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PEER REVIEW: HOW TO AVOID THE POLINER RESULT

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PART I
THE LAW AND GENERAL OBSERVATIONS REGARDING PEER REVIEW

The Importance of Peer Review

Medical peer review is the evaluation of the qualifications and skills of physicians by their colleagues with whom they practice, to monitor the quality, appropriateness and necessity of the medical care given to patients. Legitimate, good faith medical peer review is essential to the medical community and to patient care.

Nature of Peer Review

Typically, doctors with hospital privileges are not employees of a hospital; instead they are independent contractors who must be granted permission to admit patients and make use of the hospital's resources. A physician receives permission to use the hospital when he receives a vote of approval from his colleagues. Peer review is a common method for exercising self regulation and evaluating the performance of physicians. The purposes of this system is to improve the quality of health care, and reflects a widespread belief that the medical profession, in most cases, is best qualified to police its own. Undoubtedly, peer review performed in good

faith and without malice can play a critical role in the effort to maintain high professional standards in the medical practice.[1]

Competing Interests

There are competing interests in the peer review process. One interest, of course, is the interest of the public and patient safety. The peer review process is intended to encourage physicians to identify and discipline incompetent and unprofessional behavior for the protection of the patients who may be affected by such behavior.[2]

However, the goal of protecting patients and the general public from less than competent physicians must be balanced against the rights of the private physician.[3] The consequence to a physician of a poor review is harsh but may well be deserved if the peer review has been carried out in good faith and without malice. However, peer review conducted in bad faith or with malice violates the rights of the private physician. As one court has said, it is necessary to be "wary of vigilante capitalism disguised as peer review."[4] The consequence to a physician if the peer review is conducted in bad faith and with malice is devastating and unjustified.

The public's interests are not served by peer review performed in bad faith, either. If peer review is carried out because of malicious intent (anti-competitive, political, personal, or otherwise), the goals of protecting patients and ensuring patient care (which should be the pre-eminent considerations in the peer review process) take on a subordinate position. In cases of bad faith peer review, physicians subject to review are not judged on the basis of their medical

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[1] *See generally, Cooper v. Delaware Valley Medical Center*, 654 A.2d 547 (Pa. 1994), *citing* Timmothy Stoltzfus Jost, *The Necessary and Proper Role of Regulation to Assure the Quality of Health Care*, 25 Hous.L.Rev. 525, 553 (1988); M. Bertolet, *Hospital Liability Law and Practice*, 41 (5th ed. 1987).

[2] *Wayne v. Genesis Medical Center*, 140 F.3d 1145, 1148 (8th Cir. 1998).

[3] *Cooper v. Delaware Valley Medical Center*, 654 A.2d 547, 551 (Pa. 1994).

[4] *Rogers v. Columbia/HCA of Central Louisiana, Inc.*, 971 F.Supp. 229, 234 (W.D.La. 1997).

competency, and privileges may be removed in spite of this competency. Good doctors are denied the ability to practice medicine, and the public suffers for it.

Lawsuits and The Health Care Quality Improvement Act

In reaction to bad faith peer review, physicians have sued hospitals and members of peer review committees under state and/or federal law under theories of, *inter alia*, breach of contract, tortious interference, business disparagement, defamation, and antitrust violations.

In the wake of these lawsuits, the Health Care Quality Improvement Act of 1986 (the "HCQIA") created limited immunity for hospitals and members of peer review committees if the conditions of the HCQIA are met.[5] Congress enacted the HCQIA to set minimum national standards for the professional peer review of physicians' competence and professional conduct.[6] Pursuant to 42 U.S.C.A. §§ 11115(a), states can adopt their own peer-review procedures as long as they do not fall below the minimum national standards. *Id.* If the hospital or participants do not follow the requirements of the HCQIA, then they may be sued under any theory otherwise proper under federal or state law.

