

Sham Peer Review: Napoleonic Law In Medicine

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Abstract

Professional peer review is intended to protect the public from incompetent or unethical practitioners. However, it could and often does remove the most honest, ethical, and competent physicians, to the advantage of unscrupulous competitors. The Health Care Quality Improvement Act (HCQIA), which was enacted with the support of the American Medical Association, immunizes false testimony, thus allowing gossip to be converted into testimony and depriving physicians of independent judicial review. The accused physician is often ruined financially. The victim must pay his own legal fees, whereas his accusers are not responsible for any legal fees, which are paid by the hospital. The National Practitioner Databank (NPDB) transforms “disciplinary” actions into a professional death sentence. The abuse of the process is, unfortunately, widespread.

“Off With His Head!”

My own experience with sham peer review began in 1979. As is true in many cases of sham peer review, the attack was initiated by jealous competitors who viewed a hospital computer printout and discovered that I was doing approximately twice the volume that they were doing. Never mind the fact that I was going into the hospital, at hours when they would not, to take care of gunshot wounds and indigent patients. My numbers were larger, and they were intent on doing something about it. And thus the first attack against me was launched.

The pretext concerned a 6-year-old boy who presented to the hospital at an inconvenient hour with an epidural hematoma (life-threatening hemorrhage on the brain). I prevailed upon a neurosurgeon friend of mine to come into the hospital. I assisted him in the surgical evacuation of the hematoma, and the child’s life was saved. Although I was only the assistant surgeon on the case, competitors brought charges against me, accusing me of operating outside of my area of competence and expertise. My qualifications, however, as assistant surgeon in this case included training at City Hospital where I did 19 emergency neurosurgical cases. And in this case, three neurosurgeons had refused to come in to the hospital to care for the comatose child before I was called. This was a true emergency, I responded appropriately, and the documentation in the chart was accurate and complete. As I soon discovered, however, truth is not an impediment to sham peer review.

The surgery department held a fact-finding meeting, which was tape recorded, and two nights later a formal peer review hearing was conducted. Since the tape was favorable to my case, the hospital CEO ordered it to be destroyed. I continued to obtain appropriate consultations when needed, and my privileges remained intact. But this was only the beginning. Other charges soon followed. Attackers coordinated their lies and stories, and it

was open season again. Often the only evidence they could offer was “it is so because I say it is so... off with his head!” It was a collaboration between Alice in Wonderland and prestigious purveyors. The charges against me were mounting, and the predators were moving in for the kill.

Fortunately, at that time there was no immunity for peer reviewers who offered false testimony. Therefore, I filed a lawsuit against my attackers in 1984 (*Waite v. Julian Smith et al.*). Peer review documents were also discoverable and admissible in court at that time. This is no longer the case, purportedly to protect the confidentiality of the accused, although the actual effect in most cases is to protect the accusers. Although the trial itself involved only six cases, an additional 75 charges were made against me only two months before trial. This is a typical tactic used by sham peer reviewers to bolster their case and to intimidate the victim. Some of these cases also involved situations in which I was not the physician of record – another common tactic used in sham peer review.

At trial, the judge ordered the hospital to produce a transcript of the exculpatory tape that the hospital CEO had ordered to be destroyed. The hospital’s copy of the transcript was twelve pages long. The one that I was given was only two pages long. Both the judge and jury noted this glaring discrepancy. Blatant inconsistencies were also noted in testimony provided by many of my accusers. In pretrial deposition and also at trial, the hospital administrator admitted to knowing that the case against me was based on lies. The hospital CEO was subsequently fired as a result, but quickly found a job at another hospital. Physician accusers were also forced at trial to admit that they had been “careless with the truth.” Although they accused me of “having the highest complication rates and hospital stays, and death and infection rates,” the hospital’s own computer data showed the opposite. My statistics were far better than those of my accusers. “It is so, because I say it is so” just didn’t pass muster in the courtroom, where actual evidence was required.

The outcome of the case was to block an unfavorable decision from the hospital peer review committee and to award me a \$559,000 judgment against the hospital for slander. Although I remained on the hospital’s medical staff, the damage to my reputation remained largely unaltered. Half the doctors at the hospital still thought that I was a “bad doctor” and had won only because I had a sharp lawyer. A state accreditation committee also looked at the 75 last-minute charges brought by my accusers and found that my care was commendable in those cases.

Getting a judgment and actually collecting the judgement are two different matters, of course. As a victim of sham peer review, one often finds oneself in a high-stakes poker game with an opponent whose resources far exceed one’s own. The hospital can continue to raise the ante by pursuing appeal after appeal until the victim can no longer afford to play the game. In my case, the

hospital offered to pay the judgment and drop all appeals only if I agreed to go on courtesy staff and to resign from the hospital within one year. All things considered, and in view of the fact that they had succeeded in irreparably damaging my reputation at the hospital despite my winning the court case, I decided to take the \$559,000 and continue my practice at another hospital. No apology was ever received from the hospital, and none of the physician accusers who lied were ever punished for what they had done to me.

