

Clinical peer review in the United States: History, legal development and subsequent abuse

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Core tip: This article will highlight progress and drawbacks of the current clinician's peer review system prevailing in the United States.

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Abstract

The Joint Commission on Accreditation requires hospitals to conduct peer review to retain accreditation. Despite the intended purpose of improving quality medical care, the peer review process has suffered several setbacks throughout its tenure. In the 1980s, abuse of peer review for personal economic interest led to a highly publicized multimillion-dollar verdict by the United States Supreme Court against the perpetrating physicians and hospital. The verdict led to decreased physician participation for fear of possible litigation. Believing that peer review was critical to quality medical care, Congress subsequently enacted the Health Care Quality Improvement Act (HCQIA) granting comprehensive legal immunity for peer reviewers to increase participation. While serving its intended goal, HCQIA has also granted peer reviewers significant immunity likely emboldening abuses resulting in Sham Peer Reviews. While legal reform of HCQIA is necessary to reduce sham peer reviews, further measures including the need for standardization of the peer review process alongside external organizational monitoring are critical to improving peer review and reducing the prevalence of sham peer reviews.

INTRODUCTION

In 1952 the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) began requiring physician peer review at all United States hospitals^[1]. However, economic abuse of the review process and a subsequent court ruling in 1986 lead many physicians to fear the possible consequences in participating in peer reviews^[2]. In order to legislatively solidify the role of peer review as a means of physician quality improvement across the United States, Congress enacted the Health Care Quality Improvement Act (HCQIA) in 1986^[2,3]. Despite its intended role of physician quality improvement, HCQIA has unintentionally led to significant abuse of the peer review system across the United States^[4]. This review focuses on the history and legal development of physician peer review in the United States, and addresses subsequent abuses resulting in what is known today as "Sham Peer Review".

What is peer review?

Peer review is the process whereby doctors evaluate the

quality of their colleagues' work in order to ensure that prevailing standards of care are being met^[5]. The process has its roots dating back to the early 20th century when the American College of Surgeons began using peer review as a means of defining minimum standard of care requirements for hospitals and their medical staff^[6,7]. Today, the majority of peer review conducted in the United States occurs exclusively through retrospective chart review *via* peer review committees. The ultimate decision making authority however often lies with the hospital board of directors, often which follows the recommendations of the review committees^[8]. The process has continued to grow in the 20th century and is now required by the JCAHO for hospital accreditation^[9].

Currently, there are three main reasons peer reviews are conducted throughout the United States. First, in order to maintain accreditation, hospitals are required to initiate peer reviews for all privileges requested for new physicians and any new requests by existing physicians for new privileges^[9,10]. Second, while initiation of peer reviews can often be triggered by substandard physician performance as required by JCAHO, physician colleague and hospital administrators can often request peer reviews of specific physicians that can be granted or denied by the hospital's peer review committee^[4,10-12]. Finally, some hospitals have used peer review to improve quality by randomly selecting cases or designing schemes looking at poor outcome cases in order to determine root causes^[8]. Nonetheless, despite being mandated by JCAHO, the manner in which peer reviews are conducted, analyzed, and utilized varies widely across institutions^[8].

History of peer review

Physician regulation was strongly opposed by both the public and physicians in the early 19th century^[10]. Despite the opposition, governmental and medical societies saw a critical need for the standardization of care in order to protect both the public and the medical profession. In turn, State Medical Licensure Boards were created in the late 19th century with an emphasis on creating peer review systems to monitor physician behavior^[10]. However, both the American Medical Association and the United States Department of Health and Human Services saw that efforts by these organizations did not meet standardized criteria for improving care and enforcing disciplinary action^[11,12]. This deficiency was attributed mainly to physician unwillingness to conduct peer reviews^[13].

To further exacerbate these concerns, disciplinary action handed down by either hospitals or State Medical Licensure committees was often circumvented by "State Hoppers", or, physicians who avoided disciplining actions by moving to another state or hospital which were not aware of their previous disciplinary action^[3,13]. In response, States developed a national data bank of disciplinary action to stop such actions. Unfortunately, the data bank was often found to be ineffective^[13].

