Am I My Brother’s Warden? Responding to the Unethical or Incompetent Colleague

by E. Haavi Morreim

Responding to the failings of peers can be difficult, but as professionals physicians should not leave the moral management of errant colleagues to chance. Distinguishing levels of adverse outcomes helps physicians more clearly assess each others’ conduct and respond appropriately to those who threaten the integrity of the profession.

A physician should expose, without fear or favor, incompetent or corrupt, dishonest or unethical conduct on the part of members of the profession.” It is a commandment easier issued than followed. Although a rising interest in quality assessment has led to increased disciplinary actions by state boards and to treatment programs for impaired physicians, strong social norms reject spying and “snitching” on colleagues in favor of respecting professional privacy and individual responsibility.

Professional self-policing is particularly challenging with respect to physicians who are incompetent or unethical, as distinct from impaired. An impaired physician is unable to practice medicine with reasonable skill and safety by reason of physical or mental illness. He or she may be hindered by waning eyesight, dementia, or substance abuse. The incompetent physician, on the other hand, is not ill, but ignorant or unskillful, while the unethical physician knowingly and willingly violates fundamental norms of conduct toward others, especially his or her own patients.

Impairment commonly elicits sympathy and a wish to help. Even a drastic intervention, such as to remove an aging surgeon from the operating room, can be done with charity toward the physician. And in the process one may help that physician. Many states have confidential programs to treat substance abusers and return them to practice, benefiting both them and their patients. In contrast, one feels less charitable toward the incompetent, and not at all benevolent toward the unethical physician.

Furthermore, the standards by which we define impairment are considerably clearer than those by which we identify incompetence or poor ethics. Though there are borderline cases, usually we know what it is to be going blind or to be an addict. In contrast, it is not always clear what constitutes “standard” medical knowledge and skill. Practice parameters can suggest routine management of common problems, but cannot define competent care. Patients and their illnesses vary widely, and it can be difficult to distinguish between poor management of an ordinary situation and good management of an unusually complex situation.

Ethical standards are at least as difficult. Some things, of course, are clear. It is plainly wrong to demand sexual intercourse from a fourteen-year-old girl while holding a gun to her head, or to trade forty-four prescription pain pills for a pair of machine guns. But elsewhere standards are not so clear. We may never agree whether euthanasia or even assisted suicide is morally acceptable.

If identifying standards is particularly difficult in the case of competence and ethics, the same is true for gathering evidence. On the one hand, indications of impairment can be relatively straightforward. Blood tests can reveal alcohol, and medical evaluation can diagnose dementia. In contrast, incompetence is seldom easy to detect, partly because the competence of care depends on the clinical context. The patient may have looked very different when he first presented to his primary care physician, for example, than he did hours later for a consulting physician. Furthermore, incompetence typically

E. Haavi Morreim is an associate professor, College of Medicine, University of Tennessee, Memphis.

requires not just one error, even a serious one, but a pattern of them. Not often does any one colleague have the opportunity to observe such a pattern. Unethical conduct is commonly even more difficult to detect, as a devious doctor takes great care to conceal his misdeeds.

Although we must distinguish impaired, incompetent, and unethical physicians, require categories of course overlap. The demented physician is also incompetent. A surgeon who continues to operate despite failing eyesight commits moral as well as medical wrongs. Still, the concepts are distinct. And while impairment has received considerable scholarly attention, incompetent and unethical physicians have not. In this article I will therefore focus on the latter two, and will begin the analysis by looking more closely at why professional self-policing is so difficult.

Policing One’s Own

It is difficult for physicians to monitor each other for many reasons. As noted, judgments about competence and ethics require standards and facts that are often neither clear nor readily available. The practice of medicine is permeated by uncertainty, and the best physician is bound to make errors, including some serious ones. To condemn someone else is to invite scrutiny of oneself.

Beyond this, careless or unjust allegations can harm the accused economically, professionally, and personally, as they may drive away patients, reduce collegial esteem, and leave the physician feeling betrayed by those he trusted. Patients, too, can be harmed if a good medical relationship is destroyed or if a capable physician is removed from practice. Even a raised-eyebrow innuendo about a physician’s qualifications can raise troubling uncertainties that the patient is in no position to resolve. Neither is the profession as a whole enhanced by widespread mud-slinging or an accusatory, punitive atmosphere. In current times of increasing economic competition among physicians, the danger of such an atmosphere is real.

