Managing Peer Review Investigations: How to Avoid Hearings and Litigation

QUESTIONS & ANSWERS

1. The Patient Safety Act says that reports sent to the Patient Safety Organization (PSO) cannot be used for peer review. If information comes in through a patient safety network then how can it be reviewed by a peer review committee or the MEC for peer review purposes.

Response: In discussions I have had with AHRQ, peer review information can be collected and reported to a PSO and used for internal purposes and therefore reviewed by peer review committees and the MEC. Where some of the confusion may rest is that such information cannot be used for disciplinary purposes such as terminations or suspensions. The information can be used and shared for other remedial measures such as monitoring, proctoring and FPPE plans, although a provider’s Patient Safety Evaluation System should clearly identify that these actions are not disciplinary. A hypothetical peer review scenario which reflects this point is set forth in the PSO power point presentation that was listed in the Part 2 webinar materials.

2. Can you provide examples of how a peer review matter can be “settled” before the hearing begins?

Response: Settlement can take many different forms. A physician can resign, seek a leave of absence or decide not to reapply instead of proceeding with a hearing and possible litigation. The stumbling block at this stage of the proceedings is that these options could be reportable to the Data Bank and/or the state. If the hospital insists on complying with applicable reporting requirements, the physician may see little choice but to move forward with a hearing. One option we typically offer is to agree to negotiate the language to include in a report. The tact we take is that the information going into a Data Bank report after a hearing is likely to be much more detailed because it will be based on the findings of fact and details contained in the Hearing Committee report. If a resignation occurs before the hearing, or before its completion, a hospital and medical staff have more flexibility and can produce a less detailed report as long as it contains enough information to identify the reasons behind the report and show that it is based on appropriate documentation. You can also settle for a monetary payment amount but this is an unlikely option. Another settlement option is a negotiated response to third party inquiries. Such responses will often send up a red flag for seasoned health care professionals and medical staff leaders but this option is used quite often.

3. Should you provide minutes of peer review meetings to the physician?

Response: Yes. The administrative record on which an adverse recommendation is based should include whatever the Committees and others relied on in making the recommendation. Typically this will include all committee minutes, reports, data, communications, etc. Including the Committee minutes is important because they help convey to the physician the story and the basis for the Committee’s actions, and can be used as evidence that you complied with your medical staff bylaws and applicable policies. Be careful, however, to redact or delete portions of all minutes that are unrelated to the adversely affected physician.
4. **Why should you discuss with the physician what is reported to the Data Bank given the fact that the physician and his attorney have the ability to comment on the Data Bank report?**

**Response:** Our suggestion was made in the context of attempting to settle the dispute through a negotiated Data Bank report. While it is true that the physician will be given an opportunity to provide his or her version of the events in a separate report, most professionals will place greater reliance on the hospital's report. In fact, having read many physician responses over the years, they often times do more harm to themselves than if they did not respond at all. If the choice boils down to a negotiated Data Bank report and response to third party inquiries or the expenditure of significant time and money on a hearing, appeal and possible litigation, the settlement option is often the most attractive one.

5. **Is there a risk in characterizing something as behavioral without the quality emphasis from a HCQIA immunity standpoint?**

**Response:** Yes, but as a practical matter disruptive behavior and demonstrated physical or psychological impairment adversely impacts the delivery of quality patient care. If a physician either fails to improve or refuses to accept a proffered remedial action or rehab plan and you are forced to proceed down the hearing path, you definitely want to link the conduct to quality of care concerns, actual or potential, as part of the record. By doing so, the HCQIA immunity protections will apply.

6. **Should you redact other physician information in the peer review minutes?**

**Response:** As noted above, yes. Any information in the minutes that is not related to the adversely affected physician should be deleted from the minutes.

7. **Is there a right to examine peer reviewers? Can the peer reviewer consent to an examination?**

**Response:** As noted during the presentation, we advise against the right to depose witnesses in advance of a hearing or to allow interrogatories. The rules of evidence in hearings do not generally apply. Both sides have the right, however, to call witnesses which could include those who participated in the peer review process. When representing medical staffs in these proceedings, our goal is to establish that we followed the bylaws and related policies and that the proceedings were fair. In order to prove compliance, aside from the documents we have admitted into the record, we try to tell the story of what led up to the adverse recommendations through the testimony of those involved. Therefore, our witnesses typically include the Department Chair, members of the peer review committees who participated in the process, a representative or two from the MEC, and the third party reviewer so that the Hearing Committee can see how the process evolved. The physician will have the right to cross examine each of these witnesses and can also call witnesses of his own. A peer reviewer could agree to testify although the hospital probably would be reluctant to allow this unless its legal counsel also was present.

