

# Sham Peer Review: the Ultimate Fraud

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The definition of sham peer review itself suggests that it is a fraudulent scheme designed to deprive the accused physician of due process and fundamental fairness in conducting peer review. The definition of sham peer review is: an adverse action taken in bad faith by a professional review body for some purpose other than furtherance of quality care, and that is disguised to look like legitimate peer review.

The perpetrators of sham peer review knowingly misrepresent to the physician that they are conducting a good-faith peer review in accordance with the medical staff bylaws. The physician victim relies on this misrepresentation, and defends himself with the belief that all he has to do is present the truth and the facts to what he believes will be an impartial hearing panel, and he will be exonerated.

Unfortunately, in sham peer review the truth and the facts do not matter because the outcome is predetermined and the process is rigged.

Perpetrators of sham peer review frequently make other misrepresentations and use tactics characteristic of sham peer review, which reveal the bad-faith nature of the peer review.<sup>1-5</sup> These include telling the physician that if he voluntarily resigns, the matter will not be reported to the National Practitioner Data Bank (NPDB); that a voluntary abeyance is not reportable because it is “voluntary”; that focused professional practice evaluations (FPPEs) and performance improvement plans (PIPs) are never reportable to the NPDB; and that clinical practice guidelines are the standard of care and that those who do not strictly follow them are not competent.

The information presented below is not intended as legal advice or opinion. It derives from my extensive study of court documents and relevant literature, and from my own experience serving as an expert in sham peer review. Physicians should seek legal advice and opinion from their attorneys.

## Fraud

Federal and state civil fraud statutes may vary slightly among the states. As noted by a prominent law school:

Fraud is both a civil tort and criminal wrong. In civil litigation, allegations of fraud might be based on a misrepresentation of fact that was either intentional or negligent. For a statement to be an intentional misrepresentation, the person who made it must either have known the statement was false or been reckless as to its truth. The speaker must have also intended that the person to whom the statement was made would rely on it. The hearer must then have reasonably relied on the promise and also been harmed because of that reliance.

A claim from fraud based on negligent misrepresentation differs in that the speaker of the false statement may have actually believed it to be true; however, the speaker lacked reasonable grounds for that belief.<sup>6</sup>

A plaintiff can make allegations in the alternative, even in contradictory ways. Thus, both intentional fraud and negligent fraud can be alleged simultaneously, by claiming intentional fraud and in the alternative negligent fraud.

Noting that fraud often occurs in the setting of a contract (e.g., medical staff bylaws), “...most states forbid a plaintiff from recovering under both contract law and tort law.”<sup>6</sup> This is also known as the One Satisfaction Rule. Also, a physician cannot obtain punitive damages on a breach of contract claim but can obtain punitive damages on a fraud claim. Written evidence of the misrepresentation is superior to verbal evidence, but in some cases verbal evidence was found to be sufficient.<sup>7</sup>

## Constructive Fraud

According to a legal dictionary:

Constructive fraud can be proved by a showing of breach of duty (like using the trust funds held for another in an investment in one’s own business) without direct proof of fraud or fraudulent intent. Extrinsic fraud occurs when deceit is employed to keep someone from exercising a right, such as a fair trial, by hiding evidence or misleading the opposing party in a lawsuit.<sup>8</sup>

An Indiana case set forth the elements needed to prove constructive fraud as follows:

1. a duty owing by the party to be charged to the complaining party due to their relationship,
2. a violation of that duty by the making of past or existing facts or remaining silent when a duty to speak exists,
3. reliance thereon by the complaining party,
4. injury to the complaining party as a proximate result thereof, and
5. the gaining of an advantage by the party to be charged at the expense of the complaining party.<sup>9</sup>

## Civil Conspiracy

Civil conspiracy is what is known as a derivative tort. That is, “Civil conspiracy is not a stand-alone tort. Rather it is a derivative tort that requires the plaintiff to prove defendants’ participation in an underlying tort. *Tilton v. Marshall*, 925 S.W.2d 672, 681 (Tex. 1996).”<sup>10</sup> That means, for example, that the plaintiff must show that defendants engaged in concerted action for the unlawful purpose of destroying the targeted physician through fraud, constructive fraud, malicious prosecution (sham peer review),<sup>11</sup> and the preparation and filing of a false NPDB report against him. FindLaw, a website that provides legal resources for legal professionals, states:

Civil conspiracy has three main components:

- A group of individuals or entities (co-conspirators) work

together to commit an unlawful act.

