

DR. HENRY BUTLER III
Letter to AMA President, D. Palmisano, JD MD

Read Dr. Butler's response below...

Dear Dr. Palmisano:

Under different leadership, the AMA opposed Dr. Timothy Patrick in > Patrick v. Burget (Astoria Clinic, Oregon), while AAPS and Semmelweis Society supported him. Today physicians face not only rising insurance costs and falling reimbursement, but also the specter of flawed peer review.

Would you support Patrick today, and if so, will you support state and Federal legislation for independent, impartial peer review such as that suggested by William Hinnant M.D., J.D. and Ralph Bard M.D., J.D. on www.SemmelweisSociety.net?

Sincerely,

Henry E. Butler M.D., FACS

cc: Verner S. Waite M.D., FACS

December 1, 2003

Dear Dr. Butler:

Thank you for your e-mail expressing your interest in the American Medical Association's ("AMA's") support of fairness in the peer review process. As a lawyer as well as a physician, I appreciate the importance of legal and clinical fairness in peer review. The following is my response on behalf of AMA to your e-mail. Many aspects of the peer review process, including fairness, have been a consistent focus of the AMA's policy-making..

Over the years, the AMA House of Delegates, the AMA's policy-making body, has adopted a wide range of organizational policies addressing aspects of peer review that may unfairly affect physicians in the United States, in many different practice settings, e.g., hospitals, outpatient facilities, managed care entities, and peer review performed by, or in connection with, governmental payment programs. More specifically, your e-mail mentioned Patrick v. Burget, and the AMA has, in fact, adopted official policy specifically addressing the fairness of peer review subsequent to this case, entitled "H-375.983 Peer Review after Patrick v. Burget." (I have attached the entire policy at the end of this letter).

This AMA policy, which first came into effect in 1988, and was reaffirmed in 2001, sets forth very detailed and comprehensive procedural guidelines that should be implemented to ensure fairness to the physician who is subject to a proposed adverse determination. The policy endorses several

means of prohibiting conflicts of interest from interfering with fair process. For example, under subsection (f), the peer review hearing panel should "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." In subsection (g), the policy does permit physician in direct competition with the physician to testify in a peer review hearing, whether for or against the physician, but the policy specifically states that "a physician should not be deprived of his privileges solely on the basis of medical testimony by economic competitors." And, if the hearing is one to terminate the physician's privileges, the policy mandates that "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" (See subsection (g)). Please note that these conflict of interest provisions are but a small portion of the policy. Review of the policy in its entirety will reveal number of other ways in which the policy attempts to further fairness in peer review. H-375.983 Peer Review after Patrick v. Burget is just one of the many AMA policies dealing with peer review fairness.

Although these policies are too numerous to discuss individually, I will mention "H-375.979 Litigation Over Hospital Peer Review Decisions," Our AMA believes that it is important to minimize expensive and time-consuming litigation over hospital peer review decisions if hospital peer review is to be a successful and effective mechanism for assuring the quality and appropriateness of hospital services.

The AMA, therefore, recommends that state medical societies pursue one of the following alternatives to help minimize litigation over peer review decisions:

- 1) seek state legislation to create a forum that would qualify hospital peer review in the state for the state action exemption
- 2) create a privately organized forum that would not qualify for the state exemption but would minimize the possibility of litigation by allowing for an objective evaluation of the decision outside of the hospital; and
- 3) pursue legislation that would create procedural protections designed to ensure fairness in the hospital peer review process that are the equivalent of or more substantial than those set forth in the Health Care Quality Improvement Act of 1986, or encourage hospital medical staffs to adopt bylaws with the requisite protections. (BOT Rep. DD, A-91; Reaffirmation A-00). I have also attached to the end of this letter "H-375.973 Protecting Physicians at the Peer Review Process in the Current Managed Care Environment," showing just another AMA policy supporting fairness and civil rights protections in peer review. With regard to the AMA supporting any particular action regarding peer review, the way to engage the AMA is to bring your ideas to your state medical society and ask it to sponsor a resolution to be submitted to the AMA House of Delegates for consideration.

Although there are no guarantees that the House of Delegates will adopt or support any resolution, the House of Delegates will consider any resolution placed before it by the state society. In addition to engaging the House of Delegates, physicians may ask the AMA to provide

litigation support. This is done through the AMA's Litigation Center. The Litigation Center is a Coalition of the AMA and all fifty state medical societies and associations created to support issues of national importance for organized medicine through the litigation process. Physicians can bring their case to the state medical society and the state medical society decides if the case will be supported and brought to the Litigation Center for consideration.

The Litigation Center decides on a case-by-case basis whether or not to lend the Center's support to any particular request for assistance, based on a number of criteria, including the national importance of the litigation for organized medicine. An example of one case that the Litigation Center supports, in conjunction with the California Medical Association, is the San Buenaventura lawsuit that has received significant media attention recently.