Finally, the physician who challenges a colleague may herself be harmed, even if her accusations are correct. Whistle-blowers can suffer retribution1 or be sued for slander, libel, or discrimination.2 More recently, they can face antitrust allegations. Those who sit on peer review committees and other disciplinary bodies are sometimes sued on the ground that they are attempting, not to police the profession, but merely to stifle competition.3 Losers in such suits pay treble damages.

To sue, of course, is not necessarily to win. Peer review that satisfies the requirements set forth by the Health Care Quality Improvement Act (HCQIA) of 1986—good faith, good facts, good procedures, and good reasoning—enjoys antitrust immunity.4 Still, even a small prospect of legal wrangling can inhibit physicians from pointing accusatory fingers at colleagues.

The individual physician not only has reasons to be cautious, but also some reassurance that the profession already monitors its own. Physicians have a number of avenues, such as weekly morbidity/mortality conferences, by which to critique and improve each other’s performance. Most medical specialty boards now plan or require periodic recertification as a regular means of improving quality of care. Hospitals have asorted forums, from credentials review to tissue committees, to monitor staff physicians’ performance. The HCQIA of 1986 established a National Practitioner Data Bank that requires reports ranging from malpractice awards and state licensure actions, to adverse judgments rendered by hospitals and medical societies. Hospitals are required to check this data bank before granting or biennially renewing staff physicians’ credentials.5 State medical boards can revoke or suspend licenses and impose other discipline, actions also requiring reports to the data bank.

The legal system also monitors physicians. Tort law lets injured patients seek compensation for negligent injuries and broken contracts, while criminal law prosecutes those who practice without a license or commit fraud. Administrative law enforces the standards of quality and efficiency expected of physicians caring for federally insured patients: the Health Care Financing Administration uses peer review organizations (PROs) to monitor quality and necessity of care, while the Department of Health and Human Services has its Office of Inspector General to enforce laws against kickbacks, fraud, patient abuse, and incompetence.

Economics also spurs quality. Health insurance companies review utilization to identify inappropriate care, particularly overutilization, and many malpractice insurance companies aggressively monitor their physician-subscribers’ quality of service. Reviewing such factors as medical judgment, patient rapport, and record keeping, these companies educate and supervise physicians whose poor performance could cost the company too much.6 Patients also demand quality in an increasingly competitive market for health care.7

Unfortunately, these measures are generally conceded to be inadequate. State medical boards are typically hampered by inadequate funding, heavy case loads, and a demanding standard of proof that permits actions in only the worst cases.8 Hospitals and medical society committees have been hindered by inadequate funding and by political pressures. PROs concentrate more on fraud and excess costs than on incompetence. And the medical community itself, perhaps feeling under siege by myriad lawsuits and a plethora of new peer review requirements, is often so reluctant to pursue errant colleagues that the public perceives an intense mutual protectionism. Let us consider, then, why each physician should personally help to pursue incompetent and unethical colleagues. The reasons include professionalism, patient autonomy, law, and economics.

Professions, by definition, are complex fields involving esoteric knowledge that serves some important human need. Only the members of a profession are qualified to establish their standards of care, and they have an obligation to police their own ranks. In medicine this duty is magnified by patients’ vulnerability. Aside from the physical, emotional, and rational impairments accompanying illness, patients usually lack the knowledge to diagnose or treat their ail-
ments, or even to judge for themselves the quality of care they are receiving. Physicians’ obligations of fidelity therefore include protecting patients from substandard colleagues—by not referring the patient to a colleague whom one knows to be unethical or incompetent, and by removing or reforming unsuitable colleagues.

Autonomy encompasses not only the patient’s right to make medical decisions, but also to make an informed choice among providers who are willing to accept her as a patient. Any physician asked about his qualifications and experience, or those of a colleague, should therefore answer honestly. The patient is also entitled to decide what to do about errors, both medically and legally. But to do so, she must know that an error was actually committed. This does not mean that physicians must broadcast their colleagues’ flaws at every opportunity. I will discuss specifics below, but in general, physicians are morally obligated and legally advised to be frank about errors that harm patients, even where litigation might result.

Legal reasons for exposing incompetent or unethical practices go well beyond the patient’s right to seek fair compensation for negligent injuries. Most states have statutes requiring physicians to report impaired or otherwise questionable colleagues. Though these statutes are rarely enforced, reports to state medical boards have increased markedly in the last few years. Reporting statutes are supplemented by three other doctrines: the duty to warn, the doctrine of fraudulent concealment, and *qui tam*.

