

Editorial:

# Tactics Characteristic of Sham Peer Review

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The tactics used by hospitals and others in conducting a sham peer review are remarkably similar throughout the country. The common feature of these tactics is that they violate due process and/or fundamental fairness, and they often represent an attempt to make the incident or event “fit the crime.”

Although our legal system is not perfect, it does incorporate sound principles and procedures designed to protect an accused individual’s right to due process and fundamental fairness (e.g. an accused person is considered innocent until proven guilty). In evaluating the fairness of peer review, one can often find corresponding principles of due process and fundamental fairness in our legal system.

The following list is not all-inclusive, but represents common tactics of sham peer review.

## **Ambush Tactic and Secret Investigations**

Hospitals that employ sham peer review typically use the ambush tactic to place the targeted physician at severe disadvantage. An administrative secretary may call the physician’s office and request that the targeted physician attend an “informal friendly meeting” in the administrator’s office to discuss unspecified “issues.” Although the targeted physician typically asks about the specific issues or concerns, the hospital administration often refuses to provide any specific details prior to the meeting.

On arrival at the meeting, the targeted physician often finds himself facing the hospital chief executive officer (CEO), hospital attorney, vice-president of medical affairs, chief of staff, and chief of service. The meeting is anything but informal or friendly. All of the individuals in the room, except for the targeted physician, know precisely what the specific issues or concerns are that will be discussed in the meeting.

As the targeted physician fumbles to recall and explain events or patient cases that occurred weeks or months ago, his inability to recall specifics under highly stressful conditions makes him look “guilty.” Catching the physician off guard and making him look “guilty” is, of course, the purpose of the tactic. The ambush tactic is frequently enhanced by imposing an immediate summary suspension on the targeted physician, an action that elicits an expected “shock and awe” effect from the targeted physician.

Physicians who are asked to attend one of these “informal friendly meetings” should take a trusted physician colleague with them to the meeting so there will be an independent account of what was said or done at the meeting. Concealed digital recorders, either audio or audio/visual, can also be utilized depending on state laws. Consent for taping requirements is posted on the AAPS website (<http://www.aapsonline.org/judicial/telephone.htm>). Physicians should also consult a local attorney to confirm requirements.

Hospitals that employ sham peer review also frequently use secret investigations, which can continue for weeks, months, or even longer. In fact, a secret investigation can remain open almost indefinitely until a formal action is taken or the investigation is formally closed. If the physician resigns or lets his hospital privileges expire while under secret investigation, it is reportable to the National Practitioner Data Bank (NPDB), and the physician’s career may be ruined or ended. A secret investigation, however, fails to satisfy the requirement (42 U.S.C. §11112(a)(2)) that a reasonable effort be made to obtain the facts of the matter, because it fails to obtain information from the very person (physician under review) who could provide the most direct information about why a patient was treated a particular way.

## **Depriving Targeted Physician of Records Needed to Defend Himself**

Although no court of law would permit depriving an accused person of files or records needed to defend himself, as it is fundamentally unfair and in violation of due process, hospitals that employ sham peer review frequently refuse to provide records in a timely manner to the physician under review. Sometimes, hospitals delay providing the needed records to the accused physician until just prior to the peer review hearing or at the time of the hearing, leaving the accused physician inadequate time to prepare his defense. Having inadequate time to prepare a defense places the physician at severe disadvantage and makes him look “guilty” as he fumbles to defend himself at the hearing. Attorneys who represent physicians should document strong objection to this tactic both before and during the hearing.

## **Guilty Until Proven Innocent**

Even accused serial murders, serial rapists, and serial child molesters are supposed to be considered innocent until proven guilty in a court of law. However, due to unfair provisions of the Health Care Quality Improvement Act (42 U.S.C. §11112(a)(4)), and provisions often found in medical staff bylaws that have been manipulated so as to favor the hospital, targeted physicians are often essentially presumed “guilty” and the burden is shifted to the accused physician to go forward with evidence to prove his “innocence.”