The staff contact person at the Litigation Center is Leonard Nelson, JD. He can be reached at (312)-464-5532. Also, visit the AMA web site at www.ama-assn.org and see all of the advocacy efforts of AMA. In addition, visit the Litigation Center of the AMA and State Medical Societies to learn more about it and view a summary of the legal cases that the Litigation Center has entered on behalf of physicians and patients. Finally, you may find it of interest to look at PolicyFinder on the AMA web site to learn more about AMA policies and ethical opinions. Thank you for your interest in AMA..

I hope that this information is helpful to you.
Sincerely, Donald J. Palmisano, MD, JDAMA President

H-375.983 Peer Review after Patrick v. Burget.(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) Our AMA urges hospitals, medical staffs, and peer reviewers to review the guidelines for peer review conduct in Health Care Quality Improvement Act of 1986 and to observe the following guidelines: (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 clinical privileges, the advice and guidance of legal counsel should be sought by those persons who are involved in this phase of the peer review process. The attorney's participation should continue in preparation for the hearing including the written notice of charges, the marshaling of evidence and the facts, and the selection of witnesses. The attorney should be instructed that his role is not that of a prosecutor, but as an advisor in 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. (b) The attorney advising the hearing panel and the attorney representing the physician involved should be accorded reasonable latitude in cross-examination, but acrimony should not be allowed by the hearing panel. (c) Substantial latitude should be permitted in the presentation of evidence, medical reference works and testimony, within reasonable time constraints and the discretion of the hearing panel. (d) A court reporter should be present to make a verbatim transcript of the hearing which should be available to the parties and the costs borne by the hospital or health care entity. (e) Within the discretion of the hearing panel, witnesses may be requested to testify under oath. (f) The hearing panel should 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, but they need not be in the same specialty as the physician involved. (g) 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 hospital, but a physician should not be deprived of his 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. (h) When investigation indicates that a disciplinary proceeding is warranted for the purpose of terminating a physician's hospital privileges, he should not be permitted to resign without a finding that his termination occurred without cause. The disciplinary proceedings should be conducted by the hearing panel with the presentation of testimony and evidence, irrespective of whether the physician involved chooses not to be present. (BOT Rep. MMM, A-88; Reaffirmed: Sunset Report, I-98; Reaffirmed: BOT Rep. 8, I-01)

H-375.973 Protecting Physicians at the Peer Review Process in the Current Managed Care Environment. Our AMA: (1) will work with the Federation of State Medical Boards to adopt a policy to support state legislative efforts to protect the integrity and effectiveness of the peer review process by prohibiting managed care companies from automatically terminating providers who have been sanctioned by state medical boards or by information being provided by the National Practitioners Data Bank without providing due process to the provider; and (2) espouses as policy the guarantee of due process and civil rights safeguards to physicians in peer review and in credentialing. (Res. 809, I-95; Appended: Res. 723, A-00)

Thank you. I will study your suggestions. The issue, of course, is to protect patients and to avoid complex, wasteful distractions from practice, and certainly to avoid litigation by assuring such a high standard of due process that none doubts the fairness of all decisions...

I would submit that the procedure must be acceptable to all parties, that the rules of evidence apply, that the burden of proof be on the accuser, and that the Supreme Court's definition of due process be adopted. If these hearings are not perceived as simple and fair, they will lose credibility. Why go to a hospital which is perceived as unfair?

The tumor board is a potential model. Cases are brought to it whenever possible; opinions are sought. Differences are respected. Peer review could be prospective, random, and nonpunitive. If a particular standard were not being met, the doctor could be asked to take a refresher course or to pass an exam. The emphasis would be on rehabilitation rather than defamation...

When one joins a staff, often a proctor is assigned for a time, to protect patients. In cases of peer

review, the same could be done in lieu of suspension. Any summary suspension in the name of patient safety should be done by independent physicians, I would think.

Dr. Peacock said today that while most hospitals start off with the JCAHO recommendations for their bylaws, soon the hospital lawyers modify the JCAHO standards and insert summary suspension, burden of proof on the accused, and peer review flawed by bias. I took the liberty of forwarding your letter to him.

Semmelweis Society International attempts to inform every physician, especially those planning to re-locate, of the provisions for peer review at every hospital in our country, as well as other countries in which American licensure and training are recognized. I am not a lawyer, but we have the opportunity to compare this former British colony with several others: The case of Dr. David Shaller, arguing pro se about statutory judicial review denied Certiorari by the Supreme Court, is a compelling matter. How would this case go down in Australia, New Zealand, Canada, etc.? Assuming the Court again refuses to hear his case, is there any point in trying to reform the law in this country?

Would the AMA under your leadership address the issues raised by his case? I would ask the same for the several other cases cited on our web site, www.semmelweissociety.net. They are compelling examples of what can only be described, in the words of Senator Boxer in 1991 (ABC TV Nightline), as "un-American."

I re-joined AMA for the purpose of proposing these changes, and remain a member of AAPS.

HEBIII

cc: Dr. Peacock

Dr. Shaller

Dr. Orient

Dr. Johnson

Dr. Smith

Dr. Gluck

Dr. Waite