The duty to warn is admittedly imprecise and variable. First appearing as psychiatrists’ duty to warn third parties of dangers posed by their patients, the duty has expanded over the years. Some scholars see a common law duty to warn those persons, including patients, who may be endangered by an impaired physician. Where this approach is enforced by courts, a physician who fails to warn could find herself liable for the injuries that the miscreant physician causes. Other cases post a duty to warn the colleague directly so as to avoid negligent care in the first place, as where an assisting surgeon sees that the lead surgeon is doing a procedure incorrectly.

The doctrine of fraudulent concealment requires that when a physician knows he or another physician has caused a patient injury, whether or not through negligence, he should disclose it. A failure to disclose—whether actively by deliberate deception, or passively by merely being silent—can constitute fraud. The duty has been applied only to physicians actually caring for that patient, not to uninvolved physicians who just happen to hear about the situation through casual conversation.

In *Lopez v. Sawyer*, for instance, a woman receiving radiation treatments after her mastectomy developed severe burns, pain, nausea, pulmonary fibrosis, and spontaneous rib fractures requiring multiple hospitalizations. She was not aware that her care had been negligent until, during one hospitalization for reconstructive surgery, she overheard a physician tell his colleagues, “And there you see, gentlemen, what happens when the radiologist puts a patient on the table and goes out and has a cup of coffee.” In cases like *Lopez*, where the failure to disclose does not lead to further injury, the fraud may only mean that the statute of limitations restricting the patient’s time for bringing a lawsuit does not begin to run until the patient has or should have discovered the fraud.

Fraudulent concealment can also be separate tort, particularly if the concealment leads to further injury for the patient. Even a physician who did not cause the original injury, but only helped to conceal it from the patient, can be found liable for the fraud and also, in certain cases, for conspiracy and other torts leading to one such procedure a third physician warned the hospital that the patient was considering litigation, whereupon the hospital canceled the surgery. All three physicians were found liable for conspiracy and fraudulent concealment.

Because the physician-patient relationship is fiduciary, this legal duty to disclose colleagues’ errors does not permit the physician to wait until the patient asks questions. Rather, one must be affirmatively forthcoming with the information.

*Qui tam* is a Latin expression meaning “one who sues on behalf of the king as well as himself.” In a 1986 revision of the False Claims Act, Congress encouraged citizens to help prosecute those who defraud the government by promising them a share of any money recovered. In the case of medicine, such fraud could include billing for noncovered services, double billing, poor quality care, or unnecessary services. While the prospect of profit may not be a noble motive for physicians to help ferret out corrupt uses of federal health care dollars, it nevertheless promises to be a significant mechanism for rooting out some unethical conduct.

Physicians also have economic reasons to be vigilant about their profession. Cost containment mechanisms require that physicians and patients consider carefully the economic as well as the medical wisdom of their

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Assessing the Errant Colleague

In assessing an errant colleague it is useful to consider competence before proceeding to ethics. It is sorely tempting to ignore the incompetent colleague. "Anyone can make a mistake." "There but for the grace of God go I." "We've all been careless at one time or another." Although sometimes such reflections are quite right, it would be wrong to overlook all errors just because some do not warrant alarm. We need to identify five levels of adverse outcome, distinguishing ordinary mishaps and sad stories from real mistakes indicating incompetence.

The first level of adverse outcome is the complete accident, independent of any human decision or action. A sudden power failure or unusual equipment malfunction can thwart a delicate operative procedure.

At the second level, a physician's well-justified decision unexpectedly turns out badly. Penicillin may be entirely appropriate for a patient with a bacterial infection sensitive to penicillin and no known history of drug allergy. If that patient subsequently suffers an anaphylactic reaction, the outcome is adverse but the physician's decision was not faulty in any way. In this category we also find the expected iatrogenicity of necessary treatments. Chemotherapy for cancer can cause devastating side-effects. But if the chance for benefit is acceptable and the patient is willing, these adverse outcomes do not indicate poor practice.

On level three are those instances, so common throughout medicine, where good physicians disagree. They can differ about whether to recommend coronary artery bypass surgery on a patient with a serious three-vessel disease whose emphysema adds a serious surgical risk. Or they can differ about whether the superior antimicrobial coverage of a broad-spectrum antibiotic is worth risking its increased nephrotoxicity in a patient with compromised renal function. The examples are legion, because medicine is inherently uncertain and fallible. Where it happens that a physician's well-founded decision later turns out to be incorrect, we have no basis for criticism. A physician's care is best judged, not by an outcome that cannot be certainly predicted, but by the reasoning that he brought to a difficult question.

