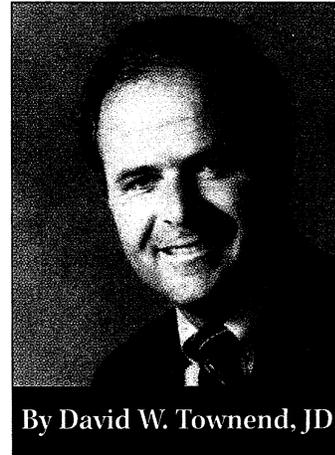


Hospital peer review is a kangaroo court

The law that provides immunity for doctors who participate in peer review should be declared unconstitutional, says this attorney.



By David W. Townend, JD

Today's hospital peer review system is inherently unfair to physicians whose privileges are challenged. After representing dozens of physicians in these hearings, I know for certain that doctors are up against a stacked deck—despite the overblown promises of due process and fairness—unless they have powerful allies in the medical community.

Often, the loss of a doctor's privileges has little to do with the quality of care he renders. Here are just a few examples of cases I've seen where physicians faced a loss of privileges with scant justification:

► A Vietnamese-born, but American-trained, cardiologist encountered racial hostility regarding the admission of Asian patients who could not speak English. Staff nurses complained about their inability to communicate with the patients, but the hospital provided few translation services. The doctor was targeted for removal from the medical staff.

► A solo FP felt that a diabetic patient had adequate blood flow to his leg and didn't need the amputation recommended by a vascular surgeon. The hospital viewed this as a turf battle and argued that the FP was practicing outside his area of expertise. He was kicked off the staff for not referring the patient back to the surgeon.

► Hospital administrators recruited a young oncologist they felt could bring in new revenue. After a few months, when their expect-

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The author, an attorney in Garland, TX, often represents physicians in peer review disputes with hospitals.

tations weren't being realized, they tried to force the doctor off the staff. He'd been behind on some dictation, at least partly because the hospital didn't provide him with necessary staff and dictation equipment. Hospitals often overlook dictation delays if the physician is well-established within the facility. In this case, however, they used this minor problem as an excuse to get out of a bad business deal.

► An ob/gyn performed a vaginal birth after cesarean. The patient's uterus ruptured, and she lost her baby. The patient sued the physician and the hospital. Although the doctor won his hearing before the credentials committee, the hospital's board of trustees removed him from the staff anyway because they felt that would shift liability away from the hospital in the malpractice suit.

There's no question that some physicians should have their hospital privileges revoked or curtailed, and I'm not suggesting that the whole peer review process be scrapped. But right now, there's an environment where questionable cases are brought against doctors who don't receive a fair hearing, and whose careers are devastated by unsubstantiated allegations. If your enemies look at enough charts, they can always find *something* to use against you.

A federal law that was touted as a measure to guarantee doctors due process has unfairly tilted the playing field in favor of hospital administrators. The Health Care Quality Improvement Act of 1986 was adopted by Congress in response to pressure from hospi-

tals and peer review participants seeking legal immunity from lawsuits by physicians who'd lost privilege battles. The same law created the National Practitioner Data Bank.

Peer review had become a high profile issue in 1984, when a general surgeon in Oregon won a \$2 million antitrust suit against his former partners. Timothy A. Patrick claimed that they had used hospital peer review to drive him out of business for purely economic reasons. His award was upheld by the US Supreme Court.

HCQIA provides immunity for physicians who serve on peer review committees as long as they act in good faith and the hospital gives due process to the physician being

**The burden of proof is turned on its head:
The doctor must prove his innocence.**

reviewed. In my view, it's unconstitutional, and as the attorney for the Vietnamese doctor mentioned earlier, I've asked a federal district court to overturn it.

The law deprives physicians of a due process right of access to the courts. Also, HCQIA denies doctors equal protection under the laws. By granting immunity to hospital peer reviewers, the law singles out physicians for removal of common-law remedies. Other professionals—teachers, architects, attorneys, and accountants—aren't forced to give up their right to sue.

Before 1986, physicians had a right to combat improper peer review by filing suits that charged breach of contract, interference with contractual relations, defamation, and antitrust violations. Now, a physician is allowed to sue under HCQIA only if he can show that hospital bylaws were violated or that the reviewers acted in bad faith. But reviewers need afford only minimal notice and hearings, and it's extremely difficult to prove bad faith, especially when hospitals are

allowed to keep their proceedings confidential. Courts rarely allow discovery to let the physician probe for bias.

