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Law and Medicine

So What Is a Sham Peer Review?

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History

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 (ie, whistleblowers) or financial competitors. All one must say is: "Dr. Joe Blow is a *bad* doctor, which is my professional opinion in this peer review, and this hospital should get rid of him." And *poof!* Dr. Joe Blow, patient advocate, financial competitor, is *gone!* And the accusing physician is *immune!*

A wonderful series has recently been written by Steve Twedt of the *Pittsburgh Post-Gazette* called the "Cost of Courage," detailing a number of physicians who have suffered from sham peer review and the consequences they have had to pay (<http://www.post-gazette.com/pg/03299/234499.stm>).

So What Is a *Sham* Peer Review?

A sham peer review exists when a practitioner undergoes chart review during which "serious" deficiencies are determined to exist and, therefore, "the practitioner must be prevented from being a risk to the public safety." This conclusion is obtained by either:

- Declaring that the practitioner does not practice within the guidelines of the standard of care -- regardless of whether that is true. (Several examples include the panel rejecting literature to support a position and being told, "We don't care what the literature shows" and "That institution doesn't know what they are doing." In essence, a new standard of care is established -- because that is not what the victim does.)
- Commissioning an outside review with prearranged outcomes. There are peer-review firms with dubious reputations who will perform a review that reflects the desired outcome of the employer.

Immunity

Once a determination has been made that a challenged peer-review action is a professional review action, immunity under HCQIA is available if the 4 safe harbor provisions set out in 42 U.S.C. §11112(a) are met. These 4 provisions stipulate that the professional review action was taken:

1. in the reasonable belief that the action was in furtherance of quality healthcare,
2. after a reasonable effort to obtain the facts of the matter,
3. after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
4. in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).

1. Reasonable Belief

The first statutory requirement or safe harbor for immunity -- reasonable belief that the action was in furtherance of quality healthcare -- has been interpreted broadly. Without exception, courts have held that this provision is judged by an objective, not subjective, standard.^[1] Claims that those credentialing decision makers have been motivated by personal animus or biases are insufficient by themselves to defeat immunity under HCQIA. Allegations that business peers acted for improper competitive reasons also have been roundly rejected. In *Austin v. McNamara*, a California federal district court noted that Congress initially considered and rejected a "good faith" standard for professional review actions. Without exception, allegations of a defendant's bad faith will not defeat immunity.

2. Reasonable Effort

The second requirement -- reasonable effort to obtain the facts -- has been satisfied in the great majority of published cases by a showing that a representative portion of a physician's practice had been examined and that the examiners had satisfactory expertise in the involved specialty area.

Among the facts cited by the courts affirming reasonable efforts to obtain facts in peer review are broad practice reviews (that is, a large number of cases extending over a reasonably long period of time), review by committees whose members include at least 1 specialist in the involved area of medicine and whose members do not include a significant number of economic competitors, the involvement of outside consultants (preferably with teaching experience or experience in heading a department of the involved specialty at another institution), and multiple levels of review of the peer-review decision.

A rare published opinion concluding that immunity was not available because of the defendant's failure to make a reasonable effort to obtain the facts is *Brown v. Presbyterian Healthcare Services*, from the 10th Circuit. A hospital terminated a staff physician's privileges after another staff member reviewed 3 cases handled by the credentialed physician, and a 3-physician panel reviewed 2 of her cases. The termination was based not on quality-of-care reasons but on the physician's failure to comply with a second-opinion requirement. The hospital also advised another physician that if he affiliated with the credentialed physician, the hospital would not recruit him for a position.

Holding that a reasonable jury could conclude that the panel's review was unreasonably restrictive and not established after a reasonable effort to obtain the facts, the court rejected the defendant's assertion of immunity.

3. Notice and Fair Hearing

HCQIA sets forth in detail at 42 U.S.C. §11112(b) and (c) the specific procedural requirements of a peer-review process that will be entitled to immunity under the third requirement. In a nutshell, the statute requires that a physician be notified of a proposed adverse action and the reasons for the action; the notice must indicate that the physician has a right to a hearing, which may be requested within not less than 30 days; and the physician must be advised of the hearing procedure, including which witnesses will be called. The statute also specifies who can be the decision maker at the hearing, that the physician may be represented by counsel at the hearing, that the hearing will be recorded, and that the physician may call and cross-examine witnesses and present evidence. The statute also requires a written report of the result of the hearing.

It is peculiar that the notice and fair-hearing requirements of HCQIA are less stringent than those of the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) and, therefore, than most hospital medical staff bylaws. JCAHO requires, among other things, a fair-hearing procedure and an appeal process. All JCAHO-accredited institutions include an appeal process in their medical staff bylaws. HCQIA, on the other hand, has no

appeal process requirement.

This could give rise to the anomalous situation wherein a hospital might violate its own bylaws but still be entitled to HCQIA immunity. In fact, this situation was commented on in *Johnson v. Greater Southeast Community Hospital Corp.*^[2] *As a practical matter, if a hospital complies with HCQIA but violates its own bylaws, a cause of action for breach of contract may arise, and this could entitle the credentialed physician to injunctive relief.*

Although HCQIA's notice and fair-hearing requirements are straightforward and less rigorous than those of JCAHO, there have been several credentialing cases in which hospitals were denied the immunity defense prior to trial for failing to comply with this HCQIA requirement. For example, in *Islami v. Covenant Medical Center, Inc.*,^[3] the federal district court found that a peer-review proceeding did not comply with either the hospital's bylaws or HCQIA in that evidence was presented in the credentialing hearing without the physician being present and without a record being made. In *Brader v. Alleghany General Hospital*,^[4] the Third Circuit ruled that HCQIA immunity would not be available to a defendant hospital if it had denied the plaintiff physician an opportunity to cross-examine witnesses that testified against him, as he had alleged.

