REPORT 29 OF THE BOARD OF TRUSTEES (A-24)
Transparency and Accountability of Hospitals and Hospital Systems
Reference Committee G

EXECUTIVE SUMMARY

At the 2023 Annual Meeting of the House of Delegates, Policy D-200.971, "Transparency and Accountability of Hospitals and Hospital Systems" was adopted. This policy directed the American Medical Association (AMA) to (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physicians complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews (Directive to Take Action).

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Barriers persist that prevent physicians from reporting patient care concerns or seeking recourse if a bad-faith peer review process has been initiated against them based on what they believe are unfounded, unfair allegations.

To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It is the AMA's position that malpractice payment information should not be made public. AMA policy requires state medical boards report disciplinary action to the AMA and Federation of State Medical Boards, but does not endorse the public reporting of such information. The AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public; however, the AMA does support transparency of physician complaints against hospitals and hospital systems through publicly accessible channels, such as the Joint Commission Quality Check reports.

Considering (1) that organizations found to have conducted bad-faith peer reviews are not granted immunity by the HCQIA, (2) the AMA has historically opposed attempts to amend the HCQIA and (3) monetary penalties at the state level have not resulted in increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.

Finally, the AMA, despite having an abundance of policy on the matter, has not published many resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. This report makes a recommendation for the AMA to enhance content offerings on this topic.

REPORT OF THE BOARD OF TRUSTEES

B of T Report 29-A-24

Subject: Transparency and Accountability of Hospitals and Hospital Systems

Presented by: Willie Underwood, III, MD, MSc, MPH, Chair

Referred to: Reference Committee G

INTRODUCTION

At the 2023 Annual Meeting, the House of Delegates (HOD) adopted Policy D-200.971, "Transparency and Accountability of Hospitals and Hospital Systems." This resolution asked that our American Medical Association (AMA) (1) identify options for developing and implementing processes – including increased transparency of physicians complaints made to the Equal Employment Opportunity Commission (EEOC) and The Joint Commission – for tracking and monitoring physician complaints against hospitals and hospital systems and (2) report back with recommendations for implementing such processes, including potential revisions to the Health Care Quality Improvement Act (HCQIA) of 1986 to include monetary penalties for institutions performing bad-faith peer reviews.

BACKGROUND

Key issues raised by the resolution that resulted in Policy D-200.971 were (1) the perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) mistreatment of or retaliation against physicians who report concerns, including through the conduct of bad-faith peer reviews; (3) the lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews. Testimony in the Reference Committee hearing on this resolution also indicated that access to information about complaints filed on health systems would be valuable to physicians considering new employment. This report will address these items, in addition to brief background on peer reviews and the HCQIA, and make recommendations for further HOD action.

DISCUSSION

Whistleblower reports

Physicians or other medical professionals may have the unfortunate experience of witnessing unethical behavior, an incident where a patient was harmed or a colleague committing some type of wrongdoing. Upholding the ethical standards of the profession is among the duties of all health care professionals, and part of fulfilling that duty includes reporting concerns and issues when they happen. Hospitals and health systems, who depend on high quality ratings and safety scores, as well as low numbers of safety violations, do not always receive these reports well. Although

unlawful, since whistleblowers are protected by dozens of laws, people who report complaints or concerns, or "whistleblowers," may be ostracized, pressured to withdraw their report or threatened with counter allegations. Worse, a hospital may turn against the complainant and punish them through other means of retaliation such as a false or fabricated peer review. Given the potential negative consequences, many health care workers may avoid reporting ethical or patient safety concerns out of fear for their own livelihood, safety or reputation.[1]

Peer review

When a patient-safety or ethical violation is investigated, peer reviews are often the mechanism for evaluating the circumstances, conduct and outcomes of the incident. Peer review processes are long-established within organized medicine, intended to ensure patient safety but also to scrutinize professional conduct and protect hospitals from liability.[2] The responsibility to ensure quality care through physician monitoring has been delegated to committees composed mainly of medical staff that review physician credentials and applications for admission to the medical staff, as well as determine the privileges physicians have at a hospital.[3] Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately.[2]

The AMA 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 (Policy H-375.962, "Legal Protections for Peer Review").[4]

