Subject: Effective Peer Review

Presented by: Gerald E. Harmon, MD, Chair

Referred to: Reference Committee on Amendments to Constitution and Bylaws (Edmund R. Donoghue, Jr., MD, Chair)

INTRODUCTION

At the 2016 Interim Meeting, the House of Delegates adopted Policy D-375.987, “Effective Peer Review.”

[Our AMA study the current environment for effective peer review, on both a federal and state basis, in order to update its current policy to include strategies for promoting effective peer review by physicians and to consider a national strategy for protecting all physicians from retaliation as a result from participating in effective peer review.

Testimony spoke of the increasing number of physicians who are employed by, or affiliated with, large hospital systems or healthcare organizations, where physicians are concerned that they exert less and less control over their employment and/or practice situations and patient care. As a result, having effective, legitimate peer review processes in place is vital to safeguarding patient care and safety. Further, physicians in the peer review process need protection from retaliation by hospitals and other lay organizations that might be at odds with the role, actions, or decisions taken by those participants. Although the amended language above was originally contained in a resolution, the House of Delegates adopted this language as a “Directive to Take Action.” This report responds to the study requested by AMA Policy D-375.987.

DISCUSSION

AMA Definition of Peer Review

AMA Policy H-375.962, “Legal Protections for Peer Review,” defines peer review, in part, as:

. . . the task of self-monitoring and maintaining the administration of patient safety and quality of care, consistent with optimal standards of practice . . . Peer review goes beyond individual review of instances or events; it is a mechanism for assuring the quality, safety, and appropriateness of hospital services. The duties of peer review are: addressing the standard of care, preventing patient harm, evaluating patient safety and quality of care, and ensuring that the design of systems or settings of care support safety and high quality care . . .

Because peer review can involve close scrutiny of all aspects of patient care and safety, both with respect to organization-wide patient care and safety issues and issues concerning individual physicians and health care practitioners, the peer review process may bring to light serious patient care and safety issues that are systemic to a hospital or other lay organization. Exposure of such

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issues could damage the hospital’s or organization’s reputation in its community or its other business interests. Consequently, a physician may be reluctant to participate in a peer review proceeding for fear of retaliation if the physician believes that the hospital or lay organization will take issue with the result of, or the physician’s role in, that proceeding. This fear is exacerbated if the hospital or lay organization dominates the physician’s community. Thus, to ensure effective peer review, physician peer review participants must be protected from the possibility of retaliation.

Market Developments: Physician Employment by Hospitals and Non-physician Entities and Increasing Hospital Consolidation

Physician concerns about retaliation against physician peer review participants have grown as hospitals employ more physicians and hospital markets become more concentrated. Many communities in the United States are dominated by only a few hospitals, or even by a single hospital. As more physicians have become employed by, or affiliated with, dominant hospitals or other powerful lay organizations, some physicians increasingly fear retaliation for expressing patient safety or care concerns during a peer review proceeding, or otherwise participating in a peer review process, that the hospital or organization perceives as being contrary to its financial interests. For employed physicians, employment contract termination may be the greatest concern, since termination may have an immediate and detrimental effect on the physician’s ability to continue practicing medicine in the community, e.g., if the termination triggers a broad restrictive covenant.

Independent physicians may also fear retaliation. Although retaliation against an independent physician would not involve employment termination, retaliation could take other forms, e.g., ending other kinds of contracts with the physician, such as a medical directorship or co-management agreement; attempting to reduce or withdraw the physician’s clinical privileges; manipulating call, surgery, or procedure scheduling; or any other myriad means of making it difficult, if not impossible, to fully and freely utilize hospital facilities and staff. If the hospital dominates the physician’s community, these kinds of retaliatory conduct could make it difficult, if not impossible, for even an independent physician to maintain his or her medical practice in the community.


The Health Care Quality Improvement Act of 1986 (HCQIA), promotes peer review by immunizing1 those who participate in the peer review process from damages.2 This immunity applies if a decision by a professional review body, e.g., a decision to revoke hospital privileges, is made using the following standards:

1. In the reasonable belief that the action was in the furtherance of quality health care;
2. After a reasonable effort to obtain the facts of the matter;
3. After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and
4. In the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).3

