

Editorial

Sham Peer Review: New Tactics and Pitfalls for Employed/Exclusively Contracted Physicians

Lawrence R. Huntoon, M.D., Ph.D.

*Strumming my pain with his fingers
Singing my life with his words
Killing me softly with his song
Killing me softly with his song
Telling my whole life with his words
Killing me softly with his song*

*He sang as if he knew me
In all my dark despair....*

Lyrics from "Killing Me Softly with His Song"
Grammy Award-winning hit by Roberta Flack, 1973

To date I have given 41 talks on sham peer review in 17 states. Almost every time, physicians come up to me after the talk and tell me that they felt I was telling *their* story in such vivid detail as to cause them to relive some of their dark despair.

I, of course, did not know them or their situations prior to the talk. They simply recognized some of the tactics characteristic of sham peer review that had been used against them, tactics that are essentially the same nationwide.

It has been about 6 years since I first revealed the "hospital playbook" for sham peer review.¹ In the interim I have encountered new tactics characteristic of sham peer review and variations on tactics already published. I have also identified certain actions that, while not specific for sham peer review, frequently accompany it.

New Tactics Characteristic of Sham Peer Review

As was the case with my initial article on tactics characteristic of sham peer review, the additional tactics described here do not represent an all-inclusive list of these tactics.

Breach of Confidentiality

Confidentiality is a hallmark of proper peer review. Keeping the fact that the physician is under review confidential is also essential so as not to damage the reputation and career of a physician who may not be "guilty" of the accusations.

Hospitals and physicians using sham peer review will at times leak confidential information so as to damage or ruin the targeted physician's professional reputation, career, and practice. Even prior to any final action taken by a hospital

against a physician, patients and referring physicians are led to believe, via strategic information leaks, that the targeted physician is being reviewed because his care is unsafe or falls below acceptable standards. Patient referrals and cash flow suffer along with the targeted physician's reputation. Even if the targeted physician is ultimately cleared of any wrongdoing, the stigma and damage of these strategic leaks remain.

Ignoring the Findings of the Hospital's Own External Reviewer

Sometimes, in the course of peer-review investigations, a hospital will hire an external expert to review the targeted physician's charts and provide opinions about whether the physician's care fell within the standard of care.

At times the hospital will try to influence the findings of the external expert by providing some, but not all, of the pertinent information about care provided by the physician under review. It is my observation that information that would tend to exonerate the accused physician is at times not sent to the external reviewer.

When the outside expert finds that the accused physician met the standard of care and did nothing wrong, some hospitals will ignore those findings and continue investigating, seeking something they can use against the targeted physician. If their fishing expedition succeeds, then the predetermined outcome is accomplished.

Blaming the Targeted Physician for Deficiencies of the Hospital or Others

Hospital officials often dislike physicians who bring patient safety or care quality concerns to their attention. Some hospitals find ways to retaliate against these whistleblowers, such as instigating sham peer reviews.

Hospitals that attack whistleblowers often blame the targeted physician for their or others' care deficiencies. This retaliation typically focuses on how the physician complained, while ignoring the actual deficiencies. This in turn leads to abuse of the "disruptive physician" label.

Physicians who complain about unsafe or poor quality hospital care are often deemed "disruptive" merely because they have complained. This can then lead to the physician being sent for anger-management courses, communication courses, or being sentenced to one of the self-proclaimed treatment centers for "disruptive physicians."

Those sentenced to go to one of the treatment centers often obtain a psychiatric diagnosis (e.g. narcissistic personality disorder, obsessive-compulsive disorder, or personality disorder

not otherwise specified) that will stay with them permanently. Psychoactive medications are often prescribed, and if the physician refuses to take the pills, he will be found to be non-compliant with the proposed treatment, typically leading to adverse action against his privileges. Some might justifiably conclude that this represents coerced drugging and abuse of psychiatry as punishment for whistleblowing.

Attempt to Present a Non-Peer-Review Report As If It Were Valid Peer Review

Some hospitals, unwilling to incur the considerable cost of obtaining a legitimate external expert peer review, or unwilling to risk that the external reviewer will find that the targeted physician's care fell within the standard of care, have resorted to using other types of reviews as if they were legitimate peer review.

A hospital may decide to use an investigation or review conducted solely by an attorney as "peer review." No actual physician peers are involved, and the desired result is assured. However, as noted by the Court in *Jesse Cole, M.D., vs. St. James Healthcare*, Montana 2nd Judicial District Court, Silver Bow County, Memorandum and Order, Jun 1. 2007, an investigation performed by an attorney does not constitute peer review.

A hospital may decide to use an insurance-liability review by a physician hired by a liability insurance company, edited by an insurance attorney, as if it were a valid peer-review report.

A hospital may also decide to use a review of an entire specialty program as part of a business agreement with another entity as if it were a focused peer-review evaluation of a single physician.

Some might justifiably conclude that these attempts to pass off non-peer-review reports as valid peer reviews represent fraud.

Misleading the Targeted Physician about Data Bank Reportability

A tactic that seems to be gaining popularity is that of misleading the targeted physician about the reportability of an action to the National Practitioner Data Bank (NPDB).

