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Editorial

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Sham Peer Review: Consequences and Remedy

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EDITORIAL

One of the key pillars for quality assurance of surgeons (and physicians in general) has been the regular review and determination of professional competence by the hospital's medical executive committee (MEC). A just, equitable and credible peer review process is important to all stakeholders and aspects in healthcare. While a judgment of competence is issued for most practitioners, a much rarer judgement of incompetence is typically ratified by the hospital's MEC upon completion of a "peer review" process. Adverse outcome leads to disciplinary action and revoking the physician's hospital privileges. Any adverse privilege action is then reported to the National Practitioner Databank (NPDB), which makes it very difficult for the surgeon/physician to get privileges at any other hospital [1]. Surgeons of all subspecialities are more frequently affected by these punitive actions than non-operative physicians.

The peer review process goes wrong when it levies false accusations against high quality practitioners, specifically when administration considers the physician to be difficult or outspoken and imposes harsh punishments mainly for political reasons. In 2011, the American College of Emergency Physicians (ACEP) defined "Sham peer review or malicious peer review…as the abuse of a medical peer review process to attack a doctor for personal or other non-medical reasons" [2]. In those instances, contrived allegations of incompetent or disruptive behavior and concocted "sham" peer review are not only retaliatory acts by hospital administration to elegantly terminate employment but they are also a career threatening process for the affected physician.

"One of the first notable sham peer reviews took place in Oregon in the early 1980s. The physician who took it up with the courts was Dr. Patrick, and the Supreme Court ruled in his favor. As a result of the publicity surrounding this case, the Healthcare Quality Improvement Act (HCQIA) was enacted in 1986. One of the concerns that arose from the Patrick case was a fear that no physician would want to participate in peer review if he or she could be potentially liable for a bad report. The HCQIA gave immunity to hospitals and reviewers participating in peer review. This immunity has been abused by hospitals and physicians to harm 'disruptive' physicians (i.e., whistleblowers) or financial competitors" [3].

The HCQIA fails to recognize this issue. Hence, "although HCQIA was enacted to prevent misuse of peer review, sham peer review is conducted with increasing frequency as retaliation against physicians whom the

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hospital regards as 'disruptive' (i.e., whistleblower)" [2,3] or incompetent. The allegation of 'disruptive' behavior is on purpose broadly drawn, vague and subjective and allows hospital administrators to interpret it however they wish [2]. Likewise, 'incompetence' of patient care can be misconstrued and requires external (rather than the typically hospital-based) review.

The current "system places the burden of proof on the accused physician, is immune from any fraud or abuse by the accuser(s)–which can destroy a physician's practice in his home town as well as nationally because of the NPDP, and, regardless of being adjudicated by a state licensing board, hospitals don't have to remove their adverse action from the NPDB on the practitioner" [3].

A 2007 American Medical Association (AMA) investigation of medical peer review concluded that at least 15% of surveyed physicians were aware of peer review misuse or abuse [2,4]. Physicians who fight perceived "sham" peer review are dealing with two obstacles. First, hospitals are provided legal immunity based on the wrong assumption of good faith. Immunity must be considered an unfair advantage as it allows hospitals to coopt it as a powerful tool to punish physicians and advance their goals. "In 2006, the Michigan Supreme Court ruled that the Michigan immunity statute does not protect the peer review entity if it acts with malice, specifically meaning that the committee acted with a reckless disregard of the truth." And the State of California allows "aggrieved physicians the opportunity to prove that the peer review to which they were subject was in fact carried out for improper purposes, i.e., for purposes unrelated to assuring quality care or patient safety" [2,4]. Second, a physician may decide not to fight in court the adverse outcome of a sham peer review primarily for financial reasons and lack of appropriate insurance coverage. Both scenarios are festering a system of injustice.

The exact frequency of sham peer review is uncertain but according to NPDB records, hospital disciplinary actions including perceived sham peer review average 2.5 per year per hospital. This number does not include the rate of false allegations made against physicians in order to coerce settlements without an NPDB report, which putatively occurs at a rate that is at least 4 times higher [5]. This correlates with a 5-figure number and it is so common that it has an impact on the growing epidemic of resignations, burnout and poor morale of hospital physicians.

