

How to Protect Physician Whistleblower—Patient Advocates—From Retaliation to Benefit Patients: A Legal Analysis Regarding Summary Suspension, Retaliation, Peer Review and Remedies

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Public safety provides new statutory protections for whistleblowers: Legislation enacted in order to address medical error and failures of hospital quality systems has paradoxically created mechanisms that are used to silence physicians and other caregivers who seek to protect patient safety by reporting breaches of professional quality and integrity. The laws enacted to protect patients can be and are currently misused to silence whistleblowers through punitive legal proceedings against patient safety advocates. Summary suspensions, deprivation of due process, and transfer of adjudicative authority to the hands of the institutions that most require oversight undermines transparency and patient advocacy. A modest set of statutory amendments, prophylactic and remedial, especially to prevent premature reporting of summary suspensions, can counteract these inequities and rebalance the House of Medicine so as to protect both patients and those who would seek to ensure their safety, so it may do no harm.

Keywords: patient safety, preventable adverse events, due process, sham peer review, retaliation against whistleblower, NPDB blacklisting, Health Care Quality Improvement Act, healthcare cost

Introduction—The Overriding Public Interest in Saving Lives¹

More than half a million people have died in a recent three year period as a result of medical error and complications in the United States (Health Grades, Inc., 2004, p. 1). According to James, John T. PhD², 400,000 patients die every year in US hospitals from preventable adverse events. Professor Martin A Makary & Michael Daniel³ determined that *Medical error is the third leading cause of death in the US*. The World Health

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¹ We are grateful to Dr. Nick Yaqub MD, JD, for valuable insight and analysis but the views expressed herein are not necessarily his. See: “Yaqub v. Salinas Valley Memorial Healthcare System” (2004) 122 Cal. App. 4th 474, 18 Cal. Rptr. 3d 780; “Mileikowsky v. West Hills Hospital. Medical Center” (2009) 45 Cal.4th 1259, 91 Cal.Rptr.3d 516, <http://www.allianceforpatientsafety.org/westhills/>

² James, John T. PhD - A New, Evidence-based Estimate of Patient Harms Associated with Hospital Care
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https://journals.lww.com/journalpatientsafety/Fulltext/2013/09000/A_New_Evidence_based_Estimate_of_Patient_Harms.2.aspx

³ Professor Martin A Makary & Michael Daniel, Medical error—the third leading cause of death in the US, BMJ 2016; 353 doi: <https://doi.org/10.1136/bmj.i2139> (Published 03 May 2016) Cite this as: BMJ 2016;353:i2139. <https://www.bmj.com/content/353/bmj.i2139.full>

Organization (WHO) and others say that American health care ranks low among the nations—third-world care at twice the cost, in effect. The Rand Corporation finds: “all adults...are at risk for receiving poor health care, no matter where they live; why, where and from whom they seek care; or what their race, gender or financial status is” (Rand Corporation, 2006, p. 1). It is, however, unlikely that the situation will improve by itself. Physicians who try to diminish patient risk and improve patient care and safety are often targeted for retaliation. The integrity of the House of Medicine is thus at risk, as is health care itself. The following proposals to counter, limit, and deter retaliation will decrease overall costs.⁴

It is a paradox of modern American medicine that patients do not get what is paid for, quality care. The Health Care Quality Improvement Act⁵ and substituted state legislation have failed to protect patients and prejudices their safety.

The Problem: Patient Safety Advocacy Risks Immediate Professional Destruction

“A lie can travel halfway round the world while the truth is putting on its shoes”, said Mark Twain. Physicians who speak out can suffer the irreversible defamation of a public report of accusation alone, in the context of hospital discipline of physicians. These physicians may or may not have done anything wrong, and may well have simply done too many things right for the comfort of some. Protecting physician patient-safety advocates from retaliatory discipline is essential to improve the quality of delivery of care.⁶ Physicians who advocate for patients’ safety must be protected from institutional retaliation, for the sake of the patients as well as the physicians. As Harvard Professor Alan Dershowitz stated: “Physicians who are entrusted with the care of their patients can see their professional careers destroyed if they dare to challenge a hospital’s practices. When a ‘whistleblowing’ physician is retaliated against, it threatens not only the physician’s livelihood, but the care of all patients. This ... affects every patient and potential patient in America” (2005).⁷ The chilling effect on physicians resurrects the old Code of Silence that formerly frustrated so many meritorious medical malpractice cases.

Unfortunately for patients, the old proverb “the way to Hell is paved with good intentions” applies. This is so because the presumably good intentions behind laws regulating medical practice have been defeated by conflicting economic interests. According to extensive research by Harvard’s Professor Lucian Leape, it is not in any hospital’s best economic interest to reduce errors and complications. He notes that there are no warranties in medical care and he reports “...*perversely, under most forms of payment, healthcare professionals receive a premium for defective products, physicians and hospitals can bill for the additional*

⁴ See the diagrams in the appendix on the economic impact of lack of patient safety.

⁵ 42 U.S.C. §11101 *et seq.*, the Health Care Quality Improvement Act of 1986 (HCQIA) as amended; 45 C.F.R. §60.1 *et seq.* (2003).

⁶ Many physicians have reportedly suffered such retaliation. See <http://www.allianceforpatientsafety.org/retaliation.php> for specifics. One type of retaliation follows assistance to a patient suing for malpractice. A paradigm case, now forty years old, is “Rosner v. Eden Township Hospital District”, 58 Cal. 2d 592, 375 P. 2d 431, 25 Cal. Rptr. 551, 599 (1962): “Dr. Rosner opposed election to the board of directors of a slate of candidates endorsed by members of the medical staff and...he has apparently testified for plaintiffs in malpractice cases”. The common law has long provided witness immunity, perjury excepted, but that salutary doctrine has eluded the prosecutors of physician discipline and peer review. A set of suggested revisions by the California Medical Association to pending bills in the California legislature (e.g., AB 632), could protect physicians who testify as patient advocates. It is such testimony that often provokes retaliation, which is ironic because such testimony is public participation in official proceedings. A communication to a hospital or medical staff about a practitioner enjoys a qualified immunity: “Hassan v. Mercy American River Hospital” (2003) 31 Cal. 4th 709.