8. **Do the attorneys mutually decide on what is admissible or is this done by the hearing officer?**

**Response:** It is always better if the parties can agree in advance on what is contained in the administrative record and what will be admissible. Where there is a dispute it will usually be resolved by the hearing officer. If there is disagreement with the hearing officer's ruling, an “offer of proof” can be made, if allowed, that will describe what the evidence would have shown if it were found admissible. This will not be shared with the Hearing Committee but could be used in an appeal to argue that relevant information was excluded.
9. **Can you use the physician’s OPPE information if it shows how the physician compares to other similar physicians in the same specialty?**

**Response:** Yes, but without using other physician names or identities as part of the comparison. The information should be de-identified and aggregated if possible. Keep in mind that the hearing officer might conclude that you have “opened the door” by introducing comparative data and therefore require you to provide other comparisons if the physician is claiming that the medical staff has singled him out unfairly.

10. **If another physician’s case or cases are discussed as examples in a hearing, does it open those cases to discovery?**

**Response:** First of all, we do not see why you would ever use another physician’s cases unless the physician in question also participated in the care of that patient and some adverse event occurred on which the disciplinary action was based. Under these circumstances, using the case is probably unavoidable but it will raise questions as to how the other physician might have contributed to a poor outcome. Aside from this circumstance, references to other physicians and their cases should be avoided.

11. **If a physician resigns while a case review is in progress (not during a formal investigation), I believe the review should be completed for some of the following reasons: case could result in a claim or litigation; other physician practice issues may be identified which would require follow up; other process/system issues may be identified which would require additional action; regulatory compliance issues. Your thoughts?**

**Response:** We agree on all counts.

12. **What if the Ad Hoc Member of the same specialty is called to testify by the accused physician?**

**Response:** As noted above, we use representatives from the various committees, including the Ad Hoc Investigating Committee, to discuss their role and vote in the proceedings so that we can establish that we followed our bylaws and the proceedings were fair. The physician has the right to call a different Ad Hoc Committee member and if the member agrees to testify, we usually would not object. The issue of who is called and who will agree to testify as a witness is an issue that we try to address during the pre-hearing stage. The Ad Hoc Committee member’s testimony clearly would be relevant.

13. **Permitted attendees: Should “expert witnesses” be permitted to remain in the entire hearing? What about a “significant other” who is a nurse?**

**Response:** As a general matter, witnesses should only be present during the time of their direct and cross examination. We do not allow them to be present during the testimony of other witnesses because it may influence their own testimony. On the other hand, if an expert has been retained to assist either the MEC or the physician as part of the “hearing team” it would be permissible for them to attend but only after they have testified. With respect to your “significant other” question, we usually show some degree of flexibility on who can attend on behalf of the physician so long as they are not a witness and agree to keep all of the materials and testimony confidential. With regard to other non-witness attendees, such as a hospital administrator, in-house counsel, physician representative, etc., this is another issue which should be addressed and resolved in advance of the hearing.
14. If your hearing goes on for more than one day, do you allow new information to be submitted before the next date?

Response: Hearings rarely are limited to one day. The number of days or sessions will depend on the length of time a Hearing Committee is willing to set aside and how many pre-hearing issues you are able to resolve in advance. As a general rule, most Bylaws require that all relevant information, i.e., the record of proceedings leading up to the adverse recommendation and all of the physician’s evidence, should be introduced in advance of the hearing so as to afford both sides adequate time to prepare. The introduction of new evidence after the hearing has commenced could be prejudicial particularly if being submitted by the MEC or hospital. If there is disagreement regarding the admission of new evidence, the Hearing Officer should make a ruling.

15. Can you give us the web address for the state and federal confidentiality laws?

Response: Most states have their own peer review confidentiality statutes and we are not able to give the cites to all 50 states. Because the questioner is from Illinois, the citation to the Illinois Medical Studies Act is 735 ILCS 5/8-2101 et seq. The federal confidentiality act is the Patient Safety and Quality Improvement Act of 2005, 42 USC Sections 299b-21-b-26.

