. However, perhaps the book's more disturbing theme is the extent to which physicians sometimes "circle the wagons" to protect their own. This article will explore the effect of this mentality on physician peer review as reflected in recent studies of the National Practitioner Data Bank.

Michael Swango, M.D.

As a medical student at Southern Illinois University between 1978 and 1983, Swango informally earned the nickname "Double-O Swango"--i.e., "a license to kill"--because of the perception that patients were more likely to die under his care.⁴ Matters escalated during his subsequent residency at Ohio State University, when an elderly hospital patient, after suffering a respiratory arrest, accused Swango of injecting something into her intravenous line that paralyzed her. Both the patient's roommate and a student nurse confirmed her story, but a subsequent investigation, conducted solely by hospital physicians in 1984, exonerated Swango--dismissing the reports of the patients as delusional and that of the student nurse as unreliable.⁵

Despite the "exoneration," the medical staff at Ohio State made a determination that Swango would be dismissed from the residency program at the completion of his first year, and informally spread the word that he should be closely watched.⁶ Notwithstanding these concerns, and Swango's ultimate release from the residency program, his generally good recommendations to the Ohio State Medical Board by Ohio State faculty members allowed him to become fully licensed to practice medicine in Ohio.⁷

Shortly after leaving Ohio State, Swango began working as a paramedic in Illinois. Several months later, after a series of suspicious incidents in which his fellow employees developed gastro-intestinal symptoms, Swango was arrested and charged with attempted poisoning. Following his felony conviction, he was sentenced to five years in prison, of which he served two.⁸ Both the Ohio and Illinois Medical Boards subsequently suspended Swango's medical licenses.⁹

It is after these events that the Swango story becomes particularly bizarre. With apparently only minimal difficulty, Swango was admitted to an Internal Medicine residency program at the University of South Dakota after his release from prison. In explaining his felony conviction to the residency committee, he characterized the charges as false allegations made by jealous co-workers. The director of the residency program not only believed Swango's story, but also characterized him as "courageous."¹⁰ Of course, the University of South Dakota was not helped by the refusal of Ohio State to release any information about Swango unless both Swango and the University of South Dakota executed hold-harmless agreements in favor of Ohio State. Because the South Dakota residency program's director decided that there was no need to engage in such legalistic hoop-jumping, he made no further inquiry and Swango was subsequently admitted to the residency program.

It was only after Swango sought membership in the American Medical Association ("AMA") that his efforts to renew his medical practice in the United States began to unravel. An AMA inquiry about Swango's felony conviction led to a phone call from the state judge who had presided over his attempted poisoning trial. Ultimately, AMA officials contacted the Dean of the University of South Dakota Medical School regarding Swango's problems at Ohio State and he was dismissed from the residency program.

Following his dismissal from the University of South Dakota, Swango made one more stop in the United States before moving his medical practice outside the country -- the State University of New York at Stony Brook ("SUNY"). Accepting Swango's explanation of his felony conviction as related to a simple barroom brawl, SUNY admitted Swango into a psychiatry program.¹¹ However, word of Swango's continued medical practice filtered back to the South Dakota Medical School Dean, who contacted the department chairman at SUNY. Swango was immediately suspended from the residency.¹² To his credit, SUNY's Medical School Dean ultimately sent a letter about Swango to the dean of every medical school in the United States.¹³ Meanwhile, Swango headed for Zimbabwe.

It is the relative ease with which Swango moved from location to location that forms the central theme of Blind Eye. The facilities to which Swango sought to move his medical practice often engaged in minimal, if any, checking of his background. Equally alarming was the extent to which Ohio State apparently went out of its way to avoid disclosing any adverse information about Swango--even after it became aware that the "exonerated" Swango had been convicted of attempted poisoning in Illinois.¹⁴

While many of the events in Swango's medical career occurred prior to Congressional establishment of the National Practitioner Data Bank ("NPDB"), and under NPDB guidelines, adverse actions involving hospital residents are not reportable, the creation of such a central repository of disciplinary information about physicians would appear to be ideally suited to prevent similar episodes. However, this conclusion assumes that the reason physicians "slip through the cracks" is simply the absence of a

central database. The fact is that the value of any database will depend upon the accuracy and completeness of the data available.

