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EDITORIAL

Consequences for Whistleblowing: Retaliation, Sham Peer Review and Hospital Immunity

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When medical professionals, usually physicians, report poor patient care or incidents in which patients have been harmed, such reports are sometimes not welcomed by hospital leadership. This issue becomes even more problematic if no action is taken internally to ameliorate patient conditions and the practitioner then decides to seek external assistance (courts, media) in the best interest of the patients' wellbeing.

"A whistleblower is defined as a person who raises concern about wrongdoing" [1]. In healthcare, this includes, but is not limited to, reports ranging from a single catastrophic ('sentinel') event over poor clinical outcomes to systemic failures. For example, some hospitals are notorious for having chronically unsafe systems in place. These are often incorrectly attributed to substandard physician care when, in fact, a system-related error was likely the more significant cause. Unfortunately, whistleblowers that make their patient concerns public are frequently ostracized, pressured to drop allegations, and threatened with counter allegations [2]. Rhodes and Strain found that institutions such as hospitals systematically ignore serious ethical problems, transform whistleblowers into institutional enemies and punish them, and fail to provide an ethical environment [2].

The U.S. Department of Health and Human Services (HHS) recognizes that "whistleblower disclosures...save lives. They...root out waste, fraud, and abuse and protect public health and safety. Federal laws strongly encourage employees to disclose wrongdoing" [3]. While federal laws for protection of federal whistleblowers exist, there is much less legal conformity at the state and local level.

Federal laws also protect federal whistleblowers from retaliation. The Whistleblower Protection Enhancement Act of 2012 prohibits "on retaliation for whistleblowing, as well as employees' rights and remedies if anyone retaliates against them for making a protected disclosure (i.e., 'whistleblowing')" [3]. The Occupational Safety and Health Administration (OSHA) Directorate of Whistleblower Protection Programs enforces the provisions of more than 20 federal laws protecting employees from retaliation [4]. However, the healthcare Whistleblower Protection

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Act appears to focus more on healthcare fraud under the False Claims Act and violations of the Stark Law or Anti-Kickback Statute than patient safety issues.

In the hospital setting, whistleblowing centers frequently on unsafe or negligent patient care, failure to properly safeguard patients, violations of the Health Insurance Portability and Accountability Act (HIPPA) and unsafe working conditions. If such ethical issues that place patients' lives at harm are not taken seriously by hospital leadership, the whistleblower may even be deemed 'inconvenient' and 'detrimental' to the organization. One way to punish whistleblowing practitioners and to retaliate against them is to produce counter allegations trough the Medical Executive Committee (MEC) and the Peer Review Process.

A just, equitable and credible peer review process is important to all stakeholders and aspects in healthcare. But the peer review process goes wrong when it levies false accusations against high quality practitioners, specifically when administration considers the physician to be difficult due to whistleblowing and imposes harsh punishments through 'sham peer review'. The American College of Emergency Physicians (ACEP) defines "sham peer review or malicious peer review…as the abuse of a medical peer review process to attack a doctor for personal or other non-medical reasons" [5]. In those instances, contrived allegations of incompetent or disruptive behavior and concocted 'sham' peer review are not only retaliatory acts against whistleblowing by hospital administration to elegantly terminate employment but they are also a career threatening process for the affected physician. Any adverse privilege action is reported to the National Practitioner Databank (NPDB), which makes it very difficult for the physician to get privileges at any other hospital [6]. Regardless of being adjudicated by a state licensing board, hospitals don't have to remove their adverse action from the NPDB on the practitioner [7].

Hospital retaliation for whistleblowing may come from different sides. First, MEC and peer review committee members are no longer independent. Members are typically hospital-employed physicians that have signed an agreement to make decisions (including those about peer review) that comport with expectations, metrics, and targets of the hospital leadership. Hospitals shy away from a true and fair peer review by mutually agreed-upon national experts because they do not necessarily align with the goals of hospital administration. And a whistleblower is usually deemed harmful to the institution despite his/her legitimate ethical and moral concerns and allegations. Hence, the judgments of hospital-appointed members are at significant risk of being biased by personal or professional ties and administrative expectations. These unfair issues add up to investigations that are often incompetently performed with tremendous adverse consequences to the whistleblowing practitioner.

