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Editorial

Editorial in Response to "What Is Sham Peer Review?"

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There is an epidemic of sham peer review[1] sweeping the country. The pattern is hard to see because it crops up individually in the confidential setting of medical staff committees from hospital to hospital, but the incidence and severity are increasing at such alarming rates that it is undeniable that the peer-review system, originally meant to resolve quality problems in a collegial and confidential manner, is being converted into a weapon to shatter the careers of targeted physicians.

Sham peer review is characterized by Draconian discipline -- usually summarily imposed -- that is founded upon little or no basis in fact. Often, charges are based on nebulous "psychological" or personality issues -- eg, the so-called "disruptive physician." Notably, a major national hospital law firm is now featuring a seminar for medical staffs on how to distinguish "whistleblowers" from "disruptive physicians." The fact that they link advocacy for good patient care and hospital discipline in the same seminar speaks volumes.

Summary suspension or revocation of privileges is like firing an employee without notice: It is a means of intimidation through a direct threat to the doctor's livelihood. Hospital and hospital lawyers know that sham peer review can be economically devastating to the targeted physician -- both from loss of hospital admitting privileges and from the inevitable damage to the doctor's reputation. When coupled with mandated reports to the state medical licensing board and the National Practitioner Data Bank, hospital discipline -- even if it is a sham -- can ruin a physician's career and make it virtually impossible for the doctor to relocate and start again.

It is not coincidental that this sham peer review epidemic is accompanied by a resurgence of economic credentialing (the use of selection criteria for medical staff membership related to the hospital's financial well-being rather than to the physician's qualifications), so-called conflict of interest policies (guidelines to limit competition from doctors), and codes of conduct (which create an entire set of rules for physicians enforced by hospital administrators, not the medical staff). Medical staff leaders are being bundled up and shipped off to retreats at fancy resorts to hear hospital lawyers such as Horty Springer & Mattern and consultants such as the Greeley Company espouse these policies that are unmistakably designed to advance the strategic objectives of hospitals.

Since 1990, the hospital industry has had a strategic plan to control doctors. That is why, in the 1990s, there was a boom in hospital purchases of physician practices, and the creation of physician hospital organizations, management services organizations, etc, in the 1990s. By and large, those strategies did not work, so hospitals have shifted their attention to the credentialing and peer-review processes as ways to deny doctors access to the hospital and thereby control physicians.

The objective of sham peer review, economic credentialing, and the hospital industry's attack on the medical staff is to control physicians so hospitals can vertically control health delivery in their market area. In most markets across the country, hospitals enjoy monopoly or monopsony power, so if hospitals achieve vertical control over physicians, they are able to control not only the local economics of healthcare but, ultimately, the quality of care in the area. The threats to the medical profession and to patient care are real and obvious.

Compounding the problem of sham peer review is sham due process, in which hospital lawyers -- who usually control sham peer-review proceedings -- afford the targeted physicians little or no meaningful rights to exonerate themselves. Sham peer review and sham due process are made possible by medical staff bylaws, which for the most part are written by lawyers selected and paid for by the hospital. Not surprisingly, these hospital lawyers create bylaws that protect the hospital's interests, not the interests of the medical staff or individual physicians. In voting on medical staff bylaws, most physicians are either naive or apathetic, thinking, "Peer review only happens to bad doctors; it'll never happen to me." Experience shows, however, that it is often good, strong doctors who are targeted by sham peer review. No physician is immune from attack. So, when reviewing bylaws, every physician should think, "There but for the grace of God go I."

In these complex times, it is essential that medical staffs hire and pay for their own pro-physician legal counsel and stop relying on hospital-furnished attorneys who, not surprisingly, protect the interests of hospitals over the interests of medical staffs and individual physicians. The American Medical Association and state medical societies have advised medical staffs for over 20 years to hire their own counsel. The common excuse offered by medical staffs for not hiring independent counsel is that they cannot afford it. They *can*.

Indeed, to fight back against the hospital industry's anti-physician offensive, physicians must reinvigorate and reinvent their medical staff to make the medical staff a separate, independent, self-sustaining entity. To create a separate legal identity, the obvious path for the medical staff is to incorporate. This new, separate corporation may, in turn, enter into a services contract with the hospital to perform medical staff duties. The only difference is that, instead of volunteering all that time for the hospital, the medical staff will charge for its services. Indeed, such hospital/medical staff services contracts seem to be required by Stark II regulations.

The revenue stream from the medical staff/hospital contract would provide more than ample funds to operate an independent pro-physician medical staff; the medical staff could then disburse stipends to its leaders and volunteers (instead of being directed by the hospital administrator) and replace the hospital-paid lawyers who are orchestrating the national campaign of sham peer review. This will not increase hospital costs, since medical staff stipends and lawyers' fees are already budgeted and expended each year. It will simply put the medical staff in control of those expenditures and, ultimately, in control of their own destiny.

Physicians must view the threat of sham peer review as ominous and real, and act to put an end to it. At stake is nothing less than the future of the profession and the well-being of patients throughout America.

References

1. Roland C Jr. So what is a sham peer review? Medscape General Medicine. 2005;7(4). Available at: http://medgenmed.medscape.com/viewarticle/515862. Accessed November 15, 2005.

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