Model Principles for Medical Peer Review of Physicians for Health Care Facilities

2010
Massachusetts Medical Society Policy
Model Principles for Medical Peer Review of Physicians for Health Care Facilities

The following recommendations are made based on the above considerations in order to enhance:

- Quality improvement
- Credibility in the process of medical peer review of physicians for health care facilities
- Fairness and due process
- Patient access — by not inappropriately removing or sanctioning physicians
- System approaches to patient safety and quality of care

That the Massachusetts Medical Society Model Principles for Medical Peer Review of Physicians for Health Care Facilities are as follows:

1. Patient safety and quality of care must be the goal.
2. Evaluation of circumstances surrounding an adverse event in a health care facility must not only include pre-event factors, but also the contributory effects of the health care system.
3. All the relevant information should be obtained promptly from the subject physician. In addition, relevant information from other sources should be obtained and made available to the subject physician to the fullest extent legally permissible followed by early discussion with the subject physician to evaluate the “incident” and explore alternate course of action.
4. The process must be mindful and attuned to prevention and recommend appropriate individual and system changes for remediation.
5. Triggers that initiate a medical peer review within a health care facility should be valid, transparent and available to all member physicians and should be uniformly applied, with objective and evidence-based pre-screening, to all cases and physicians.
6. Physician health and impairment issues should be identified and managed by a medical peer review committee which is separate from the disciplinary process.
7. At a minimum, the standards set by Healthcare Quality Improvement Act of 1986 (HCQIA) for eligibility to federal immunity must be followed if a disciplinary process is engaged during professional review. These standards are the most elementary safeguards of due process in a health care facility.

Section 1112 Standards for professional review actions
“a. In general…professional review action must be taken—
(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).”

“Adequate notice and hearing—A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action
   The physician has been given notice stating –
   (A) (i) that a professional review action has been proposed to be taken against a physician
   (ii) reasons for the proposed action
   (B) (i) that the physician has the right to request a hearing on the proposed action
   (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
   (C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing—If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating –
   (A) the place, time and date of the hearing, which date shall not be less than 30 days after the date of the notice, and
   (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice—If a hearing is requested on a timely basis under paragraph (1)(B) –
(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity) –
(i) before an arbitrator mutually acceptable to the physician and the health care entity,
(ii) before a hearing officer who is appointed by the entity and who is not in direct economic
competition with the physician involved, or
(iii) before a panel of individuals who are appointed by the entity and are not in direct economic
competition with the physician involved;
(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
(C) in the hearing the physician involved has the right –
(i) to representation by an attorney or other person of the physician’s choice,
(ii) to have a record made of the proceedings, copies of which may be obtained by the physician
upon payment of any reasonable charges associated with the preparation thereof,
(iii) to call, examine, and cross-examine witnesses,
(iv) to present evidence determined to be relevant by the hearing officer, regardless of its
admissibility in a court of law, and
(v) to submit a written statement at the close of the hearing; and
(D) upon completion of the hearing, the physician involved has the right
(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement
of the basis for the recommendations, and
(ii) to receive a written decision of the health care entity, including a statement of the basis for the
decision.”
In addition, the notice of hearing should contain a summary of the allegations and the episodes of care under
evaluation.

8. Summary suspension or restriction of clinical privileges may only be used to prevent “imminent danger to
the health of any individual.” Such summary actions must be followed by adequate notice and hearing
procedures prior to becoming final.

9. All parties involved in the peer review process must preserve the confidentiality of all records, information
and proceedings. However, all of the facts obtained for and in the peer review process shall be available to
the subject physician to the fullest extent legally permissible.

10. A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include
direct economic competitors of the subject physician or those for whom there may be bias or lack of
objectivity vis-à-vis the subject physician and should include a fair representation of
specialists/subspecialists from the subject physician’s specialty/subspecialty whenever feasible. The
subject physician shall have the right to challenge, in writing, proposed peer review committee participants
for cause prior to commencement of the proceedings. Such challenge would be a part of the procedures
specified in the health care facility bylaws, outside of peer review protections and not part of the actual
conduct of peer review and shall not be protected by peer review statutory protections.