At level four the physician exercises poor, though not outrageously bad, judgment or skill. Every physician makes such errors, even if only rarely. One misses seeing a lesion on an X ray that, retrospectively, is painfully obvious. Or one might do too cursory a history and physical examination, missing signs that were both visible and important. Or one forgets to ask the patient about allergies or to note them in the chart. These cases especially prompt the physician observing some error by a colleague to shudder, "There but for the grace of God go I." Here incompetence is marked, not by the commission of a lone error, but by a pattern of them.

At the fifth level are egregious violations of the expected quality of care. The surgeon reads the X ray backwards, or doesn't consult it at all, and operates on the wrong leg. A pediatrician injects twenty times the lethal dose of lidocaine into an eleven-month-old infant in order to lance a boil—and then fails to help the dying child because he does not know how to perform basic cardiopulmonary resuscitation. Dr. Revici claims that he can cure breast cancer without surgery by prescribing vinegar, baking soda, soft-boiled eggs, and coffee.

These five classifications must be applied with care. A bad outcome does not imply error. Nor does the bare fact that a physician has done something differently from oneself or one's closest colleagues entail that he is either wrong or generally incompetent. The important question is not how prevalent his practices are, but whether there are respected physicians who agree with him. The law's concept is "reputable minority." Or we could borrow a term from Benjamin Freedman's discussion of research ethics: we are looking for "clinical equipoise," a situation in which there is "no consensus within the expert clinical community about the comparative merits of the alternatives."

A physician uncertain how to evaluate a colleague's competence should share her concern with one or more trusted colleagues, taking care not to violate the anonymity of the person about whom she is speaking. She can thereby gather something of a "reality check" on the standards of evaluation by which she is appraising that physician's questionable care. Having done so, she should limit her attention to level-five errors, and to level-four errors that appear to be part of a pattern.

In appraising the ethical quality of conduct, it is useful to note that good
ethical decisionmaking can be remarkably similar to good medical decisionmaking. In some cases one’s best efforts do not go well. One may communicate carefully, thoroughly, and respectfully with a patient about his diagnosis and his treatment options. But if the patient is from a very different culture, he may find such discussions disturbing or even insulting, in ways that the physician could not have anticipated. Such cases would correspond roughly to adverse medical outcomes of levels one and two above.

At other times one’s ethical duties, just like medical standards, are not clear. The essence of an ethical dilemma is the conflict of one or more important values, with no resolution available that honors them all. If a patient refuses an urgently needed medical intervention, such as antibiotics for bacterial meningitis, the physician can only honor his autonomy at the expense of his medical well-being, and vice versa. In genuine moral dilemmas, one must bring the best thought and argument one can to a situation in which fundamental uncertainty preempts an obviously correct answer. As noted in the discussion of medically adverse outcomes on level three, the quality of a difficult decision in these situations is a function of the quality of the reasoning one brings to it. And where good people of good will can differ, there is no basis for condemnation or correction.

In some instances, however, it is quite clear that a colleague has violated a fundamental norm. Here, too, we can compare moral error with medical error. Medically incompetent care violates accepted standards. Admittedly those standards can change over the years, as physicians’ collective knowledge and skill increases. But medicine cannot be practiced without some shared concept of what constitutes appropriate management. Therefore, those who practice medicine must meet its basic standards of quality and keep abreast of its growth and development. As noted above, deviations below medical standards vary. An error of moderately bad judgment (level four) is not the same as outrageous malpractice (level five).

In the like manner, medicine as a profession embraces ethical standards. Physicians are expected to elevate patients’ interests above the self-interest that normally guides the marketplace. Self-interest neither can nor must be erased, of course, and the tension between altruism and self-interest is probably the most fundamental ethical challenge of medicine. Because medicine does embrace ethical standards, it is possible at least sometimes to identify instances in which a physician deviates from those standards. Not all deviations are of the same character, however. Just as a moderately bad judgment is to be distinguished from outrageous malpractice, so must we distinguish levels among ethical misconduct.