The 11th Circuit[7] clearly explains how the immunity provisions in HCQIA are designed to operate:

> Peer review, the process by which physicians and hospitals evaluate and discipline staff doctors, has become an integral component of the health care system in the United States. Congress enacted the Health Care Quality Improvement Act to encourage such peer review activities, "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.Rep. No. 903, 99th Cong., 2d Sess. 2, reprinted in 1986 U.S.C.C.A.N. 6287, 6384, 6384. . . . In furtherance of this goal, HCQIA grants limited immunity, in suits brought by disciplined physicians, from liability for money damages to those who participate in professional peer review activity. *Id.* §11111(a).

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[5] 42 U.S.C.A. §§ 11111(a)(1), (2), (b).

[6] *Walls Regional Hospital v. Altaras*, 903 S.W.2d 36, 38 (Tex.App.-- Waco 1994, *no writ*) *citing* 42 U.S.C.A. §§ 11101-11152.

[7] In *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318 (l1th Cir. 1994).

> Prior to the passage of HCQIA, the specter of litigation seriously impeded the development and vigorous enforcement of hospital peer review procedures. Congress found that "[t]he threat of private money damage liability under [state and] Federal laws, including treble damages liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." *Id.* §11101(4). Accordingly, HCQIA provides that if a "professional review action" (as defined in the statute) meets certain due process and fairness requirements, then those participating in such a review process shall not be liable under any state or federal law for damages for the results. *Id.* § 11111(a)(l). Thus, " [d]octors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of [HCQIA] are protected from damages sought by a disciplined doctor." H.R.Rep. 903, at 3, reprinted in 1986 U.S.C.C.A.N. at 6385.[8]

The Act provides that doctors and hospitals who have not acted in accordance with the reasonable belief, due process, and other requirements of HCQIA are <u>not</u> protected from a private lawsuit by the affected physician.

Although there is no private cause of action under the HCQIA itself, the defense of immunity to a physician's private cause of action has been routinely litigated in the federal courts.[9] In fact, the House Report on the immunity provisions in the HCQIA reveals that the legislature expressly contemplated that private suits would be brought by physicians. The House Report [10] provides:

> Initially, the Committee considered establishing a very broad protection from suit for professional review action. In response to concerns that such protection might be abused and serve as a shield for anti-competitive action under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill. . . . [t]he bill does not restrict the rights of physicians who are disciplined to bring private causes of action for injunctive or declaratory relief. If the professional review actions being

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[8] *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1321-22.

[9] *See e.g., Brader v. Allegheny General Hospital*, 167 F.3d 832 (3d Cir.1999); *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996); *Poliner v. Texas Health Systems*, 2003-2 Trade Cas. (CCH) ¶ 74174, 2003 WL 22255677 (N.D. Tex. 2003), opinion clarified, 2004 WL 1542164 (N.D. Tex. 2004).

10House Report No. 99-903, 99th Cong., 2nd Sess. 1986, 1986 U.S.C.C.A.N. 6384 (1986 WL 31972) (Leg. Hist.).

> challenged fail to meet the standards of [the bill], no immunity is provided and the suit can be tried without regard to the provisions of this bill.

In other words, private causes of action (under antitrust law, civil rights law, and other law) exist for a physician complaining of peer review and immunity is not available as a defense if the plaintiff physician can show that the standards of 42 U.S.C.A. §§ 11111(a)(1) have not been met.

State Counterparts to the HCQIA

After the passage of the HCQIA, many states decided to create greater immunity protections for peer review. As an example, the Texas legislature amended the Texas Medical Practice Act to adopt and apply the provisions of the HCQIA to the actions of a professional review body.[11] Like the HCQIA, the Texas Legislature granted limited immunity from civil liability to any hospital, person, or professional review body provided that the process was conducted without malice.[12] If malice is shown to exist, immunity is not available, and all claims otherwise available may be pursued by the affected physician. Although states differ in their immunity schemes, this malice standard adopted in Texas is not uncommon.