Decisions made by a peer review body are presumed to have met standards (1) through (4) above, although this presumption may be rebutted by a preponderance of the evidence.
HCQIA was enacted over 30 years ago, when most physicians practiced independently and hospital markets were not nearly as concentrated as they are today. HCQIA immunity is designed to protect peer reviewers and others who participate in the peer review process, e.g., those who provide information to peer review committees, from damage awards that might result from lawsuits filed by individuals who have been adversely affected by peer review decisions. HCQIA does not explicitly limit immunity from damages solely to lawsuits brought by adversely affected physicians. Consequently, it is possible that a court could interpret HCQIA immunity to extend to damages resulting from lawsuits filed by other parties, e.g., a hospital. However, court decisions have up to this point focused on damage claims by adversely affected physicians, so it is unclear if, and how, HCQIA immunity would apply in the context of lawsuits filed by other parties. Likely a greater concern within the context of AMA Policy D-375.987 is that HCQIA immunity applies when a lawsuit is involved. Consequently, immunity would seem not to apply to a wide variety of retaliatory actions that a hospital or other lay organization might take against a peer reviewer, for example, terminating an employment agreement or hindering an independent physician’s ability to fully and freely utilize hospital facilities or practice amenable in association with other physicians employed by, or affiliated with, the hospital or organization.

Amending HCQIA

Although it is possible that an attempt could be made to amend HCQIA to pursue the goals of AMA Policy D-375.987 your Board of Trustees does not, at this time, recommend attempting to amend HCQIA to address a peer review-related retaliation. First, Congressional attention is entirely taken up with a backlog of urgent “must pass” legislation. In this challenging and rapidly changing environment, it would be extremely difficult to draw Congressional attention to yet another major piece of health care legislation, particularly since amending HCQIA has not in recent years been an issue with which Congress has been actively interested. Second, pursuing a HCQIA amendment strategy at this time could have significant, negative unintended consequences, especially with respect to the National Practitioner Data Bank (NPDB). The enactment of HCQIA created the NPDB. In the past, some parties, whose interests are not aligned with those of organized medicine, have strongly urged Congress to amend HCQIA so that the information in the NPDB would be publicly available. Our AMA opposes such efforts. In fact, AMA Policy H-355.976, “National Practitioner Data Bank,” states in part:

. . . 3. Our AMA: (a) opposes all efforts to open the National Practitioner Data Bank to public access; (b) strongly opposes public access to medical malpractice payment information in the National Practitioner Data Bank; and (c) opposes the implementation by the National Practitioner Data Bank of a self-query user fee . . .

Our AMA has taken this position because information in the NPDB is often incomplete and inaccurate, not organized in a way that patients will understand, and is thus highly likely to be misunderstood or misinterpreted by patients. For these reasons, then, your Board of Trustees does not recommend attempting to amend HCQIA. However, while your Board does not believe that pursuing a HCQIA amendment would be appropriate at this time, your Board feels strongly that our AMA should provide assistance to any state medical association or national medical specialty society that wants to explore or pursue a state legislative strategy to protect physician peer review participants from retaliation.

Peer Review Immunity under State Law

The vast majority, if not all, states, have enacted peer review immunity laws. The conditions for immunity are usually less demanding or specific compared to HCQIA’s. HCQIA immunity is
available only if a decision by a peer review body satisfies standards (1) through (4) above. Under
most state peer review laws, immunity is available to peer review participants who act in good
faith.\textsuperscript{5} State peer review immunity extends to damages. In some circumstances, states go further,
immunizing peer review participants from civil liability generally, which would also protect peer
review participants from injunctions.\textsuperscript{6}

State peer review laws are designed to protect peer review participants from lawsuits by physicians
or health care practitioners who feel that they have been aggrieved by a peer review decision. In
many states, immunity protections may not be explicitly limited to lawsuits filed by these
individuals. In such cases, like HCQIA, it is uncertain if, or to what extent, immunity would apply
if a party other than the individual adversely affected by a peer review decision filed a lawsuit
against one or more peer review participants. However, the more important issue with respect to
AMA Policy D-375.987 is that, like HCQIA, state peer review immunity protections apply to
lawsuits. Consequently, state peer review laws would likely not protect physician peer review
participants from the gamut of retaliatory actions short of a lawsuit that might be taken against
them for their role in, or a decision resulting from, a peer review proceeding.

Unlike HCQIA, most, if not all, states protect the confidentiality of peer review information. This
means that peer review information, documents and records cannot lawfully be disclosed to anyone
except those conducting the peer review and any other specific individuals or entities identified in
the peer review statute. Similarly, states often privilege peer review information, documents and
records of peer review proceedings, meaning that such information, documents and records are not
admissible in lawsuits, such as those involving medical liability allegations.

