# Many Perversions of Peer Review Process

*by Philip R. Alper, M.D.*

Death and complications conferences during training introduced me to peer review. At Mt. Sinai Hospital, in New York City, attending physicians would travel from neighboring states to attend. The questioning was often brutal, but the aim was to improve patient care. It was done with almost religious fervor and in perfect safety.

The first variation on the theme that I encountered occurred years ago, when a rogue anesthesiologist tiedC the hospital medical staff up in knots as they sought to restrict his privileges for cause. The legalities dragged on for years and put the reviewers at personal risk due to accusations of malice and violation of antitrust laws. This was hardly a sordid quirk. The pages of *Medical Economics* Magazine regularly describe similar cases.

From such humble beginnings, peer review has gone on to extend, for better or worse, into almost every aspect of medical care. In the process, it has become perverted by misuse. The original purpose of peer review was the protection of patients and enhancement of the quality of care. Its scrupulous implementation has served as the basis for public trust and trust among colleagues. Honesty and fairness are assumed.

That is the ideal. Where peer review has taken a severe turn for the worse, in my opinion, is in the co-opting of the peer review process by numerous parties —government, insurers, hospitals, and even medical journals, to name just a few — to serve ulterior purposes. Medicare employs peer review with dual motives —no doubt to seek the best care for the dollars it pays out, but also to serve as a moral basis to enforce dubious fraud and abuse laws that leave physicians in a perpetual state of debilitating uncertainty. Although this is difficult to explain to nonphysicians, it is intuitively understood by anyone practicing medicine today.

But much further back, at the source, where we obtain the very knowledge we need to remain at the state of the medical art, we have reason for misgivings. Medical journals, including the very best of them, have come under attack recently for bias that includes commercial and political motivation. The lead editorial in the *Wall Street Journal* (11-16-06) is titled, "New England Journal of Politics." It condemns the credibility conferred by the status of a "peer-reviewed journal" to advance a variety of left-leaning political agendas.

I find this criticism credible. Shortly after I was appointed a Visiting Scholar at Stanford's Hoover Institution, I arranged an even-handed study of the impact of managed care on physicians in San Mateo County under the joint sponsorship of our Medical Association and Stanford Medical School. My most senior Stanford colleague on the paper we wrote refused to let me cite my Hoover affiliation in the manuscript we submitted to the major journals. "It would mean certain death for acceptance," this very savvy medical academic advised. (Actually, in the only analysis ever done, rather than showing the presumed "right-leaning bias," Hoover's voting pattern in a presidential election exactly replicated the national average.)

It's a given that money, fame, and power tend to corrupt. That applies most obviously to fraudulent scientists, particularly in stem cell research. The process is more complex in the current case of the Cleveland Clinic, where conflict of interest has been taken to new heights. It involves the promotion of a controversial surgical technique to treat atrial fibrillation, the patented instrument needed to perform it, stock investments by the institution in a company set up to sell it and partly owned by its inventor, who, in turn, became the chief executive of the Clinic.

More subtle is the case of Arnold Relman, M.D., former editor of the *NEJM,* and the scion of the Massachusetts school of utopians who aim to entirely demonetize medicine. I was raised in the era in which we were taught to "never consider money; just do what's right." Though desirable as policy, the notion struck me as unrealistic as a policy prescription, but I didn't dare argue then.

Dr. Relman is still beating the drum for yesterday's ideas — essentially, socialized medicine with medical academic control at its core—all emanating from Boston, where managed care has treated medical institutions (if not physicians) far more kindly than elsewhere in the country, and from Harvard, the beneficiary of the world's largest university financial endowment (by far).

The highly subsidized health delivery models that have been implemented in pilot programs in Boston serve as the basis for what is declared to be the only moral choice for the rest of the country. Elite faculty must find it difficult to consider themselves susceptible to selection bias, which makes their control of the standard-setting publication for the peer-reviewed medical literature all the more problematic. This is in addition to fad-like mind-sets that make peer review of

new scientific ideas so inhospitable. We are left wondering how skeptically to view the literature.

Coming closer to home and to our everyday lives, hospital medical staff actions constitute the form of peer review that is most familiar to us. There is a long history of argument over legitimate indications for various surgical procedures, usually with fairly wide latitude for differences of opinion. In years past, self-promotion was considered anathema. I thought it a bit strange when internationally renowned physicians in our community were treated locally as nobody special. But those were the days when advertising was not supposed to be used to seek professional advantage.

How far we have come! Now, our own hospitals promote individual physicians, procedures, and equipment with the undisguised goal of revenue enhancement. Continuing controversies over the safety of minimally invasive procedures, whether orthopaedic or cardiac, are glossed over. As the radio and television ads are broadcast, issues of visibility and credit make the difficult job of assessing professional excellence even harder. I am told that surgical departments were given monthly status reports detailing their relative place as revenue-generators for the hospital until at least one department rebelled. As one physician put it, "It's as if the indications and outcomes weren't even relevant."

Intraprofessionally, orthopaedists are unhappy that primary physicians can vote on requiring other specialties to take night call at annual staff meetings when many primary physicians no longer admit patients to the hospital. Indeed, why do such physicians maintain privileges and what do those privileges signify? Perhaps it's because hospital staff privileges are required by PPOs for accrediting primary physicians into their networks. And since primary physicians refer lucrative cases to the hospital, there is little incentive for anyone to make waves. On the other hand, nobody seems to much care that the burdens of implementing the costly clinical guidelines mandated by pay-for-performance programs fall almost exclusively on primary physicians.

A word about insurers. Every one of them is developing surveillance programs to assess physician performance and "increase compliance." Meticulously detailed literature sources and recognized clinical guidelines based on the peer-review process mix the science and the money in such inscrutable ways that they are difficult to argue against. Blue Shield of California has gone to the head of the class with its "Relative Efficiency Scores (RES)" that rate individual physicians on a "Resource Utilization Grid." The scores aggregate the physician's use of resources (a euphemism for cost) in treating selected diagnoses. Clinical outcomes are not relevant...

To summarize: peer review has been compromised in many ways—by politicization, introduction of other agendas, hidden financial considerations, and misuse of the "peer-reviewed" imprimatur to promote dubious practices. Consequently, this process that all doctors could automatically subscribe to in the past, now needs to be re-validated.

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