16. With more and more physicians being employed, how do you get a hearing officer (physician) who is not conflicted for the hearing?

Response: Hearing Officers, as distinguished from Hearing Chairs, are almost always attorneys or some other experienced professional not associated with the hospital or the medical staff. If your question is really asking about Hearing Chairs, as mentioned during the program, the best practice is to avoid the use of employed physicians either as Hearing Committee members or Chairs if possible. It is not a requirement. The fact that a physician is employed only raises the appearance of a conflict rather than an actual conflict that would require they be excluded. Most medical staffs still have independent practitioners and therefore one would hope you still have some eligible members to consider. If this is not the case and the adversely affected physician objects to an employed physician, he or she should have to assert more facts on which to base the objection aside from the physician’s employment status. Another option is to use physicians from another hospital. Depending on the issues at hand, both sides also could agree to use a judicial officer, mediator, arbitrator or other professional who acts as judge and jury instead of a physician Hearing Committee.

17. Please be sure to compare HCQIA with the PSQIA.

Response: The Health Care Quality Improvement Act is a federal law that was passed at the same time the Data Bank requirements were imposed. HCQIA provides broad immunity protections in federal and most state proceedings (because most states took advantage of the ability to opt-in) if the hospital and medical staff adopt and comply with the hearing procedures and standards set forth under the Act. HCQIA is NOT a confidentiality statute. The Patient Safety and Quality Improvement Act of 2005 provides broad confidentiality protections to all providers who collect information, such as quality improvement, peer review, risk management, etc., relating to patient safety activities, for the purpose of reporting to a CMS certified Patient Safety Organization (PSO).

18. When you have a limited number of “specialty” physicians or only one group on staff how do you select the hearing committee when they are all partners or potentially competitors?

Response: In addition to the Response provided in Question No. 16, whether there is a true economic or other conflict depends on the facts and circumstances of the case. Also, keep in mind that you may not need a Committee member on same specialty, e.g., the underlying cause is behavioral. Similarly, if a non-competing orthopaedic surgeon can follow and understand the quality of care problems of a spine surgeon, you do not need a spine surgeon on the
Committee. Keep in mind that HCQIA prevents the use of “direct” competitors. If the potential physician member practices in a different market, he is not a “direct” competitor. You should consult with legal counsel before finalizing the members of the Hearing Committee. In the end, you do the best you can with the resources available.

19. Would you repeat what you said should be done if you object to a ruling of the hearing officer or a sanction he/she has imposed?

Response: A truly objective hearing officer is not always going to rule in your favor. The question is whether the ruling is truly significant, i.e., could it substantially prejudice the physician such that a court might find that fundamental fairness went out the window. For example, let's say that the physician's attorney was so disruptive that the Hearing Officer would not allow him to engage in future cross examination or barred him from the proceedings. That happened in one of our hearings. In order to limit the potential prejudicial impact, we withdrew from the proceedings as well and simply let the physician rep for the MEC continue on under our guidance through scripted questions, closing statements, etc. At a minimum you would want to get the basis for the objection on the record and see if there were other ways to cure or limit the impact of a prejudicial ruling.

20. You have mentioned five (5) hearing committee members. Our bylaws say three (3). Any problems?

Response: There is no legal requirement about number of representatives on a Hearing Committee. Three members are easier to find although if you lose one a stalemate vote may be more likely. Five is a better number because you still have enough of a nucleus to continue if one member must be excused.

21. In our bylaws, we have removed the issue of allowing for objections to members. However, that said, when the physician has raised a concern about a panel member, we have given it to the hearing officer for determination. One time they removed the person and one time they did not. I would prefer not to spell it out in the bylaws. Do I need to?

Response: Remember that the principal goal of the hearing process is to comply with your bylaws and hearing procedures and to make sure that the proceedings are fundamentally fair. Irrespective of whether you allow a physician to object to hearing members under the bylaws, the last thing you need is a member with a substantive conflict or bias against the physician. You should be making sure that prospective members have no such conflicts before appointing them to the committee. Our concern with your bylaws is that they do not force the physician to raise an objection in advance of the hearing. Although you would argue that such an objection has been waived, they could contend that they were never given this right. Our preference is to give the physician the right to object, but not a pre-emptory right. Any objection has to be supported with sufficient information on which to make an informed judgment on whether or not to replace the member. The information should be shared with the member for comment. Rather than going to the Hearing Officer for resolution, unless empowered to do so under the Bylaws, we would go back to whoever had the right to appoint the members. They should be the decision makers and not the Hearing Officer.

