



Is peer review worth saving?

An increasingly vocal group of physicians says the hospital peer review process is misused to strike down competitors and outliers.

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Of the following statements, which best describes hospital peer review?

Your answer might depend on whether or not you're a hospital insider. Like other supercharged topics, such as malpractice litigation and tort reform, hospital peer review rarely elicits a neutral shrug from members of the medical community.

Now that some physicians who claim they've been unfairly reviewed and disciplined have been awarded millions of dollars in damages (see "Dr. Ulrich's battle," of this issue), organized medicine, long a supporter of hospital peer review, is taking a second look. The Pennsylvania Medical Society and the Association of American Physicians and Surgeons, for example, recently passed resolutions condemning what both groups call "bad faith peer review."

How is it that measures ostensibly taken to promote quality care by encouraging doctors to report incompetent, unethical, or impaired colleagues have earned the distrust of so many physicians? First, some background.

The launch of HCQIA and the NPDB

In the 1980s, when the medical community revved up its efforts to identify negligent physicians via peer review and credentialing procedures, one targeted doctor—general surgeon Timothy Patrick, who then practiced in Astoria, OR—sued his accusers on the grounds that the review was designed to drive him out of business so competitors could co-opt his practice.

A jury found in Patrick's favor and awarded him \$650,000, which the court trebled. Organized medicine, concerned that the Patrick case would chill efforts to identify problem doctors, pushed for national legislation providing liability protection to physicians who file complaints against colleagues and serve on peer review panels. The resulting measure, the Health Care Quality Improvement Act of 1986, also established the National Practitioner Data Bank.

HCQIA gives peer reviewers near-complete immunity from claims for monetary damages arising from peer review actions, provided that several prerequisites are met:

- The peer review was done in the belief that such action furthered quality healthcare.
- Those bringing the action made a good-faith effort to obtain the facts.
- The physician reviewed was given adequate notice and afforded due process.
- The hospital had a reasonable belief that peer review action was warranted.

Although physicians brought before a peer review panel are entitled to legal representation and have the right to cross-examine witnesses, present evidence, and receive a written report of the final decision, the peer review system affords the accused little opportunity to appeal. A physician who feels he has been wronged can file a lawsuit claiming that the HCQIA standards weren't met. But proving bad faith is very difficult—and very expensive.

Moreover, many hospitals have made it extremely hard for physicians to defend themselves against malicious allegations. "It's often a guilty-until-proven-innocent scenario," says Steven I. Kern, a health law attorney in Bridgewater, NJ. "Medical staff bylaws often indicate that if you're summarily suspended pending a hearing or just charged with wrongdoing, the burden is on you to prove, with clear and convincing evidence, that the suspension or charges were arbitrary, capricious, or unreasonable. It doesn't matter if the suspension or charges were wrong. As long as the decision to suspend or charge wasn't made arbitrarily, you're removed from the medical staff."

One side: Peer review is misused

"In the 30 years that I've been a health law attorney," says Kern, "I've never seen anyone who admits a lot of patients and is well-liked have a problem with the hospital disciplinary mechanism. On the other hand, if you're competing with such a doctor, especially if you're new to the hospital or on the wrong side of hospital politics, you're a potential target."

Not only is the peer review process corrupt, it's ineffective, says Ralph M. Bard, a physician turned attorney in Tullahoma, TN. "*To Err Is Human*, the Institute of Medicine's report on patient safety, was released after HCQIA and the NPDB had been in place for many years. Yet the report shows a high rate of medical errors—and that error rate remains high. Rather than being used to weed out bad doctors, peer review as it exists today is used primarily as a weapon against young, vulnerable practitioners."

Peer review wasn't intended as a means to oust qualified physicians to the benefit of their more economically successful competitors, says James Lewis Griffith Sr., a malpractice attorney in Philadelphia. "Too often, however, the golden rule applies: He who has the gold makes the rules."

Conversely, attempts to initiate the peer review process against well-connected physicians can be hazardous to one's career, says Mary H. Johnson of Asheboro, NC. Johnson, a pediatrician and former National Health Service Corps provider, asserts that she was fired from her hospital job after filing a peer review report on a colleague who had badly mismanaged a newborn's care. "The abuse of peer review for economic reasons or to perpetuate a cover-up is medicine's dirtiest little secret," Johnson says.

Bard, whose clients are primarily physicians attempting to counter peer review accusations, left medicine after tangling with a peer review panel. "I was targeted when I pointed out that the hospital's fees were too high and the nurses were poorly trained," says Bard. "They examined every chart I had. No physician can withstand that type of scrutiny." Bard currently serves as vice president of the Semmelweis Society, an organization formed to help physicians ensnared in what Bard calls "sham peer review." The society takes its name from Ignaz Semmelweis, the Hungarian obstetrician who pioneered the field of antiseptics but died a broken man after antagonizing his superiors.

"Where are the checks and balances?" wonders internist Linda Peeno, a healthcare ethicist and consultant who formerly served as a medical reviewer for Humana and as medical director of Blue Cross Blue Shield of Kentucky. "Hospital peer review is one of the most closed boxes in the healthcare system. Where's the outside, independent assessment to determine whether this information is being gathered or used appropriately? The people in charge—those who have the greatest economic and administrative incentives to select and use this data against physicians—are the ones who have access to it."