Although HCQIA does not require significant advance notice of a proposed credentialing action, summary actions are permitted under the statute in the case of emergencies involving "imminent danger to the health of any individual," and none of the notice and hearing provisions apply to privileges or restrictions shorter than 14 days (42 U.S.C. §11112(c)).

4. Reasonable Belief Action Warranted by Facts

The final safe harbor for HCQIA immunity is that there be a reasonable belief that the action taken was warranted by the facts known. Again, an objective standard is applied. Bad faith is immaterial, with the sole consideration being the sufficiency of the basis for the hospital's actions.^[5]

Generally, as long as the other 3 safe harbors have been met and the final action is supported by the majority opinion of the reviewers, the courts will conclude that the credentialing action was reasonably warranted by the facts. The courts do not view their role as being one to substitute their judgment for that of the hospital's governing board or to reweigh the evidence regarding the termination of medical staff privileges.^[6]

Due Process and Presumption of Innocence

An accused murderer has a better chance of being acquitted and having a clean record than an accused physician under HCQIA. Why? In the case of the murderer, **due process** is mandatory and the alleged is **presumed innocent until proven guilty**. This is not the case of the accused physician involved with hospital peer review. The accused physician is guilty until proven innocent since the burden of proof has switched from accuser to accused.

Who Is Involved in the Process?

Unlike the murderer who is arrested by an independent branch (the police) and tried by a different independent branch (the district attorney) before an independent judge in front of a jury of peers selected by the prosecutor and the defense attorney, the accused physician under HCQIA is at the mercy of the hospital.

The arresting body is often a group of competitors, usually in collusion with the hospital administrators. These two groups serve as prosecutors and, in many cases, will act as judge, jury, and executioner.

Is Immunity Warranted?

Yes and no.

A peer review truly done in good faith should be immune; however, too many are not being done in good faith. Therefore, immunity should be taken away or at least modified to deter any bad-faith use of the law.

Stronger Requirements to Obtain Immunity Are Required

Currently, the hospital and physicians (especially the physicians) are largely immune from a sham peer review. And what better way to get rid of a financial competitor than to accuse him of being incompetent and having the hospital foot the bill for a costly review? "Reasonable effort" and "reasonable belief" are vague enough that merely stating "I felt..." or "I thought..." or "I was concerned..." accomplishes this requirement.

While JCAHO guidelines recommend use of the literature and relevant clinical practice guidelines (JCAHO Hospital Accreditation Standards 2003 MS 8 to MS 8.4), there is no such requirement for the hospital under HCQIA. The definition of "peer" also is so open to broad interpretation that essentially anyone with an advanced degree can qualify. For example, a family practitioner can review a trauma case. The sole qualification at one hospital was that he had taken Advanced Trauma Life Support. He had not completed a surgical residency and therefore was obviously not boarded in General Surgery. In another case, a nurse - who testified she knew nothing of abdominal compartment syndrome - testified on a case of abdominal compartment syndrome.

Our forefathers constructed a form of governance whereby all citizens would be allowed true "due process" if and when allegations were directed towards them. That seems to be the case for those Americans who are fortunate enough to not have pursued a professional "license" of some sort. Unfortunately, for those of us who have spent additional years of training in medicine, these rules don't apply to us.

HCQIA has become antiquated and used unfairly by some hospitals to effectively ruin as well as run a competent doctor out of town. The notion of fairness in the medical community will never be achieved unless HCQIA is revamped and 3 areas of the law changed, primarily (1) that the burden of proof be placed on the accusers(s), (2) that "absolute immunity" not be given to those members of any committee who try to adversely affect a doctor and that the affected doctor can demonstrate malice, or fraud, and (3) that a hospital must remove any adverse disciplinary action if a state medical board (which usually reviews all adverse actions of a physician) adjudicates the action.

Currently, this 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 Data Bank, and, regardless of being adjudicated by a state licensing board, hospitals don't have to remove their adverse action from the Data Bank on the practitioner. In Texas alone, in 2004, 68% of adversely peer-reviewed doctors were adjudicated by the Texas Licensing Board, yet those affected physicians' adverse reports are still in the Data Bank. They were removed from the hospital staffs, yet those responsible for initiating the adverse decisions are immune and in many situations used the peer review to rid themselves of competition. This scenario has happened to many "good doctors" because of the actions of their direct competitors who were later adjudicated by state licensing boards, yet the competitors continue to practice while those "shammed" continue to explain the consequences to patients, insurance companies, and other practitioners.

References

1. Menon v. Stouder Mem. Hospital, No. 96-CA-27, 1997 WL 71778 (Ohio App. Feb. 21, 1997).
2. Johnson v. Greater Southeast Community Hospital Corporation, No. Civ. A. 90-192 (D.C. June 24, 1996).
3. 822 F. Supp. 1361 (N.D. Iowa 1992).
4. 64 F.3d 869 (3d Cir. 1995).
5. Mathews, 87 F.3d 624, citing Smith v. Riks, 31 F.3d 1478 (9th Cir. 1994); Bryan v. Holmes Med. Ctr., 33 F.3d 1318 (11th Cir. 1994); and Austin v. McNamara, 979 F.2d 728 (9th Cir. 1992).
6. Babcock, 543 N.W. 2d 749.

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