## **Numerator-Without-Denominator Tactic**

Although the numerator-without-denominator tactic can be used against any physician, it is most commonly used against surgeons. Hospitals that use this tactic typically select cases that are specifically designed to highlight complications or negative outcomes. The selection of cases often falls outside the routine protocol used for selecting cases for review of physicians practicing at the hospital. The hospital then presents this select group of cases to peer reviewers as evidence that the targeted physician is a bad doctor or provides unsafe care.

Hospitals that use this tactic specifically omit the denominator (how many cases of that type the physician has performed over a period of time), thus eliminating the possibility of calculating a complication rate that could be used to make a fair comparison with statistics of other colleagues, or statistics published in medical literature. Virtually all surgeons, of course, experience complications, and the only surgeons who have zero complications are those who do not perform surgery, or who do not report their complications.

### **Misrepresenting the Standard of Care**

This tactic takes advantage of the fact that it is very common for physicians to hold legitimate differences of professional opinion concerning optimal treatment for a specific patient or condition. Hospitals that employ this tactic frequently hire an outside expert who opines that because the targeted physician did not use the same surgical technique or medical treatment that the expert prefers, the targeted physician must be practicing beneath the standard of care. However, if the accused physician can provide evidence, either from the medical literature or from expert testimony, that justifies the treatment provided, then the issue is clearly a matter of difference of professional opinion and not a standard-of-care issue. In some cases, Medicare billing guidelines have even been misrepresented in peer review as a clinical standard of care.

### **Trumped-Up and/or False Charges**

Hospitals that use sham peer review frequently bring trumped-up, fabricated, and totally false charges against targeted physicians. Charges are often pretextual, consisting of more “spin” than substance. Some examples and associated characteristics include:

- A “stack” of invalid incident reports or complaints—creating an appearance of a large quantity of actual valid incidents/complaints;
- “Sanitization” of meeting minutes (altering wording so as to show the targeted physician in unfavorable light, or place targeted physician at disadvantage);
- Use of summaries or abstracts (subject to manipulation/editing) prepared by hospital employees;
- Use of hearsay evidence;
- Strategic omissions of fact that place the targeted physician at a disadvantage;
- Highly damaging accusations of alcohol or drug abuse where there is no substantial or credible evidence to suggest that the accused physician has a problem;
- Prosecution choreographed/presented by one person under the hospital’s influence or control, with an agenda not in furtherance of quality care;
- Wrongfully attributing the deficiency of the hospital or others solely to the targeted physician; and
- Accusers who are frequently guilty of the same accusations being made against the targeted physician.

In sham peer review, where the hospital controls the entire process and acts as judge, jury, and executioner, the truth or falsity of charges makes no difference, and the truth and the facts do not matter because the outcome is predetermined and the process is rigged.

### **Abuse of the “Disruptive Physician” Label**

The definition of “disruptive physician” is highly subjective and subject to manipulation and abuse. Recently, the general and vague definition of “disruptive physician” has been fortified with the more specifically vague and subjective descriptions in the “Code of

Conduct” as promulgated by the Joint Commission on Accreditation of Healthcare Organizations (JCAHO). Nonverbal conduct, such as facial expression and body language, can be used to label a physician “disruptive,” and no evidence is required beyond how the accuser feels.

Increasingly, the term “disruptive physician” has become synonymous with “mentally impaired” physician. A physician who is wrongfully labeled “disruptive” because he does not agree with the hospital administration’s views, or complains about substandard care in the hospital, can be subjected to inpatient treatment at a facility that specializes in treating “disruptive physicians.” “Treatment” at one of these facilities may include treatment with medications, which if the “dissident physician” refuses to take “voluntarily,” may result in automatic termination of privileges for failure to comply with the recommended “treatment.” Physicians typically emerge from one of these “treatment” facilities with psychiatric diagnoses of narcissistic personality disorder, obsessive-compulsive disorder, or both.

### **Dredging Up Old Cases to Justify Summary Suspension**

Hospitals that use sham peer review frequently will use cases occurring in the distant past to justify a contemporaneous summary suspension. This tactic suffers from an obvious flaw in logic: If hospital officials truly believed that the physician posed an imminent danger to patients months ago, why did they wait and allow the physician to continue to practice, instead of summarily suspending the physician at the time when the incident occurred, in order to protect patients?