The other side: Peer review is underused

On the other side of the polarized peer review debate are those who claim that the process is used far too seldom because physicians are loath to criticize their colleagues.

"Most medical staffs aren't aggressive on these subjects," says Philadelphia attorney Alice G. Gosfield. "Physicians judging their colleagues are very concerned about the potential impact of peer review, so they'll go through all kinds of contortions to avoid taking action. So, when physicians or administrators move forward, it's usually justifiable."

"A peer review is an emotionally devastating event for a physician," Gosfield continues. "As badly as physicians handle malpractice cases, it's far worse to be criticized by colleagues with respect to professional performance. Sometimes reviews do stem from clinical judgment differences or personality issues. In my experience, they're rarely motivated by economic competition."

In their book, *Internal Bleeding: The Truth Behind America's Terrifying Epidemic of Medical Mistakes*, physicians Robert Wachter and Kaveh Shojania indicate that, in the medical profession, self-policing is "inept and ineffectual." When disciplinary action is taken, Wachter and Shojania note—say, removing a physician's

hospital privileges or recommending to the state board that a doctor's license be suspended—"it comes only after an orgy of soul-searching, hand-wringing, buck-passing, second-guessing and second chances that is painful, and sometime embarrassing, to watch."

In fact, peer review and other quality assurance efforts are so inadequate, says a malpractice claims specialist who requested anonymity, that more bad doctors are identified by insurance companies after claims are filed than are identified by their peers. "Hospital-based peer review is an ineffective way of dealing with bad doctors or questionable medical care. Physicians are more likely to be sheltered by peer review than to have it used as a weapon against them."

Toward a more effective peer review system

Many observers who say that the peer review system is broken contend that the process needs, above all, to be made more objective. "If we're going to conduct peer review," says Linda Peeno, "an outside body should do it." This is difficult in small communities, where everyone knows everyone else, but one way to surmount that problem is to form reciprocal agreements with neighboring communities: We'll review your cases and you can review ours. Or a specialty board can hear the case.

Also, critics say, because peer review focuses on individual behavior, it misses systemic problems. "Healthcare is so complicated and accountability needs to be much more public, but I don't think peer review is an effective tool," says Martin Hatlie, president of the Partnership for Patient Safety in Chicago. "We need organizational accountability, not just the accountability of people in the organization."

Along those lines, Nancy Foster, senior associate director of health policy for the American Hospital Association in Chicago, would like to see the Patient Safety and Quality Improvement Act of 2003 become law. The bill, which has passed both houses of Congress, would, among other things, enable hospitals to share data garnered from peer review. "Not clinician names," Foster points out, "but information on occurrences so that we can learn from each other."

The measure would require shielding the peer review process from discovery in civil proceedings—something federal and state courts have long endorsed. "Otherwise peer review would be the inexpensive gathering of evidence for a lawsuit," says James Hilliard, a healthcare attorney in Walpole, MA. "The plaintiffs would just sit back, let the peer reviewers do their thing, then discover what peer review has done and they'd have their case."

That shield has begun to crack, however. In November the Florida electorate endorsed a constitutional amendment—touted as a patient-safety measure—that would eliminate confidentiality from the peer review process. In response, the AMA, at its interim House of Delegates meeting in December voted to seek federal legislation to prohibit discovery of records, information, and documents obtained during the course of professional peer review proceedings.

The AMA also has taken steps toward adopting a set of peer review principles based on the Massachusetts Medical Society's Model Principles for Incident-Based Peer Review. This is one of the few sets of guidelines, according to Hilliard, that stresses remediation over punishment and aims to limit the likelihood that hospital insiders or a physician's competitors will co-opt the process.

Among the model principles:

- Triggers that initiate a peer review within a healthcare facility should be valid, transparent, and available to all member physicians and uniformly applied to all cases and physicians.
- Summary suspension or restriction of clinical privileges may only be used to prevent "imminent danger to the health of any individual."
- A peer review committee, engaged in a formal peer review or disciplinary proceeding, may not include the subject physician's direct economic competitors and should include a fair representation of specialists/subspecialists from the physician's specialty/subspecialty whenever feasible.
- Membership on the peer review committee must be open to all physicians on the medical staff.
- Whenever a peer review committee adequately representing the subject physician's specialty/subspecialty can't effectively be constituted by physicians from within the institution (excluding direct economic competitors), qualified external consultants or an external peer review panel through another appropriate institution should be appointed.
- Any conclusion reached or action recommended or taken should be based upon the information presented to the peer review committee and made available to the subject physician. Indefensible and vague accusations, personal bias, and rumor should be given no credence and should be carefully

excluded from consideration. Any conclusion reached should be defensible under a "reasonably prudent person" standard.

- A healthcare facility's conclusion and recommended action should emphasize steps for remediation, as needed, for the subject physician and the system.
- A process should be available to appeal any disciplinary finding, and the requirements and procedures for all existing appeal mechanisms should be made available to the subject physician.

Orthopedic surgeon S. Jay Jayasankar, who as chairman of the MMS's Committee on Medical Service helped develop the model principles, hopes that the Joint Commission on Accreditation of Healthcare Organizations will adopt them, because the Commission can make a hospital's accreditation dependent on whether it administers peer review fairly.

"The profession and JCAHO must ensure that peer review focuses only on quality improvement," Jayasankar continues. "In the end, it's the patient who is hurt if poor practices aren't corrected and good ones promulgated."