

Pernicious Peer Review:

How “Sham” Peer Review Undermines Patient Safety

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Abstract

Peer review is the process by which a physician’s care of patients is evaluated by his or her colleagues in the interests of patient safety and quality of care. “Sham” peer review is the use of such review to threaten, punish or ostracize physicians, rather than to promote patient safety or quality of care. Much has been written about the legitimate uses of peer review. This article will explore the increasingly widespread practice of illegitimate, “sham,” or pernicious peer review. By understanding the origins, scope, and consequences of this largely secretive practice, we may begin to explore its origins and its possible solutions. Legitimate peer review protects patients, serves society, and is essential to the furtherance of quality care. The use of peer review for purposes other than promoting the health and safety of patients must be revealed for what it is: an impediment to doctors in their primary duty protect patients.

Introduction

Peer review is the process by which physicians monitor the appropriateness, necessity, timing, and quality of patient care.¹⁻⁵ By the monitoring norms, trends, and outcomes, a physician’s peers can direct an improvement in the care of patients. This is possible by a combination of giving feedback, setting benchmarks, using statistical reviews, offering closer supervision, focusing medical education and, if needed, curtailing or suspending privileges. The peer review process protects patients from substandard care and medical errors are monitored and reduced. Also physician education is focused and, it is hoped, patient safety is improved. Peer review is essential to the safety of the individual patient and to that of the larger community. At the same time, the reviewing physicians incur risk because of the potential legal liability that results from restricting and punishing the accused physician. It is therefore essential that the rights of the scrutinized physician be balanced with those of his or her reviewers, so that all parties may present information about

patient care with the common goal of improving that care in as non-punitive an environment as possible.

The Health Care Quality Improvement Act of 1986 (HCQIA) was an attempt at creating such an environment but, as with many good ideas, it has had some unintended consequences.¹⁻¹⁰ Case law since the inauguration of HCQIA has taught us that, in addition to protecting the reviewers with near-full immunity from counter-suit, peer review is also a means by which hospitals may rid themselves of physicians for reasons other than improving patient care. In addition to providing immunity for the reviewers, HCQIA also created the National Practitioner Data Bank (NPDB).^{7-9,16,19-21} This has permitted another malicious dimension to peer review. Even if ultimately proven to have been the result of malicious peer review, an NPDB entry may an indelible mark against the targeted doctor.^{2,16}

The Scope of the Problem

It has been estimated that up to 80 percent of peer review is motivated by economic, rather than quality of care reasons.⁹ A 1998 survey of 448 emergency physicians found that 23 per cent had been threatened with losing, or did in fact lose, their job because of raising concerns about quality of care.⁷

Sham peer review is not a new phenomenon.¹⁰ In the 17th century, Dr. Ignaz Semmelweis was widely heralded as the “savior of mothers” for his seminal work in reducing the rate of puerperal sepsis and maternal mortality in Vienna. He realized that the mortality rate for mothers attended to in their homes by midwives was much lower than that of mothers cared for in the hospital by physicians. His hypothesis, later confirmed by Lister and Pasteur, was that in the hospital physicians and medical students moved freely from the autopsy room to the delivery room without washing their hands.

By instituting a strict hand washing protocol in his hospital, Semmelweis was able to reduce maternal mortality from 18% to 1%. Despite this stunning accom-

plishment, Semmelweis was at a disadvantage among his peers because he was of Hungarian, rather than Austrian, origin, because he was outspoken, and because he was impolitic in his insistence that the Viennese physicians could and must improve their patient care protocols. Consequently he was ostracized by his peers, suffered from “nervous collapse,” was institutionalized, and died at age 47.

The Semmelweis Society was founded in his honor by Dr. Verner Waite and his attorneys, after they successfully fought a sham peer review action in California in the mid 1980’s.⁹ Dedicated to “peer review with clean hands,” the society seeks to shed light on the practice of “sham” peer review and to support its victims. Dr. Waite has estimated that nine out of ten physicians subjected to bad faith peer review never work again, that one fifth of these commits suicide, and that thousands of physicians have lost their careers without due process.¹¹

After his 2003 expose of sham peer review, “The Cost of Courage,” series appeared in the Pittsburgh Post Gazette,^{7,8} journalist Steve Twedt estimated that he had personally received calls from 50 to 100 physicians who felt that they too had been subjected to malicious review. Since 1990, there have been 258,000 entries into the NPDB citing 161,000 individual physicians.²⁹ Nine thousand five hundred of these entries were on the basis of peer review actions. If, as has been estimated, 80 per cent of peer review is done for purposes other than improvement quality of care, then 7,600 of the NPDB reports are due to bad faith review.