### **Ex-Parte Communications**

Although no court of law would allow a prosecutor, judge, or witnesses to meet with members of the jury outside the hearing to discuss or influence a case, similar ex-parte communications occur frequently in sham peer review. Although such ex-parte communications taint the entire hearing process and clearly violate fundamental fairness and due process, hearing officers, hired by the hospital, often allow ex-parte communications.

### **Hospital Attorney or Conflicted Attorney Used to Influence the Peer Review Process**

Hospitals that employ sham peer review often will use an attorney who represents the hospital or who represents both the hospital and medical staff simultaneously (i.e. a conflicted attorney) to influence the peer review process.

The goals and interests of a hospital administration and a medical staff are not identical. The medical staff is the primary entity in a hospital that is responsible for assuring safe and competent care of patients. Although a hospital administration also has responsibility for assuring quality care, the administration also has a fiduciary duty to assure the profitable operation of the hospital, a goal that may conflict with optimal care of individual patients.

Hospital attorneys, or attorneys who have a conflict of interest in simultaneously representing the hospital administration and medical staff, influence the peer-review process and thus violate due process and fundamental fairness. Although a medical staff can hire its own independent attorney to give advice concerning the peer-review process, peer review should be performed by peers (other physicians on staff) and should not be influenced by the hospital administration, or its attorney or a conflicted attorney, prior to the matter reaching the level of the hospital board of directors.

## Bias

Hospitals that employ sham peer review frequently bias the peer-review proceedings in a number of ways, including: stacking the investigative committee or hearing panel with physicians who have personal animus or bias against the accused physician; allowing the prosecution much more time to review records or present the case than the targeted physician; unfairly limiting the time allowed for the physician to present his case; disallowing evidence or testimony that may be favorable to the targeted physician; differential treatment of the physician whereby the targeted physician is treated more harshly than his colleagues for a similar alleged offense; use of the hospital “rumor mill” to spread negative and highly damaging rumors about the targeted physician while the peer-review process continues, and many others.

Hospitals that use the “rumor mill” to damage the targeted physician’s reputation, and influence the peer review process, may also file improper or false reports with the National Practitioner Data Bank (NPDB) so as to permanently damage or end a physician’s career. Hospitals will also frequently not allow the physician to hire a court reporter to provide an independent record of the peer review hearing, opting instead to provide a record kept by the prosecuting hospital. No court of law, of course, would permit a record of a hearing to be kept solely by the prosecutor, as it would introduce bias and would be patently unfair to the accused.

### Peer Validation of Tactics Characteristic of Sham Peer Review

The information in this current editorial about tactics characteristic of sham peer review was presented to two large groups of physicians in June and July, 2009 (AAPS meeting in Dallas, Texas,

on Jun 5, and at the Florida Medical Association annual meeting on Jul 25). Following the presentation, a survey question was posed to these two large groups of physicians: “Are any of the tactics reviewed in this presentation fundamentally fair to physicians subject to peer review, and do any of these tactics comply with due process for the accused physician?” Not a single hand in the audience at either meeting was raised, indicating that the tactics reviewed are indeed characteristic of sham peer review, because they do not provide fundamental fairness or due process for the physician under review.

### Implications for Physicians Who Conduct Peer Review

AAPS supports peer review done in good faith for the purpose of furthering quality care and protecting patients. Physicians who serve on peer-review committees need to be vigilant and diligent in conducting fair peer review. Physicians need to be aware that those who are choreographing the process and presenting the case may have underlying motives that have nothing to do with assuring quality care. Peer reviewers need to ask questions, and personally review cases, complaints, and incident reports, rather than relying on summaries provided by the hospital.

Protecting patients and assuring competent care must be balanced by a process that provides substantive due process and fundamental fairness to the physician under review. Peer reviewers need to recognize that an accused physician’s medical career and livelihood are at stake, and any adverse action taken should be justified by full and impartial consideration of all the facts.

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