Patrick vs Burget

The peer review process further suffered a major blow in

1986 when Dr. Timothy Patrick, a general and vascular surgeon, sued Columbia Memorial Hospital (CMH) after being unfairly subjected to a bad faith peer review for economic reasons^[14]. Upon starting practice in the small town of Astoria, Oregon, Dr. Patrick joined a group of established surgeons at the Astoria Clinic. After several years of employment Patrick was offered partnership at the clinic which he later refused in order to open his own, competing surgical practice in the same geographic area. In retaliation, Patrick's former colleagues at the Astoria Clinic reported Patrick to the hospital executive committee at CMH for peer review. The charges levied claimed that Patrick exhibited irresponsible behavior towards patient care. An executive peer review committee was formed and was chaired by Dr. Gary Boeling, a partner of the Astoria Clinic. After an investigation was conducted and subsequent false evidence concerning Patrick's care was presented, the committee voted to terminate Patrick's privileges at CMH. Fearing termination, Patrick instead chose to resign^[14].

A subsequent federal antitrust lawsuit filed by Patrick against partners of the Astoria Clinic, including Dr. William Burget, claimed that the defendants participated in a bad faith peer review in order to stifle competition. The United States Supreme court which later ruled in Patrick's favor awarded the plaintiff \$2.2 million and further disbanded the Astoria Clinic based on the clinic's violation of the Sherman Antitrust Act^[14,15].

Following the Patrick verdict many physicians became hesitant to participate in peer review activities as they feared possible involvement in future litigation. More concerning at the time was that malpractice lawsuits were at an all-time high during the same period. Viewing peer review as a critical means of decreasing the number of malpractice claims, then Rep. Ron Wyden (now Senator), brought forth legislation known as the HCQIA to expand reviewer immunity in order to encourage physician participation in the process^[16].

HCQIA and the national data bank

Five reasons were explicitly stated by congress for the enactment of HCQIA (Table 1). HCQIA consists of two parts. Part A of the law grants hospitals and reviewers immunity from litigation resulting from physicians aggrieved by the process. In order to qualify for this immunity however, congress set four minimum requirements that must be met when conducting peer reviews (Table 2)^[17]. Part B of the law tackled the issue of "state hoppers" by creating the National Practitioner Data Bank (NPDB). The NPDB was created to serve as a centralized repository given the authority to collect and release information relating to the competence and professionalism of physicians. Currently, in order to gain clinical privileges at hospitals, all practitioners are required by law to be screened through the NPDB^[18]. The NPDB receives three types of reports: adverse actions, malpractice payments, and Medicare/Medicaid exclusion reports. Table 3 further quantifies the types of reports in the NPDB. The NPDB can only be ac-

Table 1 Congressional reasons for law enactment

The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual state

There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance

This nationwide problem can be remedied through effective professional peer review

The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review

There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review

Table 2 Part A Health Care Quality Improvement Act peer review immunity requirements

Peer review action is taken:

- In the reasonable belief that the action was in furtherance of quality of care
- After a reasonable effort to obtain the facts of the matter
- After adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances
- In the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain the facts

Table 3 Causes of reports to the National Practitioner Data Bank (Satiani 2004)

Adverse actions (17%)

- Peer review findings adversely affect the clinical privileges of physicians or dentist for more than 30 d
- Privileges are restricted or surrendered while under peer review investigation for possible incompetence or improper professional conduct
- Privileges are restricted or surrendered in exchanged for peer reviewers not conducting an investigation
- Physician's or Dentists' license are revoked, suspended, or surrendered
- Physicians or Dentists are censured, reprimanded, or put on probation

Malpractice payments (82%)

- Insurers settling claims or judgments relating medical malpractice on behalf of physicians

Medicare/medicaid exclusion reports (1%)

Percentage refers to proportion of reports attributable to 132896 physicians in the National Practitioner Data Bank in 2002.

cessed by third parties directly involved in physician regulation including hospitals, state medical boards, and professional societies^[19]. Despite repeated efforts by public consumer groups to access the NPDB however, congress has kept the database confidential and closed to consumer review^[18,20].