\textit{State Court Decisions}

Although state court decisions involving state peer review statutes have focused on lawsuits by
persons adversely affected by a peer review decision, there is a reported case that does involve a
situation where a hospital retaliated against a peer review participant. The New Mexico Supreme
Court case of \textit{Yedidag, MD, v. Roswell Clinic Corp.}, 346 P.3d 1136 (2015) involved Emre
Yedidag, MD, a surgeon employed by Eastern Medical Center (EMC) and his alleged conduct
during a peer review proceeding. The proceeding focused on another physician’s role in a patient
death. During the proceeding, Dr. Yedidag asked the physician a number of pointed questions to
clarify the circumstances of the patient’s death, some of which the physician refused to answer.\textsuperscript{7} A
staff assistant to the peer review committee, who was not a committee member, attended the
meeting and later told hospital administration that Dr. Yedidag’s questioning had been
inappropriately aggressive (even though physician peer review committee members found nothing
untoward about Dr. Yedidag’s conduct).\textsuperscript{8} EMC subsequently fired Dr. Yedidag because of alleged
“unprofessional behavior.”\textsuperscript{9} Dr. Yedidag sued EMC, claiming that EMC violated New Mexico’s
peer review law. The New Mexico Supreme Court sided with Dr. Yedidag. The Court recognized
that the New Mexico peer review law did not “explicitly preclude employer retaliation for peer
review participation.”\textsuperscript{10} Nor did the statute explicitly authorize Dr. Yedidag to file a lawsuit for
violations of the peer review law. However, the law did protect the confidentiality of peer review
information. The law also permitted use and disclosure of such information only for specific
reasons listed in the statute, and those reasons did not include the hospital’s acquisition and use of
peer review information as part of its personnel decisions. Consequently, the Court ruled that the
hospital violated Dr. Yedidag’s right to confidentiality under New Mexico’s peer review law.

Although Dr. Yedidag won his lawsuit, this decision does not sufficiently address the issues raised
by D-375.987. First, the \textit{Yedidag} case is a single decision under one state’s law. Although most, if
not all, states protect the confidentiality of peer review information, state laws can vary
significantly in the scope of this protection. There is, therefore, no guarantee that other states would reach the same result. Second, hospitals and other lay organizations do not necessarily need access to confidential peer review information to retaliate against peer review participants. Thus, even if all states ultimately followed the Yedidag decision, doing so would probably not cover all of the instances in which a hospital or other lay organization could retaliate against a physician peer review participant. Consequently, physician advocates wanting to address the issues identified by D-375.987 may want to explore or pursue a state-based legislative strategy to ensure that physician peer review participants are protected from all forms of retaliation.

State Legislative Efforts to Protect Physician Peer Review Participants from Retaliation

While it is extremely unlikely that HCQIA could be successfully amended at this time, the prospects of amending a particular state’s laws might be more promising. Your Board of Trustees understands the serious concerns that AMA Policy D-375.987 raises. Your Board believes, therefore, that our AMA should make its Advocacy Resource Center staff and resources available to assist state medical associations and national medical specialty societies that may be interested in considering or pursuing a state legislative strategy to protect physician peer review participants from any retaliatory conduct by hospitals, lay organizations or other parties.

AMA Policy

AMA policies call for retaliation protections. The following is a list of relevant portions of AMA policies. First, AMA Policy H-225.950, “Principles for Physician Employment,” states, in part, that:

1.b. [e]mployed physicians should be free to exercise their personal and professional judgment in voting, speaking, and advocating on any matter regarding patient care interests, the profession, health care in the community, and the independent exercise of medical judgment. Employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers, for asserting these interests . . .

Next, AMA Policy H-225.952, “The Physician’s Right to Exercise Independent Judgement in All Organized Medical Staff Affairs,” states that:

[o]ur AMA supports the unfettered right of a physician to exercise his/her personal and professional judgment in voting, speaking and advocating on any matter regarding: [i] patient care interests; [ii] the profession; [iii] health care in the community; [iv] medical staff matters; [v] the independent exercise of medical judgment as appropriate interests to be incorporated into physician employment and independent contractor agreements; the right [vi] not to be deemed in breach of his/her employment or independent contractor agreement for asserting the foregoing enumerated rights; and [vii] not to be retaliated against by his/her employer in any way, including, but not limited to, termination of his/her employment or independent contractor agreement, commencement of any disciplinary action, or any other adverse action against him/her based on the exercise of the foregoing rights.

Further, AMA Policy H-230.965, “Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators,” states that:

[t]he AMA condemns any action taken by administrators or governing bodies of hospitals or other health care delivery systems who act in an administrative capacity to reduce or withdraw
or otherwise prevent a physician from exercising professional privileges because of medical
staff advocacy activities unrelated to professional competence, conduct or ethics.

AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” asserts, in part,
that:

... II. Our AMA recognizes that the following fundamental rights of the medical staff are
essential to the medical staff’s ability to fulfill its responsibilities: ...b. The right to advocate
for its members and their patients without fear of retaliation by the health care organization’s
administration or governing body . . .