In Texas, 68% of physicians adversely peer reviewed and reported to the NPDB were exonerated by the State medical board.¹¹ These adverse reports still exist in the NPDB, and there is no obligation of the data bank to expunge them. As will be shown, an entry into the data bank affects in perpetuity a physician’s ability to gain hospital and operating room privileges, state medical licenses, malpractice insurance, and participation as providers in HMO’s, PPO’s, and other insurance plans. At the same time, the Inspector General of the former department of Health and Human Services, (now Medicare and Medicaid Services), estimated that 84% of hospital and 60% of HMO’s had never reported even a single adverse outcome to the government, and the General Accounting Office found that the NPDB, “contains information that is incomplete, inaccurate, or both.”¹¹

Hospital attorneys take the view that retaliation against physicians who agitate for patient care is not a significant problem. Prominent among them, attorney John Horty, one of the coauthors of HCQIA, states, “I don’t see it as a large problem. We may have one of these [whistleblower physician] cases...most disruptive physicians are, in fact, disruptive. If it’s nothing but whistleblowing, the hospital almost never acts.” Horty’s firm is one of the leading health care law firms in the United States, having represented 400 to 500 hospitals and currently on retainer with about 30.⁷ Loyola University of Chicago professor John Blum, who has written extensively on hospital credentialing, states, “If you want your life to go on without disruption, then [remaining silent instead of reporting patient care issues] is what you do. There’s a real public health threat there”⁷ The American Medical Association code stipulates that, “Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior.”

The NPDB- Its Origins and Implications

In 1984, the United States Supreme Court overturned an Oregon appellate court decision in the case of *Patrick v. Burget*, sending a chill through the hospital administration community. Dr. Patrick, as will be more thoroughly described later, was a surgeon who was threatened with sham peer review by his economic competitors. Instead of enduring such a hearing and its foregone outcome, Patrick resigned. He then filed and won an antitrust action against the hospital. Hospitals and the physicians who participated in peer review activities were put on notice by the Patrick verdict that they were vulnerable to legal retaliation by the targeted physician. The hospital industry, the hospital bar, and many large medical organizations, including the American Medical Association, brought pressure on congress to protect the peer review process from discovery.^{1,12-14} Thus the stage was set for the passage of the HCQIA or 1984, which had two provisions. First, the hospital and its representatives would be protected by near-full immunity if their actions were taken in the furtherance of quality care and second, the NPDB was created.^{1,2,12-18}

HCQIA set minimum national standards for the professional peer review of physicians’ competence and professional conduct. It presumed that the peer review

actions are accurate and appropriate, and it specifically disallowed malicious review.¹¹ Limited immunity was guaranteed if four conditions were met: 1) that the action is taken in the reasonable belief that it is in furtherance of quality healthcare, 2) after a reasonable effort to obtain the facts, 3) after adequate notice and hearing procedures and, 4) that the action is taken in reasonable belief that it was warranted by the facts⁽¹¹⁾. Unlike criminal proceedings, peer review places the burden of proof on the defendant physician, rather than on his or her accusers. There is no right to a speedy hearing or to due process. Often the accused physician does not have access to the very patient charts needed to defend him- or herself. And, because of the relatively low threshold it sets for the terms of immunity, HCQIA protects peer review even in cases in which there is a demonstrable financial conflict of interest^(2,8). In *Matthews v. Lancaster General Hospital*, a physician whose privileges were restricted in a peer review action sued his hospital on the basis that a direct conflict of interest existed among by his peer reviewers. Despite overwhelming evidence of this conflict, a defense verdict was reached on the basis that the action was taken in the reasonable belief that it was in furtherance of quality health care⁽⁸⁾. Thus, HCQIA creates an uneven playing field for physicians by presuming that malicious review is disallowed and that the action is accurate and appropriate. It will be seen that physicians repeatedly find themselves defenseless in the face of peer review by hostile parties, or by the threat of such review and its potential consequences.