SHAM PEER REVIEW

Sham peer review is characterized as a review called for by either a single, or group of physicians, conducted in order to lead to adverse action taken by the review committee^[21]. Prior to HCQIA, such bad faith cases could often be fought in court as in the Patrick case. However, the extraordinary levels of immunity granted to hospitals and peer reviewers under HCQIA have inhibited such successful endeavors. Currently the prevalence of such cases in the medical community is undefined due the dearth of published literature on the subject^[21,22]. As an estimate however, thirty three lawsuits were brought to United States courts claiming sham peer review between 2003-2007^[23]. Further estimates put the number of sham peer reviews occurring at upwards of 10% of cases reviewed^[24].

Legislative history of HCQIA

In the process of drafting HCQIA, the Patrick *vs* Burget

ruling was delivered by the Supreme Court and many members of congress saw further need to protect peer reviewers. However, congress was simultaneously well aware of the real potential for abuse the law had. In turn, original immunity provisions granted by the HCQIA were specifically scaled back in order to avoid misinterpretation of the law^[25]. In fact, Rep. Henry Waxman, floor manager of the bill at the time, stated that "Bad faith peer review activities permitted by the Patrick case could never obtain immunity under H.R. 5540"^[26]. Nevertheless, since its initiation in 1986, the congressionally written HCQIA has been transformed from a law granting hospitals and peer reviewers limited immunity provisions into a law that today grants nearly absolute immunity by the courts^[26].

HCQIA immunity and the courts

In one example of claimed peer review abuse, Dr. Susan Meyer, an emergency room physician at Sunrise Hospital, was required to undergo review after her treatment of Adolph Anguiano, a homeless patient who two hours after being seen by her in the ER, died in the parking lot of Sunrise Hospital^[27]. Upon entering the ER, Meyer performed a full physical exam, took vital signs, measured oxygenation levels of Mr. Anguiano and subsequently determined the patient did not require any acute medical care and later discharged the patient from the

ER. Upon discovering that Mr. Anguiano had died, Dr. Graham Wilson, Chair of the Department of Emergency Services advised Dr. Meyer to finish her shift in the ER and subsequently informed her that she was being suspended due to her substandard care. She was advised to obtain legal counsel in order to undergo a fair hearing process.

Meyer, who later lost an appeal of her case in the Nevada Supreme Court, was later informed by Dr. Rick Kilburn, the Chief Operating Officer of Sunrise Hospital, that she would be suspended regardless of the result of her peer review hearing. Despite knowing the final result beforehand, Meyer requested a formal peer review by the hospital in order to have her clinical judgment assessed by her colleagues. Despite several Emergency room physicians testifying that Meyer's treatment was "well within the standard of care", the review committee found otherwise and recommended her suspension. The recommendation was reaffirmed by the Appellate Review Committee of the hospital.

Meyer in turn filed a civil action lawsuit against Columbia Sunrise hospital alleging a breach of contract and breach of the covenant of good faith and fair dealing. The hospital, claiming immunity under HCQIA in turn succeeded in dismissing the case in district court. The case was met with the same decision at the Nevada Supreme Court. However, the Justices gave a rare glimpse into the reason for Meyer's loss and the extent of the powerful immunity granted to hospitals and peer reviewers in their concluding summary statement.

I must concur in the result reached in the majority opinion because HCQIA sets such a low threshold for granting immunity to a hospital's so-called peer review. Basically, as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, whether legitimate or not, they are immune from liability. Unfortunately, this may leave the hospitals and review board members free to abuse the process for their own purposes without regard to quality medical care.... Unfortunately, the immunity provisions of HCQIA sometimes can be used, not to improve the quality of medical care, but to leave a doctor who is unfairly treated without any viable remedy [emphasis added]^[27].

In a second, similar sham review case, Dr. Carol Bender, an internist, brought a lawsuit against the Maryland Suburban Hospital to the Maryland Special Court of Appeals for a breach of contract and early termination alongside defamation *via* the peer review process^[28]. The court ruled against Bender despite having "legitimate gripe (with the hospital)" stating that the hospital was granted immunity under HCQIA despite how "reprehensible some of [the peer reviewers] actions may have been"^[28]. In another example of *Jenkins v. Methodist Hospital of Dallas*, United States District Court of the Northern District of Texas, held that the court was troubled that a statute exist under HCQIA granting immunity to individuals that are knowingly providing false information to the courts^[29].