This policy continues to discuss a "good faith peer review": a "peer review conducted with honest intentions that assess appropriateness and medical necessity to assure safe, high-quality medical care is good faith peer review. Misfeasance (i.e., abuse of authority during the peer review process to achieve a desired result other than improved patient care), or misuse of the peer review process, or peer review that is politically motivated, manipulated to achieve economic gains or due to personal vendetta is not considered a good faith peer review".[4]

Health Care Quality Improvement Act of 1986

The HCQIA of 1986 was introduced to provide protection from liability under federal and state laws for members of a professional review body and their staffs, and establish a national repository for reported information regarding medical malpractice payments and adverse actions involving physicians.[5]Since then, each state (and the District of Columbia) have passed their own laws requiring the peer review process to improve health care quality.[3]

In addition to establishing the National Practitioner Data Bank (NPDB) to monitor hospital- and state-level credentialing of physicians, the HCQIA also granted federal immunity protections to physicians that participate in good faith evaluation of their peers. To qualify for immunity protections under the Act, it is presumed that the actions of peer review committees meet four standards, unless their actions are rebutted by a "preponderance of the evidence", wherein the burden of proof is on the physician undergoing review.[3,6] First, there must be a reasonable belief that peer review action was taken to ensure quality care. Second, peer review action should only be taken after a reasonable effort to obtain the facts surrounding the case. Third, the physician

undergoing peer review must be afforded sufficient notice and hearing procedures or other fair protocols relevant to the circumstances of the case. Last, after reasonable efforts to obtain the facts of the case have been made, reasonable belief that peer review action was warranted by these facts is then also required.[3]

Bad-faith peer review

Because peer review committees are typically not independent, and often comprise hospital-employed physicians who have agreed to make decisions on behalf of the organization, judgments made by these committees have the potential to be biased. A bad-faith, or "sham" peer review, may be politically motivated, manipulated to achieve economic gains or to avoid financial risks, conducted in a way that helps the organization avoid reputational damage or is facilitated to fulfill a personal vendetta against an individual. The peer review process may also be exploited to deem the whistleblower incompetent or disruptive, undermining the merits of their report. Such inappropriate peer reviews were the subject of AMA Board of Trustees Report 24-A-08, titled "Inappropriate Peer Reviews," which described several cases of improperly motivated peer review, including *Patrick v Burget* (1998), *Rosenblit v Superior Court (*1991), *Clark v Columbia/HCA Information Services* (2001), and *Poliner vs Presbyterian Hospital of Dallas* (2006).[7]

Victims of bad-faith peer reviews often share similar characteristics that cause them to be perceived as "easy targets." Such characteristics include independent physicians that lack the social and political support and other resources frequently enjoyed by physicians who are part of large health systems, physicians who are new on staff and haven't yet had the opportunity to develop strong connections and physicians that perform "new" or "different" procedures.[3]

Racial inequities in adverse action reports

Anecdotal evidence from the media and health law bar have reported a rise in racial inequities in adverse medical staff actions. This increase is believed to be due to racially motivated actions and more physicians of color challenging such actions. One example of this involved a Black physician who, over the course of 25 years, resided in a rural community, established a practice, and maintained an honorable career in her specialty. After identifying an unmet need of a patient population in her rural community that went unaddressed by local health systems, she established an outpatient facility that thrived. After she brought forward quality of care concerns regarding the danger to high-risk patients created by a gap in specialty coverage and quality nursing care at the hospital, a medical staff investigation was initiated against her by the hospital's peer review committee in response to retaliatory nursing staff claims. To avoid a potentially career-ending report to the NPDB, the physician was forced to invest time, money and energy toward participation in the demoralizing, retaliatory medical staff investigation.[6]

Adverse medical staff actions that cite subjective reasons such as "disruptive" behavior, competency concerns and/or unprofessional conduct have served to justify racism against Black physicians and other minoritized physicians. Racially motivated bad-faith peer reviews threaten the economic and mental well-being of physicians of color in addition to the health outcomes of the diverse patient populations they care for.[6]

Some hospital- and health system-level recommendations that have been proposed to prevent racial discrimination in the peer review process include hiring racially diverse leadership, as well as representation on peer review committees and reviewing and revising peer review protocols through an equity lens.[6]

Perceived barriers to reporting patient care concerns

The authors of AMA Policy D-200.971 raised concerns about perceived barriers for physicians to report patient care or other concerns without fear of retaliation due to the large influence and market dominance many health systems have. AMA Board of Trustees Report 5-I-17, "Effective Peer Review", discussed this issue, addressing physicians' concerns with the waning influence or control they have over their employment or patient care, as they are increasingly becoming employed by or affiliated with large hospital systems or health care organizations.[8] Despite BOT Report 5-I-17 having been published more than six years ago, the issues addressed within it remain relevant and thus appropriate to cite within this current report.

