Increasing Whistleblower Protection for Physicians

By Gerald N. Rogan, MD

The Institute of Medicine reports[1] a Thomas study showing 44,000–98,000 Americans die from medical errors annually.[2] Medication-related errors for hospitalized patients cost roughly $2 billion a year.[3] Although this amount is less than 1 percent of the taxpayers' cost of the Medicare program, this money could be used to lower medical care insurance costs so that a few of the 41 million uninsured Americans[4] could get better access to care.

But more important that wasted money, only 55 percent of patients in a recent random sample of adults received recommended care.[5] Medical errors kill more people per year than breast cancer, AIDS, or motor vehicle accidents[6].

The peer review process is designed to help reduce medical errors and improve the quality of care. We can compare the hospital peer review process to the FAA review following an airplane crash. First an error must happen. Only then can it be reviewed by a team of peers. The intended result is physician education, system analysis, and future error avoidance.

Of course, a better approach is to prevent errors — a goal we are achieving. We have better information systems and computer decision support, including PDAs, e-mail, hospital information systems; and, to improve decision-making, medical evidence search capability using PubMed and its MeSH tool.[7]

Unfortunately, medical errors can persist when an institution and its leaders subvert the peer review process, motivated by economic gain or advertising enhancement. When a physician finds a medical error and properly reports it, the reporting of the error can become a problem to some stakeholders if its correction reduces patient demand for a profitable service.

If those who control an institution are threatened by the disclosure of an error, attempts may be made to suppress the whistleblower. In my work, I found two examples of whistleblower suppression — one regarding cardiac surgery and the other *in vitro* fertilization. In both cases the erroneous services were highly profitable for the institution and the professionals involved. In both situations, physician whistleblowers were effectively suppressed resulting in continuation of errors and patient harm.

The worst example I reviewed involved as many as 1,400 patients. The hospital that suppressed the whistleblower was effectively excluded from the Medicare program. At least one physician who committed errors repeatedly is no longer practicing, because of inability to be insured. Reportedly, he thought he was not making errors. A physician who reported the errors was invited to leave the medical staff so the profitable errors could remain unabated. The erroneous physician held powerful positions at the hospital. The hospital made millions more dollars until law enforcement and a search warrant stopped the despicable behavior.

But the more important question for us is: how did this happen? Did the peer review process fail? If so, in what way did the process fail? Were whistleblowers suppressed? If so, how was suppression accomplished? Were false 805 reports filed with the Medical Board, or threatened to be filed? If so, what was the motivation? What was the response of the Medical Board?

We must first provide a proper diagnosis of the system problem, before we can design an effective cure. By analyzing the problem, we might find a solution. Laws addressing the peer review process may be found California Business and Professions Code §805.5[8].

For the 2006 year, with the support of several CMA members I have written a resolution for the CMA House of Delegates to consider. The resolution calls for incremental changes in California Health and Safety Code §1278.5[9] and California Business and Professions Code §2056, but not B&P §805.5.

The proposed changes are designed to offer additional protections to a physician whistleblower who files a complaint about a medical error or poor quality of care provided in a hospital setting. The remedy proposed will extend to physicians who provide professional services in hospitals the same protection current California law allows to other workers in hospitals.

Under the excellent leadership of SSVMS, Dr. Satya Chatterjee wrote about this problem last year in this publication; the CMA legal team has reviewed the proposed resolution.

Our resolution is an attempt based on my perspective and that of an affected whistleblower in Los Angeles, under the guidance of a former CMA president and medical staff peer-review process expert. However, according to Surowiecki[10] your collective perspectives will be better than ours alone. Therefore, I urge SSVMS members to carefully review their respective peer review processes to determine if and where it is deficient in achieving its goals. Then each hospital medical staff leadership team can figure out what might work to make each process more effective.

Through discussions at medical society meetings we can diagnose the problem, and then provide a treatment. For example, are the economic conflicts of interest too great for unbiased peer review as currently performed? If so, would we be better served if the peer review process required reviews by physicians not associated with the affected medical staff?

Should the reviewers be paid, to assure their work is the best possible quality? Who should pay? How does a hospital administration relate to the peer review process? Is a conflict of interest present? Is there an appearance of a conflict of interest? Are these the important questions?

We must take action to assure physician services provided in institutional settings are the highest standard possible, just as we require of airline. The FAA does its best to assure that every flight is safe. The same standard should apply to medical practice. The collective actions we take define us as a profession, and distinguish us from a trade.

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1. *http://www.iom.edu/subpage.asp?id=14980*

2. Institute of Medicine, 2000; Thomas et al., 2000; Thomas et al., 1999

3. Institute of Medicine, 2000; Bates et al., 1997

4. Institute of Medicine, 2002; Institute of Medicine, 2003a

5. McGlynn et al., 2003

6. Institute of Medicine, 2000; Centers for Disease Control and Prevention; National Center for Health Statistics: Preliminary Data for 1998, 1999

7. *http://www.ncbi.nlm.nih.gov/entrez/query.fcgi?DB=pubmed*

8. *http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=15160417733+0+0+0&WAISaction=retrieve*

9. *http://www.leginfo.ca.gov/cgi-bin/waisgate?WAISdocID=98776714048+0+0+0&WAISaction=retrieve*

10. *The Wisdom of Crowds*, by James Surowiecki- *http://www.randomhouse.com/features/wisdomofcrowds/*