Immunity is Qualified, Not Absolute

It is important for hospitals and peer review participants to understand the HCQIA and the applicable state law immunity scheme when peer review is being conducted and before litigation. Although immunity protections are great, the immunity is not absolute. Hospital and participants can get into trouble when they believe the law affords them absolute protection. Peer review must be conducted in good faith and in the interests of patient care. Once hospitals and participants realize what the law requires of them, they can conduct peer review in a way

[11] *Walls Regional Hospital v. Altaras*, 903 S.W.2d at 38 *citing* Tex. Rev. Civ. Stat. Ann. Art. 4495b, §5.06(a) (now codified as Texas Occupations Code §160.001 (West 2000)).

[12] *Id. citing* Art. 4495b, §5.06(m) (now codified as Texas Occupations Code §160.010).

that avoids liability and protects patients, but also gives due consideration to the rights of a physician.

Issues of Concern

Issues of concern in peer review include:

1) Making the process fair—Do not stack the deck against the physician. Hospitals and peer review participants should take appropriate steps to ensure that the affected physician has every opportunity to establish that his or her standard of care is acceptable, that he or she does not pose a danger to patients, or that he or she is not "disruptive." If a lawsuit is filed, courts will look at the objective fairness of the process, so it is important for the hospital and the participants to take reasonable efforts during the process to afford the physician fundamental fairness.

2) Following the Medical Staff Bylaws—The first step to ensure the process is "fair" is to prepare and follow Medical Staff Bylaws that are carefully drafted to provide the physician with due process. If the Bylaws do not provide appropriate due process protection, they need to be rewritten to ensure fairness in all respects. Also, avoid strict use of the Bylaws that would cause actual unfairness. For example, if the Bylaws allow for a hearing on three days notice, but the physician is requesting another day or two to prepare, if no real harm will occur, it is prudent to give the additional time.

3) Selecting participants—Hospitals and participants should avoid even the appearance of bias or impropriety in the conduct of peer review. Great care should be exercised when selecting:

- Decision Makers
- Members of Ad Hoc Committees
- Investigating Committees
- Hearing Panel Members
- Hearing Officers
- Outside Experts

It is important to avoid the use of competitors as much as possible, but in order to evaluate the medicine involved, it usually is essential to have reviewers in the same specialty. This is a dilemma that is most easily solved by the use of outside experts who have no exposure or ties to the particular physician or hospital environment. Also, to the extent that there has been any past personal biases, it is crucial to be sure that those persons are removed from the review and decision-making processes.

4) Effects are Swift and Permanent on a Physician—There very often is a domino effect that occurs once an adverse peer review action is taken. Frequently, there is no way to expunge the action once it occurs. Bylaws should be written to allow an expungement remedy in appropriate cases. Even if no official report is made to outside entities, the physician must very often self-report any adverse action. This will affect the physician and his relationships with:

- Hospital Staff
- Referral Physicians
- Patients
- National Practitioner Data Bank

- Licensing Boards
- Insurance Plans
- Healthcare Organizations

5) Punishment Must Fit the Crime—To the extent that any adverse action is actually imposed, the action must be proportionate considering the gravity of the triggering incident, the record of the physician, the length of his or her career, and his or her willingness to improve behavior, be proctored, or receive additional training. Also, the adverse action should not be punitive, except in egregious cases. Instead, the action must be focused on helping the physician improve his or her abilities, while using the least restrictive means necessary to achieve the desired goal of improved health care. In situations that involve summary suspension (an action taken summarily, before the physician has due process and hearing rights), the hospital must be convinced that the action taken is actually required to prevent a "present" or "imminent" harm to patients and grant the physician a right to be heard promptly after such summary action in order to minimize the detrimental effect of the summary suspension. Only those persons necessary should be advised of the summary suspension. If not, summary suspension should not be used. In those rare instances where summary suspension is warranted, the Bylaws grant the physician a right to be heard promptly.

6) Confidentiality is Crucial—During the peer review process, every effort must be made to keep the matter strictly confidential. Peer review privilege and immunity may be lost if the substance of the peer review is disclosed to persons

outside of the process. Also, the affected physician's career can be devastated by the lack of confidentiality, which would only add to the damages should he or she sue and prevail.