The second part of HCQIA was the creation of the NPDB. This data bank lists all adverse legal actions against physicians, including monetary settlements, jury awards to plaintiffs, license restrictions, and summary suspensions from hospitals. The intent of the creation of the NPDB was to prevent substandard physicians from moving from state to state with impunity. Healthcare and privileging organizations are required by law to query the data bank before accepting a new practitioner. A NPDB entry can be a “death knell” for a physician’s career. After losing his or her privileges at a particular hospital, a physician may then find it difficult or impossible to reestablish a practice elsewhere. As has been described, there is no obligation for a hospital to expunge an NPDB entry, even after it has been proven that no adverse event ever took place.^{2,7-9,29} The very threat of such an entry is often enough to give a

physician pause before taking an unpopular position in dealing with his or her hospital.

The “Disruptive” Physician

Among the most disturbing additions to the armamentarium of hospitals in their attempts to control physicians is the introduction of the label “disruptive.”^{7,8,16,17,20-24} This designation is much more difficult to challenge than is the label of “providing substandard care.” The hospital bar offers a variety of “how-to” courses to hospital administrators that assist in them in recognizing, labeling, and punishing doctors whom they perceive to be disruptive.²⁴ Such courses may be found at multiple sites on the internet, including the site for the Pittsburgh health law firm Horty Springer and Mattern, available at: www.hortyspringer.com. It will be remembered that attorney John Horty was an architect of HCQIA and the NPDB. At that website and at others like it, are advertised a variety of CD’s, on-line and live seminars that deal with disruptive physicians. These courses promise to teach hospital administrators and attorneys, “to identify ‘problem physicians’ on the front end and helpful language to include in your bylaws,” and, “building ‘transparency’ into your process so physicians will *feel* they’re treated fairly and confidentiality is maintained, (italics added for effect).” Horty Springer also offers a seminar entitled, “Whistleblower or Disruptive Physician: How Do You Know the Difference,” whose description states: “Every disruptive physician has an excuse for his or her behavior. You have probably heard many of them: ‘the nurse was incompetent, the equipment was malfunctioning, the OR was not ready, I am only trying to protect my patients, no one else cares about quality patient care.’”

The Horty Springer advertisement asks: “Can a hospital take action against a physician who raises quality concerns in a *disruptive* manner,” and, “What conditions can be imposed without *appearing* to retaliate or muzzle the physician?” Some of the characteristics that these courses use to identify the disruptive physician include: “whistle blower, politically incorrect, (don’t join HMO, PHO), economic competitor, strong advocate for quality care, personality traits such as charismatic, energetic, creative, and charming, independent thinkers, failure to show proper respect to hospital authority, highly competent, timing- makes rounds at odd times,

and defends him/herself vigorously when attacked.” A course is also offered entitled: ‘The “Independent” Medical Staff – What Would It Really Mean?’ Included in this are segments devoted to: “How best to build the legal record you’ll need if the physician chooses to fight rather than ‘cooperate,’ preparing for likely arguments and anticipating ‘whistle-blowing’ claims, how to avoid common pitfalls such as acting hastily on too little data without talking to the physician, and imposing a suspension when there might have been a less restrictive way to protect patients.”

The disruptive physician methodology also includes “critical spin linking.”²⁴ Employing this technique, a hospital may link a physician who raises care issues or who is a whistleblower to outside agencies, with disrupting the smooth provision of care. In turn, the disruptive physician is also an impaired physician who might have substance abuse and/or psychiatric problems that require rehabilitation or punishment. Psychiatric evaluation may be mandated as a *quid pro quo* for maintenance or reinstatement of privileges. Secrecy is essential to this technique, (the targeted doctor may not have access to the charges, charts, files, accusers, or meetings for his or her case).

A hospital code of conduct may stipulate that physicians use only internal reporting of quality issues and, because most hospitals involved in these cases aren’t State actors,²⁴ first amendment rights usually do not apply. It is noteworthy that the targeted physician is often a solo practitioner or a member of small group, especially one who upsets the local pecking order.^{7-10, 24, 30} John C. Lewin, executive vice president and CEO of the California Medical Association noted, “I’m hearing from more and more doctors that peer review really represents, in too many institutions, [reviewing] physicians who are either employed by the hospital or are linked to the hospital, so they’re doing the hospital’s bidding.”