There are serious flaws in the peer review process, starting with the fact that it lacks consistent standards. Hospital bylaws are written by attorneys to shield hospitals, and they offer physicians only the barest protection. The burden of proof is often turned on its head: The doctor must prove his innocence. A lot of the time, the physician isn't even allowed to know who initially filed an allegation against him.

Many peer reviewers are novices, who apply their own subjective ideas of what constitutes the appropriate standard of care. Sometimes they're not even in the same specialty as the doctor being reviewed.

The due process requirement offers only limited protection. A doctor has a right to a hearing, but there are plenty of pitfalls.

Some physicians don't understand how serious the process is. For example, bylaws may state that a disciplined doctor must request a hearing in writing within a specified time—and that if he doesn't, he loses his chance to challenge an adverse decision.

Hospital bylaws frequently demand that a doctor applying for privileges sign a document releasing the institution from liability in the event of a peer review action. A doctor's right to counsel at the hearing is often restricted. There is only the pretense of fairness, not the substance.

It would be unfair to say that peer review committees go out of their way to target particular types of doctors. But it's unquestionably true that solo practitioners lacking political support are frequently victims of arbitrary peer review actions based on inadequate evaluation of their care. Physicians in large groups, who have politically connected mentors and colleagues, can often deflect disciplinary actions. A solo physician doesn't have the same resources. Similarly, doctors who are new on staff and haven't developed

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For intranasal use only.
 Shake Well Before Using

BRIEF SUMMARY

CONTRAINDICATIONS
 Hypersensitivity to any of the ingredients of this preparation contraindicates its use.

WARNINGS

The replacement of a systemic corticosteroid with a topical corticosteroid can be accompanied by signs of adrenal insufficiency and, in addition, some patients may experience symptoms of withdrawal, e.g., joint and/or muscular pain, lassitude and depression. Patients previously treated for prolonged periods with systemic corticosteroids and transferred to topical corticosteroids should be carefully monitored for acute adrenal insufficiency in response to stress. In those patients who have asthma or other clinical conditions requiring long-term systemic corticosteroid treatment, too rapid a decrease in systemic corticosteroids may cause a severe exacerbation of their symptoms.

Children who are on immunosuppressant drugs are more susceptible to infections than healthy children. Chickenpox and measles, for example, can have a more serious or even fatal course in children on immunosuppressant doses of corticosteroids. In such children, or in adults who have not had these diseases, particular care should be taken to avoid exposure. If exposed, therapy with varicella-zoster immune globulin (VZIG) or pooled intravenous immunoglobulin (IVIG), as appropriate, may be indicated. If chickenpox develops, treatment with antiviral agents may be considered.

PRECAUTIONS

General: In clinical studies with triamcinolone acetate nasal spray, the development of localized infections of the nose and pharynx with *Candida albicans* has rarely occurred. When such an infection develops it may require treatment with appropriate local or systemic therapy and discontinuance of treatment with Nasacort AQ Nasal Spray.

Nasacort AQ Nasal Spray should be used with caution, if at all, in patients with active or quiescent tuberculous infection of the respiratory tract or in patients with untreated fungal, bacterial, or systemic viral infections or ocular herpes simplex.

Because of the inhibitory effect of corticosteroids, in patients who have experienced recent nasal septal ulcers, nasal surgery, or trauma, a corticosteroid should be used with caution until healing has occurred. As with other nasally inhaled corticosteroids, nasal septal perforations have been reported in rare instances.

When used at excessive doses, systemic corticosteroid effects such as hypercorticism and adrenal suppression may appear. If such changes occur, Nasacort AQ Nasal Spray should be discontinued slowly, consistent with accepted procedures for discontinuing oral steroid therapy.

Information for Patients: Patients being treated with Nasacort AQ Nasal Spray should receive the following information and instructions. Patients who are on immunosuppressant doses of corticosteroids should be warned to avoid exposure to chickenpox or measles and, if exposed, to obtain medical advice.

Patients should use Nasacort AQ Nasal Spray at regular intervals since its effectiveness depends on its regular use. (See **DOSE AND ADMINISTRATION**.)