7) Use of Past Events—If the physician has had past events that have been "cleared" through the regular channels of peer review, those same events should not form the basis for a subsequent adverse action. This may create the impression that the hospital and participants are using fabricated grounds in order to get rid of the physician. If a case was cleared and the physician absolved, it should no longer be considered, unless a pattern of the same activity can be shown to exist. This is especially true if the physician never knew of the complaint regarding the cleared case and never had a chance to defend himself in the first place.

8) Search for the Truth—Hospitals and participants should search for the truth, instead of trying to "win." The results should not be preordained. Hospitals should instead engage outside experts to evaluate the medical care in order to discover the truth. It is crucial to avoid the usual result of falling into an adversarial relationship.

PART II
DR. POLINER'S CASE

Dr. Poliner's Peer Review[13]

Dr. Poliner is a board certified cardiologist with over twenty-five years of experience in interventional cardiology. He became board certified in Internal Medicine in 1972 and in his subspecialty of Cardiology in 1977, and had no past history of peer review or malpractice

[13] Facts as alleged in pleadings and/or presented at trial.

lawsuits. He performed cardiac catheterizations and other interventional and invasive procedures, such as angiograms, angioplasties and stenting.

After many years of education, training, and experience in clinical settings, academia, and out-of-state private practice, Dr. Poliner and his family decided to relocate in Dallas, Texas. He was granted privileges at the Presbyterian Hospital of Dallas (the "Hospital") in 1996. At this time, he was not drawing patients from any of the defendants' patient bases, but instead drew patients from other parts of Texas and from Oklahoma. In May 1997, Dr. Poliner left the group he had first joined to go into solo practice in the Dallas area. Dr. Poliner alleged that, until his practice began to threaten the defendants' practices at the Hospital when he went solo, no question had ever been raised – either at the Hospital or at any of the other places he had worked– about the quality of his medical care.

In May 1998, he performed a procedure on a patient that was brought to the attention of the Chief of Internal Medicine, the Director of the Cath Lab, and the Chief of Cardiology, and a peer review of Dr. Poliner was begun. Although subsequently, Dr. Poliner's experts testified that no patient harm resulted from Dr. Poliner's performance of the procedure, Dr. Poliner was required to accept an abeyance of his cardiac catheterization privileges for a two-week period while his practice was reviewed or face immediate suspension of <u>all</u> privileges.

The Option of Abeyance Versus Summary Suspension

The Hospital demanded that Dr. Poliner agree to an abeyance of his cardiac catheterization privileges, rather than impose a summary suspension. An abeyance was an option under the Hospital medical staff Bylaws (the "Bylaws") that allowed the Hospital to review a physician's care while the physician refrains from his exercise of privileges. Under the Hospital's medical staff Bylaws, a physician is required to voluntarily agree to the abeyance.

The use of an abeyance option, which many hospitals now have, is intended to provide a reasonable opportunity for hospitals to investigate patient care concerns for a limited period of time while avoiding a more draconian option, such as the imposition of a summary suspension.

In contrast to an abeyance, a summary suspension (suspension with hearing and due process afforded only after such suspension) is only allowed under the Bylaws when the Hospital determines that the doctor presents a "present danger" to the health of the patients, as specified in the medical staff Bylaws of the Hospital. Typically, a summary suspension is used in cases of substance abuse or impairment, where hospitals have an immediate need to stop the physician from exercising privileges to prevent imminent patient harm.

The Abeyance

Dr. Poliner alleged that in May 1998, the Chief of Internal Medicine demanded that Dr. Poliner agree to a 14-day abeyance to investigate his care of patients at the Hospital. This demand was made in the presence of and with the approval of the Director of the Cath Lab and the Chief of Cardiology. Even though Dr. Poliner signed a letter agreeing to the abeyance, the evidence at trial showed that his "agreement" was obtained after the Chief of Internal Medicine told Dr. Poliner that he could either agree to the abeyance of his cardiac catherization privileges or face immediate termination of all of his privileges at the Hospital. The evidence at trial also showed that Dr. Poliner protested, requested a discussion of the options available, requested an opportunity to discuss the medical case that formed the basis for the abeyance, requested more time to determine whether to agree to the abeyance, and requested time to consult with an attorney in order to determine if he should agree to the abeyance. All such requests were refused.

