No. _____

In the Supreme Court of the United States

LAWRENCE R. POLINER, M.D.,
LAWRENCE R. POLINER, M.D., P.A.,
Petitioners,

v.

TEXAS HEALTH SYSTEM, doing business as Presbyterian Hospital of Dallas Texas, a Texas non-profit corporation, JAMES KNOCHEL, M.D.,
Respondents.

On Petition for Writ of Certiorari to the United States Court of Appeals for the Fifth Circuit

PETITION FOR WRIT OF CERTIORARI

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QUESTIONS PRESENTED

The Healthcare Quality Improvement Act of 1986, §402 et seq., 42 U.S.C. §§ 11101 et seq. (2000) ("HCQIA") establishes limited immunity from money damages for professional review actions taken (1) in the reasonable belief that the action was in furtherance of quality health care, (2) after a reasonable effort to obtain the facts of the matter, (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3). A professional review action is presumed to have met these standards unless rebutted by a preponderance of the evidence. 42 U.S.C. § 11112(a) (2002).

The questions presented are:

1. Can a court exclude all evidence of subjective motives (an entire category of evidence) when it considers whether a defendant possessed a "reasonable belief" as required for HCQIA immunity under subsections (1) and (4), when such exclusion effectively:

    a) Usurps the fact-finding role of the jury?

    b) Renders state peer review immunity statutes meaningless?

c) Transforms the qualified immunity intended by Congress into absolute immunity?

2. What are the categories of evidence that can be considered in a court's determination of whether plaintiff's evidence is sufficient to rebut the statutory presumption?

PARTIES TO THE PROCEEDINGS BELOW AND RULE 29.6 STATEMENT

Petitioners Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. ("Poliner") were appellees in the court of appeals and plaintiffs in the district court. Petitioner Lawrence R. Poliner, M.D., P.A., is a Texas non-governmental corporation solely owned by Petitioner Lawrence R. Poliner, M.D. There is no parent corporation or publicly held company that owns 10% or more of the shares in Lawrence R. Poliner, M.D., P.A.

Respondents Texas Health Systems, a Texas Non-Profit Corporation doing business as Presbyterian Hospital of Dallas (the "Hospital"), and James Knochel, M.D. ("Knochel") (together "defendants") were appellants in the court of appeals and defendants in the district court.

TABLE OF CONTENTS

Pages

TABLE OF AUTHORITIES

Pages

CASES

CONSTITUTION

STATUTES

RULES

OTHER AUTHORITIES

PETITION FOR WRIT OF CERTIORARI

Petitioners Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. ("Poliner") respectfully petition for a writ of certiorari to review the judgment of the United States Court of Appeals for the Fifth Circuit.

OPINIONS BELOW

The published judgment of the district court awarding the jury verdict in favor of Poliner is available at 2003 WL 22255677 (N.D. Tex. Sep. 30, 2003) and is reprinted as Appendix 62a-65a.[1]

The Fifth Circuit's opinion reversing the district court's judgment is found at 537 F.3d 368 (5th Cir. 2008) and is reprinted as App. 1a-37a, with the portion pertaining to HCQIA immunity appearing at Appendix 16a-37a.

JURISDICTION

The Fifth Circuit issued its opinion on July 23, 2008. No motion for rehearing or rehearing en banc was filed by the parties. Pursuant to 28 U.S.C. § 2101(c) (2000), this petition was timely filed within 90 days after entry of the judgment by the Fifth Circuit. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1) (2000) and the United States Constitution, Article 3, Sections 1 and 2.

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[1] "App." refers to the Appendix attached hereto.

STATUTORY PROVISIONS INVOLVED

Section 11111(a)(1) of Title 42 of the United States Code provides, in pertinent part:

> If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as provided in subsection (b) of this section –
>
> (A) the professional review body,
>
> (B) any person acting as a member or staff to the body,
>
> (C) any person under a contract or other formal agreement with the body, and
>
> (D) any person who participates with or assists the body with respect to the action,
>
> shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

Section 11112(a) of Title 42 of the United States Code provides, in pertinent part:

> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken –
>
> (1) in the reasonable belief that the action was in furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

STATEMENT OF THE CASE

Poliner, a board-certified interventional cardiologist with twenty years of experience, sued Knochel, the Hospital, and others for barring him from the cardiac catheterization lab using a sham medical peer review,[2]

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[2] Medical peer review is the evaluation of the qualifications and skills of physicians by the colleagues with whom they practice in order to monitor the quality, appropriateness, and necessity of the medical care given to patients. Every single person who receives medical care and their family members are touched in some way by this process. Legitimate, good faith medical peer review, which takes place every day in hospitals and health care facilities across

to falsely label him a dangerous doctor. Defendants knew these actions would eliminate his growing solo cardiology practice at the Hospital and ruin his unblemished reputation. Without the ability to work in the cardiac cath lab, Poliner's healthy, growing practice and referral base at the Hospital completely dried up. The peer review tool that Knochel and the Hospital used to suspend Poliner was called an "abeyance" under the medical staff bylaws. However, because Poliner did not consent to the requests for abeyance as required in the medical staff bylaws,[3] barring him from the cardiac cath lab took on the characteristics of a summary suspension.[4] Poliner claimed that the subsequent summary suspension imposed after the abeyance periods also wrongly labeled him a dangerous doctor. Due to the immediate impact to his practice at the Hospital along with the various third-party and self reporting obligations that are triggered when a peer review action takes place, these peer review actions caused Poliner significant

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this country, is essential to the medical community and to patients.