The Semmelweis Society Is Formed

After the successful conclusion of my case and the ensuing publicity, I began receiving numerous phone calls and letters from other physicians who had been shammed. Although my attorney and I originally thought that it was just a local mob of physicians bent on killing off local competition (me), it soon became obvious that the problem of sham peer review was widespread. Seeing a need to help these other physician victims, I used a portion of the \$559,000 to found the Semmelweis Society, named for the mid-19th century Viennese physician who crusaded for sterile conditions at his hospital. The guiding principle of this Society is that peer review should be done with clean hands.

Although this Society is small, I personally have talked with more than 10,000 physicians, 2,000 face to face, between 1984 and 1997 regarding sham peer review. I have given three talks to the American College of Legal Medicine. Approximately one-fourth of this latter group of physicians with law degrees became lawyers after they themselves became victims of sham peer review. I have also manned booths at the annual American College of Surgeons meetings, California Medical Association (CMA) conferences, and many local CMA meetings. One website that deals exclusively with sham peer review, that of the Center for Peer Review Justice, www.peerreview.org, has had more than 125,000 visitors since its inception.

The Patrick Case: Immunity and Peer Review

Dr. Patrick was a general and vascular surgeon who joined the staff at Columbia Memorial Hospital, the only hospital in Astoria, Oregon, in 1972. The majority of the staff members at this hospital were either employees or partners of the Astoria Clinic. Dr. Patrick had declined an invitation to become a partner of the clinic, instead choosing to establish a private practice of his own. As a result, Clinic physicians consistently refused to have professional dealings with Dr. Patrick, referring patients to surgeons as far away as 50 miles rather than sending them to Dr. Patrick. Clinic physicians were also reluctant to assist Dr. Patrick in surgeries, declined to provide consultations, and refused to provide backup coverage. Meanwhile, these same physicians criticized Dr. Patrick for failing to obtain outside consultations or to provide adequate backup coverage.

In 1981, one of the Astoria Clinic surgeons requested the Executive Committee of the hospital to initiate a review of Dr. Patrick's hospital privileges. It was a sham peer review, and the committee recommended that Dr. Patrick's privileges be terminated. Pursuant to the medical staff bylaws, Dr. Patrick demanded a hearing. A five-member ad hoc committee was appointed, chaired by the same Clinic surgeon who had initiated the sham peer review. Other members of the ad hoc committee refused to testify about their own personal bias against Dr. Patrick. As is

typical with most sham peer reviews, the hospital made sure that the cards were stacked heavily in their favor. Recognizing that fact, and with no hope of a fair and unbiased hearing in the hospital setting, Dr. Patrick resigned rather than risk termination of his privileges and the myriad of adverse consequences that would surely follow. He subsequently filed suit under the Sherman Antitrust Act, contending that the partners of the Astoria Clinic had initiated peer review proceedings against him to reduce competition rather than to improve patient care. He was awarded a substantial award via jury verdict, which was subsequently overturned by the Ninth Circuit Court of Appeals. The Court described the peer review action undertaken by the hospital as "shabby, unprincipled, and unprofessional." Nonetheless, immunity was granted the accusers on the basis of the "State Action" doctrine. In effect, the court apparently believed that some State agency was actually responsible for supervising the medical peer review process and, therefore, the federal government was prohibited from interfering with this "State Action." As we all know, however, sham peer review is strictly a local process and is not supervised in any fashion by any state agency.

Patrick v. Burget was subsequently appealed to the U.S. Supreme Court. The Semmelweis Society joined with AAPS in filing an amicus brief in support of Dr. Patrick. Filing briefs opposing Dr. Patrick were the American Medical Association (AMA), the American Hospital Association, and many others. The AMA brief stated "peer review recommendations... can provoke anger and have a significant adverse economic impact on the affected physician. Consequently, physicians...often vigorously challenge that action through litigation."¹ The AMA and others argued that effective peer review is essential to quality medical care and that any threat of antitrust liability would inhibit physicians from participation in peer review proceedings.

In a landmark decision, the Supreme Court overturned the decision of the Court of Appeals, stating that the state action did not insulate the anti-competitive conduct of private individuals from antitrust liability unless that conduct was "fairly attributable to the state." That meant that the state had to actively supervise the conduct and actually have the power to review and overturn peer review decisions. Accountability and court access were assured, at least temporarily.^{2,3}

Following the Patrick case, the federal government passed the Health Care Quality Improvement Act (HCQIA) in 1986 under pressure from the medical industry, including the AMA, to give both hospitals and peer-review panels legal immunity from lawsuits. This same law created the National Practitioner Database (NPDB). HCQIA went into effect in 1990.