When asked the question of whether the abeyance was voluntary, the jury found that Dr. Poliner's "agreement" to the abeyance (and to a 14-day extension of the abeyance) was made under duress such that effectively it was a summary suspension of his cardiac catheterization privileges, not an abeyance.

The Imposition of the Summary Suspension

Once the jury found that the abeyance was actually a summary suspension, it was asked whether the summary suspension itself was proper under the Hospital Bylaws. In other words, the jury was asked whether the Chief of Internal Medicine reasonably believed that Dr. Poliner posed a "present danger" to his patients such that the Chief of Internal Medicine was empowered under the Bylaws to impose a summary suspension. At trial, the Chief of Internal Medicine (a renal physician with no expertise in interventional or invasive cardiology) admitted in his testimony at trial that he did not have enough information to determine whether or not Dr. Poliner actually posed a "present danger to his patients." Further, the other evidence in the case showed that personal animosity existed between the Chief of Internal Medicine and Dr. Poliner, who had previous unfriendly interactions. In addition, unbeknownst to Dr. Poliner, there were several incidents that were being investigated by peer review committees at the request of the Chief of Internal Medicine in May 1998, but Dr. Poliner had been given no notice or opportunity to defend himself, making the process look secretive. The Hospital justified its imposition of the summary suspension in part on cases that had been previously cleared by peer review committees. Dr. Poliner argued that the timing of the peer review events against him relative to his move to solo practice in the Dallas area in 1997 provided economic motive for the Director of the Cath Lab and the Chief of Cardiology (both cardiologists with practices in the Dallas area) to comply and assist in the Chief of Internal Medicine's actions against Dr. Poliner.

After its consideration of this evidence, the jury found that the imposition of the summary suspension in May 1998 was not done to prevent present danger to Dr. Poliner's patients. Thus, such imposition breached the Bylaws and formed the basis for Dr. Poliner's defamation, tortious interference, and other tort claims.

The Immunity Determination

Of course, of utmost importance in peer review cases is the determination of immunity under state and federal law. The determination that peer review defendants are entitled to immunity is typically made at the summary judgment level. In this case, the federal trial court judge found that, with respect to the forced abeyance, there was a fact issue as to whether the Hospital, the Chief of Internal Medicine, the Director of the Cath Lab, and the Chief of Cardiology were entitled to immunity under state or federal law. Therefore, the case proceeded to trial.

Federal Immunity Under the Health Care Quality Improvement Act

As stated above, the HCQIA created limited immunity for hospitals and members of peer review committees if certain conditions of the HCQIA are met, to wit: the peer review action must have been taken (1) in the reasonable belief that the action was in the furtherance of quality health care; (2) after reasonable effort to obtain facts of the matter; (3) after adequate notice and hearing procedures were afforded to the physician or after such other procedures as were fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by facts known after such reasonable effort to obtain facts and after such adequate procedures.[14] In cases of "imminent danger to the health of any individual," the HCQIA provides an exception to the notice requirement of this four pronged standard.[15] If the hospital or

[14] 42 U.S.C. §§ 11111(a)(1), 11112(a).
[15] 42 U.S.C. § 11112(c)(2).

participants do not follow the requirements of the HCQIA, then they may be sued under any theory otherwise proper under federal or state law.