- The act has an unlawful purpose.
- The act leads to harm or damages to another party.

This harm can manifest as financial losses, personal injuries, or damage to reputation.<sup>12</sup>

### Pleading Fraud with Particularity

Fraud must be pleaded with particularity, meaning that the specifics of who, what, where, and how must be stated in the claim.

Federal Rules of Civil Procedure, Rule 9(b) states: "In alleging fraud or mistake, a party must state with particularity the circumstances constituting fraud or mistake. Malice, intent, knowledge, and other conditions of a person's mind may be alleged generally."<sup>13</sup>

An exception to the requirement of pleading with particularity is when certain facts are known only to defendants and are not revealed to, or are withheld from, the plaintiff. An excellent review article noted:

[T]here are situations where fraud need not be alleged with particularity. "Less specificity is required when Respondent must necessarily possess full information concerning the facts of the controversy." (*Committee On Children's Television, Inc. v. General Foods Corp.*, 35 Cal.3d at p. 217.) "Even under the strict rules of common law pleading, one of the canons was that less particularity is required when the facts lie more in the knowledge of the opposite party..."(*ibid.*)<sup>14</sup>

According to the review article, reasonable, justifiable reliance on the misrepresentation is a major issue defendants frequently argue in fraud cases. This is a fact issue to be decided by a jury. The review article noted:

It is not...necessary that [a plaintiff's] reliance upon the truth of the fraudulent misrepresentation be the sole or even the predominant or decisive factor in influencing his conduct...It is enough that the representation has played a substantial part, and so has been a substantial factor, in influencing his decision. (*Engalla v. Permanente Medical Group, Inc.* (1997) 15 Cal.4th 951, 976-77.)<sup>14</sup>

The review article also pointed out the problem of inconsistent findings by a jury on a verdict form with respect to intentional fraud vs. negligent misrepresentation, and the issue that can create on appeal.<sup>14</sup>

In intentional fraud, it is alleged that the perpetrator knew that the representation was false when it was made. In negligent fraud, the defendant(s) may claim that they believed the representation to be true at the time, and the plaintiff must demonstrate that the defendant(s) had no reasonable grounds to believe the representation was true.

The typical argument advanced by defendants in lawsuits involving sham peer review, that they believed the charges against the physician to be true and accurate at the time they were made, seeks to exploit the reasonableness standards of the Health Care Quality Improvement Act (HCQIA, Sec. 11112(a)(1-4)) so as to obtain immunity. So, one may encounter the same argument both to obtain immunity under HCQIA and to explain why defendants should not be found liable for negligent fraud. There is, of course, no immunity for fraud.

The author of the review article recommends the following solution to avoiding a jury making a contradictory finding as to the defendant's state of mind (i.e., the defendant knew the representation was false, but at the same time believed the representation was true but had no reasonable basis for believing that).

[First], while displaying the actual jury instructions, we argue that it is either one or the other, hopefully having enough circumstantial evidence to prove the intentional conduct.

Second, [they employ] a practice of placing the questions related to the intentional-fraud claim before the negligent-misrepresentation claim in the verdict form. We place a transition instruction after the intentional-fraud claim, after the damages question, which instructs the jury to skip the negligent-misrepresentation claim entirely.<sup>14</sup>

### Examples of Fraud, Constructive Fraud, and Civil Conspiracy in Sham Peer Review

(1) A Notice letter sent by a hospital administrator to the accused physician represented that the peer review would be conducted according to the medical staff bylaws. A copy of the relevant section of the bylaws was attached to the Notice letter. However, the hospital leaders had no intention of following the medical staff bylaws, as evidenced by the fact they repeatedly violated them so as to achieve the desired outcome during the peer review. The physician reasonably relied on this misrepresentation and was harmed as a result.

(2) The vice president of medical affairs and the department chairman represented to the accused physician that it "would go better for him" if he simply "voluntarily" resigned. They misrepresented to him that if he voluntarily resigned, it would not be reportable to the NPDB. The physician reasonably relied on this false representation, resigned, was immediately reported to the NPDB, and his medical career was irreparably harmed as a result.