Some physicians are told that it will go better for them if they just "voluntarily" reduce or withdraw certain privileges, and if they do, it will not be reported to the NPDB. And, the physicians are told that if they do not "voluntarily" reduce or withdraw their privileges they will face immediate suspension or some other adverse action, including termination of hospital employment. Such physicians are often shocked to learn that shortly after they agreed to "voluntarily" reduce or withdraw privileges, the hospital reported them to the NPDB.

Some physicians are told that they must agree to a "voluntary" abeyance (agree not to perform certain surgeries or procedures until further notice) or face summary suspension, and that the voluntary abeyance is not subject

to reporting to the NPDB. However, voluntary abeyances that go beyond 30 days are reportable to the databank.

This tactic is a win for a hospital because a physician who "voluntarily" reduces or withdraws privileges typically is not entitled to any due process under the medical staff bylaws. The goal, of course, is to deprive the targeted physician of the due process to which he would otherwise be entitled.

Moreover, the "voluntary" nature of these self-imposed restrictions by the targeted physician is a complete sham and represents a coerced reduction, withdrawal, or abeyance of privileges.

Retroactively Applying New Medical Staff Bylaws or Policies

In conducting sham peer review, some hospitals come to recognize that the existing medical staff bylaws or policies may not be adequate to "get" the targeted physician. So, they arrange to change the bylaws or policies so as to better suit the goal of eliminating the targeted physician. Once the hospital board approves the policy revisions, the hospital applies them retroactively against the physician. In a hospital or any setting, this is a clear violation of due process and fundamental fairness.

Variation of the Numerator-without-Denominator Tactic

As reviewed in the initial publication of the "hospital's playbook" for sham peer review,¹ certain hospitals and physicians will frequently cite a numerator, consisting of selected cases showing complications or bad outcomes, without citing any denominator (number of comparable cases that the physician has treated).

This tactic ignores the fact that morbidity and mortality rates require both a numerator and a denominator, and one cannot draw any valid conclusion or make any comparisons by looking only at a numerator.

Some hospitals, apparently recognizing the blatant flaw of citing only a numerator, have discovered that by manipulating the denominator, they can accomplish the same goal of making the targeted physician look bad.

Hospitals, for example, can control the way that certain surgeries are categorized so as to under-report the total number of cases of that type of surgery the surgeon has performed. That results in inflation of morbidity and mortality statistics for the targeted physician. This covert tactic works particularly well if the surgeon performs highly specialized and innovative surgeries that do not fit well within certain standard categories.

Hospitals that use sham peer review will also frequently compare statistics of the targeted surgeon with other surgeons at the hospital without taking complexity and comorbidities into account. If the targeted surgeon performs more complex surgeries involving high-risk patients with multiple co-morbidities, then morbidity and mortality rates would be expected to be higher than for surgeons who perform non-complex, low-risk surgeries.

Actions Frequently Seen in Association with Sham Peer Review

One can smell the scent of a skunk for many miles, yet never see the skunk. Likewise, there are certain actions taken by hospitals or unethical physicians that, while not specific for sham peer review, are frequently associated with it.

Switching Prosecutorial Theories during Peer Review

When a hospital's case against a targeted physician for quality care issues begins to fall apart because the facts blatantly do not support it, hospitals will frequently abruptly change course and focus instead on conduct or behavioral accusations.

Accusations involving behavior or conduct are much easier for a hospital to prosecute, since typically the only "evidence" required is the accusation itself. And, the accusation often hinges on the way the accuser felt as a result of the alleged misconduct. How one feels cannot be contested.

Based on the Joint Commission Standard LD .03.01.01, which was implemented on Jan. 1, 2009, facial expression and body language can now be used to prosecute a physician for "disruptive conduct" in a hospital. The accuser merely has to claim that she felt the physician's facial expression or body language was intimidating or demeaning to make the physician eligible for prosecution as a "disruptive physician."

The Pot Calling the Kettle Black

Some physicians are so eager to "get" the targeted physician that they will often accuse the targeted physician of things of which they themselves are guilty. Some physician accusers may be driven by jealousy of the targeted physician's superior outcomes, or by the fact that the targeted physician may be well-liked by his patients.

A surgeon may, for instance, accuse the targeted surgeon of having high morbidity and mortality. However, on review of the statistics of other surgeons in the department, one may discover that the accuser's morbidity and mortality statistics are worse than those of the targeted surgeon.

Hospitals that conduct sham peer review will often move to suppress the worse morbidity and mortality statistics of the accusers, claiming that they are protected by peer-review privilege.

Hospital Board or MEC Overruling Recommendations of Peer Review Committees

Hospital boards are generally required to give great weight to the recommendations of a medical executive committee (MEC). Likewise, an MEC is also generally required to give great weight to the findings and recommendations of a peer-review committee (e.g. fair-hearing panel).

It is common sense that the peer-review hearing panel, which has heard and analyzed all of the evidence presented in a case, would have a better basis on which to make recommendations about what action to take than an MEC or a hospital board that has not seen or heard all of the evidence.