"In a large health system or hospital, peer review systems are integral to safeguarding patient safety and 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 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".[8]

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.[8]

Existing mechanisms for reporting complaints or concerns

To understand the issue of the perceived limitations for physicians to safely report patient care concerns due to the large influence and dominance of their health systems and/or seek recourse if they believe a peer review process has been initiated against them based on unfounded, unfair allegations, we evaluated the landscape of reporting mechanisms currently in place. Numerous systems exist for physicians to report complaints about a peer, patient safety concerns within their health system or other unethical or egregious practices they experience or observe within their place of practice. These systems are in place at multiple levels to promote patient safety and typically great efforts are made to ensure reports are confidential, so individuals feel safe and confident in reporting concerns without fear of retaliation.

The most appropriate organization for a physician to file a complaint against a health care system or hospital is their state medical board. Each state has at least one medical board that licenses allopathic or osteopathic doctors, investigates complaints, disciplines physicians, and refers physicians for evaluation and rehabilitation when appropriate.

Health care organizations should have in place reporting mechanisms through which physicians or other professionals can confidentially submit concerns or complaints without fear of recourse or retaliation. While this may be reasonable for expressing concerns about one's peer or colleague, due to concerns about privacy or fear of consequences many physicians may not feel comfortable bringing organization or system-level issues to their organization's leadership.

If physicians do not feel comfortable reporting concerns directly to their leadership or organization, they may report concerns or complaints about their health system or hospital to The Joint Commission if the organization is accredited or certified by The Joint Commission.[9] The Joint Commission's standards require leaders to provide and encourage the use of systems for blame-free reporting of a system or process failure. The Joint Commission encourages practices to engage frontline staff in internal reporting in a number of ways including (1) creating a nonpunitive approach to patient safety event reporting, (2) educating staff on and encouraging them to identify patient safety events that should be reported and (3) providing timely feedback regarding actions taken on reported patient safety events.[10]

The U.S. Department of Health & Human Services (HHS) provides a mechanism for physicians employed by HHS or one of its agencies, or whose employer receives HHS contract or grant funding, to have their whistleblower retaliation complaints processed by HHS-Office of the Inspector General. The actions of these physicians to expose unlawful activities such as abuse and mismanagement within an HHS agency, (sub)contractor or (sub)grantee organization are protected by HHS.[11] Individuals that submit a complaint can choose whether to provide identifying information or remain anonymous.[12]

Also at the federal level, if a physician has been unfairly subjected to a peer review due to underlying racial discrimination or denied compensation or benefits following a bad-faith peer review, for example, they can report such violations to the U.S. Department of Labor (DOL). The agency within the DOL that handles whistleblower retaliation allegations is the Occupational Safety and Health Administration (OSHA). OSHA enforces the retaliation protections of more than 20 federal laws.[13]

If a physician believes they have been subjected to a bad-faith peer review in retaliation for making complaints about discriminatory behavior, disclosing violations of the law, fraud, or abuse, refusing to obey an order believed to be discriminatory or participating in discrimination or whistleblower proceedings, one resource available to them for recourse is the EEOC.[14,15] A physician in this circumstance must provide evidence that (1) they participated in a protected activity, (2) their employer took materially adverse action and (3) retaliation was the driving force behind the employer's adverse action. Employer retaliatory action is any action that might deter a reasonable person from engaging in protected activity.[14]

Two additional resources that may be beneficial to physicians harmed by a bad-faith peer review are the Association of American Physicians and Surgeons (AAPS) Sham Peer Review Hotline and the Center for Peer Review Justice. Physicians can call or email the AAPS hotline for an attorney referral – a free resource for AAPS members.[16] The Center for Peer Review Justice offers complimentary second opinions, legal services, lectures and consultations regarding the NPDB.[17]

Lack of publicly available information about complaints against hospitals and health systems

There are no publicly available universal repositories that house information about U.S. physician or hospital misconduct, sanctions, malpractice incidents or other complaints. Some entities collect and track these elements, but none provide large-scale searchable tools for the public or for

physicians seeking information about health systems or hospitals. Most, if not all, states protect the confidentiality of peer review information, meaning 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.[8] Here we describe the available resources and their respective access levels.

