



Peer or Sham Review?

PRESIDENT'S MESSAGE



By Satya N. Chatterjee, MD

Too often, hospital peer review is being used for the wrong purposes.

THE AMERICAN COLLEGE OF SURGEONS, as early as 1918, decided something had to be done about the quality of hospital care. It developed a "Hospital Accreditation Program" that evolved into the Joint Commission for Accreditation of Healthcare Organizations (JCAHO). The JCAHO requires hospitals to have an ongoing process to evaluate physicians. This is done for the hospitals by the medical staff organizations (MSO) through their peer review programs.

The current mandate for peer review goes back to the Federal Health Care Quality Improvement Act of 1986. By statute, most peer review information is protected from discovery in civil proceedings.

This shield has begun to crack. Florida voters passed a constitutional amendment to eliminate confidentiality from the peer review process. The AMA opposed it and instead adopted model principles which include an event that initiated a peer review in a hospital should be valid, transparent and uniformly applied to all cases and physicians. Most importantly, summary suspension or restriction of clinical privileges may only be used to prevent "imminent danger to the health of an individual."

Peer review need not be punitive. Its goal is to avoid repetition of errors and to improve delivery of care. Above all no patient's health or life should be exposed to any danger. However, over the years the basic purpose has been forgotten. The process has been used to curb competition, to punish outspoken doctors for pointing out faults in hospital delivery of care, or doctors investing in competing surgery centers or even to discipline an off-the-bell-curve doctor or to retaliate against a physician for not "playing ball" in one manner or another. (Artz 2001 Physician News Digest)

Examples:

In the famed Patrick versus Burget case in Oregon during the mid-1980s, Dr. Patrick claimed peer review was done to drive him out of practice. The appellate court found that peer review was conducted properly, but ultimately Dr. Patrick won at the Supreme Court level.

I personally know of a case in which a renowned doctor pointed out a grave error in patient care to the hospital administrator. He demanded the hospital make restitution. It did, but soon thereafter, the hospital started to comb through hundreds of his charts. He was summarily suspended. Committees of cooperating doctors supported the suspension. Ultimately, the judicial review committee (final review panel) totally exonerated him. The hospital was not sued. Only last year, the Association of American Physicians and Surgeons passed a resolution requesting additional protection for whistle blowers targeted by "sham peer review."

In 2004, many resolutions before the California Medical Association (CMA) House of Delegates dealt with the subject. The House adopted a resolution presented by a Los

Angeles doctor that review be performed by unbiased peers, and quality of care concerns should have external review - thus extending the earlier CMA support (RES.813-97) of a physician's fundamental right to an unbiased jury.

The Sacramento Business Journal of May 23, 2005, mentioned a case in which a physician claimed in a lawsuit that she was pushed out of her group on bogus quality of care issues. The Sacramento Superior Court, while not ruling on the issue, found fault with the defendant's peer review. The case has been appealed to the Third District Court of Appeals.

In general, the courts are not sympathetic to doctors. A physician must prove bad faith and malice to have a peer review decision overturned (Donnell versus HCA of Kansas).

"Disruptive physicians" are also a category for sham reviews. I was brought up in a strict medical system through English residency and fellowship for 11 years. I don't tolerate people shouting in operating rooms, using foul language or treating others in a demeaning manner. These individuals should be punished. They need to go through whatever it takes to modify their behavior so that it is fitting for a decent society. It can be done through psychiatric help, CME for anger management and intermittent monitoring, but not by summary suspension. Summary suspension will not correct behavior. It is incorrectly used and is a misuse of power by any chief of staff.

The CMA suggested the development of a policy to define "disruptive physician" and to take disciplinary action against such physicians only if there is evidence of danger to patients' safety or a compromise to the delivery of quality care (RES.605-05).

Recently, Dr. David Limonick, an emergency physician, sued the West Penn, Allegheny Health System, claiming his dismissal was a retaliation for his good faith reports made to the department chair, hospital administrator and even to the president about delivery of care. (AM News) There, Dr. Bill Monnig, chair of Organized Medical Staff Section was quoted as follows: "While there are physicians who need to be disciplined, hospitals are using a more liberal definition of the term to deny privileges to a doctor who for example may have invested in a competing surgical facility."

In another incident personally known to me, a family practitioner was threatened with further consequences for not responding to a voice page from a nurse to discharge a patient. The nurse is required to use a pager, and a voice pager is not legally acceptable. The department chairman wanted to use hospitalists; his stance was, "you guys are not available as the hospitalist will be and the hospital will not be losing money on late discharges." Fortunately, higher authorities saw no reason to proceed further.

What can the Medical Board of California do?

Dr. Ronald H. Wender of MBC in Action Report of July 2005 wrote:

"The quality of peer review in this state is unknown. A law was passed in 2002 to study the quality of peer review, but due to the board's current fiscal situation it has not been funded."

MBC should not only look at 805 reports, more importantly it should see if hospitals are sending all potential peer review reports that require an 805. I like Dr. Wender's statement that "we must police ourselves" but why doesn't the medical board reach out to independent bodies such as the local medical society or, even better, to the CMA for complaints on delivery of quality of care issues, leaving MBC investigators to concentrate on doctors involved in drug abuse, drug dealing, alcoholism, felonies, misdemeanors, sexual encounters with patients, altered mental status, kickbacks, theft, healthcare fraud, etc., thus justifying their status as peace officers.

Legislative help may be on the way. CMA sponsored SB932, introduced by Senator Kuehl, to establish an unbiased process for conducting peer review. The bill would add

procedural protection common in the civil court setting - that no person sitting in a peer review setting have any financial connection to the hospital or the physician. An appeal would have to be heard by a body with no connection to the underlying hearing process. This bill is presently on the Senate's inactive file.

The final message is this:

1. For chiefs of staff, negotiate with a big stick. Don't use it. Don't abuse your power.
2. For hot headed physicians, cool it. This is not your father's work environment.
3. For hospitals and the MBC, try to use neutral peers, preferably outside your precincts.

But then - who listens?

patiec@cwnet.com

Sierra Sacramento Valley Medical Society
5380 Elvas Avenue #100 • Sacramento, CA 95819
916.452.2671 PH • 916.452.2690 FX • Email: info@ssvms.org

Copyright © 2000-2008 Sierra Sacramento Valley Medical Society - All Right's Reserved