⁷ From a 2005 statement by Prof. Dershowitz’s office, reported by the Association of American Physicians and Surgeons, <http://www.aapsonline.org/press/nr-12-20-2005.php>.

services that are needed when patients are injured by their mistakes” (Leape & Berwick, 2005, p 2388). Inasmuch as hospitals profit from high-cost, high-complication bad medicine they have every incentive to encourage it, making more than enough money to pay premiums for malpractice insurance, at most a nuisance. Persistent bad medicine is encouraged all the more by retaliation against those who oppose it, especially because of effective good faith peer review that reduces errors and complications would diminish hospital revenues.⁸ In the present environment, dollar signs trump patients’ vital signs. “Retaliation” is wrongful in many ways, on many levels and on various legal grounds, including its violation of Equal Protection of the Laws and of Due Process of Law. As one model of public protection by way of proscription of retaliation, the California Business and Professions Code protects physicians against retaliation with respect to insurance companies, and medical groups.⁹ This does not yet apply to hospitals that suspend or revoke privileges of physicians who are not employees.¹⁰ It is both ironic and unjust that the members of the learned professions of medicine, who enjoy mere “privileges” at hospitals, have less protection as patient advocates than any employee including orderlies and night custodial staff, as valuable and necessary as their labors may be. A summary suspension of a physician from practice in a hospital is just that: Summary, without any process at all in which the physician can participate.¹¹ A registered report of a summary suspension of a physician ends that physician’s career. The physician is condemned before any hearing is even initiated. This is professional capital punishment before trial.¹²

Once a hospital reports a physician’s summary suspension to a state medical board or agency, it creates an avalanche effect and a mandatory report to the National Practitioner Data Bank (NPDB) ends that physician’s career. Other hospitals will then deny that physician’s clinical privileges as well, followed by suspension of

⁸ See appendix of simplified diagrams; further research is suggested to advance the policy goal of effective and never retaliatory peer review to promote better patient care. The background inference is: Ineffective physician peer review promotes bad medical care by immunizing it from remedy, and frustrates good medical care by hampering better medical practices and punishing physicians who advocate better patient care.

⁹ This statute applies not just to insurance companies, but to anyone with the power to penalize a physician and the legal capacity to conspire to do so: “*Khajavi v. Feather River Anesthesia Medical Group*” (2000) 84 Cal. App. 4th 32, 100 Cal. Rptr. 2d 627. See, e.g., California Business and Professions Code §2056 subdivision (c): “The application and rendering by any person of a decision to terminate an employment or other contractual relationship with, or otherwise penalize, a physician and surgeon principally for advocating for medically appropriate health care...violates the public policy of this state. No person shall terminate, retaliate against, or otherwise penalize a physician and surgeon for that advocacy, nor shall any person prohibit, restrict, or in any way discourage a physician and surgeon from communicating to a patient information in furtherance of medically appropriate health care”. See B. & P. C. §510 to the same effect. An enacted and signed 2007 amendment (A. B. 632) to Health and Safety Code §1278.5 enlarges the retaliation protections to cover physicians with privileges.

¹⁰ Hospitals often employ some specialized physicians, and related organizations (in California often denominated “foundations”) may employ “hospitalist” physicians, but most physicians admitting patients into hospitals are not employees. According to hospital industry lawyers protections are available to employees only, a view now vitiated by Health and Safety Code §1278.5.

¹¹ And when a physician can participate, California law permits the hospital by-laws to deny legal representation in the proceedings. The then California governor vetoed the predecessor California statute (SB 2565) in part because it “would mandate legal representation” (veto letter September 30, 1988). Accused felons have more rights in this regard: “*Gideon v. Wainwright*” (1963) 372 U.S. 375, and Anthony Lewis, *Gideon’s Trumpet* (Random House, 1964). Hearing officers are, however, healthcare lawyers, and lawyers and doctors think differently, leading to challenges for unrepresented physicians. See Martin J. Stillman (2003), MD, JD, “A Difference of Degree”, *Journal of the American Medical Association (JAMA)*, 290(9), 1135-1136: “The way each [professional education] shapes one’s thinking and approach to problem solving helps to account for a principal difference in how physicians and lawyers deal with their working environment. Specifically, physicians find comfort in a world of definites, while lawyers feel at ease with indefinites”. See also: Anon, Lawyerly Comments: “We [physicians] dislike the adversarial system because we have no data to convince us that it results in truth finding. Our entire orientation focuses on truth finding. This cultural chasm likely cannot be crossed. Our training emphasizes the difference. Our subcultures make us distrust the other side...” <http://medrants.com/archives/2005/03/18/lawyerly-comments/>.

¹² “‘No, no!’ said the Queen. ‘Sentence first—verdict afterwards’”. Lewis Carroll, *Alice’s Adventures in Wonderland* (1865) ch. XII, Alice’s Evidence, cited and quoted in “*People v. Casillas*” (2001) 92 Cal. App. 4th 171, 111 Cal. Rptr. 2d 651, 658.

medical liability insurance coverage and preclusion of participation with medical insurance providers. Moreover, there is no penalty for a false report and no private judicial redress available, unlike for example a private libel. Making the problem worse, there is no administrative remedy for a state Medical Board's continuing to post an accusation which that Board has itself found to be unfounded.

"In contrast to blacklisting sexual predators, when physicians are blacklisted¹³ by the federal government, they have not been provided with a procedurally safeguarded opportunity to contest the accuracy of the facts included in the reports that are filed with, and then disseminated by, the NPDB.... The same comparison can be made with regard to suspected gang members and terrorists as well as to no-fly lists..." Prof Katharine A. Van Tassel (page 2040 - 2041)

The goal to be achieved, immediately lest it become meaningless, is "name-clearing" of the physician advocate, besmirched and tainted by suspension or worse. This is a matter of substantive and not procedural due process of law. Unless a physician can prevent the professional libel of a public report of the summary suspension, other remedies for retaliation are for all practical purposes moot, too late and ineffective. "Substantive" due process in economic matters is much disfavored since about 1905. On the other hand, protection of many constitutional rights other than property rights amounts to substantive due process in disguise.