In addition, there are often lay members of hospital boards who have little or no understanding of clinical evidence and

standard-of-care issues. Some lay hospital board members, for instance, may think that the physician must have done something wrong, just because complications or a patient death occurred, or a malpractice lawsuit is filed.

In cases of sham peer review, where a hearing panel and MEC make a recommendation that does not satisfy the hospital's desire to get rid of the targeted physician, the hospital board may totally ignore the recommendations of clinicians and take a much harsher action than the MEC recommends. In that circumstance, the hospital board essentially takes an action that is not warranted based on the facts known in the case (42 U.S.C. §11112(a)(4)).

The same type of thing can occur with an MEC ignoring and overruling the recommendations of a fair-hearing panel.

How this occurs is well known. Hospital boards receive most of their information about what goes on in the hospital from the hospital chief executive officer or his designee. If the CEO tells the board that there is a dangerous physician on staff, and the board needs to terminate that doctor's privileges so as to protect patients, board members likely will vote accordingly, irrespective of MEC recommendations to the contrary.

Likewise, hospitals are gaining control over MECs via physician employment, exclusive contracts, paid directorships, and similar financial relationships that make many MEC physicians dependent on the hospital for financial survival. If a hospital CEO or hospital board, under the advice of the CEO, pressures an MEC to terminate a targeted physician's privileges, even though the evidence and facts in the case do not support that, then financially dependent physician MEC members will likely vote accordingly.

Steering Patients Away from the Targeted Physician

Hospitals that use sham peer review will often engage in a subtle, and sometimes not so subtle, form of defamation consisting of steering patients away from the targeted physician. This of course harms the physician's reputation and cash flow, making it harder for the physician to fight back against the hospital—the likely goal.

Hospital employees, especially those who work in the emergency department, will often suggest that the patient be treated by another physician. Referring physicians who send patients to the hospital to be treated by the targeted physician may also be told that the process may go more smoothly if the patient is referred to another physician.

Thus, word spreads in the hospital community that there is something wrong with the care provided by the targeted physician, and that referring physicians and patients would do well to choose another physician.

Assassination of Professional Reputation by PowerPoint

Some hospital attorneys and others have become highly skilled in making presentations to an MEC or hospital board of directors that amount to an assassination of the physician's professional reputation. The professional reputation assassination is typically carried out using a highly scripted, visually persuasive PowerPoint presentation.

Hyperbole in bold, bulleted outlines often trumps the truth and the facts.

After watching one of these bold and colorful presentations,

hospital board members can feel much more comfortable voting to terminate the privileges of the “evil” and “bad” physician.

Pitfalls for Employed/Exclusively Contracted Physicians

Physicians who opt for hospital employment, or who enter into exclusive contracts with hospitals, are often unaware that hospitals have taken action to ensure that employed or exclusively contracted doctors will be deprived of any due process peer review if the hospital decides that their services are no longer wanted.

Hospitals have manipulated medical staff bylaws by inserting clauses that specifically state that the employed physician or exclusively contracted physician will not be entitled to any hearing or appeal rights on termination of the contract.

Termination of an employment contract is not reportable to the NPDB, but if the reason for termination is related to professional competence or professional conduct, it could be reportable to the NPDB.

If it is reportable to the NPDB, the employed physician could face the ruin of his career without any due-process peer review hearing at all, according to employment contract terms.

A hot topic at courses for the hospital bar is how best to get rid of unwanted hospital-employed physicians. Perhaps the employed physician did not bring in the anticipated level of revenue, or perhaps the employed physician rebelled against pressure by the hospital administration to practice medicine a certain way.

If the hospital decides to just terminate the contract, then it is quick and simple. But, if the hospital decides to take the sham peer review route, the process will take longer, but the hospital will enjoy the benefit of very strong immunity under the Health Care Quality Improvement Act (HCQIA).

All Physicians Should Be Aware of New ‘Loser-Pays’ Provisions in Medical Staff Bylaws/Policies

Under HCQIA there is a “loser-pays” provision stating that if the defendant(s) substantially prevail and plaintiff’s conduct during litigation is deemed to be frivolous, unreasonable, without foundation, or in bad faith, then the court shall award to the prevailing party the cost of the lawsuit, including “reasonable” attorney fees (42 U.S.C. §11113).

If the plaintiff successfully obtains permanent injunctive or declaratory relief, the defendant shall not be considered to have “substantially prevailed.”

Recently, hospitals have adopted medical staff bylaws/policies whereby if a physician simply initiates a lawsuit against a hospital in a sham peer review case, and the physician does not prevail, the physician is liable for the hospital’s costs including “reasonable” attorney fees (See *Sternberg v. Nanticoke Memorial Hospital* 62 A.3d 1212 (Del.2/28/2013)). The physician’s case need not be frivolous, unreasonable, without foundation, or in bad faith. If the physician simply loses, the physician is liable for the hospital’s costs.

Combined with the nearly absolute immunity HCQIA provides to hospitals, this new policy will serve to further discourage physicians from filing lawsuits against hospitals for an abusive peer-review process that harms or ends their medical careers.

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REFERENCE

1. Huntoon LR. Tactics characteristic of sham peer review. *J Am Phys Surg* 2009;14:64-66.

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