An improvement in some patient symptoms may be seen within the first day of treatment, and generally, it takes one week of treatment to reach maximum benefit. Initial assessment for response should be made during this time frame and periodically until the patient's symptoms are stabilized.

The patient should take the medication as directed and should not exceed the prescribed dosage. The patient should contact the physician if symptoms do not improve after three weeks, or if the condition worsens. Patients who experience recurrent episodes of epistaxis (nose bleed) or nasal septum discomfort while taking this medication should contact their physician. For the proper use of this unit and to attain maximum improvement, the patient should read and follow the accompanying patient instructions carefully.

It is important to shake the bottle well before each use. Also, the bottle should be discarded after 120 actuations since the amount of triamcinolone acetate delivered thereafter per actuation may be substantially less than 55 mcg of drug. Do not transfer any remaining suspension to another bottle.

Carcinogenesis, Mutagenesis, and Impairment of Fertility: In a two-year study in rats, triamcinolone acetate caused no treatment-related carcinogenicity at oral doses up to 1.0 mcg/kg (approximately 1/30 and 1/50 of the maximum recommended daily intranasal dose in adults and children on a mcg/m² basis, respectively). In a two-year study in mice, triamcinolone acetate caused no treatment-related carcinogenicity at oral doses up to 3.0 mcg/kg (approximately 1/12 and 1/30 of the maximum recommended daily intranasal dose in adults and children on a mcg/m² basis, respectively).

No mutagenicity studies with triamcinolone acetate have been performed.

In male and female rats, triamcinolone acetate caused no change in pregnancy rate at oral doses up to 15.0 mcg/kg (approximately 1/2 of the maximum recommended daily intranasal dose in adults on a mcg/m² basis). Triamcinolone acetate caused increased fetal resorptions and stillbirths and decreases in pup weight and survival at doses of 5.0 mcg/kg and above (approximately 1/5 of the maximum recommended daily intranasal dose in adults on a mcg/m² basis). At 1.0 mcg/kg (approximately 1/30 of the maximum recommended daily intranasal dose in adults on a mcg/m² basis), it did not induce the above mentioned effects.

Pregnancy, Teratogenic Effects, Pregnancy Category C: Triamcinolone acetate was teratogenic in rats, rabbits, and monkeys. In rats, triamcinolone acetate was teratogenic at inhalation doses of 20 mcg/kg and above (approximately 7/10 of the maximum recommended daily intranasal dose in adults on a mcg/m² basis). In rabbits, triamcinolone acetate was teratogenic at inhalation doses of 20 mcg/kg and above (approximately 2 times the maximum recommended daily intranasal dose in adults on a mcg/m² basis). In monkeys, triamcinolone acetate was teratogenic at an inhalation dose of 500 mcg/kg (approximately 37 times the maximum recommended daily intranasal dose in adults on a mcg/m² basis). Dose-related teratogenic effects in rats and rabbits included cleft palate and/or internal hydrocephaly and axial skeletal defects, whereas the effects observed in the monkey were cranial malformations.

There are no adequate and well-controlled studies in pregnant women. Therefore, triamcinolone acetate should be used in pregnancy only if the potential benefit justifies the potential risk to the fetus. Since their introduction, experience with oral corticosteroids in pharmacologic as opposed to physiologic doses suggests that rodents are more prone to teratogenic effects from corticosteroids than humans. In addition, because there is a natural increase in glucocorticoid production during pregnancy, most women will require a lower exogenous corticosteroid dose and many will not need corticosteroid treatment during pregnancy.

Nonteratogenic Effects: Hypoadrenalism may occur in infants born of mothers receiving corticosteroids during pregnancy. Such infants should be carefully observed.

Nursing Mothers: It is not known whether triamcinolone acetate is excreted in human milk. Because other corticosteroids are excreted in human milk, caution should be exercised when Nasacort AQ Nasal Spray is administered to nursing women.

Pediatric Use: Safety and effectiveness in pediatric patients below the age of 6 years have not been established.

Corticosteroids have been shown to cause growth suppression in children and teenagers, particularly with higher doses over extended periods. If a child or teenager on any corticosteroid appears to have growth suppression, the possibility that they are particularly sensitive to this effect of corticosteroids should be considered.