The notion of a substantive right to protect one's good name is implemented by the procedure of a "name-clearing hearing". It is well established in a leading California case that a professional has a liberty interest in his professional reputation (name) that is distinct and separate from property interest in his medical license.¹⁴

The California Supreme Court ruled with respect to the California Constitution:

It is clear that the due process clause of article I, section 7(a) is self-executing, and that even without any effectuating legislation, all branches of government are required to comply with its terms. Furthermore, it also is clear that, like many other constitutional provisions, this section supports an action, brought by a private plaintiff against a proper defendant, for declaratory relief or for injunction....¹⁵ (1996, pp. 416-418)

One's good name is a liberty interest and substantive interest, and the law protects liberty interests more than property interests.¹⁶

In this case, a professor of medicine at a University of California medical school and Chair of its Department of Radiology was investigated for alleged misappropriation of funds. At the conclusion of investigation the University announced that it initiated "appropriate personnel actions", but did not name any specific employee. The professor was then removed as the Chair, but remained tenured at the medical school and a staff physician at its medical center. The California Supreme Court held that

¹³ Blacklisted: The Constitutionality of the Federal System for Publishing Reports of "Bad" Doctors in the National Practitioner Data Bank by Katharine A. Van Tassel, *Cardozo Law Review* Vol. 33:5. 2031, 2096 (2012). <https://commons.cu-portland.edu/cgi/viewcontent.cgi?referer=https://www.google.com/&httpsredir=1&article=1091&context=lawfaculty>.

¹⁴ "Katzberg v. Regents of University of California" (2002) 29 Cal. 4th 300, 305 (application of the California Due Process Clause, mandamus relief available under Code of Civil Procedure §1085 but not money damages) (Katzberg); "Gray v. Superior Court" (2005) 125 Cal. App. 4th 629, 637 (Gray).

¹⁵ The court here cites: "Skelly v. State Personnel Board" (1975) 15 Cal. 3d 194 [124 Cal. Rptr. 14, 539 P. 2d 774—holding that the Due Process Clause controls physician termination (Civil Service)]; Friesen, *State Constitutional Law: Litigating Individual Rights, Claims, and Defenses* (2d ed. 1996) 7-5(a), pp. 416-418 ("Katzberg", 29 Cal. 4th at 3007).

¹⁶ "Santa Monica Beach, Ltd. v. Super. Ct." (1999) 19 Cal. 4th 952, 973 fn.4; "Brown v. Los Angeles County" (2002) 102 Cal. App. 4th 155, 169.

[a]lthough the department chairmanship was an at-will position, terminable without cause at the discretion of the chancellor of the ... campus (and hence plaintiff concedes that he had no due process property right to that position), it is well established that an at-will [public] employee's liberty interests are deprived when his discharge is accompanied by charges that might seriously damage his standing and associations in his community or impose on him a stigma or other disability that foreclose[s] his freedom to take advantage of other employment opportunities.¹⁷ (p. 305)

To establish the right to a name-clearing hearing a petitioner "...must first establish that the due process clause applies by showing a protected liberty or property interest" (p. 637).¹⁸ A liberty interest is shown if "the accuracy of the charge is contested, there is some public disclosure of the charge, and it is made in connection with the [petitioner]". Thus, the liberty interest a physician has in his or her good name justifies an immediate opportunity for at least a temporary restraining order, followed by injunctive relief, against at least registration or publication of a summary or otherwise unadjudicated suspension.

The Law Today Favors Bad Medicine

Once a hospital hearing to test a summary suspension commences, the administrative process controls the suspended physician. Due to the "doctrine of exhaustion of administrative remedies" no court will intervene to prevent administrative dissemination of the defamation of the report of the summary suspension, even though there has been no adverse finding or adjudication. "Exhaustion of administrative remedies" usually means exhaustion of physician resources, in litigation and its antecedents, especially inasmuch as the physician cannot (on interim suspension) practice medicine.

Furthermore, due to the abuse by hospitals of that doctrine, hospitals can prolong that administrative process with many delays, e.g., by an ostensibly favorable ruling of the hospital's appeal board granting yet another, new "hearing" to the still suspended physician.¹⁹ That is a most effective strategy, at worst malicious prosecution, at best "good intentions gone awry", to exhaust the physician as an adversary emotionally, financially, and physically. Hence, the hospital wins by attrition before any litigation is even possible. In the end, the physician's "exhaustion of administrative remedies" may be futile.²⁰ It all too often ends up with a final blow by the governing board of the hospital (even if members of that board may believe that this physician is innocent). This so, because a ruling by the governing board in favor of the physician, would open the door to claims for monetary damages for the physician against the hospital. The board in its perceived fiduciary responsibility will wish to prevent such a financial loss.²¹ The hospital simply must bury its mistake,²² and take

¹⁷ "Katzberg" at 305, italics original, internal quotations omitted.

¹⁸ "Gray", *supra*, 125 Cal. App. 4th at 637, internal quotation omitted.

¹⁹ "United States v. Antelope", 395 F. 3d 1128, 1133, (9 Cir., 2005) disapproves of legal proceedings that look "...like a never-ending loop tape..."

²⁰ And that exhaustion must await the end of all administrative proceedings, whatever the risk of prejudice; see, e.g., "Eight Unnamed Physicians v. Medical Executive Committee [etc.]" (May 2, 2007)—Cal. App. 3rd—, 2007 WL 1272062, 2007 CDOS 4863.

²¹ Such a board is arguably disqualified by this conflict of interest under such cases as "Gibson v. Berryhill", 411 U.S. 564, 570-571, 577 (U.S., 1973) deriving from Lord Coke's decision on the financial conflict of a disciplining London medical society in "Dr. Bonham's Case", 8 Coke's Reports 107a, 114a C. P. 1610 (Court of Common Pleas, 1610 [AD]. But see "Weinberg", *infra*, note, item (3).

