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Client Alert: When Resignation Equals Surrender: How Physician Departures During Investigations Trigger National Practitioner Data Bank Reporting

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A physician under investigation resigns—problem solved? Not quite. Federal law may treat that resignation as a surrender of clinical privileges, and if so, the reporting obligation follows automatically.

The Reporting Obligation: What Hospitals Need to Know

Under the Health Care Quality Improvement Act (HCQIA), hospitals bear a mandatory obligation to report certain adverse actions to the National Practitioner Data Bank (NPDB). Among the most consequential—and most frequently litigated—of these obligations is the requirement under 42 U.S.C. § 11133(a)(1)(B) to report to the NPDB when a hospital accepts the surrender of a physician's clinical privileges while the physician is under investigation relating to possible incompetence or improper professional conduct.

The statute was designed to prevent a well-known workaround: a physician facing scrutiny simply resigns and moves on to another institution, leaving no record of the concerns that prompted the investigation. Congress intended the NPDB reporting framework to close this gap and ensure that future credentialing bodies have access to meaningful disciplinary history.

For hospital administrators and in-house counsel, the practical question is often deceptively simple: when does a resignation become a "surrender" that triggers reporting? Recent federal court decisions have provided important and hospital-favorable answers.

Resignation During a Fact-Finding Investigation

In a 2023 federal case, a physician employed at a Veterans Affairs hospital resigned after the facility initiated a fact-finding investigation into complaints about his clinical performance. The physician subsequently

challenged the NPDB report, arguing that he resigned his *employment* but did not intend to surrender his *clinical privileges*. He contended that the two concepts were distinct and that the hospital had no basis to report the resignation as a surrender.

The court rejected this argument. It held that under hospital policy, the physician's resignation inherently resulted in the surrender of his clinical privileges, and the two were inextricably linked. More importantly, the court emphasized that the physician's subjective intent was irrelevant to the reporting analysis. The statute requires only that the hospital "accepted the surrender" of clinical privileges; it does not require the surrender to have been voluntary or knowing. As the court explained, 42 U.S.C. § 11133(a)(1)(B) was designed precisely to prevent physicians from "beating their employers to the punch" by resigning before an investigation reaches its conclusion. *Breda v. United States*, No. 20-3308 (RDM), 2023 U.S. Dist. LEXIS 54173 (D.D.C. Mar. 29, 2023).

Resignation After Receiving Investigation Recommendations

In another instructive case, an orthopedic surgeon resigned the day after being informed that the Medical Executive Committee (MEC) had recommended he undergo a psychiatric evaluation and an external chart review. The physician argued that the investigation was effectively over by the time he resigned and that no reportable event had occurred.

The court disagreed. It upheld the Department of Health and Human Services' (HHS) finding that the investigation remained ongoing at the time of the resignation. The MEC's recommendations were subject to Board review, further fact-finding had been planned, and no final action had been taken. The court reasoned that an investigation does not conclude simply because an intermediate committee has issued preliminary recommendations, and it continues until the decision-making authority takes final action.

The physician also raised a "sham peer review" defense, alleging that the investigation was pretextual and motivated by competitive retaliation from rival surgeons. The court rejected this argument as speculative, noting that the physician offered no evidence beyond his own suspicions. *Long v. HHS*, 422 F. Supp. 3d 143 (D.D.C. 2019).

Disruptive Behavior as a Reportable Basis

The NPDB reporting framework is not limited to clinical incompetence. A physician's disruptive behavior, even when no patient is directly harmed, can constitute a basis for a reportable action.

In a case before the Eleventh Circuit, a physician was suspended for 60 days following an extended outburst in which he broke a telephone, shattered a copier's glass panel, threw jellybeans, shoved a metal cart, and verbally berated hospital employees. The physician challenged the NPDB report, arguing that his conduct did not relate to patient care because no patient was directly involved in the incident.

The court firmly rejected this argument. It held that disruptive behavior is reportable because it "could affect adversely" patient health or welfare, even in the absence of direct patient harm. The court's reasoning was compelling: disruptive conduct "intimidates other health care workers, discouraging the kind of open communication and close cooperation that is essential to providing the best care to patients." The message to hospitals is clear: a toxic workplace environment is not merely an HR problem; it is a patient safety issue that triggers reporting obligations. *Leal v. Sec'y, Dep't of Health & Human Servs.*, 620 F.3d 1280 (11th Cir. 2010).

Practical Implications for Hospital Compliance

Taken together, these cases reinforce several critical principles for hospital administrators and medical staff offices:

- **Resignation does not end the story.** When a physician resigns during an active investigation, the resignation constitutes a surrender of clinical privileges regardless of the physician's stated intent. The hospital's obligation to report is triggered by the acceptance of the surrender and not by the physician's characterization of the departure.
- **Investigations remain "ongoing" until final action.** Preliminary recommendations, even from the MEC, do not conclude an investigation. Hospitals should ensure that their bylaws clearly define when an investigation begins and when it is deemed complete.
- **Disruptive behavior is reportable.** Conduct that creates a hostile or intimidating clinical environment can adversely affect patient care, even without direct patient involvement, and is therefore reportable.

Key Takeaways

- **Document investigations thoroughly from the outset.** Maintain contemporaneous records of all complaints, committee deliberations, recommendations, and communications with the physician under review. Thorough documentation is the foundation of a defensible NPDB report.
- **Provide clear written notice.** When notifying a physician that an investigation has been initiated, include explicit language that resignation during the investigation will be treated as a surrender of clinical privileges and will trigger mandatory NPDB reporting.
- **Remember: physician intent is irrelevant.** The reporting obligation turns on the hospital's acceptance of the surrender, not on the physician's subjective understanding or characterization of the resignation.
- **An investigation remains "ongoing" until the decision-making authority takes final action.** Interim recommendations by committees or subcommittees do not terminate an investigation for purposes of 42 U.S.C. § 11133(a)(1)(B).
- **Treat disruptive behavior as a patient safety concern.** Even absent direct patient harm, conduct that intimidates staff and disrupts the clinical environment can adversely affect patient care and warrants NPDB reporting.

If you have questions or would like more information about how and why physician departures during investigations trigger NPDB reporting, please contact Grant Dearborn.

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