The Joint Commission does not publish information about complaints, but its publicly available Quality Check reports provide an indication of accreditation and quality performance. These reports could be accessed by a physician looking to verify an organization's accreditation status and quality reports before considering employment. The Quality Check reports published by The Joint Commission could serve as a publicly accessible channel in which to publish final determinations of physician complaints against hospitals and hospital systems.

Complaints to the EEOC are confidential and maintained for record-keeping purposes, as well as to determine if the situation is covered by the EEOC, unless and until an individual files a discrimination charge. After a charge is filed, the individual's name and basic information surrounding the allegations are released to their employer. However, by law, this information is not available to the public. Different protocols apply to federal employees.[18]

Individuals seeking information about a hospital or health system's involvement in malpractice cases have the right to access public records through the federal, state or county court systems. Typically, the public-facing systems provide basic information about cases, and do not disclose information about proceedings or outcomes. More detailed court records may be accessible by the public for a fee. These systems only demonstrate legal actions involving individuals or businesses, however, and are not necessarily an indication of a hospital's quality or a physician's medical competence. It is not recommended public court records be used as a basis for making employment decisions.

State licensure and hospital credentialing entities require reporting of disciplinary investigations and related actions on applications and renewal forms, which may include peer review committee investigations. The NPDB collects and maintains information reported by the states and hospitals including adverse licensure, professional review actions, clinical privileges actions, and medical malpractice actions. It is the only federal database containing information about physician malpractice, but the lack of contextual information about individual cases makes it an incomplete and potentially misleading resource. The NPDB does not track and publish individual complaints about health care organizations, health systems or other health care employers. The NPDB provides access about individual practitioners only to authorized users, such as hospitals and medical boards, but not the general public.[19] Since its inception, there have been multiple attempts from members of Congress and other stakeholders to make the NPDB public.[20–22]

Of note, the AMA has historically maintained opposition of attempts to make the NPDB available to the public, instead supporting state-level efforts and the Federation of State Medical Boards (FSMB) Physician Data Center (Policy H-355.975, "Opposition to the National Practitioner Data Bank").[23]

The FSMB Physician Data Center collects information reported from state medical boards, government regulatory entities, and international licensing authorities. Hospitals and health care organizations, not the public, can search licensure history and past regulatory actions, including revocations, suspensions, loss of license, probation restrictions and licensure denials, for actively licensed physicians.[24]

State medical boards provide the public with access to information about physician licensure status. Many, if not most, also include general information about whether a physician has had disciplinary action against them. These systems do not publish information about health care organizations.

Amending the HCQIA to mandate monetary penalties for bad-faith peer reviews

Policy H-200.971 recommends amendments to the HCQIA to impose monetary penalties for institutions performing bad-faith peer reviews. Similarly, proposals for the imposition of monetary penalties against hospitals that fail to report adverse actions to the NPDB have been attempted but not adopted.[25] Some states impose financial penalties on hospitals for failure to report physician misconduct, but they are reportedly difficult to enforce due to lack of resources for investigations and a tendency for the state medical board to investigate the individual physician rather than the entity that failed to report the incident.[25,26]

Sham peer reviews are difficult to identify, prove, and track. The burden of proof lies with the complainant, and it is challenging to acquire tangible proof that a hospital acted maliciously in conducting a peer review. If an organization is found to have participated in or conducted a bad-faith peer review, it is no longer protected by the immunity the HCQIA otherwise offers these entities. It is thus subject to exposure to lawsuits, claims for damages and the risk of very costly rulings.

Your Board of Trustees does not at this time recommend pursuing a HCQIA amendment strategy because doing so could result in significant, negative unintended consequences, especially with respect to the NPDB. Opening the law for amendment to mandate monetary penalties for health care organizations could present opportunities for parties, whose interests are not aligned with those of organized medicine, to reintroduce changes that have in the past been attempted. For example, stakeholders outside organized medicine have strongly urged Congress to amend the HCQIA so that the information in the NPDB would be publicly available. AMA opposes such efforts. For example, AMA Policy H-355.976, "National Practitioner Data Bank" states in part: "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." The 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 and those previously mentioned, the Board does not recommend attempting to amend HCQIA.

