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Review Article

Protection from Sham Peer Review should be an Essential Physician Right

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There is a dire need in this country for a new insurance product for protection of physicians from sham peer review.

Sham peer review, whistleblowing, retaliation, lack of due process, and hospital immunity are all intertwined in this potentially career-threatening issue which also has constitutional implications. Our group has extensively published on this topic in the fields of medicine and healthcare [1-14]. Yet the time has come to share our findings and conclusions with the broader public including public health professionals, politicians and legislators, professionals of the law and justice system, and insurance companies in order to better protect physicians.

"Sham" peer review is the malicious act of purposefully terminating "difficult" physicians through a seemingly objective process called peer review. Peer review itself has been for a long time one of the key pillars for quality assurance of physicians through regular review and determination of professional competence by the hospital's medical executive committee (MEC). "Sham" comes into play when the peer review process goes wrong by intentionally levying false accusations against high quality practitioners, particularly 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." [15] 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. Any adverse privilege action as the result of sham peer review is reported to the National Practitioner Databank (NPDB), which makes it very difficult for the physician to get privileges at any other hospital [16] This is even further compounded by the fact that after being adjudicated by a state licensing board, hospitals don't have to remove their adverse action from the NPDB on the practitioner. [17]

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 for the 6,100 U.S. hospitals in total. 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 [15]. This correlates with a 5-figure number in the 30,000-60,000 case range and it is so common that it has an impact on the growing epidemic of resignations, burnout, and poor morale of the roughly 600,000 hospital-employed physicians.

Sham peer review is usually a retaliatory action to a physician who, for various reasons, is labeled "difficult". One such reason, for example, is whistleblowing when a physician points out to unsafe or negligent patient care, failure to properly safeguard patients, violations of the Health Insurance Portability and Accountability Act (HIPPA) and unsafe working conditions. If such ethical issues that place patients' lives at harm are not taken seriously by hospital leadership, the whistleblower may be deemed "detrimental" to the organization. The retaliatory punishment under such circumstances is sham peer review with subsequent termination of employment.

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While federal law protects federal whistleblowers from retaliation ("Whistleblower Protection Enhancement Act" of 2012), it fails to equally do so for physician employed in a non-federal setting. And the law also fails to protect physicians who are victims of sham peer review.

"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. HCQIA gave immunity to hospitals and reviewers participating in peer review. This immunity has been abused by hospitals and physicians to harm 'disruptive' physicians (ie, whistleblowers) or financial competitors." [17]

HCQIA fails to recognize this issue. "Although HCQIA was enacted to prevent misuse of peer review, sham peer review is conducted with increasing frequency as retaliation against physicians whom the hospital regards as 'disruptive'(i.e., whistleblower)" or incompetent. [15,17] The allegation of "disruptive" behavior is on purpose broadly drawn, vague and subjective and allows hospital administrators to interpret it however they wish. [15] Likewise, "incompetence" of patient care can be misconstrued and requires external (rather than the typically hospital-based) review. Unfortunately, the immunity protection provided to hospitals by HCQIA is overly broad and only requires adherence to "fundamental fairness" for the process to satisfy the Act.

Sham peer review in retaliation for a physician's right to whistleblowing has denied accused physicians a level playing field in our legal system. Although this fact in itself is anti-constitutional, the legal system through HCQIA has, more likely than not, unintentionally provided immunity and the right of NPDB reporting to hospitals. However, the NPDB reporting provision of HCQIA violates the 5th, 8th, 9th and 10th amendments of the Constitution for a number of reasons that we have previously reported in detail. [6,8,11,13] Reasons include the lack of due process (5th amendment), cruel/unusual punishment (8th amendment), prevention of a physician from exercising his/her rights under a state license (9th amendment), and confounding federal (NPDB) with state (medical license) laws. The remedy for an accused physician found "guilty" in a sham peer review and facing grave professional consequences is to file a lawsuit against perceived sham peer review in spite of the legally guaranteed immunity that allows hospitals to keep their actions confidential and information privileged from legal discovery. Courts of law have become 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.

Of course, there are legal solutions to the issue of sham peer review. Theoretically, at least. A first step to regain trust would be 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." [16] This has not happened voluntarily despite mounting evidence in the literature that broadly granted immunity is simply an unfair advantage to hospitals. However, immunity under HCQIA has been successfully challenged in state courts. "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". [15,18]

An even more important step is to address the unintended deficits of HCQIA about 30 years after its enactment and make changes that make this law more applicable to the present healthcare environment. Although this could correct the aspect of unfairness against individual physicians that have become victims of arbitrary sham peer review decisions, such a change in the law will take years, potentially decades.

What are potential solutions to sham peer review and its daunting consequences? As already mentioned, a falsely accused 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. These scenarios also highlight the need for an insurance

product that provides coverage against sham peer review and a complete defense against wrongful hospital allegations of incompetent, whistleblowing, or disruptive behavior. Only then can physicians substantively fight sham peer review decisions with their career-threatening consequences. The market for a successful launch of such an insurance product clearly exists: there are more than 30,000 cases per year in a workforce of 600,000 hospital-employed physicians. The need for protection from sham peer review must be a right for all physicians.

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