²² An example may be "Weinberg v. Cedars Sinai Medical Center", 119 Cal. App. 4th 1098, 15 Cal. Rptr. 3d 6 (2004), in which the Court of Appeal held that:

- (1) As matter of first impression, board's decision was subject to deferential judicial review;
- (2) Board accorded requisite great weight to recommendation of peer review committee;
- (3) "Rule of necessity" precluded claim that board was structurally biased against physician;
- (4) Hospital governing bodies are authorized by statute to act in all peer review proceedings;
- (5) Board's contact with chief of staff was authorized by medical staff's constitution.

advantage of the reluctance of judges to substitute judgment for medical professionals in staff matters.²³ Moreover, a physician who can get to court generally at most wins a remand to the administering hospital, for yet another round of hearings.

When it is understood that hospitals' attorneys drafted the amended federal Health Care Quality Improvement Act (HCQIA—1989), the insertion of a quasi-judicial immunity provision can also be explained.²⁴ The effect if not the object was not so much protection of physician participants in good faith peer review; rather it was the perhaps unintended consequence of protection of hospitals that sponsor bad faith peer review. Hence, only very few injured physicians in the last 20 years have been able to get past the twin peaks of judicial deference to medical prosecutors and administrators and immunity for the complicit as well as the innocent.

As if this were not enough, the HCQIA also provides that a peer review body's failure to meet the conditions described in the law does not constitute failure to meet the applicable standards. In other words, failure to comply with this particular law is not a violation of this particular law.²⁵ Such a caveat sacrifices the health care quality improvement spirit of the law by gutting the letter of the law. In effect, the hospitals' lawyers' lobbying has loaded the dice.

The public cannot expect this process to be either fair or reasonable. An objective observer could join advocates (Townsend, 2000) in concluding that at this time, the "peer review" disciplinary hearing process is rigged to a point way beyond any "stacked deck" of cards. Even without malicious intent, physicians from the same hospital are frequently too close to the personalities to avoid bias one way or the other (unlike, for example, a jury of one's peers in court, who are strangers to the parties). Hospital administrators face economic incentives to maximize income, but not to minimize complications.

Ironically, bad physicians are rarely subject to such malicious prosecution. This is so because they are often significant income providers to the hospital and thus enjoy the protection of a hospital more concerned with revenues than patient well-being. This was the case in Redding, California for two heart doctors who did hundreds of sometimes fatal heart procedures, utterly unneeded, and full of risk.²⁶ All monitoring and inspection by several agencies failed to detect this enormity. When hospital managements, closest to the problems, are compensated only in proportion to revenue growth, patient safety suffers.

Often bad physicians, without the leverage of big revenue, simply agree to leave the hospital, provided the hospital does not report them to the state medical board, thereby minimizing its own exposures. They thus evade the "radar screen" of mandatory reporting. The public is not protected. The reporting system tells of summary suspensions of even outstanding physicians without adjudications, but cannot report cover-ups. Thus,

²³ In California, "Westlake Community Hosp. v. Superior Court" (1976) 17 Cal. 3d 465, 482-486 requires successful writ proceedings before damages claims. See the unpublished opinion in "O'Meara v. Palomar-Pomerado Health System" (2007), 2007 WL 731376 (Cal. App. 4th Dist.) for an application of this rule.

²⁴ "Pittsburgh [Penn.] lawyer John Horty, who is nationally known for his work on hospital legal issues, said the immunity provision ... came out of discussions he'd had with [two members of Congress]". Steve Twedt, "Rules of Fair Play Don't Always Apply", from: Post-Gazette.com, "The Interactive Edition of the Pittsburgh Post Gazette" October 27, 2003.

²⁵ "A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a) (3) of this section". 42 U.S.C. § 11112(b) (3) but *compare* Lewis Carroll, *Alice's Adventures in Wonderland* (1865), cited note, *supra*. A simple and direct remedy is suggested below.

²⁶ Stephen Klaidman, *Coronary—A True Story of Medicine Gone Awry* (Scribner, New York, 2007). See also Melissa Davis, "Tenet Tangles With California Blue Cross", from TheStreet.com, Nov. 4, 2003 regarding unneeded (60%) and expensive heart surgeries in Tenet hospitals. http://www.thestreet.com/_yahoo/stocks/melissadavid/10124365.html. Tenable damages allegations in the subsequent Redding litigations exceeded one billion dollars.

the goals of the Health Care Quality Improvement Act are undercut by hospitals' economic conflicts of interest. Even motivated patients cannot get undistorted information about physicians.

Policy-makers, law-makers, courts, legislative staffs, federal and state agencies, employers, unions, and experts responsible for drafting public healthcare law appear not to grasp Professor Leape's point. The healthcare costs explosion will continue to erode the quality of delivery of medical care in America as long as bad medicine is lucrative. It is thus all the more important, as a counter-force, to provide effective protection for all physicians and healthcare providers who show that they care about patient safety by standing up for it. Advocacy for patient safety is to be encouraged, not punished. These health care professionals are "whistleblowers", a legal term that well describes them as the people who call attention to wrongdoing. They are to be protected from the often inevitable retaliation against them. That retaliation, usually beginning with a summary suspension, destroys them professionally and compromises patient care deeply. Such protection is in the best interest of patients, the economy, and ultimately it is to the benefit of the many excellent physicians and the "House of Medicine" itself.

Remedies Proposed

Although private redress can provide deterrents to retaliation, as discussed below, it is often too little and too late. An immediate resort to the judicial process of the *ex-parte* temporary restraining order to review a summary suspension would be more effective, followed by substantive litigation if need be. One model appears from administrative practice: In California, its Medical Board may summarily suspend a physician from all medical practice. The device is an Interim Order of Suspension (IOS). Such an order may, however, be challenged immediately in court, and a stay obtained.²⁷ Inasmuch as a summary suspension by a hospital quickly results in equivalently draconian effects on a physician's practice, an equivalently swift and sure remedy is only fair. An amendment to HCQIA or California's governing statute²⁸ could provide for such an immediate resort to court upon summary suspension, without *res judicata* effect either way. Thus, statute could and should provide for a way for a summarily suspended physician to obtain the judicial redress of an immediate stay of the suspension, or at least any report to the medical board of it, and a stay of the medical board making any report of the suspension until after a final and adverse adjudication. This is the necessary procedural vehicle to prevent effective retaliation. The courts may be relied upon to deny such immediate relief to any physician who, by reason of impairment or otherwise, does present any danger to the public. The career-ending report of a summary suspension should not be the unreviewable decision of an adversary hospital, but rather follow only a neutral adjudication.