22. As to the role of counsel, we think there needs to be two, one to advise the process and one to assist the medical staff in presenting their position as advocate. Comment?

Response: In most proceedings, if attorneys are present and allowed to participate, there are three attorneys: one representing the MEC, one representing the physician and one representing the Hearing Committee. If there is a Hearing Officer, who usually is an attorney, then an additional attorney for the Committee is not needed. One question which arises is who represents the MEC/Medical Staff when there is in-house counsel? In more than 250 hearings we have handled over the years we have typically represented the Medical Staff. Where there is in-house
counsel, if they play a role at all it usually is to advise the Hearing Committee on procedural issues, as would a Hearing Officer. The problem that can arise, however, is that the physician’s attorney is likely to allege that a conflict of interest exists because in-house counsel, who is employed by the hospital, will allegedly provide biased advice to the Hearing Committee in favor of the hospital. Although there is not much substance to this argument our goal is to avoid any and all claims of bias that may result in judicial information or reversal of an adverse decision. Under these circumstances it would be better to have in-house counsel represent the MEC/Medical Staff rather than the Committee. This may be easier said than done for either political reasons or because in-house counsel simply does not have the time. As mentioned during the program, if a Hearing Officer is utilized they should not have had a prior professional relationship with either the hospital or the medical staff.

23. During the program you stated that there should be no ex parte communications. What about between hospital counsel and the physician’s counsel?

Response: No ex parte contact means that neither the attorney for the MEC nor the attorney for the physician should be having direct/unilateral communications with the Hearing Officer and/or the Hearing Committee Chair or members. Both sides should be participating in such communications. It is entirely appropriate and is to be expected that the attorneys for the MEC and the physician will be engaged in discussions during the pre-hearing, hearing and appellate stages of the proceedings.

24. Is it possible for a Medical Staff to abuse the peer review process?

Response: Anything is possible but the benefit of the typical multi-layered peer review process is that there are many checks and balances within the system. For example, if a Department Chair is treating a physician unfairly by exaggerating the alleged adverse impact on patients, this hopefully will be recognized and objectively assessed by established medical staff committees. In addition, you have senior management, CMOs/VPMAs, other medical staff leaders, inside and outside legal counsel, a hearing committee and ultimately a board of directors who will be monitoring and reviewing the process and proceedings to make sure that the physician is being treated fairly. In over 30 years of practice I can think of only one instance where a medical staff department engaged in unfair and anti-competitive conduct not truly based on quality of care concerns. Because of the “there but for the grace of God go I” perspective, that applies, to all medical staffs, true abuse or discrimination that rises to the level of terminating or suspending physicians is rare. A medical staff and hospital should have zero tolerance for such behavior.

25. Is appellate review required under HCQIA?

Response: No, but most bylaws include the right of an appeal by both parties. The Joint Commission Medical Staff Standards 10.01.01, EP 5, however, requires that the “organized medical staff has developed a fair hearing and appeal process addressing quality of care issues that has the following characteristics...With the governing body, provides a mechanism to appeal adverse decisions as provided in the medical staff bylaws.” You also need to check state law which might also require an appeal.

26. If the hearing committee modifies the recommendation, does it go back to the MEC for further consideration or does it become the final recommendation to the Board?

Response: Our position is that the Hearing Committee recommendation should be sent directly to the Board or a designated Board Committee and that the MEC not be given the right to modify the recommendation. Instead, both the MEC and the physician should be provided the Committee's recommendation and report and be given an opportunity to comment and appeal.
27. How far back can you go to review cases?

Response: There is no set answer to this question. We do not go on fishing expeditions. We look for substandard patterns which occur over time. Because of the requirement to engage in ongoing monitoring of physicians and not wait until they come up for reappointment every two years, one would expect that any such patterns are identified and acted on sooner than later. If so, there is less need to reach far back in time. The answer to this question, however, also depends on the robustness of your peer review and quality procedures. If your systems have been lax and your personnel and medical staff leaders have been less than vigilant, going back further in time may be required. That being said, going back more than three or four years should really be questioned. As always, it depends on the facts and circumstances and the particular purpose of the review.