NPDB Basics

The NPDB was part of the Health Care Quality Improvement Act of 1986 (HCQIA). *See* 42 U.S.C. §11101, et. seq. The HCQIA was largely a political compromise that began as an effort to immunize physician peer review activities from state and federal lawsuits, including anti-trust actions, and thus encourage effective peer review.¹⁵ In an apparent effort to increase support for the immunity provisions, the legislation's sponsors coupled it with a quid pro quo provision establishing a national data bank for certain disciplinary and litigation information about health care providers--particularly physicians.¹⁶

NPDB provisions involve two basic requirements--reporting and querying. Hospitals are required to report particular disciplinary matters to the NPDB.¹⁷ Generally, reportable actions are those that adversely affect the clinical privileges of a physician for over thirty (30) days and are based on the physician's competence or professional conduct that could adversely affect the health or welfare of a patient. Hospitals may report similar actions taken against other licensed health care practitioners such as allied health professionals. Additionally, medical malpractice payors must report any payments resulting from a final judgment in, or from written settlement of, a medical malpractice claim.¹⁸

Only hospitals are required to query the NPDB. Such a query must occur when any physician or other licensed health care practitioner seeks admission to the medical staff or applies for clinical privileges and every two (2) years thereafter. Other health care entities such as HMOs and group medical practices that have entered into employment or affiliation relationships with a physician or practitioner are allowed, but not required, to seek information from the NPDB.¹⁹

NPDB Flaws

The Swango story has served to draw public attention not only to flaws in one particular peer review process, but also to the fact that hospital reports to the NPDB have been significantly less numerous than anticipated at the Data Bank's inception. Indeed, between 1990 and 1998, 7,453 reports were received from hospitals--an average of less than 1,000 per year. The United States Public Health Service had anticipated that there would be around 5,000 hospital reports per year.²⁰ A 1995 study by the HHS Office of the Inspector General revealed that in the first three years of the NPDB, about 75 percent of all hospitals in the United States had made no reports of adverse actions to the NPDB.²¹ More recent data demonstrates little change in the succeeding five years; approximately 67 percent of hospitals have still never reported an adverse action to the NPDB.²²

It is unrealistic to conclude that the low number of reports is solely the result of an absence of questionable provider conduct.²³ In fact, in the first three years of NPDB existence, while there were only about 3,154 adverse actions reported by hospitals, state licensing boards took disciplinary actions against about 8,000 physicians.²⁴ One might expect the threshold for hospital adverse action to be lower than that for state licensure action, yet these ratios are the reverse of what might be anticipated.

The peer review system . . . should address problems of physicians before they impact a physician's license to practice medicine. Notwithstanding the differences between what the hospital peer review system is designed to accomplish and the state physician licensing system, the significantly higher rate of state actions raises the question of whether hospital peer review activity is taking place at an adequate level.²⁵

On the other hand, it is unlikely that relatively low hospital reporting represents wholesale non-compliance with the NPDB reporting requirements.²⁶ Nonetheless, it is at least worth noting that there is currently no direct penalty imposed upon hospitals that fail to satisfy the NPDB reporting requirements. Hospitals can lose the immunity from liability for damages provided by the HCQIA for peer review activities,²⁷ but at least as of 1998, no hospital had ever been so penalized -- most likely because hospitals are given the opportunity to correct any nonreported incident before future immunity is lost.²⁸ Failure of an entity to report payment in satisfaction of a medical malpractice claim, however, can have direct consequences--a civil fine of up to \$10,000 per unreported payment.²⁹ Some studies have suggested that hospital disciplinary actions are more likely to be reported to the NPDB in states that impose a similar civil penalty for non-reporting of such actions to a state licensure board.³⁰ Virginia law, however, contains no such penalty.

Of course, it is not simply problematic provider conduct that must be reported to the NPDB; it is disciplinary actions of a certain magnitude. What seems a more likely explanation for the disparity between anticipated hospital reporting levels and actual reporting levels is that hospitals are simply avoiding taking adverse actions against physicians--or at least avoiding taking adverse actions of a sort for which reporting would be required, such as imposing suspensions of under thirty (30) days duration or issuing letters of reprimand.³¹

Simply avoiding taking adverse action against physician peers is consistent with the "blind eye" that was trained on Dr. Swango by his peers. However, one would like to assume that the protection provided to Swango is an aberration.³² On the other hand, shortly after the development of the NPDB, hospitals often turned more frequently to a quality improvement tool--"continuous quality improvement" ("CQI")--that focused on hospital systems and processes, rather than on individuals.³³ Indeed, the American Medical Association, in responding to early concerns raised by the OIG regarding reporting of adverse incidents to the NPDB, offered that argument in suggesting that the OIG's concerns were misplaced.