Further Proposed Statutory Amendments to Deter Hospital Retaliation

Two initial ways to protect physicians whistleblowers could harness existing means of redress, to facilitate immediate judicial relief as well as ultimate remedy. One is to deny wrongdoers a shield under Health Care Quality Improvement Act HCQIA. The second is to provide physician advocates a sword under the Civil

²⁷ "Silva v. Superior Court (Heerhartz)" (1993) 14 Cal. App. 4th 562, 17 Cal. Rptr. 2d 577.

²⁸ Business and Professions Code §805 *et seq.* California elected to "opt-out" of the federal Health Care Quality Improvement Act (1986), 42 U.S.C. §§11101-11152 (2000) (HCQIA). For a thorough critique of some of the unintended consequences of this statutory regime, see Bryan G. Hall, "The Health Care Quality Improvement Act and Physician Peer Review: Success or Failure". http://www.usd.edu/elderlaw/student_papers_f2003/health_care_quality_improvement_act... (2005), published by the Simmelweis Society at <http://www.semmelweis.org/articles.htm> (accessed February 2, 2006).

Rights Act (1872).²⁹

(1) The shield is removed by two amendments to the HCQIA:

First: “Retaliation against a physician or other health-care provider for advocacy for health care quality improvement, including testimony, is not immune, under this Act or any state law, to private judicial redress by way of damages and injunctive relief, and attorneys’ fees”. Immunity is the doctrine that precludes private redress irrespective of wrongdoing; judges for example, enjoy civil immunity, although they can be prosecuted criminally, impeached, or disciplined. Physicians on peer review disciplinary panels enjoy civil immunity under the Health Care Quality Improvement Act (HCQIA).

Secondly, inasmuch as defective peer review is the cause of so much harm and error, rethinking the immunity that derives from the mere presence of some peer review process is appropriate. HCQIA, 42 U.S.C. 11112 (b) (3) provides the loophole that a retaliation-minded hospital can work a way through: “A professional review body’s failure to meet the [peer review] conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section”. Meeting those standards provides the wide immunity of HCQIA. The way to fix the problem this section causes is to amend this section thus: “A professional review body’s failure to meet the conditions described in this subsection *shall, in itself, constitute failure* to meet the standards of subsection (a) (3) of this section”. That is, take out the “not”. A hospital tempted to run a kangaroo court should not get to take advantage of its own wrongdoing. Each and every National Practitioner Data Bank report that results from a peer review body that fails to meet the specified conditions should not be privileged, should be enjoined in equity in state or federal court, and should give rise to a damages action including attorneys’ fees. A kangaroo court “peer review” should not enjoy immunity from any damages causes of action including antitrust treble damages upon a showing of violation and impact.

All of this may well drive some physicians out of the business of judging other physicians, as do many other factors. The hospitals have pretty much taken that over anyway, once the process gets out of departmental whitewashes and into “discipline”. If it is going to be a legal rather than a medical process, it must be fair to afford due process of law and implement adequate legal remedies for those who are injured by wrongdoing, including attorneys’ fees for intentionally or negligently injured or wronged physicians.

(2) The sword is provided by an amendment to the Civil Rights Act, §1983: “Retaliation, against a physician or other health-care provider for advocacy, including testimony, for health care quality improvement or patient safety, by or in any institution that is governed by HCQIA or related state law, or funded directly or indirectly by the United States, is a denial of due process of law and equal protection of the laws, for which private judicial redress by way of monetary damages for all injury, and injunctive relief, and attorneys’ fees, shall be available under this Act, notwithstanding any post-deprivation administrative remedy or any requirement of exhaustion of remedies”. This amendment provides judicial redress for deprivation of the substantive right to speak out, testify and act in the public interest free of retaliation. This is the Right to Petition for Redress of Grievances guaranteed by the First Amendment.

²⁹ The requisite “color of law” appears, hence the Equal Protection and Due Process Clauses are both enforceable by private actions for damages and attorneys’ fees under the federal Civil Rights Act, 42 U.S.C. §§ 1981 *et seq.* That “color” appears because hospitals in California govern themselves with respect to peer review by way of “official proceedings” required by law whether they are public or private: “Kibler v. Northern Inyo County Local Hosp. Dist.” (2006) 39 Cal. 4th 192, 138 P. 3d 193, 46 Cal. Rptr. 3d 41. Under federal law (Medicare) hospitals must afford peer review as a Conditions of Participation whether they are public or private.

(3) In California, amendment to the Unruh Civil Rights Act, Civil Code §51, can also provide a sword: “Retaliation by any person, organization, healthcare institution or the like, that is governed California law such as the Business and Professions Code, the Health and Safety Code, and the like, or funded in whole or in part, directly or indirectly, by the State of California or any of its subdivisions, districts or the like, against a physician-advocate or any other health care professional for advocacy, including testimony, for health care quality improvement or patient safety, is a denial of equality before the law and due process of law, as they are guaranteed by the Constitution of this state, for which private judicial redress by way of monetary damages for all injury, and injunctive relief, and attorneys’ fees, shall be available under this Act, notwithstanding any post-deprivation administrative remedy or any requirement of exhaustion of remedies and without application of any provision of law respecting strategic litigation against public participation”. This amendment³⁰ also provides judicial redress, under California law, for deprivation of the substantive right to speak out, testify, and act in the public interest free of retaliation.