AMA Policy H-225.942 also contains the following:

... IV. Our AMA recognizes that the following fundamental rights apply to individual medical
staff members, regardless of employment, contractual, or independent status, and are essential
to each member’s ability to fulfill the responsibilities owed to his or her patients, the medical
staff, and the health care organization: ...c. The right to exercise personal and professional
judgment in voting, speaking, and advocating on any matter regarding patient care or medical
staff matters, without fear of retaliation by the medical staff or the health care organization’s
administration or governing body . . .

In addition, AMA Policy H-225.957, “Principles for Strengthening the Physician-Hospital
Relationship,” states that:

... 6. The organized medical staff has inherent rights of self-governance, which include but are
not limited to: ...c) Identifying the indications for automatic or summary suspension, or
termination or reduction of privileges or membership in the organized medical staff bylaws,
restricting the use of summary suspension strictly for patient safety and never for purposes of
punishment, retaliation or strategic advantage in a peer review matter . . .

Finally, it is notable that our AMA also has policies calling for peer review immunity, two of
which are most relevant to this report. First, AMA Policy H-375.962, “Legal Protections for Peer
Review,” states, in part, as follows:

... Peer Review Immunity. To encourage physician participation and ensure effective peer
review, entities and participants engaged in peer review activities should be immune from civil
damages, injunctive or equitable relief, and criminal liability . . .

Likewise, AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” states, in
part, that the rights of individual medical staff members must include: “... f. The right to immunity
from civil damages, injunctive or equitable relief, and criminal liability when participating in good
faith peer review activities . . .”

Although protection from any kind of retaliation because of peer review participation might be
implied from AMA policies, AMA policies do not explicitly call for such protection in the context
of peer review participation. This report, therefore, recommends amending AMA Policies
H-225.942 and H-375.962 to explicitly include protection from any retaliatory conduct.
RECOMMENDATIONS

The Board of Trustees recommends that the following be adopted per AMA Policy D-375.987, and that the remainder of the report be filed:

1. That AMA Policy H-225.942, “Physician and Medical Staff Member Bill of Rights,” be amended by addition as follows:

   . . . IV. f. The right to immunity from civil damages, injunctive or equitable relief, criminal liability, and protection from any retaliatory actions, when participating in good faith peer review activities. (Modify Current HOD Policy);

2. That AMA Policy H-375.962, “Legal Protections for Peer Review,” be amended by addition as follows:

   . . . Peer Review Immunity and Protection from Retaliation. To encourage physician participation and ensure effective peer review, entities and participants engaged in peer review activities should be immune from civil damages, injunctive or equitable relief, and criminal liability, and should be afforded all available protections from any retaliatory actions that might be taken against such entities or participants because of their involvement in peer review activities. (Modify Current HOD Policy); and

3. That our AMA will provide guidance, consultation and model legislation concerning protections from retaliation for physician peer review participants, upon request of state medical associations and national medical specialty societies. (Directive to Take Action)

Fiscal Note: $5000.
APPENDIX

D-235.984, “Medical Staff Non-Punitive Reporting Processes”
Our AMA will provide guidance, including but not limited to model medical staff bylaws language, to help medical staffs develop and implement reporting procedures that effectively protect medical staff members from retaliation when they report deficiencies in the quality, safety, or efficacy of patient care.

H-285.910, “The Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession and the Community”
Our AMA endorses the following clause guaranteeing physician independence and recommends it for insertion into physician employment agreements and independent contractor agreements for physician services:

Physician’s Right to Engage in Independent Advocacy on Behalf of Patients, the Profession, and the Community
In caring for patients and in all matters related to this Agreement, Physician shall have the unfettered right to exercise his/her independent professional judgment and be guided by his/her personal and professional beliefs as to what is in the best interests of patients, the profession, and the community. Nothing in this Agreement shall prevent or limit Physician’s right or ability to advocate on behalf of patients’ interests or on behalf of good patient care, or to exercise his/her own medical judgment. Physician shall not be deemed in breach of this Agreement, nor may Employer retaliate in any way, including but not limited to termination of this Agreement, commencement of any disciplinary action, or any other adverse action against Physician directly or indirectly, based on Physician’s exercise of his/her rights under this paragraph.

REFERENCES

1 Unlike state peer review laws, HCQIA does not address the confidentiality of peer review information or records of peer review proceedings. Nor does HCQIA address the issue of whether, or to what extent, peer review information, documents, or records may be admitted into lawsuits or administrative proceedings. The Confidentiality and admission of peer review information is determined by courts on a case-by-case basis.
2 See 42 U.S.C. §§ 11101, et seq.
3 42 U.S. Code § 11112(a)
4 Id.
6 Id.
7 Yedidag, at 1143.
8 Id. at 1143-1144.
9 Id. at 1144.
10 Id. at 1151.