Process for Initiating an Investigation

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4.1 Introduction

Many clinical and behavioral issues that arise with physicians can be resolved by medical staff leaders through progressive steps, beginning with collegial intervention efforts. However, when there are serious questions regarding a physician’s clinical practice or when a physician’s behavior threatens to undermine the culture of safety – and progressive steps have not succeeded in improving the problem – an investigation may need to take place. An investigation may also be necessary when the concern is so significant that a formal review must take place even if no collegial efforts or other progressive steps have been taken to attempt to address the issue, though this situation is rare.

Even where the medical staff leadership is experienced and deliberate, it is appropriate at the outset to do some quick education and assurance regarding the medical staff’s rights and obligations, and regarding the protections afforded to participants in the process under applicable state and federal law. In particular, it is a good time to make the participants aware of the likely focus of judicial review, in the event the decision to investigate leads to that. Given that focus, this stage of the process is a good time to ensure that the entire corrective action process set forth in the bylaws is a fair process that qualifies for all the available statutory protections. It also is appropriate to remind the participants – particularly those who see the process as a series of annoying formalities that merely delay the correct result – that they need to follow scrupulously the process outlined in the bylaws.

This stage also is a good time to review the process to ensure that it maximizes the confidentiality protections afforded under state law, and to remind the participants of the importance of maintaining confidentiality. Otherwise, the protection that many of the participants view as inviolate may be lost.

Finally, the participants need to understand all of the legal and practical implications of the decision to initiate an investigation. Given the legal implications of initiating an investigation, this decision may have irrevocable consequences.

4.2 Bylaws Provisions Relating to Investigations

The Joint Commission standards do not mandate any particular form for the peer review process, and state and federal statutes and case law do not mandate, or even suggest, any particular approach to the decision as to whether to initiate an investigation. Different medical staff bylaws articulate
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different grounds for the initiation of an investigation, but the reasons typically fall into one or more of the following categories:

(1) Clinical concerns;
(2) Behavioral concerns;
(3) Ethical concerns; or
(4) Reported violations of medical staff bylaws, rules, or regulations.

Bylaws also typically identify the categories of individuals who can request an investigation, the individuals or committees to whom such requests should be directed, and the individuals or committees responsible for deciding whether to initiate an investigation. Given the consequences of initiating an investigation, it would be reasonable to require that the request for an investigation and the grounds for the request be submitted in writing.

The fact that an investigation can have significant consequences also makes it reasonable to designate the MEC as the appropriate body to make that decision in situations that are not particularly time-sensitive. Where the circumstances giving rise to the request for an investigation suggest that immediate action is necessary to avoid “imminent danger to any individual,” most bylaws authorize the chief of the medical staff or others in leadership positions to impose a summary or precautionary suspension.

4.3 Notifying Physician of Investigation

As will be discussed, certain reporting obligations arise when a physician “surrenders” his or her privileges while the physician is “under investigation.” For this and other reasons, it is wise to clearly document in the medical staff bylaws the point at which the investigation is initiated, and to advise the physician that the investigation has in fact commenced. To reduce uncertainty on this point, events leading up to the decision to investigate should not be characterized as part of an investigation, either in the medical staff bylaws or in minutes or communications describing those events.

Although applicable case law may not require notice to the physician prior to the decision to investigate, it would be hard to imagine a situation in which the sense of urgency would outweigh the benefits of at least an informal discussion with the affected physician before the decision is made. Because the affected physician’s ability to respond will depend on understanding the nature of the complaint, counsel should consider giving him or her the full details of the complaint. Some medical staffs wrestle with the balance between giving the affected physician all of the information relevant to the complaint and the desire to protect the complainant(s). One way to strike that balance is to provide the affected physician with all of the information relevant to the complaint, along with a warning regarding the serious consequences of unapproved contact with or retaliation against the complainant(s).

4.4 The Investigating Body

The next two components of the decision to investigate are the designation of the investigating individual or group and the development of its charge. Again, few express mandates are available
regarding the composition of the investigating body or the scope of the investigation. A few practical considerations should influence these decisions, however.