On a fairly mundane level are misdeeds arising, not out of evil intent, but from ignorance, thoughtlessness, or insensitivity. These surely are the majority of ethical infractions in the medical profession. The physician may want to do good, but may be misguided in some way, or unable for some reason to do what he knows he should. An internist, for instance, might refuse to tell patients truthfully about diagnoses of life-threatening illness or other disturbing information. Or a surgeon may refuse to honor patients’ DNR requests because he doesn’t believe in them. An oncologist may steer all his patients toward last-ditch, aggressive experimental treatment, even those who are clearly dying and in desperate need of comfort and solace: “I’m a fighter, and so are all my patients.” The misdeeds of misguidance and insensitivity are fundamentally different from outrageous, deliberate moral wrong—the commission of moral evil, if you will. In medicine that evil would consist in the calculated use of physician’s knowledge and power to exploit patients or others for personal gain. A psychiatrist who has sex with a desperately dependent female patient. A surgeon capitalizes on his patients’ ignorance to secure their consent to unnecessary, dangerous, lucrative procedures. An internist exploits her power of prescription and her authority to file insurance claims to profit from fraudulent billings.

Physicians who violate traffic laws or shoplift also commit wrongs, but these are not the stuff of professional self-policing. Rather, peer supervision, lest it degrade into generic vigilantism, should generally be limited to misconduct that arises out of the special status and duties of physicians as professionals.

Accordingly, as one evaluates a colleague for possible ethical misconduct, one must consider several dimensions. First, one must determine how clearly the conduct violates the accepted ethical standards of medicine and the community. As noted above, many ethical dilemmas do not admit of clear resolution, and people of good conscience can differ. Colleagial scrutiny must be confined to instances of clear violation.

Second, one must consider the seriousness of the violation. In most cases, this is a function of the seriousness of the actual or potential harm that may occur as a result of the wrongdoing. In other cases an action is intrinsically wrong, regardless of whether it is likely to cause anyone direct physical or psychological harm. Many uses of placebo, or other lies to a patient, are wrong even if they do not cause harm. Intrinsically wrongs and harms alike can vary in their seriousness. The psychiatrist who engages in sexual relations with a patient is likely to precipitate profound, lasting damage. The physician who prescribes an unnecessary lab test to enhance his profits has also done wrong, but the harm to the patient is substantially less.

The seriousness of the harm also depends on the likelihood that harm will occur. Where the psychiatrist has sex with a patient, the harm is virtually certain, not speculative. In contrast, some misdeeds are less likely to injure patients and may be, on that dimension at least, morally less serious. The physician who accepts one costly gift from a pharmaceutical representative has arguably done wrong. Yet this lone episode is not as likely to corrupt his decisionmaking and harm patients as a widescale acceptance of such gratuities.

Obviously, these guidelines do not tell the physician precisely which conduct is unethical, or which unethical conduct warrants his or her intervention. No formula can do
that. Still, they represent foundations on which concerned physicians can begin their inquiry. And they help one to delimit the kinds of problem that are, and are not, fit subjects for collegial scrutiny.

Responding to the Errant Colleague

One cannot decide how to respond to an errant colleague without determining first precisely to what one is responding. Where ignorance or lack of skill is the problem then education, not punishment or discipline, is the answer. Where poor ethics is misguided, not evil, then moral education may be in order. In contrast, responsibility and retribution are appropriate for deliberate exploitation. Such unethical conduct is committed by free agents who do or should know better and who could have done other than as they did.

Therefore, one's first step in pursuing a problematic colleague is to "diagnose," beginning with careful factual investigation. One cannot judge whether someone's care is incompetent without knowing the circumstances. The man who obviously has appendicitis by the time he presents to the emergency room may only have had vague symptoms of upset stomach when he saw his local physician a few hours earlier. Analogously, ostensibly unethical conduct may have a deeper source. The oncologist closer inspection, she may have judged this to be the only way of securing badly needed resources for her patient. Such an explanation does not entirely excuse her conduct, yet an earnest desire to help the patient is far preferable, morally, to mere greed.

When careful investigation concludes that a colleague has committed a serious error, one is obligated to act. Sometimes one can resolve the problem alone. A careful investigation, for instance, may itself be the resolution. A consultant might phone the primary care physician to learn the detailed information that can help him both to evaluate the patient and to appraise the referring physician. At the same time, the follow-up information he then provides about the patient may be just the extra bit of education the primary physician needs to improve her future management of similar cases. Such discussions need not be accusatory or condescending, because both physicians can learn from each other.