Illustrative Cases

A watershed event in peer review that occurred in 1984, was the United States Supreme Court’s decision¹²⁻¹⁴ in *Patrick v. Burget*. Dr. Timothy Patrick was a general and vascular surgeon who, after completing his residency in 1972, entered private practice at Columbia Memorial Hospital, the only hospital in Astoria, Oregon. After several years in solo practice Dr. Patrick

had declined multiple invitations to join the Astoria Clinic, of which most of his colleagues were employees or partners. As a consequence of his competing with, rather than joining, the majority of his fellow surgeons, Dr. Patrick was largely bypassed by referral sources who also declined to provide requested consultations and assistance in his surgeries.

A sham peer review then took place, and Dr. Patrick demanded that a hearing be held. That hearing though, was to have been conducted by a panel composed of his detractors. Rather than submitting to what he predicted would be a hostile interrogation and likely loss of his privileges, he voluntarily resigned. Patrick then filed suit under the Sherman Antitrust Act, and won a \$2.2 million jury verdict. This verdict was subsequently overturned by the Court of Appeals on the basis that peer review was a state sanctioned activity that was protected from antitrust claims. On appeal to the U.S. Supreme Court the decision of the Court of Appeals was overturned, despite the protests of the AMA and the American Hospital Association. As a consequence of this verdict and the sense of vulnerability that it created among hospitals and peer review participants, HCQIA was enacted in 1986, and the NPDB was established in 1990.^{2-5, 7}

The second illustrative case is that of Dr. John Ulrich who in 1988 was working in a San Francisco County facility, Laguna Honda Hospital.^{7,8,26,27} In a cost-containment effort, the county decided to reduce staffing at the hospital and, although the cuts did not affect Dr. Ulrich directly, he stood up in a staff meeting and declared that the move was an “injustice to patients.” Many of his coworkers then signed a petition that was submitted to the county, decrying the austerity efforts as jeopardizing patient safety. Less than two weeks later Dr. Ulrich was informed that he was under investigation by the hospital for “gross incompetence.” Sensing the impending sham peer review, he precipitously resigned. He was then reported to NPDB for resigning under investigation. Realizing that he had made an ill-considered decision, Dr. Ulrich immediately withdrew his resignation. After an investigation, The California Medical Board found no problem with Ulrich’s care of patients but the hospital still refused to remove the data bank report. He sued and was awarded \$4.3 million in Federal Court, based upon the hospital’s viola-

tion of Ulrich's right to free speech and the denial of his right to a fair hearing to clear his name. Despite "winning" his case, the effect of the NPDB entry was that Dr. Ulrich was unable to work for six years. His NPDB entry still exists. Dr. Ulrich's attorney, William Gordon Lewis, says the case underscores "how a hospital administration can abuse the peer review system to stifle physicians who are speaking out in favor of patient care." "This was not an instance of reprisal," maintains a hospital spokesperson.³¹

In 1993, anesthesiologist Danae Powers relocated with her husband to his hometown of State College, Pennsylvania for family reasons.^{7,8,22} Her credentials were impeccable: she had worked in the transplant programs at the University of Pittsburgh and at Emory University, and she found the cases at Centre Community Hospital to be "bread and butter" cases that would have been covered by residents in her former jobs. The peer review that took place at that community hospital involved trivial issues, such as chipped teeth and bruised eyebrows. Yet some significant quality of care events were not discussed at all. One such case involved an anesthesiologist who routinely fell asleep in the operating room, once needing to be awakened because the surgeon was doing cardiopulmonary resuscitation on his patient. Another example was a fellow anesthesiologist who had a habit of accidentally administering paralytic agents in the preoperative holding area, necessitating emergent airway control and artificial ventilation. In another pair of cases, significant co-morbid conditions in surgical patients were not identified preoperatively because of inadequate medical screening, and both of these patients died postoperatively.^{7,20} Dr. Powers brought her concerns to the attention of the hospital administration, and she was labeled disruptive and was warned that her comments were "derogatory, if not slanderous." Later she was criticized for being uncooperative, and for not adhering to the medical staff bylaws, rules and regulations.

