

**[Appendix I]**  
**AMA Policies on Principles for Incident-Based Peer Review**

The following AMA Policies on Incident-Based Peer Review are provided as directed by AMA Policy D-375.992.

**H-375.984 Peer Review**

Our AMA affirms that it is the ethical duty of a physician to share truthfully quality care information regarding a colleague when requested by an authorized credentialing body, so long as the information that is shared with the credentialing body is protected by statute or regulation as confidential peer review information. Quality of care and patient safety are the goals of peer review. Peer review should address the prevention of medical errors and appropriate system changes.

**H-225.992 Right to Relevant Information**

(1) The AMA advocates "timely notice" and "opportunity to rebut" any adverse entry in the medical staff member's credential file, believes that any health care organization file on a physician should be opened to him or her for inspection, and supports inclusion of these provisions in hospital medical staff bylaws.

(2) Triggers that initiate a peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied to all cases and physicians.

(3) A physician accused of an infraction of medical staff bylaws, rules, regulations, policies or procedures and faced with potential peer review action shall be promptly notified that an investigation is being conducted and shall be given an opportunity to respond.

(4) All relevant information pertaining to a potential peer review action should be obtained promptly from the subject physician and other relevant sources. Relevant information includes, but is not limited to, pre-event factors, names of other health professionals involved in the care of the patient, and the contributing environmental factors of the health care facility/system.

(5) All material information obtained by the peer review committee regarding the subject of the peer review should be made available to the physician under review in a timely manner prior to the hearing.

(6) The investigating individual or body shall interview the practitioner, unless the practitioner waives his/her right to be heard, to evaluate the potential charges and explore alternative courses of action before proceeding to the formal peer review process.

**H-375.983 Appropriate Peer Review Procedures**

(1) Our AMA urges state medical associations to investigate applicable state law to determine if additional state agency supervision of peer review is needed to meet the active state supervision requirement set forth by the Supreme Court.

(2) Peer review procedures and actions should, at a minimum, meet the Health Care Quality Improvement Act of 1986 standards for federal immunity: (a) In any situation where it appears

that a disciplinary proceeding may be instigated against a physician that could result in the substantial loss or termination of the physician's medical staff membership and/or clinical privileges, the advice and guidance of legal counsel should be sought. The accused physician should have legal counsel separate from the health care organization or medical staff. The health care organization and the medical staff should each have separate legal counsel. The attorney of the body bringing the peer review action, be it the health care organization or the medical staff, should undertake the procedures needed to prepare for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. This health care organization or medical staff attorney should be instructed that his or her role includes assuring that the proceedings are conducted fairly, bearing in mind the objectives of protecting consumers of health care and the physician involved against false or exaggerated charges. The attorney for the body which is not bringing the peer review action should work to ensure that proper peer review processes as outlined in the medical staff bylaws are followed. The role of the attorney for the accused physician is solely to defend his or her client. (b) The medical executive committee, through its attorney, may consult with the health care organization, through its attorney, regarding appointment of a hearing officer. If an attorney is sought to be the hearing officer, those solo attorneys or attorneys from a firm regularly used by the hospital, medical staff, or the involved medical staff member or applicant for membership for legal advice regarding their affairs and activities, should not be eligible to serve as hearing officers. The hearing officer shall gain no direct financial benefit from the outcome. (c) The attorney advising the medical staff or, in the limited situation where the hospital is prosecuting the correction action, the attorney advising the health care organization, and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing officer. (d) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and at the discretion of the hearing officer. (e) A court reporter should be present to make a record of the hearing proceedings, and the pre-hearing proceedings if deemed appropriate by the hearing officer. The cost of attendance of the court report shall be borne by the hospital, but the cost of the transcript, if any, shall be borne by the party requesting it. (f) Within the discretion of the hearing officer, witnesses may be requested to testify under oath. (g) The role of the hearing panel should be defined in the medical staff bylaws. The role of the hearing panel may include, without being limited to, such duties as: acting as an objective arbiter of evidence, examining witnesses, determining adherence to the standard of care, providing well-reasoned documented opinions and decisions, and other duties noted herein. The hearing panel should only consist of physicians, none of whom are direct economic competitors with the physician involved or who stand to gain through a recommendation or decision adverse to the physician. It is desirable that members of the hearing panel be physicians who have the respect of the medical community, and should include a fair representation of the same specialists/subspecialist physicians as the physician involved, whenever feasible. (h) Physicians serving on the hearing panel should receive information and training in the elements and essentials of peer review. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and available to the extent feasible. Wherever feasible, data collection and analysis, or similar assessment instruments, and multiple reviewers should be used to increase reliability in evaluating whether peer review disciplinary proceedings are warranted. Where feasible, statistical analysis to compare with peers' performance must be used with appropriate case mix adjustments. (i) Physicians who are direct economic competitors of the physician involved may testify as witnesses, whether they are called by the physician or the hearing panel or the health care organization, but a physician should not be deprived of his or her privileges solely on the

basis of medical testimony by economic competitors. In any proceedings that result in the termination of privileges, there should be testimony from one or more physicians who are not economic competitors or who do not stand to gain economically by an adverse action, but who are knowledgeable in the treatment, patient care management and areas of medical practice or judgment upon which the adverse action is based. (j) The hearing panel should credit the evidence brought before it in a manner reflective of the specificity of the evidence and the personal or economic biases of witnesses. (k) When investigation is underway and indicates that a disciplinary proceeding is warranted for the purpose of reducing, restricting, or terminating a physician's hospital privileges, he or she should be notified that resignation will result in a report to the National Practitioner Data Bank.