Similarly, if one feels that a colleague is not sufficiently honest with his patients, one may help that physician by sharing stories about the kinds of communication that seem most effectively to help patients participate intelligently in their own care. One can portray the indignity and helplessness felt by patients whose wishes are ignored, and

The medical profession as a whole needs to develop a more constructive approach to error than the punitive, litigation-wary atmosphere that currently prevails.

who is a fighter may be emotionally unable to accept death without feeling desperately like a failure. The family physician who never truthfully shares bad news may fear that he cannot cope with a patient's horrified response; he may not know how—what words—to convey bad news in a way that helps the patient address the future with hope alongside realism. The internist may appear to defraud an insurance company, but on course, but the potential consequences of our medical mistakes are so overwhelming that it is almost impossible for practicing physicians to deal with their errors in a psychologically healthy fashion. Not only is the possibility of committing serious error a constant threat, but in medicine one is taught to reproach oneself even for minor deviations below optimal care. To compound the problem, medical education usually does not prepare physicians well to deal with their errors. Precision, accuracy, and completeness are emphasized, often with an unrealistic neglect of medicine's enormous fallibilities and uncertainties. And those who have erred are encouraged mainly to determine how they could have been better, not helped to face the emotional guilt of having done less than the best for their patients. This rather punitive approach need not dominate. In any enterprise, the assumption that error is the product of bad performers' incompetence or carelessness yields a system of inspections and penalties that inspires evasiveness, defensiveness, and conflict. A far better approach, some suggest, is a "continuous improvement" in which people are presumed to be capable and motivated, so that error presents a welcome opportunity for improvement.

Admittedly, continuous improvement is no panacea. Some physicians are seriously incompetent, and some are truly unethical. Their problems are not reducible to organizational imperfection. Still, a more constructive, mutually helpful attitude toward error might improve performance and reduce unproductive defensiveness.

In responding to an errant colleague an individual can be most effective by acting alone in situations permitting informal resolution, and in those requiring immediate corrective action. If one witnesses a colleague disclosing confidential patient information to entertain friends at a cocktail party, one can take that physician aside and remind him of the moral rules. Similarly, ethical problems arising from ignorance or insensitivity must be handled immediately. Only the person who is present and
assisting in a surgery can correct an error before it becomes a disaster.48 In other cases the concerned physician can seek informal help from a colleague. A pediatrician, even one who is hospital chief of staff, may be "eaten for lunch" if he complains directly to a prominent surgeon about his mortality rates. But a word to that surgeon’s own department chairman could be highly effective.49

Though many situations can thus be managed with one-on-one collegial support, other occasions require more serious or long-term action. The morally misguided physician may refuse to recognize that his poor communication can harm patients; the out-of-date practitioner may shun informal education. And the most egregious wrongs and malpractice usually require explicit correction or sanctions. In such contexts, formal group action has important virtues. A committee can more easily assemble the breadth of information needed to establish, for instance, that a pattern of problems is occurring rather than just an occasional mistake. Further, an established peer review group is in a better position to be fair. Several people, with their differing perspectives and questions, are more likely than any one individual to look at all sides of a question. And an official committee has greater power than any private party to gain access to necessary records and other information. Finally, careful due process by a formal body may be less likely to prompt antitrust or other legal problems.

Once one has decided that it will be better to take his concerns to a formal body rather than to manage the problem by himself, he must still consider to which body he should turn. Where incompetence is the problem, hospital committees are usually preferable because they have powerful reasons to ensure both that serious peer review is undertaken and that it is careful and fair.

Hospitals' peer review is not just a requirement of the Joint Commission on Accreditation of Healthcare Organizations. In a competitive market, it is also economically imperative to have a highly qualified staff whose excellence can attract patients and their revenues. Legally, the doctrine of corporate negligence places on hospitals a direct duty to patients to select and maintain a competent staff.

Hospitals have long borne vicarious liability for the actions of their employees, such as nurses or laboratory technicians. But until recently they could not be held liable for the actions of staff physicians, who are independent contractors over whom hospitals have no direct control. Many jurisdictions, however, have now determined that hospitals have a corporate responsibility to their patients to use reasonable care in selecting staff physicians, to review the medical care given to their patients, and to suspend or restrict the privileges of physicians found to be incompetent.41 As noted by the Supreme Court of Florida, "the hospital is in a superior position to supervise and monitor physician performance and is, consequently, the only entity that can realistically provide quality control."42

Hospitals also must ensure that such review is carried out fairly, else they will not enjoy immunity against antitrust litigation. Because each physician being evaluated is likely to be known to the members of the peer review committee, it is usually possible to assemble a more complete factual picture, and to be flexible in helping an errant physician to improve the quality of his care. The flexibility is in marked contrast to state medical boards, for example, which are mainly restricted to actions regarding the physician's license, and whose findings typically must meet a strong burden of proof, namely, the "clear and convincing" rather than "preponderance of the evidence" standard. These limits account, in part, for the great difficulty that state medical boards have had in effectively addressing physician incompetence.43

Hospital-based peer review is an important, but not sole solution to physician incompetence. Not all physicians practice in hospitals, and physicians on hospital peer review committees may be reluctant to weed out their own colleagues. Therefore other approaches are also important, such as the peer supervision undertaken by malpractice insurance companies or health insurers, as noted above.