(3) In another case, the vice president of medical affairs and the department chairman represented to the accused physician that if he did not "voluntarily" agree to not perform surgery until an investigation could be completed, he would immediately be summarily suspended. They further represented to the physician that this voluntary abeyance would not be reportable to the NPDB. The physician reasonably relied on this false representation, agreed to the voluntary abeyance, and when the voluntary abeyance reached the 30-day mark, he was reported to the NPDB, and his medical career was irreparably harmed as a result.

(4) The chief medical officer falsely represented to the accused physician that following an incident, a formal peer review screening had been completed and that he must agree to take a voluntary leave of absence and go to the state medical society's Physician Health Program (PHP) for assessment for alleged alcohol impairment. The physician reasonably relied on this false representation and agreed to go to the PHP for assessment. Upon learning that no peer review had actually been conducted, the physician stated he never would have gone to the PHP had he known that. His reputation was harmed as a result.

(5) An attorney representing a hospital wrote to the physician's attorney and stated that none of the physicians who would be serving on the peer review hearing panel had previously participated in the decision to summarily suspend the physician. The hospital attorney knew that this was a false representation. All members of the hearing panel had previously participated in the decision to summarily suspend the physician. This information was deliberately withheld from the physician, and the physician did not learn about it until the time of the peer review hearing. The physician was harmed as a result of this misrepresentation.

(6) An attorney representing a hospital wrote to the physician's attorney and stated that the peer review hearing would be limited to a single patient case. The hospital attorney knew that this was a false representation, and planned to introduce a number of cases from the remote past at the hearing, as he did. The physician reasonably relied on this false representation, and as a result was unable to review these additional charts so as to provide a defense. The physician was harmed as a result.

(7) An attorney representing a hospital and the hospital CEO represented to a physician that if he completed his patient charts by a specific date, he would not be reported to the NPDB. Prior to that date, the hospital suddenly decided to report the doctor to the NPDB. The doctor completed all of the patient charts he was given prior to the agreed-upon date. The physician reasonably relied upon the false representation that he would not be reported to the NPDB if he completed his charts by the agreed-upon date, and was harmed as a result.

(8) An attorney representing a hospital and the vice president of medical affairs represented to the physician and to a peer review hearing panel that the physician had given a patient a medication that killed the patient. The attorney and the vice president of medical affairs knew, based on the hospital's pharmacy records and on the patient's nurse stating that she never gave that medication, that this was a false representation. The physician and the hearing panel reasonably relied on this false representation, and the physician was harmed as a result.

(9) An attorney representing a hospital and the hospital CEO implicated a physician in patient abuse, based on the false allegation that during a procedure the patient had yelled "stop" several times and that the physician refused to stop. The hospital's own post-procedure patient phone contact record the following day, however, failed to sustain this accusation. The patient also testified under oath that the physician did, in fact, pause the procedure when asked to do so. As neither the hospital attorney, CEO, or anyone else at the hospital asked the patient what happened, they had no reasonable grounds to support their false belief, but nevertheless summarily suspended the physician. Moreover, the hospital reported this false information to the NPDB. The physician was harmed as a result of this misrepresentation.

(10) An attorney representing a hospital, the CEO of the hospital, and the department chairman held meetings at which they discussed how they were going to "prosecute" the charges against the physician so as to achieve the desired outcome—removing the physician from the hospital and ruining his medical career. Part of the plan was to use false charges against the physician. The hospital attorney, CEO, and department head then conspired to knowingly file a false databank report against the physician. The physician was harmed as a result of this conspiracy.

## **Knowingly Filing a False NPDB Report Is a Crime**

It is a crime to knowingly and willfully file a false report in the NPDB. Federal law, 18 U.S.C. §1001 states in part:

(a) Except as otherwise provided in this section, whoever, in any matter within the jurisdiction of the executive, legislative, or judicial branch of the Government of the United States, knowingly and willfully—

(1) Falsifies, conceals, or covers up by any trick, scheme, or device a material fact;

(2) makes any materially false, fictitious, or fraudulent statement or representation; or

(3) makes or uses any false writing or document knowing the same to contain any materially false, fictitious, or fraudulent statement or entry; shall be fined under this title, imprisoned not more than 5 years or, if the offense involves international or domestic terrorism (as defined in section 2331), imprisoned not more than 8 years, or both. If the matter relates to an offense under chapter 109A, 109B, 110, or 117, or section 1591, then the term of imprisonment imposed under this section shall not be more than 8 years.<sup>15</sup>

The National Practitioner Data Bank is under the Department of Health and Human Services, which is part of the executive branch of the federal government.