Clearly, adverse events do occur. In a majority of instances, though, the event is not the responsibility of a “bad physician.” Rather, adverse events are frequently attributable to flawed systems or processes. It is universally recognized that punitive measures against physicians do not prevent adverse events from occurring and overall is not an effective patient safety/quality improvement measure. It is more effective to improve the process or system by which health care is delivered than to penalize a physician who practices in a bad system.³⁴

While the use of CQI may have decreased individual disciplinary actions in hospitals, careful selection of remedial measures by in-hospital peer review groups is at least as likely an explanation for the relative infrequency of hospital adverse action reports. A 1994 study of hospitals in several far-west states revealed a twenty percent increase in the use of non-reportable peer review sanctions³⁵ and a second survey in that same year indicated that some practitioners sought settlements involving non-reportable actions.³⁶ While the immunity granted by the HCQIA to peer review activities was intended to encourage institutional peer review, the reporting requirements of the NPDB may have actually provided a paradoxical disincentive to effective peer review and discipline.³⁷

Government Reaction

Regardless of the reasons, HHS and the OIG have expressed active concern about the effectiveness of the NPDB. Stories such as that about Swango will do little to assuage the government’s more fundamental concerns about the effectiveness of peer review activities. It was just such fundamental concerns that led, at least indirectly, to the enactment of the HCQIA. Continued concerns may easily lead to more onerous changes.

For example, HHS proposed last year that even non-parties to medical malpractice litigation be subject to reporting to the NPDB if the non-party’s acts or omissions were the basis for a malpractice claim.³⁸ Although the proposed regulations imposing this requirement have reportedly been withdrawn, HHS took this position because it believes that there have been instances in which medical malpractice plaintiffs have agreed to substitute a hospital for an individual provider defendant, “at least in part for the purpose of allowing the practitioner to avoid having a report on a malpractice payment made on his or her behalf submitted to the Data Bank.”³⁹

The most recent addition to the genre of federal databases affecting physicians also points to the government’s increased attention to physician discipline. The Healthcare Integrity and Protection Data Bank (“HIPDB”), which became operational on November 22, 1999, was formed to work in concert with the NPDB and is administered by the same agency. *See* 45 C.F.R. §61.1, et. seq. The HIPDB requires that health plans and federal and government agencies report final adverse actions taken against health care providers, suppliers or practitioners. Adverse actions include adverse licensure actions of any kind, criminal convictions or civil judgments related to the delivery of a health care item or service (regardless of the status of an appeal), exclusions from state or

federal health care programs, and “other adjudicated actions” (excluding clinical privileging actions). Failure of a health plan to report, may result in the imposition of a civil money penalty of up to \$25,000 for each unreported action. Although hospitals are not permitted to request information from the HIPDB at this time, the existence of the HIPDB emphasizes the government interest in deterring questionable provider conduct, promoting quality health care and protecting the public.⁴⁰ Like the NPDB, reporting entities are granted immunity for making truthful reports and information contained in the HIPDB is considered confidential. 42 C.F.R. §§61.14, 61.16. Interestingly, the HIPDB regulations contain no mandatory querying requirement.

More recently, and more to the point, the OIG has recommended that the Health Resources and Services Administration (“HRSA”), the agency responsible for administration of the NPDB, undertake a legislative initiative seeking enactment of a civil fine of up to \$10,000 for each instance of a hospital’s failure to report an “adverse action” to the NPDB.⁴¹ HRSA, for its part, has expressed a preference for an increased maximum fine and application of the fine to all covered health care entities, not just hospitals.⁴²

Of even greater concern is a current Congressional proposal that would open the NPDB to public access. Virginia Congressman Tom Bliley, Chairman of the House Commerce Committee, has announced his intention to hold hearings in 2000 with an eye toward opening the data bank files to the public.⁴³ Similarly, Virginia Code §54.1-2910.1, enacted in 1998, directs the Virginia Board of Medicine to require physicians to report certain information regarding practice setting, education, qualifications and disciplinary actions, and to make such information publicly available. Proposed regulations implementing this statutory requirement would make the failure of a physician to report such information, “unprofessional conduct” which could itself subject the physician to disciplinary action by the Board.