Regarding the composition of the investigating body, it may be impossible to avoid inclusion of some who are viewed as the affected physician’s competitors. At least some courts recognize that a review by one’s professional peers makes the involvement of competitors unavoidable.\(^1\) From a practical standpoint, however, the process is more likely to lead to a fair resolution, less likely to be challenged, and less likely to be challenged successfully if the investigating body does not include individuals who are perceived as “rabid critics” of the affected physician. Consequently, a fair and balanced investigative body is a benefit on several levels.

Another factor to consider in appointing the investigating body is that individuals who serve on that body might be good choices for service on the hearing panel if the investigation leads to that end.\(^2\) Consider keeping some “reasonable minds” in reserve for hearing panel duty, particularly on small medical staffs where choice is limited.

The scope of the investigating body’s duties should be clearly defined in the minutes of the committee that establishes and charges that body, or in a memorandum or letter authored by the individuals who perform those tasks. If, in the course of the investigation, new concerns are unearthed, then those concerns should be funneled back into the process for a determination as to whether they warrant investigation. Otherwise, the investigating body’s unilateral decision to expand the scope of its investigation could cause procedural irregularities that might taint the entire proceeding and result in judicial intervention.

The scope and conduct of the investigating body’s work should be driven by the nature of the events that led to the investigation, and bylaws provisions dealing with the conduct of the investigation should be permissive, not mandatory. Some medical staffs prefer to mandate precise processes to ensure that the investigating body conducts a thorough investigation. Although this approach arises from good intentions, it can lead to undesirable consequences, as a medical staff’s failure to follow its own rules is a common reason for judicial intervention. Because different problems require different approaches, counsel should consider giving the investigating body broad discretion and only general direction.

### 4.5 Maintaining Confidentiality

Again, a full discussion of the confidentiality protections afforded to the peer review process would exceed the scope of this chapter. This stage of the process is a good time, however, to review the process from a confidentiality standpoint, and to remind the participants of the importance of preserving confidentiality.

One potential trouble spot regarding confidentiality is that the courts seem to be very creative in boring holes in statutory protections.\(^3\) This problem can be exacerbated where the process followed by the staff and administration fails to evidence an intent to maintain confidentiality.

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\(^1\) *Rogers v. Columbia/HCA of Cent. La.*, 971 F. Supp. 229 (W.D. La. 1997) (“Some degree of competition is inherent in professional peer review.”).


\(^3\) See, e.g., *Ashokan v. State of Nev.*, 856 P.2d 244 (Nev. 1993) (although the statute prohibits compulsory production of peer review materials, a plaintiff who obtains the materials from undisclosed sources is free to use them).
In some medical staffs, for example, risk-management personnel review or participate in some aspects of the peer review process. Where this occurs, the medical-malpractice plaintiff seeking information gathered in the peer review process may argue that, by sharing the information with individuals who are not an inherent part of the peer review process, the staff and administration have waived the statutory protections.\(^4\)

Also, it is not uncommon for someone seeking discovery of peer review information to point to alleged conversations or communications regarding the subject of the peer review that occurred outside the peer review setting. The participants need to be reminded that these “parking-lot conversations” can jeopardize confidentiality – as well as the immunity protections that would otherwise be available under HCQIA and applicable state law.

Finally, the rules governing confidentiality change dramatically when the peer review process is the subject of federal court proceedings. HCQIA protects only the information reported to the NPDB, not the information generated in the peer review process.\(^5\) In addition, state statutes providing for the confidentiality of peer review materials offer diminished protection where claims are pursued in federal court.\(^6\)

### 4.6 The Implications of Investigations or Reporting Requirements

Under HCQIA, the initiation of an investigation in and of itself does not trigger any reporting obligation. However, health care entities are required to report to the National Practitioner Data Bank and, consequently, the state licensing board, “surrender of clinical privileges or failure to renew clinical privileges while under investigation.”\(^7\)

It is important for hospitals to clearly define when an investigation begins because uncertainty about whether an investigation has been initiated can lead to uncertainty regarding reporting obligations. Even worse, such uncertainty could end up having to be resolved by a jury despite the availability of statutes designed to protect against that risk. The dangers of such uncertainty are highlighted in District of Columbia v. Simpkins.\(^8\)

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\(^7\) NPDB GUIDEBOOK, supra note 76, at E-34.


