How To Protect the Physician Whistleblower: A Legal Analysis

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Editor's note: In the coming elections, healthcare is playing a large role in candidates' platforms. But one side of the problems is rarely discussed, and that is how physicians are supposed to handle exposing problems they see within their own environment. Dr. Mileikowsky addresses those in the following article: Dr. Mileikowsky is founder of www.allianceforpatient-safety.org.

Introduction–The Overriding Public Interest in Saving Lives

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. The World Health 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." 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 at risk. The following proposals to counter, limit and deter retaliation will decrease overall costs. Now patients don't get what they pay, quality care. The Health Care Quality Improvement Act and substituted state legislation has 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. Protecting physician patient-safety advocates from retaliatory "discipline" is essential to improve the quality of delivery of care. 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."

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 warrantees 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 services that are needed when patients are injured by their mistakes." Dollar signs are trumping patients' vital signs.

"Retaliation" is wrongful in many ways, including its violation of Equal Protection of the Laws and of Due Process of Law. 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. California alone, in 2007, has acted to remedy this.

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. The physician is condemned before any hearing is even initiated. This is professional capital punishment before trial. Once a hospital reports a physician's summary suspension, it creates an avalanche effect by mandatory reporting to the National Practitioners Data Bank, (NPDB). Other hospitals will then deny that physician's clinical privileges as well, followed by suspension of medical liability insurance coverage and preclusion of participation with medical insurance providers. 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. 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. 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. 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. Furthermore, due to the abuse by hospitals of that doctrine, hospitals can prolong that administrative process with many delays. That is a most effective strategy, to exhaust the physician as an adversary. 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. 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 is 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. The hospital simply must bury its mistake, and take advantage of the reluctance of judges to substitute judgment for medical professionals in staff matters.

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 is explained. 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.

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. In effect, the hospitals' lawyers' lobbying has loaded the dice.

The public cannot expect this process to be reasonable. An objective observer could join advocates in concluding that at this time, the "peer review" disciplinary hearing process is rigged. 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). 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. 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. Thus, the goals of the Health Care Quality Improvement Act are undercut by hospitals' economic conflicts of interest.

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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. 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 pro-

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tected from the often inevitable retaliation against them. 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, it is often too little, too late. An immediate resort to the judicial process of the ex-partetemporary 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. Such an order may, however, be challenged immediately in court, and a stay obtained. 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 statute could provide for such an immediate resort to court upon summary suspension.

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. 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 Rights Act (1872).

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. 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 a loophole: "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 enjoin-able in equity in state or federal court, and should give rise to a damages action including attorneys' fees. 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, 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 pubic interest free of retaliation. This is the Right to Petition for Redress of Grievances guaranteed by the First Amendment.

4) Another avenue may effect better health care by means of deterrence. Private enforcement is distributed widely, not centralized, promoted by private incentives such as treble damages, and highly effective (as in the case of antitrust treble damages). Inasmuch as so much of the revenue of the hospital industry comes from the federal government (e.g., Medicare, 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 could provide private incentives to litigation for large amounts of money. This in turn could effect 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."

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 These could be adapted to physician-advocate reports of inadequate health care practices and instances. By this means, the physician-advocate avoids retaliation of officially sponsored anonymity.

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.

Phil Blazer's interview with Dr. Gil Mileikowsky will air on Sunday, January 27 on KSCI (Channel 18 on Time-Warner Cable in Los Angeles) at 9:00 A.M on 'Jewish Life with Phil Blazer,' and on the internet at www.jltv.tv.