AMA POLICY

The AMA has numerous policies affirming its position supporting retaliation protections, including specifically in the context of peer review participation.

Our AMA: (1) opposes mandates from employers to supervise non-physician providers as a condition for physician employment and in physician employment contracts; and (2) supports whistleblower protections for physicians who report unsafe care provided by non-physicians to the appropriate regulatory board (Policy H-405.950, "Preserving the Practice of Medicine").

AMA policy states that physicians should be free to exercise their personal and professional judgment in advocating on any matter regarding patient care interests and that employed physicians should not be deemed in breach of their employment agreements, nor be retaliated against by their employers for asserting these interests (Policy H-225.950, "Principles for Physician Employment";

Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs").

Further, the 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 (Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators").

Our AMA (1) supports whistleblower protections for health care professionals and parties who raise questions that include, but are not limited to, issues of quality, safety and efficacy of health care and are adversely treated by any health care organization or entity and (2) will advocate for protection in medical staff bylaws to minimize negative repercussions for physicians who report problems within their workplace (Policy H-435.942, "Fair Process for Employed Physicians").

AMA policy also states that entities and participants engaged in good faith 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. This policy also defines a "good faith peer review", supports the confidentiality of peer review committee proceedings and opposes efforts to make these proceedings or any resulting decisions public or available via self-query (Policy H-375.962, "Legal Protections for Peer Review").

Moreover, the AMA monitors legal and regulatory challenges to peer review immunity and non discoverability of peer review records/proceedings and continues to advocate for adherence to AMA policy, reporting challenges to peer review protections to the HOD (Policy D-375.997, "Peer Reviewer Immunity").

Additional AMA policies call for fair and unbiased peer review procedures that enable due process for all participants.

In 2016, the AMA adopted policy directing it to study the current environment for effective peer review in order to update 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 (Policy D-375.987, "Effective Peer Review").

Additionally, the AMA published policy outlining appropriate peer review procedures that urge state medical associations 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, and that peer review procedures should, at a minimum, meet the HCQIA standards for federal immunity (Policy H-375.983, "Appropriate Peer Review Procedures").

The AMA also adopted guidelines for obtaining outside reviewers when a fair review cannot be conducted by hospital medical staff (Policy H-375.960, "Protection Against External Peer Review Abuses").

AMA policy encourages the use of physician data to benefit both patients and physicians and to improve the quality of patient care and the efficient use of resources in the delivery of health care. services. The AMA supports this use of physician data when it is used in conjunction with program(s) designed to improve or maintain the quality of, and access to, medical care for all

patients and is used to provide accurate physician performance assessments (Policy H-406.991, "Work of the Task Force on the Release of Physician Data").

However, the AMA opposes the requirement that peer review organizations and private accreditation entities report any negative action or finding to the NPDB (Policy H-355.975, "Opposition to the National Practitioner Data Bank"), advocates for amendments to the Freedom of Information Act to exempt confidential peer review information from disclosure under the Act, and supports appropriate efforts to prohibit discovery of information obtained in the course of peer review proceedings (Policy D-375.999, "Confidentiality of Physician Peer Review").

Finally, the AMA Code of Medical Ethics includes opinions related to physicians' right to report concerns about their peers or organizations, the peer review process, and protections against retaliation.

The AMA believes that physicians have mutual obligations to hold one another to the ethical standards of their profession. Peer review, by the ethics committees of medical societies, hospital credentials and utilization committees, or other bodies, has long been established by organized medicine to scrutinize professional conduct. Peer review is recognized and accepted as a means of promoting professionalism and maintaining trust. The peer review process is intended to balance physicians' right to exercise medical judgment freely with the obligation to do so wisely and temperately (Opinion 9.4.1 Peer Review & Due Process).

The AMA also believes that physicians who become aware of or strongly suspect that conduct threatens patient welfare or otherwise appears to violate ethical or legal standards should:

a) Report the conduct to appropriate clinical authorities in the first instance so that the possible impact on patient welfare can be assessed and remedial action taken;
b) Report directly to the state licensing board when the conduct in question poses an immediate threat to the health and safety of patients or violates state licensing provisions.
(c) Report to a higher authority if the conduct continues unchanged despite initial reporting.
(d) Protect the privacy of any patients who may be involved to the greatest extent possible, consistent with due process.
(e) Report the suspected violation to appropriate authorities (Opinion 9.4.2 Reporting Incompetent or Unethical Behavior by Colleagues).

