



Sham Peer Review and Its Consequences to Surgeons

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Editorial

Hospitals acknowledge two things about patient safety: 1) it is their primary goal and 2) if not achieved, medical professionals, including surgeons, are frequently to blame. The root cause of the latter issue is problematic. Hospitals have frequently lost judicious and objective responsibility for measured and appropriate corrective actions against surgeons. Nowhere is this punitive culture more on display than in the process known as peer review. Consequently, clinicians often perceive such hospital actions as iniquitously punitive.

Sometimes a surgeon or physician is so incompetent that no form of improvement would keep patient safe. Such a case is very rare but has an outsized impact on a nascent just culture. Incompetent performance that harms patients require hospital employers to act swiftly, thoughtfully and with the utmost integrity. A wide array of stakeholders are watching, including the public that demands their local hospital to be high quality.

For the last century, one of the key pillars for quality assurance of physicians and surgeons has been the regular review and determination of professional competence by a committee of local peers. A judgment of incompetence by that committee is typically ratified by the hospital's Medical Executive Committee (MEC) and ultimately the board of directors, leading to disciplinary action such as 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 physician to get privileges at any other hospital [1].

However, this peer review process goes wrong either when it ignores festering problems from low quality physicians or levies false accusations against high quality physicians. The federal law that supports peer review (Health Care Quality Improvement Act of 1986, HCQIA) fails to recognize these two (in) actions as different sides of the same coin. Underlying both is "sham peer review", a process that becomes untethered from truth or justice or concern for the furtherance of quality health care. Notably, HCQIA grants the corrupted process legal immunity based on the wrong assumption of good faith. This tempts many hospitals to co-opt it as a powerful tool to reward or punish physicians and advance their business goals. The frequency that shams peer review ignores poor performance is uncertain but all accusations (including false ones) are recorded in the NPDB, which shows that hospital disciplinary actions including 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]. It is evident from these numbers that the issue at hand is common enough to have a real impact on the growing epidemic of resignations, burnout and poor morale of hospital physicians. As a by-product of hospital politics, sham peer review is hard to speak up against even as it has evolved into a growing public health emergency [3].

The problems caused by providing immunity for the hospitals' peer review process illustrates a basic rule of system thinking: Today's problems come from yesterday's solutions. Hospitals of the 1980's when HCQIA was first implemented were far different than today [4]. Physicians were largely autonomous and had significant leverage over hospitals. Changes in reimbursement have now led physicians to become hospital employees, governed by the terms of hospital contracts and not solely an independent organized medical staff. Recognizing this shift, Medicare amended its conditions of participation in 2014 to enable hospitals to integrate their medical staff into a larger system medical staff [5].

This system-wide MEC is no longer independent. Members are typically 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 strategic goals of a CEO who may want to exploit sham peer

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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 by-laws grant the hospital the right to remove MEC members that are unwilling to comply with such capricious decisions. An actual phrase contained in some hospital bylaws is the right to remove MEC members due to "conduct detrimental to the interests of the hospital". 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 co-opted to protect business decisions of the hospital or, even worse, assist in terminating "difficult" physicians.

The current system is not set up for collaboration. The accused surgeon fearing punishment becomes defensive and refuses accountability for the hospital's concerns, signaling an end to their business relationship. The hospital knows that evidence of incompetence and/or poor clinician behavior is ambiguous and can be rebutted. Their fear of a lawsuit creates a jaundiced view of traditional due process as something that only prolongs the investigation and weakens their case against someone they no longer trust. The inevitable outcome of this dilemma are penalties imposed by hospitals based on less and less strong evidence. The simple antidote is to get both parties to continue to interact which, according to game theory, steers both towards reconciliation and improvement, not punishment [6]. With such a positive state of affairs, hospitals would no longer have to worry about legal immunity. Unfortunately, none of this exists.

In many cases, surgeons that lose privileges view such a harsh punishment as unfair. It is even more problematic if such punishment is taken because a physician is considered to be "difficult", "outspoken" or "inconvenient". In those instances, concocted "sham" peer review is not only a retaliatory act by hospital administration to "elegantly" terminate employment but it is also a career-threatening process for the affected physician or surgeon.