Second, MEC members may accept the political or strategic goals of a Chief Executive Officer (CEO) to label the whistleblower as incompetent or disruptive in an effort to exploit sham peer review for the hospital administration's purposes. However, as ACEP recognizes, the accusation of 'disruptive behavior' can be "easily manipulated to include a physician who properly defends patient care, exercises his/her right of free speech on political matters, seeks to improve various clinical practices, or who properly demands adherence to excellence." [5] Likewise, 'incompetence' of the whistleblower can be misconstrued and requires external (rather than the typically hospital-based) review. Through sham peer review, the whistleblower is now no longer the victim, but the wrongdoer and tortfeasor.

Our group has previously reported in detail on the ill-fated connection between whistleblowing and retaliation through sham peer review [8-11]. Medical societies increasingly report and provide information on this topic as well. A 2007 American Medical Association (AMA) investigation of medical peer review concluded that at least 15% of surveyed physicians were aware of peer review misuse or abuse [5,12].

The exact frequency of sham peer review is uncertain but according to NPDB records, hospital disciplinary actions including perceived sham peer review average 2.5 per year per hospital. This number does not include the rate of false allegations made against physicians in order to coerce settlements without a NPDB report, which putatively occurs at a rate that is at least 4 times higher [5]. This correlates with a 5-figure number in the 20-60,000 case range and it is so common that it has an impact on the growing epidemic of resignations, burnout, and poor morale of hospital physicians.

Physicians who fight perceived sham peer review are dealing with one huge obstacle: the Health Care

Quality Improvement Act (HCQIA) of 1986. The intent of HCQIA was to encourage self-policing by the medical profession by protecting physicians who participate as members of peer review committees, or as witnesses in such proceedings, from retaliatory lawsuits. As a result, the immunity protection provided by HCQIA is broad and only requires adherence to 'fundamental fairness' for the process to satisfy the Act.

In order for a whistleblowing physician to challenge peer review, Congress adopted the 'preponderance of evidence' standard for the peer review proceedings. This shifts the burden of proof unilaterally to the physician and makes the physician demonstrate preponderance of the evidence.

Thus, a CEO who selects the route to terminate a wrongfully accused 'disruptive' or 'incompetent' whistleblowing physician becomes immune under HCQIA from any lawsuits by merely labeling those actions 'peer review'. While the original intent of immunity was to protect the judgments of physician reviewers about the medical competency of their peers, it has now been also coopted to protect political decisions such as in terminating whistleblowing or difficult physicians. In essence, "HCQIA has (unintentionally) provided a shield of nearly absolute immunity for bad faith, malicious peer reviewers. Absolute immunity, like absolute power, corrupts absolutely" [13]. HCQIA immunity must now be considered an unfair and discriminatory advantage as it allows hospitals to coopt it as a powerful tool to punish physicians and advance their goals.

Thankfully, immunity under HCQIA has been successfully challenged in court. "In 2006, the Michigan Supreme Court ruled that the Michigan immunity statute does not protect the peer review entity if it acts with malice, specifically meaning that the committee acted with a reckless disregard of the truth." And the State of California allows "aggrieved physicians the opportunity to prove that the peer review to which they were subject was in fact carried out for improper purposes, i.e., for purposes unrelated to assuring quality care or patient safety" [5,12]. A physician may decide not to fight in court the adverse outcome of a sham peer review primarily for financial reasons and lack of appropriate insurance coverage. Both scenarios are festering a system of injustice.

The remedy for an accused physician facing grave professional consequences as the result of whistleblowing and subsequent retaliation is to file a lawsuit against perceived sham peer review. Hence, wrongfully accused physicians have started "filing complaints with professional boards against the perpetrators of sham peer review for professional misconduct" [13].

A physician is most likely to succeed in court when there is evidence that the procedure that was used in the investigation and decision-making process was in retaliation and/or fundamentally flawed. A first step to regain trust is for hospitals to voluntarily forgo their legal immunity against lawsuits by an accused physician with a legitimate claim that peer review was corrupt. "Immunity should be taken away or at least modified to deter any bad-faith use of the law" [7].

Courts of law are important game changers for the problem of sham peer review for retaliation due to whistleblowing. Yet many affected physicians still do not take legal action, primarily for financial reasons. Suing a hospital is expensive, time-consuming and requires mental resolve. This scenario highlights the need for an insurance product that provides a complete defense against wrongful hospital allegations of incompetent or disruptive behavior secondary to whistleblowing. Such an insurance product is currently not available but needs to be created. The time has come for hospitals to accept whistleblowing as an ethical process to improve the quality of patient care, to not engage in retaliatory actions against whistleblowing practitioners, to make peer review in case of counter allegations truly objective and fair without the cover of immunity, and for physicians to introduce a defense insurance system that, if necessary, fights retaliation and sham peer review with their career-threatening consequences.

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