Finally, a recent report from the Institute of Medicine, which indicated that up to 98,000 individuals die each year from health care errors.⁴⁴ The report recommends establishment of another federal database—this one for reporting of health care adverse events.⁴⁵ At least one senator has already announced his intention to introduce federal legislation that would require hospitals to notify state governments of all adverse events that cause death or serious injury.⁴⁶

It may be too late to slow the momentum of official attention to the workings or effectiveness of the NPDB, but it is presumably not too late for lawyers with health care clients to remind those clients of their direct reporting obligations under the HCQIA--and of the peer review obligations which were supposed to be encouraged by that Act. Importantly, the HCQIA itself as well as state law, provides valuable immunity from civil liability to members of or consultants to committees performing peer review functions, and the HCQIA provides immunity to the hospital or entity itself. State law provides additional immunity to communications and records of such committees.

One apparent reason why Ohio State did not aggressively investigate what on its face, appeared to be a serious and substantial allegation of attempted murder by Swango as a hospital medical resident, was concern over possible legal action by Swango if he was terminated from his residency prematurely.⁴⁷ That fear, along with worries about adverse publicity and possible liability to patients, prompted the hospital attorney's recommendation that the investigation be handled without police involvement.⁴⁸ However, peer review and related NPDB reporting obligations represent an instance in which the public interest and health care entities' interests, as well as their ethical and legal obligations, actually coincide.

Given the immunity provided by state and federal law to legitimate peer review activities and the reporting of such actions, any legal argument against engaging in such activities is weak.⁴⁹ Put simply, it is much easier to defend a lawsuit attacking a health care entity for undertaking serious peer review activities than to defend the lawsuit focusing on deficient peer review activities. Health care providers should be encouraged to overcome what sometimes appears to be an instinctive, preservation of the species mind set. The importance of health care to individuals, coupled with increased public awareness of difficulties and conflicts within the health care system, make public scrutiny of health care providers, including their efforts at self-policing, more intense. Even if only for this reason--and there are presumably better reasons--health care providers should be encouraged to engage in meaningful peer review and to impose appropriate sanctions without regard to their reportability.

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³ Although Swango is suspected of causing the deaths of at least thirty patients--in both the United States and Zimbabwe--no criminal charges have yet been filed. He was convicted of attempted poisoning of paramedics with whom he worked in Illinois and is currently in prison for filing fraudulent documents when seeking employment in a Veteran's Administration Hospital. J. STEWART, BLIND EYE 301-02 (1999)

⁴ See id. at 34.

⁵ See id. at 65-87.

⁶ See id. at 84.

⁷ See id. at 98-99.

⁸ See id. at 143 & 155.

⁹ See id. at 153.

¹⁰ See id. at 173. Indeed, Swango successfully assuaged the Director's primary concern--that the felony conviction would prevent Swango's medical licensure in South Dakota--by offering to "research" the question for him. Not surprisingly, Swango reported that the conviction would not be a bar to South Dakota licensure. While that statement was true to the extent that no law barred convicted felons from medical licensure, it was apparently also the practice in South Dakota to deny such licensure to convicted felons in the belief that the underlying crime in a felony conviction constituted sufficiently unprofessional conduct to warrant a denial of licensure. See id.

¹¹ See id. at 205-06.

¹² See id. at 217-18.

¹³ *Id.* at 220.

¹⁴ Ohio State, which had resisted police involvement at the time of the initial inquiry into Swango's alleged injection of a patient, continued to resist police efforts to investigate Swango after the police learned of the Illinois conviction. See id. at 106-114.

¹⁵ See Scheutzow, *State Medical Peer Review: High Cost But No Benefit -- Is It Time for a Change?*, 25 *Am. J.L. & Med.* 7, 19-20 (1999) (referring to *Patrick v. Burget*, 486 U.S. 94 (1988)) (hereinafter Scheutzow, *State Medical Peer Review*); see also 42 U.S.C.A. § 11111(a).

¹⁶ See Scheutzow, *State Medical Peer Review*, *supra* note 4, at 20.

¹⁷ See 42 U.S.C.A. § 11133(a)(1).

¹⁸ *Id.* § 11131(a).

¹⁹ See id. §§ 11135(a) & 11137(a).