The HCQIA includes a presumption that a professional review action meets each of the four prongs of Section 11112(a), unless the plaintiff can rebut the presumption by a preponderance of the evidence.[16] The standard for reviewing summary judgment under the HCQIA is therefore unconventional: although the defendant is the moving party, the court must examine the record to determine whether the plaintiff has "satisfied his burden of producing evidence that would allow a reasonable jury to conclude that the peer disciplinary process failed to meet the standards of HCQIA."[17]

Immunity Under Texas Law

As set forth above, in the context of the Texas peer review immunity statutes, malice is the standard by which defendants' conduct is measured.[18] Malice means "the making of a statement with knowledge that it is false, or with reckless disregard of whether it is true."[19] "Reckless disregard" means that a statement is made with "a high degree of awareness of probable falsity."[20] In the context of the summary judgment motion, a plaintiff must raise a fact issue of malice rather than defendants prove the absence of malice.[21] "Negligence, lack of investigation, or failure to act as a reasonably prudent person are insufficient to show actual malice."[22] However, inadequate investigation coupled with the presence of ulterior motives may be sufficient to raise a fact issue as to actual malice.[23]

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[16] *See Brader v. Allegheny Gen. Hosp.,* 167 F.3d 832, 839 (3rd Cir.1999).
[17] *Brader*, 167 F.3d at 839.
[18] *Johnson v. Hospital Corp. of America*, 95 F.3d 383, 395 (5th Cir.1996).
[19] *Duffy v. Leading Edge Products, Inc.*, 44 F.3d 308 at 313 (5th Cir.1995).
[20] *Id.*
[21] *Duffy v. Leading Edge*, 44 F.3d at 314.
[22] *Id.*, at 313 (citing *Shearson Lehman Hutton, Inc. v. Tucker*, 806 S.W.2d 914, 924 (Tex.Civ.App.Corpus Christi 1991, writ dismissed w.o.j.)).
[23] *Id.* at 315.

The Summary Judgment Ruling

In Dr. Poliner's case, the trial court determined that there were fact issues as to whether the Hospital, the Chief of Internal Medicine, the Director of the Cath Lab, and the Chief of Cardiology acted outside of the federal standards or with malice with respect to the forced abeyance. In its analysis, the trial court discussed each of the four prongs of the federal statute and the malice requirement under Texas law and determined that there was a fact issue as to whether the totality of the process leading up to the forced abeyance evidenced a reasonable effort to obtain the facts of the matter. Therefore, immunity was not granted at the summary judgment level. In its summary judgment opinion,[24] the trial court took note that Dr. Poliner had raised a fact issue as to whether defendants were motivated by a combination of ulterior motives—personal animosity toward him and the desire to eliminate him as an economic competitor. In addition, the Court observed that this was "not simply a claim of inadequate investigation, but a complete failure to investigate and to gather all of the facts from both sides" before the abeyance was imposed.[25] Although defendants could have still been entitled to immunity if there was an "imminent danger" under 42 U.S.C. § 11112(c)(2), the trial court observed that Dr. Poliner, through the testimony of his own medical experts, had raised the issue as to whether defendants actually believed that such danger existed.

Post-Abeyance Actions Were Granted Immunity

Importantly, the trial did grant immunity to some defendants. Due to the trial court's ruling on the immunity determination, the trial focused on the "forced abeyance" that occurred in May 1998. However, this was not the end of the peer review. The Hospital used the abeyance period to investigate Dr. Poliner's practice. The peer review investigation was directed by the

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[24] 2003 WL 22255677 (N.D.Tex.).
[25] 2003 WL 22255677 at 15.

Chief of Internal Medicine, whom Dr Poliner alleged appointed his competitors to review a number of his cases. At the end of the abeyance period in June 1998, the Hospital summarily suspended Dr. Poliner's privileges to perform both cardiac catheterizations and echocardiograms. Ultimately, Dr. Poliner's privileges were restored as a result of a November 1998 administrative hearing at the Hospital. The Hospital administrative panel found that Dr. Poliner's privileges should be restored. Dr. Poliner later sued to recover the damages he sustained as a result of these events.