Characteristics of sham peer review

Two types of physicians are targeted in sham peer review. The first are often competitors to an often larger, more powerful physician group^[21,22]. The second are often outspoken critics of patient quality of care or safety issues seen as whistleblowers by hospital leadership^[21,22]. William Parmley, currently the immediate past Editor-in-Chief of the *Journal of the American College of Cardiology*, has recently characterized three sham peer review cases he has recently been presented with^[21]. The cases describe either solo practitioners or practitioners working in small groups at private hospitals. Their accusers are often large groups that appear to be moving against them using peer review in order to stifle competition. The accusers often have positions on the executive hospital board or, are deeply connected to the board. In one case, Parmley describes a situation where an external peer review committee was hired by the hospital to give a bad faith review. The result was the loss of hospital privileges for two of three physicians and in turn their forced relocation. The third physician was cleared of any wrongdoing at the expense of severe financial loss. Parmley further describes these scenarios as being "far more common than is appreciated"^[21].

NPDB reporting

Hospitals are mandated by law to query practitioner's request of clinical privileges, or admission to the medical staff and re-queries are required every 2 years for any clinician on staff^[30,31]. Moreover, hospitals are required to report any adverse actions to the NPDB (Table 3)^[31]. Sham peer reviews rely heavily on the fear of physicians being reported to the NPDB^[4]. Physicians reported to the NPDB face significant hurdles when seeking employment, licensure, and credentialing^[4]. Physicians are often questioned about all previous reports to the NPDB prior to receiving any hospital credentialing activities^[4,31]. Furthermore, HMOs and insurance carriers are increasingly using the NPDB when choosing physicians to be covered under provider panels^[4]. Single transgressions in the NPDB or loss of medical privileges can often result in further negative consequences as physicians become progressively dropped from these provider panels^[4,32].

Consequences of sham peer review

In light of the immunity granted to peer reviewers and hospitals, many physicians find themselves victims of sham peer review without any timely legal recourse. Consequently, upon seeing the signs of an impending sham peer review, wrongly accused physicians will choose one of two dire possibilities. On one hand, practically all peer reviews meet the "reasonable belief" provision of HCQIA and in turn qualify for near absolute immunity. Moreover, proving malicious intent to the courts is almost practically impossible^[23]. Despite the odds, some physicians will choose to fight sham peer reviews in court often at substantial financial and reputational cost, mental stress, and time^[27-29,33,34]. On the other hand, as previously

stated, physicians acknowledge that being reported to the NPDB can negatively affect future employment and reputation. In this situation, many physicians will often instead decide to resign from their hospitals or retract statements seen as unfavorable by hospital executives in exchange for early termination of the investigation and subsequent failure to report to the NPDB.

Hospitals are required by law to report situation in where physicians resign in the midst of a peer review investigation^[31,35]. Nevertheless, several studies have shown that there is significant evidence of hospital underreporting to the NPDB every year^[9,36-38]. Furthermore, a five year study looking at hospital reporting to the NPDB showed that 67% of hospitals did not report a single adverse event to the NPDB^[39]. Another study showed that 75% of potentially reportable actions and 60% of unquestionable reportable actions were not reported to the NPDB by their respective hospitals. While ambiguous, such significant underreporting can likely account for such an arrangement.

FUTURE DIRECTION

Evidently legal immunity is necessary to protect hospitals and physicians conducting good faith peer review as not every review of a physician is unwarranted, abusive or malicious. These peer reviews serve to protect the public and the medical profession from poorly behaved, unethical, or incompetent physicians. However, such absolute immunity under HCQIA has evidently weakened the process and lead to significant abuse. In the case of Dr. Timothy Patrick, a direct competitor was able to chair the peer review committee and was able to maliciously affect the peer review outcome in order to gain economic advantage. In order to change this paradigm, a multifaceted approach must be employed focusing on standardization, external peer reviews and finally legislative reform.

