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Sham Peer Review, Consequences to Surgeons, and Remedies

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Editorial

For the last century, 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). 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.

A just, equitable and credible peer review process is important to all stakeholders and aspects in healthcare. However, 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 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. The federal law that supports peer review (Health Care Quality Improvement Act of 1986, HCQIA) fails to recognize this issue.

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. 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 a NPDB report, which putatively occurs at a rate that is at least 4 times higher [2]. This correlates with a 5-figure number and it is common enough to have a real impact on the growing epidemic of resignations, burnout and poor morale of hospital physicians.

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 CEO who may want to exploit sham peer review for the hospital administration's purposes. A CEO that selects this route becomes immune under HCQIA from any lawsuits by a terminated physician 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 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

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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.

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 [3]. 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 to 5 years [4]. 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 a 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 [5].

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.

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 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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