(4) Another avenue may affect better health care by means of deterrence. Enforcement of the criminal law has as one of its primary purposes deterrence, but it fails for its apparent near-random impact, compromised by implicit political considerations, delay, and leniency for the white-collared. Private enforcement, on the other hand, is distributed widely, not centralized, promoted by private incentives such as treble damages, and highly effective. An example is the treble damage action of the Clayton Antitrust Act³¹, Antitrust Act³² for violations of the earlier Sherman Inasmuch as so much of the revenue of the hospital industry comes from the federal government (e.g., Medicare and Medicaid), systemic improvements in such federally funded care will also benefit all others receiving care from the industry. An amendment to the False Claims Act (FCA)³³ could provide private incentives to litigation for large amounts of money. This in turn could affect the deterrence needed to protect physician-advocates (and others) from retaliation. Such an amendment could provide: “Violations of statutory or regulatory conditions of participation in federally funded programs, by a recipient of direct or indirect federal funding, coupled with certification of compliance therewith, shall be fraud on the United States notwithstanding apparent compliance with any other regulation, or accreditation”.³⁴

Use of the False Claims Act with respect to Medicare Conditions of Participation (COP) requiring good faith, as opposed to retaliatory, “peer review” may provide some deterrence to bad faith peer review, almost

³⁰ The last clause of which is necessitated in California by the *Kibler* case, *supra*, holding that inasmuch as peer review proceedings are all official proceedings, California’s prohibition of strategic litigation against public participation (its Anti-SLAPP law) comes into play. This law, when invoked, requires proof at the level of a preliminary injunction to proceed beyond the complaint stage (without discovery) and raises another barrier to relief against bad faith peer review. Retaliation in the absence of administrative review is directly actionable: “O’Meara v. Palomar-Pomero Health System” (2007), 2007 WL 731376 (unpublished, Cal. App. 4th Dist.) cited note *supra*.

³¹ 15 U.S.C. §§ 12-27, 29 U.S.C. §§ 52-53 (1914).

³² 15 U.S.C. §§ 1-7 (1890).

³³ 31 U.S.C. §§ 3729-3733.

³⁴ Relevant considerations include: Peer review is defined in part by HCQIA (1989). Medicare requires peer review. Failure to do peer review violates Medicare Conditions of Participation (COP). Violation of COP renders hospital Medicare billings false. Such false billings are actionable under the False Claims Act (FCA). FCA provides large financial incentives to avoid false claims for which there are also criminal penalties. The intent and the effect are to foster peer review, but perhaps differentially. By reasons of the sanctions associated with violations of COP, hospital resources could go to effecting and documenting peer review of treatment of older patients. Resources (beyond Medicare payments) including those required for peer review could move away from non-Medicare patients.

always retaliatory, or anti-competitive.³⁵ It may be noted that Medicare affects only people over 65 years of age.³⁶ In practical terms, the effect of enforcement of law such that institutions must enable only good faith peer review because of Medicare constraints, protects all by protecting the favored. In other words, what the economists call “positive externalities” makes for equitable results assuming effective enforcement of Medicare Conditions of Participation. Denial of good faith peer review to the treatment of younger patients, at least as effective as that as required by law for treatment of older patients, is a denial of equal protection of the laws. To obviate this inequality, acceptance of any federal funding for any aspect of hospital care should by legislation be subject to explicit acceptance of Medicare-equivalent COP with respect to peer review. Violation of such extended COP should be subject to FCA enforcement. Patients are best equally protected by physician peer review only when the incentives to do it right are equal for younger and older patients. Moreover, all hospital care as affected by peer review is protected and promoted by “official proceedings”. These proceedings cannot equitably be different for patients simply by reason of the patients’ age. Any such invidious difference should be actionable under the Civil Rights Act. Questions of juridical standing may arise, but FCA claims for relief could be accompanied by Civil Rights Act Equal Protection claims for relief as well.

For the False Claims Act to provide deterrence, the private complainants, denominated “relators”, need the encouragement of the monetary reward. Now, only the “original source” of the information about the false claim proven qualifies to participate in the recovery.³⁷ An amendment is appropriate to enable all sources of the non-public information leading to the prosecution to share in the reward.

A related disincentive to the consequences of bad faith peer review could be civil forfeiture of the “ill-gotten gains” from the revenues generated in the absence of effective peer review that minimizes complications. The Tenet Redding, California hospital case cries out for such a remedy. Forfeiture could reach the parent corporations *and* the company executives who personally prosper from failing to prevent predatory and malicious medicine.

(5) Another way to protect such physicians is to interpose a neutral evaluator unconnected to the hospital industry to process possibly retaliatory claims against physicians to determine merit. This would require creation by statute of a dedicated adjudicatory mechanism, not unlike the administrative courts system in the federal and many state governments. Awaiting such a development, an existing system for air industry safety could be adopted: The National Aeronautics and Space Administration (NASA) operates two anonymous safety-advocate reporting systems, one in healthcare for the Veterans Administration,³⁸ which could be adapted to physician-advocate reports of inadequate health care practices and instances. By this means, the

³⁵ The successful antitrust case that led to the HCQIA amendments in 1989 was “Patrick v. Burget” (1988) 486 U.S. 94, 108 S.Ct. 1658, 100 L.Ed.2d 83; in “Poliner v. Texas Health Systems”, not reported in F.Supp.2d, 2006 WL 770425 (U.S.D.C., N.D.Tex. 2006) bad faith peer review by way of summary suspension led to a \$366,000,000 jury verdict. See generally William W. Parmley (2000), MD, “Clinical Peer Review or Competitive Hatchet Job”, *Journal of the American College of Cardiology*, 36(7), 2347.

³⁶ Certain issues could lead to a perceived need for an explicit requirement that any institution subject to Medicare Conditions of Participation must insure *institution-wide* good faith, non-retaliatory peer review and discipline: Where a set of laws indirectly effects significant protection to a class of persons not entitled to special protection, is this merely a privilege? Do others have any call on the law for similar protection? When does the Equal Protection Clause require that all be entitled to enjoy a privilege extended to the few by operation of law? Analogously, if enforcement of the criminal law protects rich people, is it a denial of Equal Protection to fail to enforce the law such that the poor are not equally well protected?