In the summary judgment ruling, the trial court found that the peer review investigation that took place after the May 1998 abeyance (that lead to the June 1998 summary suspension) met the federal standards and was taken without malice such that the seven physicians who were also initially sued and who reviewed Dr. Poliner's cases during the post abeyance investigation were dismissed from the lawsuit. The trial court took note that during the post-abeyance investigation, Dr. Poliner had notice of the cases and meaningful opportunities to address the concerns raised against him, and that the due process given to Dr. Poliner was adequate.[26] Thus, the seven physicians who participated only in the post-abeyance investigation were dismissed. In addition, the remaining defendants were granted immunity for their post-abeyance actions. Trial was limited only to the abeyance of Dr. Poliner's privileges.

The Jury's Verdict

However, Dr. Poliner was allowed to present to a jury his claims against the Hospital, the Chief of Internal Medicine, the Director of the Cath Lab, and the Chief of Cardiology for their actions leading up to the abeyance. After hearing the evidence, the jury determined that the abeyance effectively amounted to a summary suspension and that the actions of the remaining defendants relating to the abeyance were taken with malice and did not meet the four prongs of

[26] 2003 WL 22255677 at 11 through 13.

the federal statute. The jury also found that, at the time the forced abeyance was imposed, the defendants did not believe that Dr. Poliner posed an "imminent danger to the health of any individual" or a "present danger" to his patients. Thus, defendants' actions did not fall under the exception of 42 U.S.C. § 11112(c)(2) and breached the requirement in the Bylaws that a summary suspension be imposed only where there is a reasonable belief that the physician poses a present danger to his patients. Once the jury found that Dr. Poliner had overcome the immunity hurdles, it found the defendants liable for breach of contract, defamation, tortious interference with existing and prospective contracts, and intentional infliction of emotional distress. The jury also awarded punitive damages against the defendants for their behavior.

The amounts awarded by the jury were:

Amount of Poliner Jury Verdict August 27, 2004					
Reason for Award	**Chief of Internal Medicine**	**Head of Cardiac Cath Lab**	**Chief of Cardiology**	**Presbyterian Hospital**	**All Defendants**
Breach of contract				$30 million	$30 million
Loss of earnings (Defamation)	$10,526.55	$10,526.55	$10,526.55	$10,526.55	
Injury to career and reputation (Defamation)	$20 million	$5 million	$5 million	$15 million	$45 million
Mental anguish (Defamation)	$20 million	$5 million	$5 million	$15 million	$45 million
Loss of earnings (Business Disparagement)	$1 million	$1 million	$1 million	$1 million	$4 million
Loss of earnings	$37,000.00	$37,000.00	$37,000.00	$37,000.00	

(Contractual Relations)					
Injury to career and reputation (Contractual Relations)	$20 million	$5 million	$5 million	$15 million	$45 million
Mental anguish (Contract Relations)	$20 million	$5 million	$5 million	$15 million	$45 million
Loss of earnings (Emotional Distress)	$10,526.55	0.00	0.00	$10,526.55	
Mental anguish (Emotional Distress)	$20 million	$1 million	$1 million	$20 million	$42 million
Punitive Damages	$40 million	$10 million	$10 million	$50 million	$110 million
TOTALS	Over $141 million	Over $32 million	Over $32 million	Over $161 million	**Over $366 million**

Post trial motions have not yet been filed, and the case will be appealed. Dr. Poliner will cross-appeal the granting of summary judgment to the other peer review participants.

Lessons from the Poliner Case

1) Good Faith Must Be Preeminent—Hospitals and peer review participants must perform peer review in good faith and in the interest of patient care, period. Just because hospitals and participants claim that they took the action in the interest of patient care does not make it so. The jury will be allowed to draw its own conclusions about the defendants' motivations.

2) Know and Follow the Bylaws—Hospitals and peer review participants must follow the Bylaws, not only in form, but also in substance. This includes making sure that the participants know the correct standards to use when making decision. For example, it is crucial for the decision makers to know the standard for obtaining an abeyance (that there be a voluntary agreement, without duress) and the standard for imposing a summary suspension (there be a reasonable belief that a present danger to patients exists).

3) Cautious Use of Summary Suspensions—Summary suspensions should be used sparingly and only in cases where the failure to take such action would lead to "imminent danger to the health of an individual." Impairment cases usually meet this standard. However, if the issue is standard of care, unless there is clear evidence that a danger exists, a corrective action that provides notice and hearing before such action is taken is a better option. The physician should be given "due process" before taking away his privileges.