Where unethical conduct is the problem one can, as with incompetence, consult hospital committees. Hospital committees need to know about unethical physicians to take appropriate credential actions or other measures. They also can address more subtle infractions such as a chronic refusal to honor patients' advance directives. In general, such cases must represent violations of hospital policies or of fairly clear ethics guidelines. Considerations of due process require that the hospital state its expectations in advance, before it can cite breaches of those standards as justifications for disciplinary proceedings. The hospital can cite its DNR policy, for instance, as a basis on which to proceed with their further investigation and potential sanctions. Such sanctions can be very flexible, ranging from mandated education, to formal censure, to suspension of certain privileges, to removal from the hospital staff. Other avenues include medical societies, which can revoke an errant physician's membership—an action that must now be entered into the National Practitioner Data Bank.

Serious or systematic ethical misconduct requires serious, formal action. Such cases should be presented to bodies that have social and legal authority to protect all potential patients from that physician. State medical boards can revoke or limit the physician's license and should be consulted if the unethical conduct threatens patient welfare or otherwise challenges the physician's right to practice. Crimes, such as rape or fraud, should be reported to appropriate legal authorities.

**Integrity of One, Integrity of All**

Whether one addresses a colleague's incompetence informally or oneself or takes those concerns to higher authorities, two principles surely must apply. First, problems of collegial competence and ethics should not be ignored. Admittedly, investigating colleagues is difficult. One often remains unsure whether he has all pertinent facts, partly because of medicine's inherent complexity, and partly because of the need to be discreet in any such in-
quity. And one may fear the whistle-
blower’s common fate of bringing
more trouble on oneself than on the
bad colleague. It is sorely tempting to
ignore such problems. And yet "due
process" does not mean "do noth-
ing." If medicine as a profession is to
retain its authority to supervise its
own, it must use that power or lose it.
Second, one must address the
problem directly and not pass it on to
someone else, as by sending the
incompetent colleague elsewhere with
one’s warmest recommendations.44
The point seems obvious, yet de-
serves emphasis. Donal Billig, a naval
surgeon whose incompetence eventu-
ally resulted in criminal convictions
for involuntary manslaughter and
negligent homicide, was hired at
Bethesda Naval Hospital in part be-
cause he had favorable letters of re-
ference from three professors of sur-
gery—one at Harvard and two at
Tufts—who even at that date had good
reason to doubt his skills.5

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colleagues poses one of the most dif-
cult, yet important issues a physician
can face. Traditional professional vir-
tues such as compassion, conscien-
tiousness, honesty, and fidelity are
familiar mandates for the care of
patients. Here, however, physicians
must call on the more difficult virtues
of courage, integrity, and wisdom.
The incentives to ignore such prob-
lems are nearly overwhelming, as one
fears the dual dangers of being either
the agent or the recipient of unfair
accusations and reprimands. Yet there
is no choice. One’s own professional
integrity is compromised when one
permits the integrity of one’s profes-
sion to be compromised. And the
care of all patients is jeopardized if
physicians do not care about their
own profession.

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References

1. American Medical Association, Cur-
rent Opinions of the Judicial Council
(Chicago: American Medical Associa-
tion, 1984).

2. James Gray, "Why Bad Doctors
Aren’t Kicked Out of Medicine," Medical
Economics 69, no. 2 (1992): 128-49; L.
Page, "MD Scalp Hunting: Discipline Re-
port Puts Heat on State Boards," American
J. E. Fisher, "The Chemically Dependent
Physician: Liability for Colleagues and
Hospitals in California," San Diego Law
Review 21 (1984): 431-53; R. S. Walzer,
"Impaired Physicians: An Overview and
Update of the Legal Issues," Journal of

3. Gray, "Why Bad Doctors Aren’t
Kicked Out of Medicine"; R. S. Walzer,
"Impaired Physicians."

4. A. R. Tarlov, J. E. Ware, S. Green-
field et al., "The Medical Outcomes
Banta and S. B. Thacker, "The Case for
Reassessment of Technology: Once Is
Not Enough," JAMA 264 (1990): 235-40;
L. L. Leape, T. A. Brennan, N. Laird et al.,
"The Nature of Adverse Events in Hospi-
talized Patients: Results of the Harvard
Medical Practice Study II," NEJM 324

