

Editorial

# The Unintended Consequences of Peer Review Immunity

Robert Poston<sup>1</sup>; Farid Gharagozloo<sup>2</sup>; Rainer WG Gruessner<sup>3\*</sup>

<sup>1</sup>Attending Surgeon, Mercy Lourdes Hospital, Paducah, KY 42003, USA.

<sup>2</sup>Professor and Surgeon-in-Chief, Institute for Advanced Thoracic Surgery, University of Central Florida College of Medicine, Orlando, FL 32827, USA.

<sup>3</sup>Professor of Surgery, State University of New York (SUNY), Brooklyn, NY 11203, USA

\*Corresponding Author: **Rainer WG Gruessner**

Professor of Surgery, SUNY Downstate, USA.

Email: Rainer.Gruessner@downstate.edu

## Article Info

Received: Jan 25, 2023

Accepted: Feb 15, 2023

Published: Feb 22, 2023

Archived: www.jclinmedsurgery.com

Copyright: © Rainer WGG (2023).

## Editorial

One of the most important responsibilities of hospital administrators is to assure the quality of the medical care they provide. A key pillar of quality assurance has been the use of a committee of local peers to determine professional physician competence. On occasion, adverse events happen in which clinician incompetence or disruptive behavior is found to have played a major contributing role. The peer review committee holds the deficient physician accountable and the hospital uses their authority to impose swift corrective action including remedial education, proctoring or the restriction or revocation of hospital privileges.

It is a drastic step to deprive a physician of their right to maintain hospital privileges. Many peer review committees are reluctant to act in such a severe way. Their priority is 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. Committees recognize it is "cruel and unusual" to revoke a physician's hospital privileges when less severe action might be effective and when other factors are often more important contributors to patient harm such as chronically unsafe systems of care.

The premise of the Healthcare Quality Improvement Act of 1986 (HCQIA) is that any reluctance to revoke privileges is due to physician's fear of retaliatory litigation. This was likely true forty years ago, when hospitals and their committees were staffed by independent physicians who directly competed in private practice. Negative comments about a peer could justify anti-trust

litigation, thereby chilling a physician's desire to speak up about clinical concerns. Based on report of low-quality physicians being ignored, Congress passed a law that provided qualified immunity to peer reviewers willing to speak up. Immunity blocks liability claims and makes it difficult for an aggrieved physician to file a lawsuit by keeping evidence privileged from discovery.

The main downside of legal immunity is that - without accountability - abuse of power is inevitable. But, evidence of abuse by hospitals remains elusive; all peer review proceedings remain privileged and confidential. As a result, only 15% of physician plaintiffs are successful at rebutting the presumption of hospital immunity.

The unintended consequences of immunity illustrate a rule of systems thinking: today's problems come from yesterday's solutions. HCQIA was designed to limit anti-trust lawsuits which are less of a concern in the modern era of corporate medicine. Over the last four decades, physicians abandoned independent practice and became employed by hospital corporations. Peer reviewers and the medical staff they evaluate are now both employees and no longer in direct competition. The contractual terms they are governed by often explicitly require peer reviewers to make decisions that comport with expectations, metrics and targets of a profit driven healthcare system. Based purely on business or political motives, hospital administrators may want to remove a physician considered to be "difficult", "outspoken" or "inconvenient". Their status as an employer empowers them to concoct a "sham" peer review to terminate the physician while shielded by immunity. Moreover, there is often little agreement about how to define clinical competency or disruptiveness, so the peer review committee's subjective judg-

**Citation:** Poston R, Gharagozloo F, Gruessner RWG. The Unintended Consequences of Peer Review Immunity. 2023; 3(1): 1076.

ments are open to undue influence by their employers. While the original intent of immunity was to protect the judgments of physician peer reviewers, it has been coopted to protect decisions of the hospital.

Abuse of immunity also damages the culture of safety. Advocates of immunity accept a risk of false accusations against high quality physicians based on the presumption that ignoring a poor performing physician is the more significant hazard. This tradeoff fails to recognize these two (in)actions as different sides of the same coin. Either false actions or failure to act signal a peer review committee entangled in poorly conducted investigations untethered from the truth. Flawed investigations signal an organization unable to learn the proper lessons from adverse clinical events, putting patients at risk from repeated clinical mistakes.