AMA RESOURCES

The AMA, despite having an abundance of policy on the matter, has not published a significant number of resources to help physicians navigate the tumultuous processes of reporting concerns or being the subject of a peer review. Existing resources include the following.

The AMA's Principles for Physician Employment include principles for peer review and performance evaluations and state that employed physicians should be accorded due-process protections, including a fair and objective hearing, in all peer review proceedings.
For medical staff leadership, the AMA Credentialing Services offers a webinar entitled, "Medical Group Peer Review: Legal Issues and Possible Protections", that provides information about the importance of ensuring fair peer review proceedings to mitigate liability.

Finally, physicians can submit concerns or complaints about another physician or health professional to the AMA, although the AMA Code of Medical Ethics states that grievances against a medical professional who is believed to be acting unethically or not providing a certain standard

of care should be directed to the state medical licensing board. The AMA will not investigate any complaints of misconduct or unethical behavior by physicians or health care organizations, nor does the AMA have legal authority or the proper resources to investigate individual cases.

CONCLUSION

The key issues underpinning Policy H-200.971 are the (1) perceived limitations for physicians to safely, and without fear of retaliation, report patient care concerns due to the large influence and market dominance many health systems have; (2) the conduct of bad-faith peer reviews or other mistreatment or retaliation against physicians that have reported concerns; (3) lack of publicly available information about complaints against hospitals and health systems; and (4) the potential amendment of the HCQIA to add monetary penalties for entities found to have conducted bad-faith peer reviews.

This report provides detailed information about multiple systems in place for physicians to report concerns about their health system or hospital employer. Despite the attempts to make these systems safe and confidential, and the fact that employed physicians are protected from retaliation by state and federal laws, there are often still barriers that prevent physicians from reporting concerns without fear of retaliation in some form and/or seeking adequate recourse if a bad-faith peer review process is initiated against them.

Peer reviews in medicine will continue to be a mainstay in ensuring safe and ethical patient care is provided by competent physicians. When conducted appropriately and according to acceptable standards, peer reviews are a valuable tool for the health care system. The conduct of bad-faith peer reviews, however, is morally, ethically and professionally abhorrent, and runs counter to everything that physicians and the practice of medicine stand for.

Also highlighted in this report are several entities that collect and publish data on physician licensure, malpractice payments, and disciplinary actions. None of the systems that house this data make it available to the public. To our knowledge, no systems are in place to track and publicly report malpractice information or complaints against hospitals or health systems. It has long been the position of the AMA that malpractice payment information should not be made public. And while AMA policy requires state medical boards report disciplinary action to the AMA and FSMB, it does not call for or endorse the public reporting of such information. Physicians have numerous other options for locating organization-related information when seeking new employment, and the AMA does not support efforts to require the AMA, FSMB, The Joint Commission or any state or federal entity to dedicate resources to providing this information to the public for the purposes of aiding job seekers in their employment decisions. It is also the AMA's position that providing the public with access to incomplete information devoid of context would invite more issues than it would resolve. The AMA does, however, support transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as The Joint Commission Quality Check reports.

Finally, we address the request for the AMA to recommend amendments to the HCQIA to impose monetary penalties on perpetrators of bad-faith peer reviews. The HCQIA provides protection for hospitals and peer review committees, so long as their peer reviews are conducted in a manner consistent with the law. They are no longer entitled to such immunity if it is found they participated in or led a bad-faith peer review. In the U.S., the justice system is in the position to facilitate the appropriate penalization of organizations faced with lawsuits and damages brought on by their participation in bad-faith peer reviews. Considering (1) that protection under the HCQIA is not

provided to organizations failing to meet the HCQIA's four standards of professional review; (2) the AMA has historically opposed attempts to amend the HCQIA; and (3) monetary penalties at the state level have not resulted in increased reporting or reduced incident rates, the AMA does not recommend new attempts to amend the HCQIA for the purposes of adding such penalties for organizations involved in bad-faith peer reviews.[25,27,28]

RECOMMENDATIONS

The Board of Trustees recommends:

