Challenges to Physicians: Hospital Immunity and Sham Peer Review

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Editorial

One of the most critically important responsibilities of hospitals is to assure the quality of the medical care they provide. A key pillar of quality assurance has been to use a committee of local peers to determine the professional competence of physicians. On occasion, incompetence or disruptive behavior of a clinician is found to have caused patient harm. The peer review committee then holds the deficient physician accountable and the hospital uses its authority to impose swift corrective action ranging from remedial education, proctoring or the restriction or revocation of hospital privileges.

Absent a serious patient safety concern, physicians have a legal right to maintain their privilege to work at a hospital. There are important reasons that most hospitals have never deprived a physician of that right. First, most hospitals and their peer review committees know that their priority should be to improve underperforming peers and avoid recidivism. Revoking privileges fails that duty by "canceling" the accused physician through shaming, loss of status and removing them from the control of those who should be helping. Second, it is "cruel and unusual" to revoke a physician's hospital privileges when less severe action might be effective. Finally, factors other than physician performance are often more important contributors to patient harm such as chronically unsafe systems of care [1].

In many ways, hospitals efforts to self-police are analogous to those of actual police. Police officers must act on incomplete information and make quick decisions to protect the public. An arrest requires depriving a suspect of their right to freedom. Like hospitals, police face legal claims based on the 14th and 8th amendments that they punished capriciously, without due process or in a "cruel and unusual" way. Because it is not feasible to make such decisions and protect the public in a way that always comports with abstract legal concepts, police and hospitals are given the benefit of the doubt. Both are granted qualified immunity against lawsuits, except when there is evidence that a clearly established right was violated. Both are indemnified, meaning the costs of liability are borne by their organizations and not them personally [2].

The source of hospital immunity is a federal law called the Healthcare Quality

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Improvement Act of 1986 (HCQIA). Based on reports that many low-quality physicians were being ignored at the time, Congress passed HCQIA with the explicit goal to protect physician peer reviewers from retaliatory litigation after speaking up against poor quality colleagues. The law makes peer review proceedings privileged and confidential to avoid ever having to defend against a frivolous lawsuit from a disgruntled “bad apple”. Hospitals argued that these protections are critical for avoiding unnecessary costs and for performing legitimate peer review. When HCQIA was first implemented, hospitals and their review committees were staffed by independent physicians who directly competed in private practice. Negative comments about a competitor could be seen as anti-competitive and justify anti-trust litigation, thereby chilling a physician’s desire to speak up against colleagues. In that context, immunity effectively encouraged legitimate peer review [3].

The last four decades changed the context. Physicians have left private practice in favor of hospital employment, which means both those taking part in a professional review action and the targets of their investigations are employed by the hospital. According to the principles of anti-trust law, co-employees cannot be in direct financial competition. With the risk of anti-trust litigation between rival doctors now mitigated, hospitals have become the primary beneficiaries of immunity. Like any employer, hospitals might want to get rid of employees considered to be “difficult”, “outspoken” or “inconvenient” even if there is no clinical competency reason to do so. Hospitals can terminate an employed physician by revoking privileges after a “sham” peer review and coopt immunity to circumvent the risks of a wrongful termination lawsuit or severance pay. This betrayal of immunity is a predictable illustration of a tenet of systems thinking: today’s problems come from yesterday’s solutions [4].

Poor performance and poor evaluation of performance both seriously harm public safety. Both hospitals and police have the power to self-evaluate and can abuse that power without appropriate checks being in place. When police use excessive force, their behavior is often captured on the video of police body cameras or the ubiquitous recorders within the public domain. Credible recordings of abuse or eyewitness reports receive massive attention from the media, prompting rouge police to be fired by their departments and/or face civil and even criminal courts. In stark contrast, evidence of abuse of power of the peer review process by hospitals is confidential, privileged from discovery and rarely public. In addition, widespread hospital employment created a conflict of interest that was unforeseen when HCQIA immunity was first granted. Every stage of a peer review action involves hospital employees that are implicitly (and sometimes explicitly) required to act according to the expectations of their employer. Even the witnesses that an accused physician would call to defend him/herself are hospital employed and prohibited from testifying without quitting their job [5].