5. Viloria v. Sobol, 547 N.Y.S. 2d 688
(A.D. 3 Dept. 1989).

6. Jon Hamilton, "Board Disciplines
2 Local Physicians," Memphis Commercial
Appeal, 21 October 1990.

7. "Suspension of VA MD Delayed
Pending Investigation," American Medical
News, 13 March 1987, p. 18; Brian McCor-
mick, "MD Says Her Whistle-Blowing Led to
a Court-Martial," American Medical
News, 14 October 1991, p. 8; L. Page,
"Two Physicians Claim Whistle-Blowing Led
to Retaliation," American Medical
News, 23-30 March 1992, p. 14; L. Page,
"Stakes are High When You Blow the
Whistle," American Medical News, 27 April

8. William J. Curran, "Medical Peer
Review of Physician Competence and Per-
formance; Legal Immunity and the Anti-

(1988); William J. Curran, "Legal Im-
munity for Peer Review Programs: New
233-35; C. C. Havighurst, "Professional
Peer Review and the Antitrust Laws,
Case Western Reserve Law Review 36

10. Curran, "Legal Immunity"; John K.
Iglehart, "Congress Moves to Bolster Peer
Review: The Health Care Quality
Improvement Act of 1986," NEJM 316

11. Curran, "Medical Peer Review"; Igl-
ehart, "Congress Moves to Bolster Peer
Review"; J. R. Bierig, R. M. Portman,
"The Health Care Quality Improvement
(1988): 977-1014; S. L. Horner, "The
Health Care Quality Improvement Act
of 1986: Its History, Provisions, Applica-
tions and Implications," American Journal
of Law and Medicine 16 (1990): 453-98; F.
Mullan, R. M. Politzer, C. T. Lewis et al.,
"The National Practitioner Data Bank:
Report from the First Year," JAMA 268

12. William B. Schwartz and Daniel N.
Mendelson, "The Role of Physician-
Owned Insurance Companies in the De-
tection and Deterrence of Negligence," JAMA
262 (1989): 1342-46; "High-Risk
Physicians Aided in Oregon," American
Medical News, 6 March 1987, p. 15.

13. Timothy S. Jost, "Regulatory
Approaches to Problems in the Quality of
Medical Care: Diagnosis and Prescrip-
tion," University of California Davis Law Re-

14. Richard P. Kusserow, Elisabeth A.
Handley, and Mark Vessian, "An Overview
of State Medical Discipline," JAMA 257

15. Joseph H. King, The Law of Medical
Malpractice, 2nd ed. (St. Paul: West Pub-
lishing Co., 1986).

16. Sudre v. Hackney, 297 S.E.2d 515

17. L. M. Peterson and Troyen Bren-
nan, "Medical Ethics and Medical Injuri-
es: Taking our Duties Seriously," The
Journal of Medical Ethics 1 (1990): 207-11;
American College of Physicians, "Ameri-
can College of Physicians Ethics Manual,
Annals of Internal Medicine 117 (1992):
947-60, at 956.

18. Gray, "Why Bad Doctors Aren’t
Kicked Out of Medicine"; Fisher, "The
Chemically Dependent Physician"; Walzer,
"Impaired Physicians."

19. Tarasoff v. Regents of the Univer-

20. Larry O. Gostin, "The AIDS Litig-
tion Project: An National Review of Court
and Human Rights Commission Deci-
sions, Part I: The Social Impact of AIDS,'
JAMA 263 (1990): 1961-70; Walzer, "Imp-
aired Physicians."

21. Fisher, "The Chemically Depen-
dent Physician"; King, Law of Medical
Malpractice.

22. McMillin v. L.D.L.R., 645 S.W.2d
836 (Tex. App. 1982). The physician may
also be obliged to warn about his own
inadequacies. One court recently held
that a surgeon’s failure to disclose his
chronic alcohol abuse was a violation
of the patient’s right to make an informed
consent to the proposed surgery. The con-
dition does, after all, create a "material
risk associated with the surgeon’s ability to
perform" the procedure. Hidding v.
Williams, 578 S.2d 1192 (La. App. 5 Cir
1991), at 1196.

23. Lopez v. Sawyer, 300 A.2d 563 (N.J.
1973), at 565.
42. Fisher, "The Chemically Dependent Physician."
44. Kusserow, Handley, and Yessian, "An Overview of State Medical Disciplines"; Gray, "Why Bad Doctors Aren't Kicked Out of Medicine.