[Physician’s] claims that defendants are not entitled to immunity because there was a failure to comply with the provisions of § 11133(c)(1) concerning the reporting of peer review actions. There is no need for the Court to resolve this factual dispute because 42 U.S.C.A. § 11133(c) provides that the loss of immunity occurs only if “[t]he Secretary [of Health] publishes the name of the entity under section 11111(b) of this title.” Thus, answer to the [physician’s] argument is there never was a publication of the name of [the hospital] for a failure to report, and, accordingly, there is no basis for the plaintiff’s claim.
In Simpkins, a physician supervising Dr. Simpkins wrote a memorandum to Dr. Simpkins’ section chief describing his concerns about Dr. Simpkins’ clinical competence and judgment. In response, the section chief wrote a letter (presumably to Dr. Simpkins, although the opinion is not clear) imposing retrospective review and other conditions. There was a factual dispute as to whether the conditions imposed in the letter became effective.

Subsequently, Dr. Simpkins, a hospital employee, “submitted his resignation to the Hospital.” The resignation cited Dr. Simpkins’ concerns about substandard management and patient care issues at the hospital. The hospital’s general counsel advised Dr. Simpkins that his resignation would be reported to the NPDB. A report submitted to the NPDB some months later stated that Dr. Simpkins had resigned his privileges following “a request for a review of quality of care rendered by Dr. Simpkins. . . .”

Dr. Simpkins sued the former general counsel and others. The general counsel claimed immunity under HCQIA, based on her conclusion that she was required to submit the report. Dr. Simpkins countered that that report was not required by HCQIA because “he resigned his employment with the hospital as opposed to surrendering his privileges” and because he was not under investigation when he resigned his employment. Dr. Simpkins also argued that the general counsel was not entitled to indemnity because HCQIA requires a report to the licensing board, while the general counsel’s report was sent to the NPDB.

The appellate court remanded the case to the trial court for further proceedings, based on the following analysis:

The present record does not enable this court to determine whether Dr. Simpkins’ resignation was tantamount to a surrender of privileges, nor are we able to discern whether Dr. Simpkins was ‘under investigation’ as contemplated by the HCQIA Act, at the time of his resignation. Further, even if Dr. Simpkins was under investigation, as matters stand we cannot determine from the record the point at which the correspondence between [the supervising physician and the section chief] became a formal investigation of Dr. Simpkins.9

This case demonstrates that the risks of failing to report a surrender of privileges must be balanced against the risks of making inaccurate or inappropriate reports. The Simpkins case also highlights the potential benefits of establishing a clear process for the initiation of investigations, adhering to that process, and documenting adherence to the process. Otherwise, uncertainty about whether an investigation has been initiated can lead to uncertainty regarding reporting obligations. Worse, the uncertainty may need to be resolved by a jury, despite the availability of statutes designed to protect against that risk.

4.7 Form of the Investigation Report

Once again, the form and content of the report are driven not by statutory mandates, but rather by practical analysis. A detailed written report should be prepared which outlines the investigating

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body’s findings, conclusions and recommendations. If the investigating body intends to recommend corrective action, then setting forth the details of the investigation (including a list of witnesses interviewed, the substance of their statements, a description of documents reviewed, and a summary of the discussion with the affected physician) is also helpful in that it demonstrates that the investigation was a “reasonable effort to obtain the facts of the matter.”\footnote{\textsuperscript{10} 42 U.S.C.S. § 11112(a)(2) (LexisNexis 2013).} This will help build the case for the qualified immunity provided under HCQIA.