Moreover, "there is no standard for impartiality and specifically no standard for due process in the peer-review 'process'"[4]. MEC and peer review committee members are no longer independent. Members are typically hospital-employed physicians that have signed an agreement to make decisions (including those about peer review) that comport with expectations, metrics and targets of the administration of the healthcare system. At times, this requires MEC members to accept the political or strategic goals of a Chief Executive Officer (CEO) who may want to exploit sham peer review for the hospital administration's purposes. The ACEP recognized the fact that the accusation of 'disruptive behavior' can be "easily manipulated to include a physician who properly defends patient care, exercises his/her right of free speech on political matters, seeks to improve various clinical practices, or who properly demands adherence to excellence" [2].

A CEO that selects the route to terminate a wrongfully accused 'disruptive' or 'incompetent' physician becomes immune under HCQIA from any lawsuits by merely by labeling those actions "peer review". Most hospital bylaws grant the hospital the right to remove MEC members that are unwilling to comply with such capricious decisions. While the original intent of immunity was to protect the judgments of physician reviewers about the medical competency of their peers, it has now been also coopted to protect political decisions such as in terminating "difficult" physicians. In essence, "HCQIA has (unintentionally) provided a shield of nearly absolute immunity for bad faith, malicious peer reviewers. Absolute immunity, like absolute power, corrupts absolutely" [6].

In addition, most hospital-appointed peer review committee members lack specific training and are not experts in that specific field. Hospitals shy away from true and fair peer review by mutually agreed-upon national experts because they do not necessarily align with the goals of hospital administration. However, the judgments of hospital-appointed members are at significant risk of being biased by personal or professional ties and administrative expectations. These "unfair" issues add up to investigations that are often incompetently performed with tremendous adverse consequences to the practitioner. Hence, "relying on a fair hearing to adjudicate highly subjective accusations has the potential to invite more abuse" [2].

Physicians are granted immunity on the premise that they are the best ones to identify incompetent peers. The same "insider" knowledge allows them to recognize when one is falsely accused, but they have no authority for remedy. For example, some hospitals are notorious for having chronically unsafe systems in place. These are often incorrectly attributed to substandard physician care when, in fact, a system-related error was likely the more significant cause [7]. Singling out the "difficult" physician for punishment while ignoring others is inherently arbitrary and capricious. This is one of the reasons for a general mistrust among physicians of

the peer review process. In order to restore confidence in it, protections for members of MEC, peer reviewers and hearing panels must be implemented so they cannot be fired or retaliated against for their review opinions. In addition, those involved in the peer review process should not be hired into positions in hospital administration for 3-5 years [8]. Another step is to institute a full divestiture of the peer review process from the ulterior goals of the hospital.

The remedy for an accused physician facing grave professional consequences as the result of a violation of his constitutional rights is to file a lawsuit against perceived sham peer review. But the hospital has always had this very potent ace-in-the-hole. Its legally guaranteed immunity allows hospitals to keep their actions confidential and information privileged from legal discovery. It also allows hospital administrators to officially distance themselves from the accused physician for several reasons and from a process they know was corrupt or fear of being blamed for a negative outcome [9]. For these reasons, wrongfully accused physicians have started "filing complaints with professional boards against the perpetrators of sham peer review for professional misconduct" [10].

A physician is most likely to succeed in court when there is evidence that the procedure that was used in the investigation and decision-making process was fundamentally flawed. A first step to regain trust is for hospitals to voluntarily forgo their legal immunity against lawsuits by an accused physician with a legitimate claim that peer review was corrupt. "Immunity should be taken away or at least modified to deter any bad-faith use of the law" [3].

Courts of law are important game changers for the problem of sham peer review, yet many affected physicians still might not take legal action, primarily for financial reasons. Suing a hospital is expensive, time-consuming and requires mental resolve. This scenario highlights the need for an insurance product that provides a complete defense against wrongful hospital allegations of incompetent or disruptive behavior. Such an insurance product is currently not available, but needs to be created. The time has come both for hospitals to make peer review truly objective and fair without the cover of immunity and for physicians to introduce a defense insurance system that, if necessary, fights sham peer review decisions with their career-threatening consequences.

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