### **H-265.998 Guidelines for Due Process**

While it is not possible to develop universal guidelines for due process, voluntary utilization of the following general guidelines for due process, adapted in each instance to suit the circumstances and conditions of the health care organization and within the requirements of the applicable laws of the jurisdiction, should assist in providing the type of hearing which the law in each jurisdiction requires:

- (1) The physician should be provided with a statement, or a specific listing, of the charges made against him or her.
- (2) The physician is entitled to adequate notice of the right to a hearing and a reasonable opportunity of no less than 30 days to prepare for the hearing.
- (3) It is the duty and responsibility of the hearing officer to conduct a fair, objective, expeditious and independent hearing pursuant to established rules.
- (4) The rules of procedure should clearly define the extent to which attorneys may participate in the hearing.
- (5) The physician against whom the charges are made should have the opportunity to be present at the hearing and hear all of the evidence against him or her.
- (6) The physician is entitled to the opportunity to present a defense to the charges against him or her.
- (7) To the extent feasible, the hearing panel should evaluate the issues and evidence presented related to the proposed corrective action while blinded to the patient outcome.
- (8) The hearing panel should render a decision based on the evidence produced at the hearing.
- (9) The hearing panel should include in its decision the conclusions reached and actions recommended and, as an important focus if feasible, remedial steps for the physician and for the health care facility itself. When feasible, the hearing panel should include terms that permit measurement and validation of the completed remediation process.
- (10) The hearing panel should endeavor to state its findings, the clinical basis and support for its findings, its recommendations, and actions as clearly as possible.

(11) Within 10 days of the receipt of the hearing panel's decision, the physician, medical executive committee or health care organization, if it brought the correction action, has the right to request an appellate review. The written request for an appellate review shall include an identification of the grounds for appeal and a clear and concise statement of the facts and/or evidence in support of the appeal. The grounds for an appeal of the decision shall be:

- (a) substantial non-compliance with the procedures required in the medical staff bylaws; or
- (b) the decision is against the manifest weight of the evidence. If an appellate review is to be conducted, the appeal board shall schedule the appellate review and provide notice to the physician, medical executive committee and the health care organization. The MEC shall appoint an appeal board consisting of members of the medical staff who did not sit on the original hearing panel, or, at the request of the MEC, the governing body or at least three members thereof may sit as the appeal board. The appeal board shall consider the record of the hearing before the hearing panel. If the appeal board determines that significant relevant evidence, which could bare on the outcome of the proceeding, was not entertained by the hearing panel, it may refer the matter back to the hearing panel for further deliberation or, at the appeal board's discretion, it may receive and consider the new evidence. Similarly, if the appeals board determines that there was not substantial compliance with the hearing procedures in the medical staff bylaws, the appeal board may refer the matter back to the hearing body or, at the appeal board's discretion, it may convene additional hearings to correct any defect in the process. Upon completion of the appeal board's deliberations, the appeal board shall present its recommendation(s) to the governing body as to whether the recommendations(s) of the hearing body should be affirmed, modified, or reversed.

(12) In any hearing, the interest of patients and the public must be protected.

### **H-375.990 Peer Review of the Performance of Hospital Medical Staff Physicians**

Our AMA encourages peer review of the performance of hospital medical staff physicians, which is objective and supervised by physicians. Membership on peer review committees and hearing panels should be open to all physicians on the medical staff and should not be restricted to those physicians who have an exclusive contract with the hospital, salaried physicians, or those on the faculty.

### **H-375.965 Principles for Incident-Based Peer Review and Disciplining at Health Care Organizations**

AMA policy is that:

(1) Summary suspension of clinical privileges is an extraordinary remedy which should be used only when the physician's continued practice presents an "imminent danger to the health of any individual." The decision to summarily suspend a member's medical staff membership or clinical privileges should be made by the chief of staff, chair or vice-chair of the member's clinical department, or medical executive committee. The medical executive committee (MEC) must meet as soon as possible, but in no event more than 14 days after the summary suspension is imposed, or before the time in which a report would be required to the state licensing agency if applicable, whichever is shorter, to review and consider the summary suspension. The MEC shall then promptly modify, continue or terminate the summary suspension. The suspended physician must be invited to attend and make a statement concerning the issues under investigation, but the meeting with the MEC shall not constitute the physician's fair hearing. If the MEC sustains the

suspension, said action will trigger the fair hearing procedures contained in these policies.

(2) At the request of a medical staff department or of a member under review, or at its own initiative if needed for adequate and unbiased review, the medical executive committee may arrange, through the state or local medical society, the relevant specialty society or other appropriate source, for an external hearing panel to hear the case in order to assure professional and impartial clinical assessment.

(3) Prior to any disciplinary hearing, the physician should be provided with a clear, and if applicable, clinically supported basis for the proposed professional review action. A hearing panel of a health care organization should be guided by generally accepted clinical guidelines and established standards in its review actions.

(4) Physician health and impairment issues should be identified and managed by a medical staff committee, which should operate separately from the disciplinary process.