ADVERSE REACTIONS

In placebo-controlled, double-blind, and open-label clinical studies, 1483 adults and children 12 years and older received treatment with triamcinolone acetate aqueous nasal spray. These patients were treated for an average duration of 51 days. In the controlled trials (2-5 weeks duration) from which the following adverse reaction data are derived, 1394 patients were treated with Nasacort AQ Nasal Spray for an average of 19 days. In a long-term, open-label study, 172 patients received treatment for an average duration of 286 days.

Adverse events occurring at an incidence of 2% or greater and more common among Nasacort AQ-treated patients than placebo-treated patients in controlled adult clinical trials were:

Adverse Events	Patients treated with 220 mcg triamcinolone acetate (n=857) %	Vehicle Placebo (n=962) %
Pharyngitis	5.1	3.6
Epistaxis	2.7	0.8
Increase in cough	2.1	1.5

A total of 602 children 6 to 12 years of age were studied in 3 double-blind, placebo-controlled clinical trials. Of these, 172 received 110 mcg/day and 207 received 220 mcg/day of Nasacort AQ Nasal Spray for two, six, or twelve weeks. The longest average durations of treatment for patients receiving 110 mcg/day and 220 mcg/day were 76 days and 80 days, respectively. Only 1% of those patients treated with Nasacort AQ were discontinued due to adverse experiences. No patient receiving 110 mcg/day discontinued due to a serious adverse event and one patient receiving 220 mcg/day discontinued due to a serious event that was considered not drug related. Overall, these studies found the adverse experience profile for Nasacort AQ to be similar to placebo. A similar adverse event profile was observed in pediatric patients 6-12 years of age as compared to older children and adults with the exception of epistaxis which occurred in less than 2% of the pediatric patients studied.

Adverse events occurring at an incidence of 2% or greater and more common among adult patients treated with placebo than Nasacort AQ were: headache, and rhinitis. In children aged 6 to 12 years these events included: asthma, epistaxis, headache, infection, otitis media, sinusitis, and vomiting.

In clinical trials, nasal septum perforation was reported in one adult patient although relationship to Nasacort AQ Nasal Spray has not been established.

In the event of accidental overdose, an increased potential for these adverse experiences may be expected, but acute systemic adverse experiences are unlikely. (See **OVERDOSAGE**.)

OVERDOSAGE

Like any other nasally administered corticosteroid, acute overdosing is unlikely in view of the total amount of active ingredient present. In the event that the entire contents of the bottle were administered all at once, via either oral or nasal application, clinically significant systemic adverse events would most likely not result. The patient may experience some gastrointestinal upset.

Caution: Federal law prohibits dispensing without prescription.

Please see product circular for full prescribing information.

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Patent Pending

Rev. 10/97
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**THE WAY
 I SEE IT**

strong relationships are on the hot seat. So are physicians who do procedures that are new or different.

The HCQIA immunity enables peer reviewers to be arbitrary. Since there's little risk of being successfully sued, they're more likely to defer to a colleague's desire to oust another physician. And through creation of the data bank, HCQIA has increased the stakes of unfair decisions. Although there is a process for the disciplined doctor to dispute the data bank report, the damage it does may be too difficult to overcome. In the case of a summary suspension, a doctor's career can be crippled before he even gets a hearing.

I have a concrete suggestion that could ease things. So long as hospital officials elect to be

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If we remove peer reviewers' legal immunity, a greater sense of fair play would be injected into the process.

involved in credentialing, they are going to be subjected to the threat of litigation. One alternative would be to create an agency within each state that would be responsible for credentialing and for removing physicians' hospital privileges. This would free hospital officials from the credentialing process and eliminate the need for immunity from peer review suits.

Such an agency, perhaps operating under the state board of medical examiners, would apply uniform rules of due process and standards of proof. The physician should have a right to challenge an adverse decision in court. Similar administrative procedures are already in place regarding license revocation.

I know many physicians distrust medical boards as much as they distrust peer reviewers—perhaps with good reason. But it makes

little sense to have each hospital duplicate efforts in credentialing, and there's a need to enhance the fairness of the

review system.

Obviously, we need a peer review system to protect patients from physicians who clearly represent a danger. If we remove legal immunity, and the biases it encourages, a greater sense of fair play would be injected into the process. ■

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What's your feeling about the peer review system and legal immunity for reviewers? Do you agree or disagree with the author of this article? Please fax your comments to the Editor at 201-722-2688.

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