When individuals at a hospital conspire to engage in unlawful conduct, such as knowingly filing a false databank report containing false and/or fictitious information, it is a very serious matter.

## **The Impact of Filing a Lawsuit for Fraud**

The impact of filing a lawsuit for fraud is very different from the impact of filing other tort claims. In particular, when an attorney is named as a defendant in a lawsuit alleging fraud, it may impact how others view his professional reputation. Suddenly, the "shoe is on the other foot," with the reputation and career of the attorney placed at risk.

Moreover, an attorney or CEO of a hospital committing fraud would be considered to be outside the normal scope of his employment/job function/contract (*ultra vires*). Given that committing fraud is not in his official "job description," a hospital may decide not to provide legal representation as might otherwise be provided as part of a lawsuit arising out of a peer review action. The hospital may also decline to indemnify employees against any award of damages.

In addition, claims for fraud are often not covered by professional liability and other insurance policies. Defendants who perpetrate such fraud are typically on their own in defending and paying damages for it, as they should be for such egregious wrongdoing.

Viewpoints with respect to possibly settling a case change when certain individuals face personal liability.

## **Example of How Fraud, Constructive Fraud, and Civil Conspiracy Are Pleaded**

A recent, excellent example of how fraud, constructive fraud, and civil conspiracy to commit fraud are pleaded is the case of

Jared L. Matthews, M.D. v. Shannon Tacker, Matthew Wilson, M.D. and Jana Finder.<sup>16</sup> The complaint is well worth reading.

## Conclusion

Knowingly and willfully making a misrepresentation on which a physician relies and is harmed as a result constitutes intentional fraud. Filing a lawsuit for fraud, constructive fraud, and civil conspiracy presents yet another opportunity for the victim of a sham peer review to hold the perpetrators accountable. Retaining a knowledgeable and experienced attorney is a key to success.

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# AAPS PRINCIPLES OF MEDICAL POLICY

**Medical care is a professional service, not a right.** Rights (as to life, liberty, and property) may be defended by force, if necessary. Professional services are subject to economic laws, such as supply and demand, and are not properly procured by force.

**Physicians are professionals.** Professionals are agents of their patients or clients, not of corporations, government, insurers, or other entities. Professionals act according to their own best judgment, not government "guidelines," which soon become mandates. Physicians' decisions and procedures cannot be dictated by overseers without destroying their professionalism.

**Third-party payment introduces conflicts of interest.** Physicians are best paid directly by the recipients of their services. The insurer's contract should be only with subscribers, not with physicians. Patients should pay their physician a mutually agreed-upon fee; the insurer should reimburse the subscriber according to the terms of the contract.

**Government regulations reduce access to care.** Barriers to market entry, and regulations that impose costs and burdens on the provision of care need to be greatly reduced. Examples include insurance mandates, certificate of need, translation requirements, CLIA regulation of physician office laboratories, HIPAA requirements, FDA restrictions on freedom of speech and physicians' judgment, etc.

**Honest, publicly accessible pricing and accounting ("transparency") is essential to controlling costs and optimizing access.** Government and other third-party payment or price-

fixing obscures the true value of a service, which can only be determined by a buyer's willingness to pay. The resulting misallocation of resources creates both waste and unavailability of services.

**Confidentiality is essential to good medical care.** Trust is the foundation of the patient-physician relationship. Patient confidences should be preserved; information should be released only upon patient informed consent, with rare exceptions determined by law and related to credible immediate threats to the safety or health of others.

**Physicians should be treated fairly in licensure, peer review, and other proceedings.** Physicians should not fear loss of their livelihood or burdensome legal expenses because of baseless accusations, competitors' malice, hospitals' attempts to silence dissent, or refusal to violate their consciences. They should be accorded both procedural and substantive due process. They do not lose the basic rights enjoyed by Americans simply because of their vocation.

**Medical insurance should be voluntary.** While everyone has the responsibility to pay for goods and services he uses, insurance is not the only or best way to finance medical care. It greatly increases costs and expenditures. The right to decline to buy a product is the ultimate and necessary protection against low quality, overpriced offerings by monopolistic providers.

**Coverage is not care.** Health plans deny payment and ration care. Their promises are often broken. The only reliable protection against serious shortages and deterioration of quality is the right of patients to use their own money to buy the care of their choice.