In spite of her unpopularity with the hospital's administration, Dr. Powers went on to win the position of Chief of Medical Staff, having run on a position of improving patient safety and quality of care. When her hospital elected to privatize its anesthesia services, Dr. Powers refused to join. Without her knowledge, several of her colleagues then contacted a state health

official raising concerns about quality issues and the lack of reporting of them. Soon after the hospital came under State scrutiny, Dr. Powers learned that her privileges were about to be terminated. She sued the hospital alleging that it had negligently allowed patients to suffer, and that suit was settled for an undisclosed sum. A state investigation into the hospital's safety record ultimately substantiated the deficiencies she had sought to correct.^{7,8,11,20,22}

A fourth example of sham peer review also took place at Centre Community Hospital. When Dr. Powers joined the staff in 1992, another anesthesiologist, Dr. Edward Densch, was pointed out to her as a "troublemaker."^{7,8,20,22} He had informed hospital officials that an anesthesiologist was covering several surgeries simultaneously, and was fraudulently billing Medicare for all the procedures. Further, Dr. Densch refused to handle surgeries taking place simultaneously on different floors of the hospital, maintaining that billing for these services was unethical and illegal. He was told by an administrator that, "it will help the schedule and you won't get caught." Soon thereafter he was written up for a variety of trumped-up care deficiencies and for being uncooperative. Densch, who later became the president of the Pennsylvania Medical Society, also left Centre Community Hospital voluntarily under threat of retaliatory peer reviews. He continues today to lobby for statewide independent peer review panels to which doctors can appeal for outside, objective expertise.

As a result of Densch's and others' efforts, a bill was passed in the Pennsylvania State House by a vote of 194-0. This bill calls for just such a panel, whose decisions would be binding upon both hospitals and physicians.^{7,8,24} Of the current state of peer review, Dr. Densch states, "it is being used to protect people who are bad, and it's being used against people who are good. It protects the doctor who has good economic income for the hospital and it targets the whistleblower." His colleague, Dr. Terrance Babb stated, "When you talk about disruptive doctors, it's more disruptive to complain about quality-of-care issues than it is for patients to actually die. If you do speak up for the patient-which you're supposed to do under the AMA Code of Ethics-you risk being labeled 'disruptive', which can lead to termination. The system has been perverted."²⁰

Dr. Larry Poliner is a fifth victim of anticompetitive and malicious peer review.^{7,8,19,21,23,32} He is an interventional cardiologist, echocardiographer, NASA investigator, and Baylor and Southwestern Medical School professor who had directed catheterization labs, echocardiography labs, and resident training before he opened a solo practice at Presbyterian Hospital of Dallas. He was competing there with large, well-connected, and entrenched cardiology group. From the beginning, his tenure there was marked by animosity and undermining from the other cardiologists, many of who were in key political positions in the hospital. Unsubstantiated charges of substandard care were brought against Doctor Poliner by the Presbyterian Hospital of Dallas, and his privileges were suspended. He then filed suit alleging antitrust and malicious peer review. In the process of this suit, he spent his life savings, mortgaged his house and was out of work for over 2 years. In 2004, a Dallas federal court awarded him \$366 Million from PHD and from three physicians, but dismissed the malicious peer review allegation. In 2006, the 5th Circuit Court of Appeals reduced the award to \$22.5 Million. The case is still working its way through the courts. Poliner stated, "It's unfathomable that a process that should be about healing could be used to attack doctors."³²

The final example of malicious peer review is Dr. Thomas Wieters, a surgeon at Roper Hospital in Charleston, SC.^{7,8,26} Dr. Wieters had become aware of a general decline in patient care at that facility, and was particularly upset when serious errors directly led to patient injury. In one case of a patient with acute diverticulitis, no antibiotic was administered for ten hours after the order was written. Her colon perforated, and she spent a month in the intensive care unit. In another instance no post-operative vital signs were recorded on a patient for 48 hours and in yet another instance, an incorrect dosage of a laxative resulted in profound hypokalemia and an unscheduled ICU stay for a preoperative patient awaiting aneurysm repair. Dr. Wieters sought out and publicly and loudly accosted a hospital administrator about these shortcomings. Two weeks later he received a certified letter from the hospital accusing him of being disruptive. The medical executive committee put Wieters on probation for one year and required him to undergo anger management counseling and psychiatric evaluation. Ultimately, Wieters was summarily suspended.