³⁷ “Rockwell International Corp. v. United States”—U.S.—, 127 S.Ct. 1397, 167 L.Ed.2d 190, 2007 WL 895257 (No. 05-1272, March 27, 2007).

³⁸ See: Aviation Safety Reporting System, <http://asrs.arc.nasa.gov/> and: VA Patient Safety Reporting System, www.nasa.gov/centers/ames/news/releases/2000/00_44AR_prt.

physician-advocate avoids retaliation by means of officially sponsored anonymity.³⁹

Conclusion: Public Safety Merits New Statutory Protections for Whistleblowers

The health of the public is at stake here. Physicians are closest to their patients and best able to advocate for better health care for them. Present healthcare industry structure and unintended consequences of regulatory legislation lend themselves to punitive legal proceedings against whistleblower patient safety advocates. A modest set of statutory amendments, prophylactic and remedial, especially to prevent premature reporting of summary suspensions, can counteract these inequities and rebalance the House of Medicine so it may do no harm.

References

- Carroll, L. (1865). *Alice's adventures in wonderland*. London: Macmillan.
- Davis, M. (2003). Tenet tangles with California blue cross. *TheStreet.com*. Retrieved from <http://www.allianceforpatientsafety.org/davis-tenet-tangles-blue-cross.pdf>
- Health Grades, Inc. (July 2004). *Patient safety in American hospitals; Health Grades quality study*. Retrieved from http://www.allianceforpatientsafety.org/HG_Patient_Safety_Study_Final.pdf
- Hall, B. G. (2005). *The health care quality improvement act and physician peer review: Success or failure*. Retrieved from <http://www.allianceforpatientsafety.org/bryanhall.pdf>
- Klaidman, S. (2007). *Coronary—A true story of medicine gone awry*. New York: Scribner.
- Leape, L. L., & Berwick, D. M. (2005). Five years after to err is human—What have we learned. *Journal of the American Medical Association (JAMA)*, 293(19), 2384-2390.
- Lewis, A. (1964). *Gideon's trumpet*. NY: Random House.
- Parmley, W. W. (2000). Clinical peer review or competitive hatchet job. *Journal of the American College of Cardiology*, 36(7), 2347.
- Rand Corporation. (2006). *The first national report card on quality of health care in America*. Retrieved from http://www.rand.org/pubs/research_briefs/2006/RAND_RB9053-2.pdf
- Stillman, M. J. (2003). A difference of degree. *Journal of the American Medical Association (JAMA)*, 290(9), 1135-1136.
- Twedt, S. (2003). *Rules of fair play don't always apply*. Retrieved from <https://www.post-gazette.com/news/nation/2003/10/27/Rules-of-fair-play-don-t-always-apply/stories/200310270026>
- Townsend, D. (2000). Hospital peer review is a kangaroo court. *Medical Economics*. Med Econ. 2000 Feb 7;77(3):133-6, 141. Retrieved from <http://allianceforpatientsafety.org/townend.pdf>

³⁹ The air safety “black box” instrument is an analogy. See Gil Mileikowsky MD, “In Search of the Black Box—For a Reliable and Cost-effective Quality Control of the Delivery of Medical Care” at <http://www.allianceforpatientsafety.org/blackbox.pdf>.

Appendix

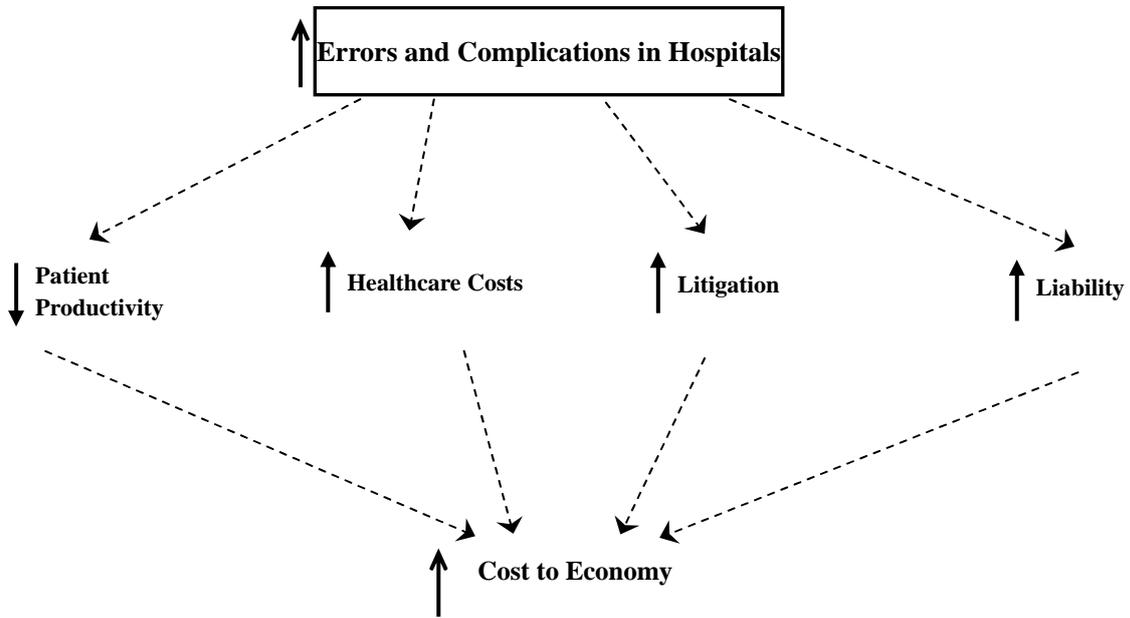


Figure 1. The economic impact of the lack of patient safety.