Standardization of peer review

Lack of standardization of the peer review process at the majority of hospitals leaves the door open for abuse. Today, only 62% of hospitals consider their review process to be either highly, or greatly, standardized^[9]. The variation in structure in turn leaves two variants of peer review systems in place at most hospitals. The first is a highly standardized process involving several committees, revolving peer reviewers, and finally objective measures of quality assessment. The second is an unstandardized review process that can be significantly prone to exploitation due to the complete subjective nature of such committees.

Moreover, studies have shown that peer reviews are often unreliable measures of quality and have not served their intended role in quality improvement^[6,40]. Standardization of the review process stands to benefit from both significant quality improvement and likely decreased abuse of the process to allow for sham peer reviews^[41]. However, national standardization efforts of peer review remains difficult as the process is both costly and requires signifi-

cant resources. Nevertheless, several models implemented at both large and small United States hospitals have shown that standardization and structuring of the review process can significantly improve medical care^[42-48].

External peer reviews

Recognizing the concerns peer review has placed on hospitals and physicians, recent JCAHO reforms of the Medical Staff Standards for hospitals were released in 2007. These changes require mechanisms allowing for fair hearings and appeal process in decisions adversely affecting medical staff members^[49]. However, it is unclear how much these reforms have contributed to mitigating sham peer review. Furthermore, while hospitals are required to implement such reforms, these standards still do not provide for independent peer review or oversight of the review process to ensure proper implementation. One approach to solving this issue is the creation of a second layer of protection involving external peer reviewers to verify that actions are taken in compliance with HCQIA and JCAHO requirements. Another suggested approach requires the use of Quality Improvement Organizations (QIOs) to independently review and supervise peer reviews conducted across United States hospitals. QIOs are physician operated organizations contracted by the Centers for Medicare and Medicaid Services in order to conduct reviews and further improve quality of services provided to Medicare beneficiaries in all 50 states^[50]. These QIOs are currently accustomed to dealing with quality across United States hospitals and could be primed to serve as important, external supervisors of the peer review process.

Legislative reform of HCQIA

Despite countless physician lawsuits against sham peer reviews reaching high level United States federal courts, the United States Supreme Court has continually denied to preside over such appeals in order to rule certiorari over the legality of HCQIA immunity^[51-54]. Considering the extent of immunity granted, several legal commentators have argued that these antitrust immunities should be repealed^[40,41,55,56]. Nonetheless, considering the firm position for immunity in the medical community and congress, this is unlikely. In turn, several measures can be taken to ensure peer review fairness *via* HCQIA reform rather than repeal^[23]. While these recommended reforms have been described in extensive detail elsewhere, we will provide a short overview here^[23].

First, due process requirements under HCQIA are inadequate and must be reformed in order to inhibit partial or biased reviewers from passing judgments on physicians. Second, the “reasonable belief” standard under HCQIA is virtually impossible to challenge in court and often place a significant burden on the targeted physicians to overcome. In turn, Congress or the Department of Health and Human Services needs to narrowly clarify what is meant by “reasonable belief” in order to qualify for HCQIA immunity. Third, legislation reform should

effectively mandate umbrella oversight by outside institutions in order to ensure fair, evidence-based, and appropriately motivated peer reviews are conducted^[23]. Lastly, if congressional reform unlikely, advocacy at the state level, which cannot be preempted by HCQIA, should be sought to further protection against Sham peer reviews^[26].

CONCLUSION

Peer review serves to discipline incompetent or unethical physicians in order to protect the public. Immunity granted under HCQIA serves to protect hospitals and peer reviewers from litigations from appropriately sanctioned physicians. Unfortunately, HCQIA extends these immunities to sham peer reviews. In the hypercompetitive and highly political United States medical system, this immunity has been abused and has led to the devastating destruction of many physicians careers. Considering Congressional and Judicial forbearance on this crisis, significant leadership by physicians, professional societies, and hospital administrators is needed in order to remedy the faults of peer review. Furthermore, there is considerably need to study the precise prevalence of sham peer review across the United States. Moreover, further research is needed to show if the recent JCAHO reforms have decreased the prevalence of such cases. Lastly, further research is needed in order to determine the cause of NPDB underreporting of adverse events.

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