HCQIA and California Law: Immunity for False Testimony

Although the AMA is officially opposed to the NPDB, it accepted it as a quid pro quo for immunizing peer review.⁴ The process was explained thusly:

The AMA was determined to secure immunity. Of course, the constructive quid pro quo end result wasn't articulated in the statute. As a quid pro quo, that would have looked too weird in the language of a federal statute. But based on the hearings and my review of the reports of behind the scenes negotiations that were going on, that was what was going on. It's just another example of how as a

result of the legislative process you end up with odd compromises that end up getting codified to try and get everyone a little piece of what they really want (*sic*)” (Ryzen V, personal communication, 2000).

The first antitrust case arising from medical peer review heard after the Patrick decision by the Supreme Court was *Simon J. Pinhas, M.D. v. Midway Hospital*, in 1989. A 5-4 decision upheld the antitrust judgement in favor of Dr. Pinhas. The Court noted that the alleged restraint of trade was accomplished by an alleged misuse of a congressionally regulated peer review process that constitutes the gateway to market access.⁵ The Court found that immunity applied only if the peer review process was conducted in conformance with certain requirements including such things as adequate notice, legal representation, a right to cross-examine, and a right to a transcript of the proceedings. Despite this win in court, Dr. Pinhas had his California license revoked based on the same fraudulent charges involved in the initial peer review.

Once again, organized medicine intervened in favor of complete immunity for peer reviewers. Previously, the CMA had lobbied to have a bill passed that granted immunity to peer reviewers. As described in the LA County Medical Association’s journal “With heartening speed in a moment of need, the legislature passed and Governor Brown signed legislation intended to restore absolute immunity to the quasi-judicial proceedings at hospitals and medical associations.”⁶ In 1990, a critical amendment was passed in S.B. 2375, adding Section 43.8.⁷ As a result of this new law, the accusers no longer had to act in good faith, without malice, and with reasonable belief that the information was true. Protection of the accusers was deemed to be a higher priority than protecting an innocent physician from false accusations and ruin of his career.

“Yes, it is possible that in rare instances the immunity might protect a statement made with malice, but the greater evil would be to permit the ‘bad apples’ to bludgeon whistle blowers with defamation actions,” wrote the CMA in response to my letter to the editor.⁸

And on March 18, 1994, during a question-and-answer session, the CMA’s legal advisor made it clear that those who bring false and malicious charges against colleagues have nothing to fear from the law. I posed the question: “I am Dr. Waite, a really rotten, greedy, established physician who continues to destroy enlightened competitors with peer review, knowingly using false, malicious statements. Do I have anything to fear?” The answer was no, with 1157 you can continue to do so.

In February, 2003, the CMA filed an amicus brief in the California Supreme Court in a medical credentialing case, *Hassan v. Mercy American River Hospital*. The CMA argued that the appeals court had improperly eliminated the application of immunity “in those situations where information is communicated with ‘knowledge of falsity’ of the information or where the information is ‘patently irrelevant’.” The legislature intended immunity to be absolute, “regardless of the subjective intent of the communicator,” stated the CMA. The recourse for a practitioner injured by lies, in the CMA’s view, is to hold the *recipients* of the information liable for relying on the false information “if they take adverse action not warranted by the state of the practitioner’s current competence.”⁹

What Factors Place One at Risk for Sham Peer Review?

A large proportion of peer review cases are brought against solo practitioners or members of a small practice, particularly

those who are upsetting the local pecking order. In sham peer review, size matters. Most communities have a “spider web” of referrals and a disturbance at any point often puts the spider in attack mode while the victim remains totally oblivious to impending attack.

In other cases, it may be the hospital’s desire to rid itself of a “disruptive” physician. Most hospital medical staff bylaws contain a reference to “disruptive physicians” in the section on corrective actions, and the term can be defined by the hospital administration to suit its needs. Anyone who opposes the establishment of a medical service organization or a physician hospital organization, or speaks out against managed care, or challenges changes in the medical staff bylaws can be labeled a disruptive physician.

Increasingly, economic credentialing plays a role in peer review actions. Many hospitals use computerized systems to identify which physicians are money raisers or money losers for the hospital.⁹ The physician who treats sicker-than-average patients and thus has a longer average length of stay may be causing the hospital financial loss and thus become eligible for termination of staff privileges.

Summary Suspension: Weapon of Choice in Sham Peer Review

Once a hospital decides to target a physician, various hospital committees are “encouraged” to review the victim’s charts closely and to write up any “errant behavior.” These secret reports may be placed in the targeted physician’s personal file without his knowledge. The victim may receive complaints that seem so trivial that he does not bother to respond. His first clue that something malignant is underfoot is often a notice of summary suspension.