11. Physicians should rotate service on the peer review committee (round robin).

12. Membership on the peer review committee must be open to all physicians on the medical staff and not be
restricted to one or more groups such as those practicing exclusively at a given institution, salaried
physicians only or faculty physicians only.

13. Only physicians should be voting members of committees conducting medical peer review of physicians.

14. Whenever a peer review committee adequately representing the specialty/subspecialty of the subject
physician cannot effectively be constituted with physicians from within the institution while excluding
direct economic competitors or at the request of the subject physician, qualified external consultants or an
external peer review panel through another appropriate institution authorized to conduct peer review of
physicians should be appointed in accordance with the medical staff bylaws and medical peer review
protection statutes.

15. Physicians serving on the peer review committee should receive information and where available, training,
in the elements and essentials of medical peer review.

16. The hospital or the organization on whose behalf the peer review is done must ensure that the physicians
serving on any peer review committee are provided with appropriate indemnification and insurance for peer
review acts taken in good faith. The organization must also provide assistance to the committee in abiding
by the requirements of HCQIA to be eligible for federal immunity.

17. The peer review committee of a health care facility should be guided by generally accepted clinical
guidelines and established standards and practices, when available, in making their determination. When
the matter before the peer review committee involves professional conduct such as an allegation of
disruptive behavior, the peer review committee should be guided by applicable professional ethical
principles (e.g., the MMS Code of Ethics, the AMA Principles of Medical Ethics, relevant specialty society
ethical codes). Those guidelines, standards and practices must be made available in a timely manner to the
subject physician before any hearing on the matter.
18. Clinical guidelines, standards and practices used for evaluation of quality of care should be transparent and
available to the extent feasible.
19. Wherever feasible, structured assessment instruments and multiple reviewers should be used to increase
reliability.
20. Where feasible, statistical analysis to compare with peers’ performance must be used with appropriate case
mix adjustment.
21. Adequate notice (no less than 30 days) should be given to the subject physician for any formal hearing or
appeal.
22. All the pertinent information obtained by the peer review committee regarding the subject matter should be
made available to the subject physician to the fullest extent legally permissible in a timely manner before
the hearing.
23. To the extent feasible, the reviewers should evaluate the process of care given while blinded to the outcome.
24. Any conclusion reached or action recommended or taken should be based upon the information presented to
the peer review committee and made available to the subject physician. Indefensible and vague accusations,
personal bias and rumor should be given no credence and should be carefully excluded from consideration.
Any conclusion reached should be defensible under a “reasonably prudent person” standard.
25. If the conclusion reached is that improvement is necessary, any action recommended by a health care
facility should include, as an important focus, steps for remediation, as needed, for the subject physician
and for the system.
26. The findings, recommendations and actions of the peer review committee of a health care facility should not
be vague or stated in general terms, but should clearly and specifically state in writing the nature of the
physician’s act or omission, how it deviated from the standard of care or ethical principle, what the
standard or ethical principle is and its source, and what specific step the physician could have taken or not
taken to meet the standard of care or ethical principle. Where applicable, it must address what specific
remediation, if any, is recommended for the physician and what, if any, for the system (whenever feasible,
in terms that permit measurement and validation of remediation, when completed).
27. A process should be available to appeal any disciplinary finding of a health care facility following the
hearing, and the requirements and procedures for all existing appeal mechanisms should be made available
to the subject physician. An appeals process before a disinterested third party, not connected to the medical
staff or the hospital, should be made available to the subject physician within statutory peer review
protections. If the original action was part of a peer-review protected process, the appeal should be part of
the peer-review protected process as well.
(MMS House of Delegates, November 8, 2003; Amended, 5/14/10)
28. The Society recognizes that when a physician performs a medical peer review function he/she should render
the same opinions that would pertain if he/she were the treating physician with responsibility to provide
appropriate patient care. These opinions should not be rendered solely on the basis of cost containment.
(MMS Council, 5/17/91; reaffirmed House of Delegates, May 7, 1999)
(HP)

MMS House of Delegates, 11/08/03
*Health Care Facilities Principles amended MMS House of Delegates, 5/08/09
Amended, MMS House of Delegates, 5/14/10