1. The following policies be reaffirmed:
    a. Policy H-405.950, "Preserving the Practice of Medicine"
    b. Policy H-225.950, "Principles for Physician Employment"
    c. Policy H-225.952, "The Physician's Right to Exercise Independent Judgement in All Organized Medical Staff Affairs"
    d. Policy H-230.965, "Immunity from Retaliation Against Medical Staff Representatives by Hospital Administrators"
    e. Policy H-435.942, "Fair Process for Employed Physicians"
    f. Policy H-375.962, "Legal Protections for Peer Review
    g. Policy D-375.987, "Effective Peer Review"
    h. Policy H-375.960, "Protection Against External Peer Review Abuses" (Reaffirm HOD policy); and

2. That the following policy statement be adopted to supersede Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems,":
    a. The AMA supports transparent reporting of final determinations of physician complaints against hospitals and health systems through publicly accessible channels such as the Joint Commission Quality Check reports (New HOD Policy).
    b. The AMA will develop educational materials on the peer review process, including information about what constitutes a bad-faith peer review and what options physicians may have in navigating the peer review process (Directive to Take Action).

3. That the title of Policy H-200.971, "Transparency and Accountability of Hospitals and Hospital Systems," be changed to:
    a. "Transparent Reporting of Physician Complaints Against Hospitals and Health Systems"

4. That the remainder of this report be filed.

Fiscal note: Minimal

REFERENCES

1. Gharagozloo F, Poston R, Gruessner RW. Consequences for Whistleblowing: Retaliation, Sham Peer Review and Hospital Immunity. J Biomed Res Environ Sci. 2023;4(2):235-238.
2. American Medical Association. Chapter 9.4.1: Peer Review & Due Process. AMA Code of Medical Ethics. American Medical Association; 2022. Accessed February 26, 2024. https://code-medical-ethics.ama-assn.org/ethics-opinions/peer-review-due-process
3. van Geertruyden YHH. The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community Comment. *J Contemp Health Law Policy*. 2001;18(1):239-272. https://heinonline.org/HOL/P?h=hein.journals/jchlp18&i=249
4. American Medical Association. *Legal Protections for Peer Review*. H-375.962.; 2017. Accessed February 27, 2024. https://policysearch.ama-assn.org/policyfinder/detail/Legal%20Protections%20for%20Peer%20Review?uri=%2FAMADoc%2FHOD.xml-0-3167.xml
5. Wyden R. *Health Care Quality Improvement Act of 1986*.; 1986. Accessed February 27, 2024. https://www.congress.gov/bill/99th-congress/house-bill/5540
6. Welch SS, Hoffler T "CK." An Epidemic of Racism in Peer Review: Killing Access to Black and Brown Physicians. Race, Racism and the Law. Published June 12, 2022. Accessed February 23, 2024. https://racism.org/articles/basic-needs/54-health-and-health-care/230-health-care-generally/191-barrierstoaccess/10414-an-epidemic
7. American Medical Association. Inappropriate Peer Review. *Proceedings of the American Medical Association House of Delegates 157th Annual Meeting*.; 2008. Accessed February 26, 2024. http://ama.nmtvault.com/jsp/PsImageViewer.jsp?doc_id
8. American Medical Association. Effective Peer Review. *2017 Interim Meeting of the AMA House of Delegates Reference Committee on Amendments to Constitution and Bylaws*.; 2017. Accessed February 27, 2024. https://www.ama-assn.org/sites/ama-assn.org/files/corp/media-browser/public/hod/i17-refcomm-conby.pdf
9. The Joint Commission. Report a Patient Safety Concern or File a Complaint. The Joint Commission. Published 2024. Accessed February 27, 2024. https://www.jointcommission.org/resources/patient-safety-topics/report-a-patient-safety-concern-or-complaint/
10. The Joint Commission. Patient Safety Systems (PS). The Joint Commission. Published January 2024. Accessed February 27, 2024. https://www.jointcommission.org/-/media/tjc/documents/standards/ps-chapters/2023/camobs_ps_20230905_115451.pdf
11. Office of the Inspector General. Report Whistleblower Retaliation: Eligibility. OIG-HHS. Published 2024. Accessed February 24, 2024. https://tips.oig.hhs.gov/report-whistleblower-retaliation/eligibility
12. Office of the Inspector General. Report Whistleblower Retaliation: Your Identity. OIG-HHS. Published 2024. Accessed February 24, 2024. https://tips.oig.hhs.gov/report-whistleblower-retaliation/identity
13. Meyers C. How to Report an Employer to the Department of Labor. Findlaw. Published November 19, 2021. Accessed February 24, 2024. https://www.findlaw.com/employment/whistleblowers/how-to-report-an-employer-to-the-department-of-labor.html
14. U.S. Equal Employment Opportunity Commission. Questions and Answers: Enforcement Guidance on Retaliation and Related Issues. US EEOC. Published August 26, 2016. Accessed February 23, 2024. https://www.eeoc.gov/laws/guidance/questions-and-answers-enforcement-guidance-retaliation-and-related-issues