Summary suspension, which typically has “privileged and confidential” stamped prominently on the front page for the protection of the accusers, is intended only for rare instances in which there is imminent danger to a patient or patients. The intended effect and result of summary suspension are several: It causes the immediate interruption of the targeted physician’s income at a time when he will incur significant legal expenses. It will provide immediate damage to the targeted physician’s reputation in the eyes of his colleagues and patients. It provides a “shock and awe” effect that is emotionally devastating to the targeted physician, who may instantly find himself ostracized by his colleagues. No one wants to be near the fly when the spider comes for his meal.

The Myth of Due Process

Once the summary suspension process has been initiated, a committee or committees are appointed to carry out the sentence. These ad hoc committees are almost always stacked with physicians who are either employed by or contracted with the hospital. The hospital also will frequently involve the medical staff president or chief of staff in the scheme, providing him with contrived, slanted, or biased data that he does not have the time or the inclination to investigate on his own. The key factor is that the hospital administration maintains complete control of the process at all times. In order to further the process, the hospital may begin a rumor campaign, leaking allegations to the medical staff and the community at large. Charges against the targeted physician may be as vague as they are numerous. In some cases the victim may be denied access to his own hospital charts, which he needs to defend

himself. In certain cases, a court order has been required just to obtain these records. Moreover, the usual rules of evidence do not apply to these quasi-judicial proceedings. Nearly all medical staff bylaws contain the phrase "the proceedings are semi-judicial and the rules of evidence do not apply" or something similar.

The process is so biased in favor of the hospital, that "if a hospital and its medical staff henchmen wish to eliminate a solo practitioner, regardless of how good a doctor he is, they can probably succeed, if they are patient and follow the rules" (Peacock EE, personal communication, 1996). The parallel to the Soviet KGB creed of "show me the man and I'll show you his crime" is inescapable.

If a physician loses in the peer review proceeding, recourse is very limited. More than 500 other California physicians have been denied their day in court since my case in 1984 because of the legal shield of immunity. Federal court is still available to those who are able to sustain themselves in an office-only practice and who have \$500,000 to spend on legal fees. It costs the accused victim \$200 per hour to educate his lawyer about the sham peer review process and medical care. This educational process can take literally hundreds of hours. The accusers, of course, pay nothing. Young physicians just out of residency may be particularly vulnerable and unable to fight back due to their financial condition. Most medical students and residents have no idea the dangers that await them in the realm of sham peer review. It is a non-covered topic in medical schools and residency programs.

What Can Be Done?

Eternal vigilance is the price of due process protection for physicians. Physicians need to ensure that their medical staff bylaws provide meaningful due process for accused physicians. The judge and jury must be impartial; the accusers should neither comprise nor appoint the adjudicators. Medical staffs need to hire their own attorney to review the medical staff bylaws and proposed changes thereto instead of deferring to the hospital's attorney. Unfortunately, most physicians simply don't read the bylaws or proposed changes to the bylaws, thus allowing the hospital administration to insert deadly weapons for later use.

One of the most difficult obstacles to overcome, other than physician apathy, is the reluctance of physicians to fight for one of their own colleagues who is under attack. It has been said that the hunted physician will find that the sham peer review process is a lot like hunting gazelles in Africa. Thousands of gazelles will be grazing peacefully on the plain. When a lion decides to attack a chosen victim, most of the herd will continue grazing placidly as the surprised victim attempts to run for its life.¹ Physicians of the herd simply believe that unfair peer review isn't their problem and will never happen to them.

Most importantly, HCQIA and state laws that permit complete immunity for malicious and false testimony by sham peer reviewers must be overturned. Absolute immunity, like absolute power, corrupts absolutely. The peer review process needs to be fair and unbiased, and peer reviewers must be held accountable for their actions so as to insure the integrity of the process.

Finally, sham peer review needs to be labeled as such and exposed wherever and whenever it occurs. Physicians must demand a high standard of proof before adverse actions are taken

and a physician's career and livelihood are summarily destroyed. There must be a mechanism to right wrongs, and also to rehabilitate physicians who have lost their license as a result of honest and independent peer review. A medical education and career is a terrible thing to waste without at least making an effort, comparable to that made for drug and alcohol abusers, to rehabilitate a colleague.

Sham peer review, in addition to depriving physicians of their livelihood, is inimical to excellent patient care and deprives patients of access to good physicians. Physicians must not stand mute but must work to correct this problem.

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On Sham Peer Review

Run fast, my little gazelle,
Jump high, dart left and right.
Expect no help;
The herd will graze
And just maintain its poise.

Run fast, my little gazelle,
Jump high, dart left and right.
Sharp claws and teeth
A breath behind,
Your death will make no noise.

L.R. Huntoon, M.D.

Editor, and survivor of sham peer review
Musical setting available at www.jpands.org