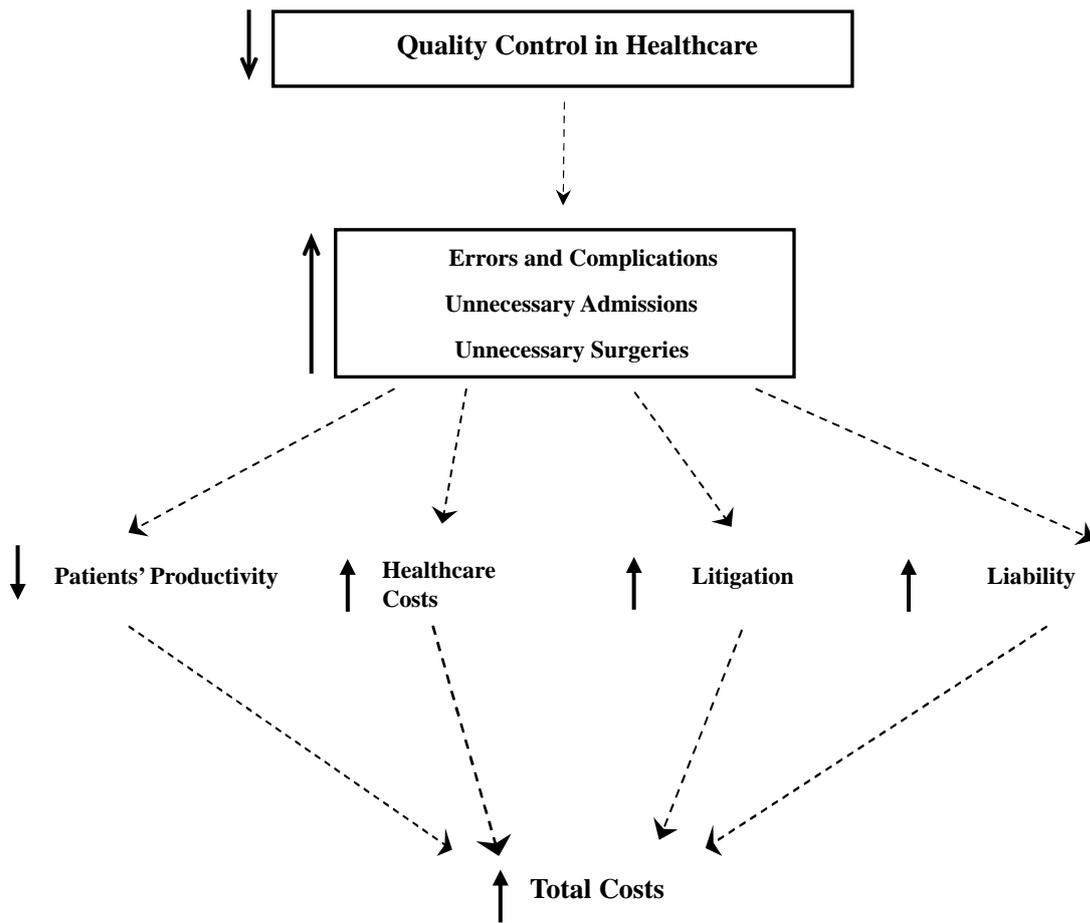


Figure 2. No peer review or sham peer review.

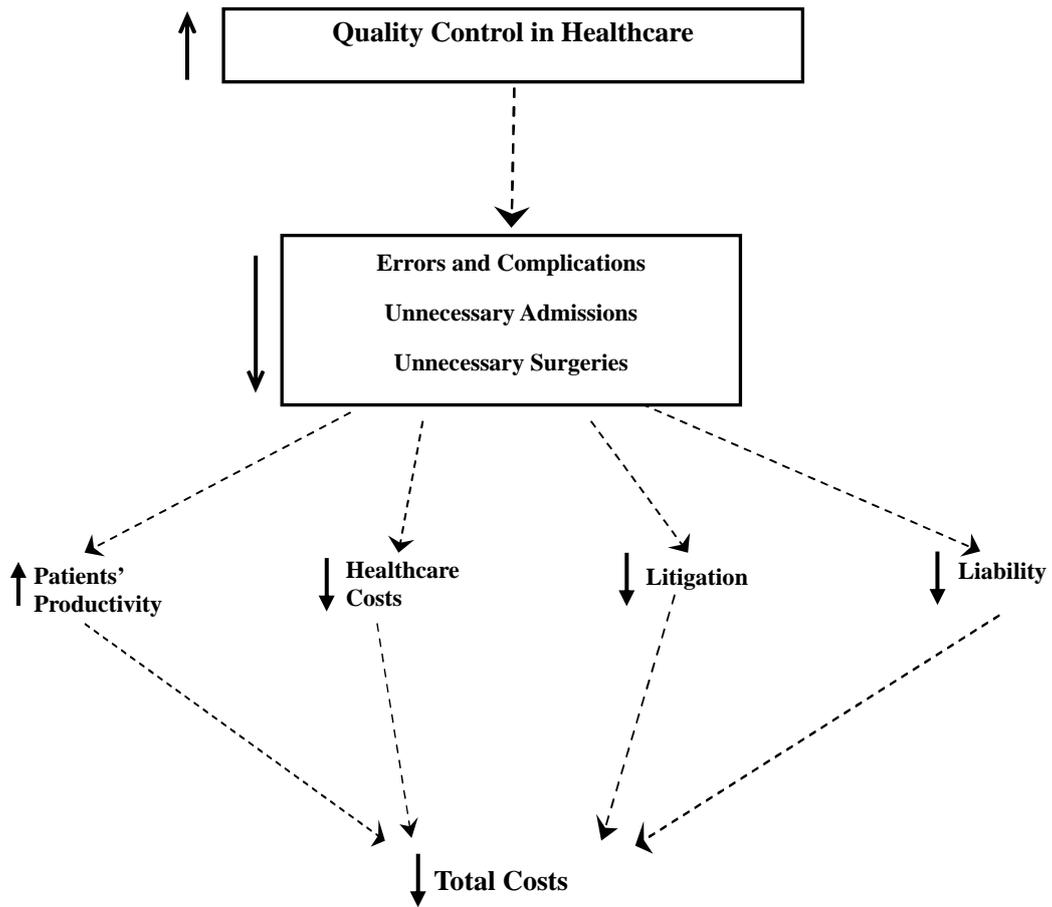


Figure 3. Legitimate peer review.