Several aspects have to be considered in this regard. First of all, since clearly documented incompetence is rare, the primary focus of a peer review committee should be on improving an underperforming physician and avoid recidivism. Revoking hospital privileges fails that duty by removing the physician to be rehabilitated from the control of those who should be helping him. To borrow a social media term, that "cancels" the physician through shaming, loss of status and potentially permanent exclusion from the medical community. Second, many hospitals are notorious for having chronically unsafe systems in place. While physicians are frequently aware of them, they have no authority for remedy. Hence, it is well recognized that adverse events are often incorrectly attributed to substandard physician care when, in fact, a system-related error was likely the more significant cause [4]. Similarly, singling out one physician with a bad outcome for punishment while ignoring others with equally bad results and doing little to correct chronic systems issues is inherently arbitrary and capricious. Third, all hospitals are either public or quasi-public institutions because they receive government funding and have a public mandate. Therefore, they have at least a moral (if not legal) obligation to uphold constitutional rights of US citizens.

One of those rights is described in the 8th Amendment prohibiting "cruel and unusual punishments". Legally, a punishment is considered "excessive" if it is grossly out of proportion to the severity of the offense or serves no societal benefit [7]. For example, it is grossly out

of proportion when someone with no past history of performance problems has their privileges revoked for an offense that is not an imminent safety concern when less severe actions (further education, proctoring, restricted privileges) would be more appropriate. Societal benefit is defined by whether the action "makes a contribution to acceptable goals of punishment". To determine this, one considers the public health goals of a hospital. Administration wants to remove "bad apples" and at the same time promote a just culture where staff are free to speak up. The evidence shows that privileges are revoked sporadically in some hospitals and against some physicians but not others [1]. As already mentioned, in some cases, it is clear that hospital administrations have imposed these harsh punishments for political reasons only. The fact that this could happen argues against any legitimate social policy being advanced by the right to revoke privileges without accountability.

Another right is described in the 14th amendment as the right to due process prior to deprivation of one's property, which includes hospital privileges. The reality about how physician in competency is determined is that it often follows a poor factfinding process that violates "due process". First, most hospital-appointed peer review committee members are not experts in that specific field. Hospitals shy away from peer review by national experts because they do not necessarily align with the goals of hospital administration. Second, the hospital-appointed members are not selected for their legal expertise and lack an understanding of due process and how to perform an efficient, objective and fair investigation. Finally, ambiguous judgments are at significant risk of being biased by personal/professional ties or administrative expectations. These issues add up to investigations that are often incompetently performed.

The remedy for an accused physician or surgeon facing grave professional consequences as the result of a violation of his constitutional rights is to file a lawsuit against perceived sham peer review. The threat of a lawsuit incentivizes hospitals to communicate with accused physicians better, in part so they don't sue [8]. 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 [9].

A physician or surgeon is most likely to succeed in a lawsuit when there is evidence that the procedure that was used in the investigation and/or decision-making process was fundamentally flawed. Hospitals have a fiduciary duty to make judgments about physician competence in a fair and accurate manner. If a hospital makes a mistake about this judgment, it should willingly accept accountability in a court of law. As a disinterested third party with expertise in due process, the courts could provide critically important feedback to hospitals. The ability to perform adverse event investigations accurately is critical to safety culture. It takes humility for hospital leaders to accept feedback, but that gesture would provide the leverage needed to cause a large change in safety behavior. A legitimate threat of lawsuits provides a strong incentive to improve the peer review process, reducing the chance it might be abused and co-opted for other ulterior goals. Hopefully, it would trigger hospitals to ask why their doctors want to sue them in the first place.

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 and creates a general mistrust among physicians of the peer review process. The first step to regain that 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. The next step is to institute a full divestiture of the peer review process from the business goals of the hospital. Protections for members of MEC, peer reviewers and hearing panels should be implemented so they cannot be fired or retaliated against for their review opinions. In addition, following the logic of the Sarbanes-Oxley law to maintain the independence of financial auditors, those involved in the peer review process should not be hired into positions in hospital administration for 3 to 5 years [10]. All this serves to acknowledge that relying on professionalism alone is an insufficient safeguard against decision errors.

Courts of law are important game changer for the problem of sham peer review, yet many affected surgeons 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 sham hospital allegations of incompetent or disruptive behavior. Such an insurance product is currently not available. The time has come both for hospitals to act and make peer review truly objective, reproducible and transparent and for surgeons to introduce a defense insurance system that, if necessary, fights sham peer review decisions with their career-threatening consequences.

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