Ironically, two other physicians with behavior issues were allowed to remain on the Roper staff: a psychiatrist who had sexual relations with his patient, and another physician who exposed himself at a local drive-in restaurant.

As a result of his summary suspension, Wieters' was entered into the NPDB. His income dropped 80-85%. Although hired in another state, because of the data bank entry Wieters couldn't get his license there for over a year. He sued Roper, but after all his legal options ran out he was faced with court costs of \$357 thousand, and he was forced to declare bankruptcy.^{7,26}

What Every Doctor Should Know

- In 2005, Dr. Poliner's attorney, Michael A. Logan, addressed a meeting of the American Association of Physicians and Surgeons, a leading organization working toward peer review reform.²¹ In that address, Logan cited eleven specific lessons that doctors may learn from the Poliner case. The first is that the deck is stacked against the physician in peer review cases. The physician thus must be meticulous in his or her manners, patient care, documentation, and interactions with colleagues and administrators. Doctors must avoid aggravating or trying to intimidate the existing power structure, so as to avoid being labeled "disruptive," in the first place.
- **Second**, in any peer review the participants are likely to include ones with professional and personal biases. It is important to object in writing to their involvement in your case. Also the medical issues in the case should be reviewed and supported by reputable outside experts in the field, and at the earliest opportunity.
- **Third**, having privileges at other hospitals gives a physician an exit strategy in the unlikely event that he loses privileges at a facility as a result of peer review action. There is a definite domino effect of negative after-shocks after revocation of privileges that affects referring physicians, patients, licensing, insurance plans and healthcare organizations. These effects are attenuated when a physician already has privileges elsewhere.
- **Fourth**, peer review actions must be taken seriously, as they have the potential for dramatic and permanent outcomes. For this reason, expert legal advice early in the process may be a very cost-effective investment. Although some physicians have been given advice to the

contrary, it is imprudent to wait for one's privileges to be revoked to begin a legal defense. It is easier to fight to retain ones privileges than to have them reinstated.

- **Fifth**, the hospital's goals in peer review are often other than, or tangential to, finding of the truth. A physician's best defense in these cases is to focus on the facts, the sequence of events and the circumstances of what, in fact, occurred. This information should be used by the physician to save his or her privileges early in the process, at the administrative level. Given the near-absolute control that the hospital has over the "fair hearing" process, the physician may be facing a nearly-foregone outcome. He or she is advised to focus on the clearest presentation of the patient care issues involved as the best defense.

- **Sixth**, the immunity that the peer review process enjoys is nearly absolute. HCQIA is predicated on good faith peer review, but case after case shows that hospitals' motives are often other than the furtherance of health care and patient safety. The possibility that counter suit might eventually be filed against the hospital is rarely enough of a deterrent to prevent bad faith review. It may be possible to prove malicious peer review at the fair hearing level and to achieve reinstatement, and this option should be pursued.

- **Seventh**, be active in your own defense. If you are notified of an investigation, respond and defend yourself and the care you provided. A resolution to each case is essential, consisting of "cleared" or "of no concern." This will protect you from having these cases dredged up a "laundry list" to be revisited in the future.

- **Eighth**, confidentiality is crucial to minimize the damage to your practice, to your relationships, and to your reputation. If there is to be a future claim that the hospital was indiscreet with the confidential information pertaining to its case against you, then your best defense is never to be a source of confidential information leaks yourself.

- **Ninth**, because summary suspension can be a death knell to a physician's practice, any alternative should be considered. Such alternatives include retraining, supervision, further medical education, and second opinions. At the same time, such alternatives to summary suspension must be taken with caution. Sometimes these rehabilitative corrections are also reportable to the NPDB.

- **Tenth**, be familiar with your hospital's bylaws and fair hearing procedures, including deadlines involved. This allows maximum use of the right to contest and appeal decisions. The bylaws also set forth your right to meet with investigating committees and to know all the allegations involved.