Unacceptable performance is harder to define for a physician than for police, putting this judgment at risk for undue influence by ulterior motives of the hospital. The appropriate check on this is to give the accused physician the same degree of due process that medical licensing boards provide prior to any disciplinary action. Hospitals are “state actors” when they report an adverse peer review action to the government agency that administers the national practitioner databank. This entails an ethical duty to confirm adequate due process before making a report. Evidence suggests this duty is widely ignored. A comprehensive review of peer review in California found the hospital peer review process to be plagued by inconsistencies, variations, and conflicts of interest (x2). Privileges are revoked sporadically in some hospitals and not others. Given this notoriously high base rate of randomness and inconsistency, it is in the interest of any hospital that faces credible evidence of peer

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review dysfunction to forgo their immunity so they can obtain corrective feedback from the courts.

Hospitals cover the decisions of peer reviewers and administrators with a policy called Directors and Officer's insurance. While they provide employed physicians with medical malpractice insurance, that policy often specifically excludes litigation costs related to peer review. The limited financial resources available to a physician without hospital privileges adds further to the ironclad advantages of hospital immunity. This final finger on the scale essentially stops courts from providing any oversight. The difference in how unreasonable hospitals vs. police are investigated explains why only 15% of physician plaintiffs are successful at overcoming the presumption of hospital immunity whereas police immunity is overcome in nearly half of civil court cases. No social policy is advanced by denying this oversight [6].

Peer review acting with impunity has a profound negative impact on the culture of safety. Hospitals accept the occasional mistake of falsely accusing a high-quality physician based on the premise that ignoring a low-quality physician is the more significant safety hazard. This tradeoff fails to recognize these two (in)actions as different sides of the same coin. Either false accusations against a quality physician or failure to act against a low-quality physician are a sign of a hospital entangled in poorly conducted investigations untethered from the truth. An organization that carries out flawed investigations is unable to learn the proper lessons from adverse clinical events, putting future patients at risk. In addition, the risk of being falsely accused has a chilling effect on the willingness of physicians to act as a whistleblower and speak up about safety problems. Evidence shows the main reason physicians are reluctant to participate in peer review committees is not from fear of lawsuits by an accused peer, but from lack of trust in the process, particularly when they learn of a peer falsely accused based on ulterior motives [7].

Hospitals that provide their employed physicians with insurance to covers peer review, rigorous due process and forgo immunity when there is credible evidence of peer review dysfunction will be exposed to the risk that accused physicians would file more lawsuits, at least initially. However, those suits should expect to have no greater chance of success than in the past. A variety of legal safeguards against frivolous lawsuits would remain (e.g. attorney's fees awarded to the winning party, sanctions against a lawyer who files a frivilous suit). Physicians would not be able to turn to the courts without having exhausted all administrative remedies in the hospital (informal MEC meeting, formal Fair Hearing, appeals). Courts would continue to presume good faith in how hospitals define physician quality as they have with legal injunctions and other declarative relief where immunity has never been applied. None of these massive advantages would change [8].

Another change would result: more symmetric balance of power in the physician-hospital relationship. Game theory suggests such a balance forces mutual accountability to each other's long-term interests and steers both parties towards reconciliation and improvement, rather than punishment (5). Hospital lawyers know that people sue when they perceive an unfair process cloaked in secrecy. Due process is the antidote for that perception but the courts have recognized that hospitals have little experience in this area. A lawsuit is often the best way to engage external reviewers and expert counsel that let an accused physician tell their side of the story. Those falling below accepted standards will gain a more transparent understanding of the evidence against them and make realistic decisions about their future. Those wrongly accused will use the courts to speak up about potential problems with the peer review investigation, ultimately providing feedback that is invaluable to the hospital. Any rise in the cost of indemnification will eventually fall over time as physicians perceive the peer review system as being

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fair and stop turning to the courts. Hospitals wanting to improve perceptions of fairness will pay greater attention to integrity, accountability, reconciliation, process improvement and transparent communication. Coincidentally, all the same ingredients of a safe culture [9].

Hospitals can begin the journey towards a sustainable safety culture by making the first move. The past 30 years have proven that changing the patient safety culture requires a different approach. Hospital willingness to uproot their inherently unfair legal advantages provided by legal immunity is a high leverage way for culture change. This gesture of vulnerability would serve as proof that the hospital truly wants everyone to speak up about problems and has rededicated itself to patient safety. The long road to the high-quality investigations and safe culture seen in other hazardous field is not paved with immunity [10].

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