15. U.S. Department of the Interior. What are Discrimination, Harassment, Harassing Conduct, and Retaliation? DOI. Published December 14, 2017. Accessed February 23, 2024. https://www.doi.gov/employees/anti-harassment/definitions
16. Association of American Physicians and Surgeons. Sham Peer Review: Resources for Physicians. AAPS. Published November 17, 2023. Accessed February 24, 2024. https://aapsonline.org/sham-peer-review-resources-for-physicians/
17. Center for Peer Review Justice. Center for Peer Review Justice. Center for Peer Review Justice. Published 2018. Accessed February 24, 2024. https://peerreviewjustice.org/
18. U.S. Equal Employment Opportunity Commission. Confidentiality. US EEOC. Published 2024. Accessed February 23, 2024. https://www.eeoc.gov/confidentiality
19. National Practitioner Data Bank. How to Get Started for Practitioners. NPDB. Published 2024. Accessed February 27, 2024. https://www.npdb.hrsa.gov/pract/howToGetStarted.jsp
20. Bliley T. *Patient Protection Act of 2000*.; 2000. Accessed February 27, 2024. https://www.govinfo.gov/app/details/BILLS-106hr5122ih
21. Barker Pape J. Physician Date Banks: The Public's Right to Know Versus the Physician Date Banks: The Public's Right to Know Versus the Physician's Right to Privacy Physician's Right to Privacy. *Fordham Law Rev*. 1997;66(3). Accessed February 27, 2024. https://ir.lawnet.fordham.edu/cgi/viewcontent.cgi?article=3417&context=flr
22. Wolfe SM. Congress Should Open the National Practitioner Data Bank to All. *Public Health Rep*. 1995;110(4):378-379. https://www.ncbi.nlm.nih.gov/pmc/articles/PMC1382144/
23. American Medical Association. *Opposition to the National Practitioner Data Bank*. Vol H-355.975.; 2014. Accessed February 27, 2024. https://policysearch.ama-assn.org/policyfinder/detail/Opposition%20to%20the%20National%20Practitioner%20Data%20Bank?uri=%2FAMADoc%2FHOD.xml-0-3050.xml
24. FSMB. PDC Query. FSMB. Published 2024. Accessed February 27, 2024. https://www.fsmb.org/PDC/pdc-query/
25. Sawicki NN. State Peer Review Laws as a Tool to Incentivize Reporting to State Peer Review Laws as a Tool to Incentivize Reporting to Medical Boards Medical Boards. *Loyola Univ Chic Law ECommons*. Published online 2021. Accessed February 27, 2024. https://lawecommons.luc.edu/cgi/viewcontent.cgi?article=1727&context=facpubs
26. Pendo E, McIntosh T, Walsh H, Baldwin K, Dubois JM. Protecting Patients from Physicians Who Inflict Harm: New Legal Resources for State Medical Boards. *J Health Law Policy*. 2022;15(1). Accessed February 27, 2024. https://papers.ssrn.com/abstract=4078215
27. U.S. Government Publishing Office. Chapter 117, §11112- Standards for Professional Review Actions. *Title 42, Chapter 117- Encouraging Good Faith Professional Review Activities*. 2011th ed. United States Code; 2011. Accessed March 5, 2024. https://www.govinfo.gov/content/pkg/USCODE-2011-title42/html/USCODE-2011-title42-chap117.htm
28. Rodgers AW. Procedural Protections During Medical Peer Review: A Reinterpretation of the Health Care Quality Improvement Act of Reinterpretation of the Health Care Quality Improvement Act of 1986. *Dickinson Law Rev*. 2007;111(2006-2007). Accessed March 5, 2024. https://ideas.dickinsonlaw.psu.edu/cgi/viewcontent.cgi?article=3838&context=dlra