²⁰ See Report, *Hospital Reporting to the National Practitioner Data Bank*, HHS Office of Inspector General, at 4 (February, 1995) (hereinafter *Hospital Reporting*); see also Memo from Inspector General to Claude Earl Fox, M.D., Administrator, HRSA, July 21, 1999, at 2 (hereinafter *OIG Memo*) (citing an American Medical Association prediction of roughly 10,000 hospital reports annually).

²¹ *Hospital Reporting*, *supra* note 9, at 3.

²² *OIG Memo*, *supra* note 9, at 2.

²³ See Baldwin, Hart, Oshel, Fordyce, Cohen & Rosenblatt, *Hospital Peer Review and the National Practitioner Data Bank*, 282 *JAMA* 349, 351 (July 28, 1999) (hereinafter *Hospital Peer Review*) (citing studies of adverse incidents due to negligence during hospitalizations).

²⁴ *Hospital Reporting*, *supra* note 8, at 4.

²⁵ Scheutzow, *State Medical Peer Review*, *supra* note 4, at 16.

²⁶ See *Hospital Peer Review*, *supra* note 11, at 352.

²⁷ See 42 U.S.C.A. §§ 11111(b) & 11133(c).

²⁸ Scheutzow, *State Medical Peer Review*, *supra* note 4, at 37.

²⁹ 42 U.S.C.A. § 11131(c).

³⁰ Scheutzow, *State Medical Peer Review*, *supra* note 4, at 9. There is a direct link between health care entity reports to a licensing board and to the NPDB. Under the statutory scheme, reportable adverse actions against physicians are reported to the state Board of Medical Examiners that, in turn, provides the information to the NPDB. See 45 C.F.R. § 60.9(a) & (b).

³¹ See *id.* (citing two studies that "provide evidence [of] preferential imposition of penalties that did not require reporting").

³² Nevertheless, organized medicine often reflexively engages in rear guard actions against disciplinary actions, or potential disciplinary actions, involving medical practitioners. Following Swango story, along with similar publicity given the story of a high school graduate who bluffed his way into a medical residency program and subsequently obtained a medical license, the Federation of State Medical Boards proposed that states license and monitor medical residents--resulting in quick opposition from various medical organizations and medical school officials. "Medical school is filled with stress, anxiety and uncertainty. It is too early in the educational process to put [disciplinary actions] on students' permanent records. . . . This will undermine the process for remediation and ruin our evaluation process." See Greene, *Critics: Resident Oversight Plan Goes Overboard*, American Medical News (Mar. 22/29, 1999) reprinted by MS JAMA Online, available at: http://www.ama-assn.org/scipubs/msjama/articles/vol_281/no_13/critics.htm.

³³ *Hospital Peer Review*, *supra* note 11, at 353.

³⁴ Letter from James S. Todd, M.D., AMA Executive Vice President, to the Inspector General, HHS, Feb. 1, 1995, included in *Hospital Reporting*, *supra* note 8, at B-1.

³⁵ *Hospital Peer Review*, *supra* note 11, at 352 (citing Neighbor, W.E., Baldwin, L.M., West, P.A., Hart, L.G., *Rural Hospitals Experience With the National Practitioner Data Bank*, 87 Am. J. Pub. Health 663-66 (1997)).

³⁶ See *id.*

³⁷ Public Health Service Comments on OIG Draft Report, included in *Hospital Reporting*, *supra* note 8, at B-1.

³⁸ 63 Fed. Reg. 71255, 71257 (Dec. 24, 1998).

³⁹ *Id.* at 71255.

⁴⁰ 64 Fed. Reg. 57743 (1999).

⁴¹ See *OIG Memo*, *supra* note 9.

⁴² See Memo from HRSA, included with *OIG Memo*, *supra* note 9.

⁴³ *M.D. Discipline: Bliley Calls For Public Access To Records*, American Health Line (Nov. 3, 1999).

⁴⁴ Institute of Medicine, Committee on Quality of Health Care in America, TO ERR IS HUMAN: BUILDING A SAFER HEALTH SYSTEM 22 (1999)

⁴⁵ *Id.* at 75.

⁴⁶ *Clinton to Urge Steps to Curb Medical Errors*, Washington Post Dec. 7, 1999, at A14.

⁴⁷ See, e.g., STEWART, *supra* note 1, at 74.

⁴⁸ See id. at 76.

⁴⁹ See 42 U.S.C.A. § 11111(a); Va. Code Ann. § 8.01-581.16; Va. Code Ann. §54.1-2906, -2909.