- **Finally**, some hospitals may offer the physician an opportunity to resign voluntarily rather than to be summarily suspended. This is an attractive alternative because summary suspension implies that the physician poses a "present" danger to patients. Before choosing to resign the physician should know whether resigning under investigation will result in a NPDB entry or in a report to the state licensing board.

If a physician becomes aware of patient quality of care or patient safety issues at a hospital, the dates and details for each incident should be documented. These details become important if the doctor gets no response when reporting the problems to hospital administrators. Copies of these reports, and a record of the hospital's response to them, become critically important if the response is hostile or threatening. If there is no meaningful response from the hospital, the physician may need to bring case to the state or federal health authorities. This may represent a "point of no return" for the physician's cooperative relationship with the hospital, so that consultation is advised with an attorney familiar with the laws in that state. Many states have some form of whistleblower laws, but these vary in terms of how they define retaliation and what situations they cover.³¹

Remedies

There have been a number of recommendations made for the reform and improvement in the peer review process from a variety of authoritative sources.^{2-11, 18, 25} Foremost among these is the resolution that no doctor, nurse, medical student or hospital worker should be harmed for standing up for a patient. All contractual language should be eliminated that inhibits the ability of a health-care worker to advocate for patient safety. Indeed, it is these very people who should feel obliged to speak up when a quality-of-care concern is evident. Staff bylaws should also require that rules of evidence apply to peer review cases, and that define due process for doctors in a manner analogous to that is currently applied to other professionals in law, law enforcement, and airlines pi-

lots. Doctors must also have access to all documents pertaining to the charges against them, and must be able to confront and cross-examine their accusers.

Public scrutiny of the peer review process should be guaranteed when requested by the individual being reviewed. Appeal to a public body, such as a court, must be available to hear peer review cases de novo. This would allow the establishment of bad faith peer review on which Medicare and Medicaid Services (formerly HHS) could operate for its enforcement role. MMS would have the authority to cut off federal funds to hospitals that engage in bad faith peer review.

“Absolute immunity” should not be given to any member of any committee who is demonstrated to have malicious, anti-competitive, or fraudulent intent. The hospital’s board should be legally, not just administratively, responsible for the outcome of peer review. Final say of a peer-review hearing by the hearing panel, not the hospital administration, trustees, or Medical Executive committee. Partnering or business dealings between hospitals and doctors’ groups must be discoverable in any hospital receiving government money.

Hospital by-laws should allow for speedy investigation and review and for independent external review of cases and committees findings and recommendations. If no disciplinary action is indicated, then suspensions and curtailments of privileges should be stricken from the physician’s record. The burden of proof should be shifted to the accuser, and any administrative privileging action must allow a review of the entire system, to look at everyone’s outcomes. There must be independent external review of cases and committees findings and recommendations.

Finally, State and Federal governments should support changes in bylaws to rotate committee memberships, and only state medical boards should be allowed to report to the NPDB.

Conclusion

Sham peer review is a means by which hospitals may dominate and rid themselves of doctors for reasons other than the furtherance of healthcare. This travesty hijacks a vital function of medical oversight and quality improvement that is designed to protect patients and to improve procedures, processes, and outcomes in hos-

pitals. As such, it should be revealed to the public for what it is: deceit, fraud, and malice.

The practice of malicious peer review is rampant, and every healthcare provider is vulnerable to its effects. Therefore, he or she must be familiar with the protean manifestations and far-reaching effects of fraudulent peer review. Doctors must be prepared to respond to any adverse action against them from a position of knowledge and preparedness.

Since the practice of medicine is a human endeavor, it is fraught with all the uncertainties and subtleties inherent in applying scientific knowledge to healing skills and arts. Medical mistakes, adverse outcomes, and institutional shortcomings inevitably will contribute to less-than-perfect outcomes for patients. Anything that inhibits or punishes a physician’s ability to review and critique of patients’ care, or efforts to improve that care, is to be condemned. As doctors, we are in a unique and vital position to advocate for patient safety, and we have a duty to identify and correct anything that stands in the way of protecting our patients. Sham peer review is one such obstacle. It should be exposed to the light of day and it should be eliminated.

In the words of philosopher Edmund Burke, “All that is necessary for evil to flourish is for good men [and women] to remain silent.”

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