Hospitals argue that using immunity to block frivolous lawsuits from disgruntled physicians empowers the quick removal of a “bad apple”. Without immunity, hospitals would be saddled with the administrative burdens of litigating with disgruntled physicians and peer participation in this performance review would be chilled. This argument assumes that aggrieved physicians were provided due process, which is often not correct. A comprehensive review of peer review in California found the process to be plagued by inconsistencies, variations, and conflicts of interest (x2). Privileges are revoked sporadically in some hospitals and not others. Immunity prevents oversight of a notoriously random and inconsistent process responsible for harming physician careers, patient lives and ultimately public health. No social policy is advanced by denying the courts oversight, particularly when corruption is alleged. Even without immunity, a variety of legal safeguards remain to block frivolous lawsuits. Physicians are required to exhaust available administrative remedies prior to turning to the courts. Lawsuits without merit are discouraged by awarding attorney’s fees to the winning party and by levying sanctions against the lawyer who files such a suit.

Moreover, the main reason physicians are reluctant to participate in peer review committees is not from fear of lawsuits, but from lack of trust in the process, specifically if physicians realize that their peer is falsely accused and ulterior administrative motives are involved. Physicians always know when a peer is falsely accused. Their widespread unwillingness to participate serves as a signal of how common this problem is.

Now reimagine a future without immunity. Aggrieved physicians might file more lawsuits, at least initially, but can expect to have no greater chance of success. Courts will still give hospitals the presumption of good faith and defer to their judgment about professional competency, as they have when ruling against injunctions and other declarative relief where immunity has never applied. However, the threat of lawsuits makes the physician-hospital balance of power more symmetric, forcing mutual accountability to each other’s long-term interests. Game theory suggests this steers even the most self-interested parties towards reconciliation and improvement, rather than punishment [5]. Hospital lawyers know that an unfair process cloaked in secrecy is a recipe for retaliatory lawsuits and strive to avoid that by making greater use of external reviewers and

expert counsel for more objective investigations and thorough due process. The discovery process of a lawsuit provides accused physicians with better and more transparent understanding of the evidence against them. Those falling below accepted standards will see that evidence and make better decisions about their future. Those wrongly accused will use the courts to speak up about potential problems with the hospital’s process of investigation, ultimately providing feedback invaluable for the quality and credibility of peer review. For the first time, peer reviewers will need indemnification, but the cost of that insurance will fall over time as physicians perceive the peer review system as being 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 that are needed to create a safe culture.

Incompetence and disruptiveness can exist within either clinicians or peer review committees. Poor performance and poor evaluation of performance are both serious impediments to a safe culture. Hospitals can begin the journey towards a sustainable safety culture by making the first move: voluntarily forgo legal immunity. 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.

## References

1. Skarlicki DP, Folger R. Retaliation in the workplace: The roles of distributive, procedural, and interactional justice. *Journal of Applied Psychology*. 1997; 82: 434.
2. Au HD, Kim DI, Garrison RC, Yu M, Thompson G, et al. Redesigning Hospital-Wide Peer Review Processes to Identify System Errors. *Cureus*. 2020; 12: e8466.
3. Fitzpatrick K, Gregg v. Georgia (1976). *The Encyclopedia of Civil Liberties in America*, 2015; 427.
4. Seago JA, Benroth R, McDougall MB, Fernandez M, Giberson A, et al. Comprehensive study of peer review in California. 2008.
5. Picker RC. *An introduction to game theory and the law*. 1994.
6. Shaw JC, Wild E, Colquitt JA. To justify or excuse?: A meta-analytic review of the effects of explanations. *Journal of Applied Psychology*. 2003; 88: 444.
7. Kohatsu ND, Gould D, Ross LK, Fox PJ. Characteristics Associated with Physician Discipline: A Case-Control Study. *Arch Intern Med*. 2004; 164: 653-658.
8. AHRQ. Hospital Survey on Patient Safety Culture: “2021 User Comparative Database Report.” Agency for Healthcare Research and Quality. 2021.
9. Picker RC. *An introduction to game theory and the law*. 1994.
10. Van Tassel K. Hospital peer review standards and due process: moving from tort doctrine toward contract principles based on clinical practice guidelines. *Seton Hall L. Rev*. 2005; 36: 1179.