4) Abeyances Must Be Voluntary—If the Bylaws allow for an abeyance, an agreement to the abeyance cannot be obtained under duress. If the physician will not agree to the abeyance, the hospital should not threaten the physician with other sanctions. The hospital should summarily suspend the physician only if the standard for such summary suspension is met.

5) Checks and Balances are Essential—Allowing one administrator or physician complete authority over the peer review process without checks and balances is dangerous. Any contemplated peer review action, especially action as drastic as summary suspension, should be reviewed by others in authority to be sure that there is a legitimate patient safety concern that must be addressed in an imminent fashion. If not, the normal peer review process should be utilized.

6) No Ulterior Motives—Personal animosity, economic motivations, and other ulterior motives have no place in peer review. Although not always possible, obtaining the opinions of persons outside of the particular hospital environment (such as outside experts qualified to review the medicine at issue) helps dispel the impression that actions were taken for reasons other than patient care.

7) Know that Immunity Not Absolute—Qualified immunity helps protect peer review not only for individual physician who may be subjected to a peer review, but also for hospitals and participants. Hospitals and peer review participants have long held the belief that absolute immunity exists for peer review activities. Most participants, even with absolute immunity, will conduct peer review in good faith and ethically. However, there are some who, because they believe that immunity is absolute, will act for reasons other than patient care. Once hospitals and participants realize that the immunity given under state and federal law is qualified (only available if done within good faith standards and without malice), then hospitals will have a better chance of convincing all peer review participants that peer review must only be performed in the interest of patient care.

8) Punish Bad Faith Peer Review – If it is shown that any participant in a peer review proceeding took action or provided testimony in bad faith or for personal or other reasons

unrelated to health care, the hospital must take immediate corrective action against such individual.

9) Encourage the Process to Be Transparent-- Transparency of peer review is important to the process. In the past, peer review has been a secretive process, always taking place behind closed doors. The basis for the hospital's action should be open to scrutiny by hospitals and physicians who can ensure that the peer review actions taken are fair and ethical.

10) Realize the Consequences—Remember the severe impact that a peer review action has on the affected practitioner. The imposition of summary suspension or similar actions can dramatically impact the professional life, practice, referral base, earning potential, and future employability of a physician. The summary suspension and abeyance are events that such doctors must self report on applications for the rest of their professional careers and will likely affect their ability to transfer to another location as well as enroll in new health plans, should they choose to do so. A report to the National Practitioner's Databank (a national data base that is queried by hospitals and other eligible institutions when a physician applies for privileges) or an action by the state against the physician's license may have a "domino effect" on licenses from other states and privileges at other hospitals. But most importantly, peer review actions have an effect on the affected practitioner's reputation, self-esteem, and family, with depression and suicide being a not unexpected result in some cases. Hospitals and participants must realize the devastation that can occur so that the process can be undertaken with appropriate care and caution.

11) Search for the Truth—Again, the goal of peer review should be truth. The peer review process should not be adversarial. Instead, it should be about finding the truth about whether a danger exists, whether a physician is practicing below the standard of care, or whether

the physician needs additional training or proctoring. Hospitals and participants should not be focused on winning, but instead should make all efforts to find the truth and get a fair result.

Conclusion

Peer review is a vital process to the health care industry. Hospitals owe the public the obligation to use the process fairly, and not to abuse the enormous power this process represents. Hospitals must train its staff members in the appropriate use of peer review proceedings. Hospitals must take reasonable precautions to eliminate competitive or other personal biases for entering into the process. Outside professional help should be consulted, including unbiased medical experts if issues of medical judgments are involved. A doctor's career should not be ruined unless it can be demonstrated that such action was truly warranted. Rather than blame the lawyers, hospitals must look in the mirror and accept responsibility for ensuring that peer review is done in good faith such that the immunity protection of the law can continue in place.

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