[3] The jury clearly found that Poliner did not consent. S*ee* App. 125a-126a.

[4] Summary suspensions are typically reserved for situations where present and imminent harm exists. The false label, and thus, the defamation, emanates from the jury's finding that Poliner did not consent to the abeyance requests and was effectively summarily suspended. At trial, Knochel admitted that when he forced Poliner into the abeyance and the extension of the abeyance, he did not have enough information to determine that Poliner was a present danger to patients, which was required in order to properly impose a summary suspension under the medical staff bylaws. App. 197a.

damage and resulted in permanent black marks on his career and reputation. The jury agreed, finding defamation *per se* and awarding Poliner substantial sums in loss of earnings, injury to career and reputation, and mental anguish. App. 139a-145a.

The facts of Poliner's case are quite complex. App. 184a-202a. Poliner complained of three peer review actions taken against him by defendants: first, Knochel's threat on May 14, 1998 to immediately suspend Poliner if Poliner did not agree to an abeyance of his privileges in the catheterization lab (due to this threat, Poliner signed a letter "accepting" the abeyance); second, Knochel's threat on May 29, 1998 to immediately suspend Poliner if Poliner did not agree to extend the abeyance to June 12th (due to this threat, Poliner signed a letter "accepting" the extension); and third, Knochel's decision to summarily suspend all Poliner's privileges on June 12, 1998. App. 181a-182a.

After extensive discovery, defendants moved for summary judgment claiming immunity from damages under HCQIA and the Texas peer review immunity statute. App. 76a-77a. Poliner responded with extensive summary judgment evidence showing defendants' actions were based on false and malicious criticisms of Poliner's work, were biased and pretextual, and were undertaken after woefully inadequate investigation, notice, and hearing. App. 182a. Despite this evidence, the trial court granted partial summary judgment on September 30, 2003, holding that the June 12 suspension met the standards for statutory immunity. App. 94a-106a. But the court also determined that fact issues existed as to whether

the actions taken on May 14 and May 29 met the standards for immunity. App. 94a-106a. Subsequently, the court held that Poliner could not recover damages flowing from the June 12 suspension. App. 66a-70a.

Following a two-week trial that focused on the May 14 and May 29 actions taken by Knochel, the Hospital, and two other defendant doctors (Dr. Harper, chief of cardiology, and Dr. Levin, head of the cath lab), the jury unanimously found in Poliner's favor on every question submitted (App. 123a-162a), and made explicit findings that defendants acted with malice (App.132a-134a). Although the actual and exemplary damage figures in the verdict totaled over $366 million, Poliner recognized that the awards overlapped. Thus, he sought actual damages of approximately $70 million and exemplary damages of $90 million against Knochel and the Hospital (the other two defendants having settled). App. 183a. Defendants filed extensive post-trial motions. App. 38a-39a.

After considering defendants' motions, the trial court ruled that: (1) defendants waived a number of arguments by not raising them at trial; (2) sufficient evidence supported the jury's findings that defendants were not entitled to immunity; (3) sufficient evidence supported the jury's findings of contract breach, defamation, and tortious interference, and judgment would be rendered on the defamation claim; (4) there was sufficient evidence that damages awarded to Poliner resulted from the May actions (as opposed to the immune June 12 action); (5) defendants were not entitled to a new trial based on alleged trial errors or

claims of jury passion and prejudice; (6) the awards of actual damages for injury to career/reputation and mental anguish were excessive and should be remitted to a total of $21 million; and (7) exemplary damages should be statutorily capped at $750,000 against each defendant. App. 38a-61a and 183a. Poliner accepted the remittitur (App. 183a-184a), and the trial court rendered an amended final judgment consistent with its opinions. App. 62a-65a.

Defendants appealed to the Fifth Circuit. On July 23, 2008, the Fifth Circuit reversed and rendered judgment in favor of defendants, holding they were, as a matter of law, immune from money damages under HCQIA. App. 1a-37a. In its ruling, the Fifth Circuit clearly refused to consider Poliner's evidence that his peer review was malicious and based on subjective motives unrelated to health care (anticompetitive and political motives and personal dislike). The Fifth Circuit, in applying the "objective reasonableness" test for determining immunity stated that "the good or bad faith of the reviewers is irrelevant." App. 22a. The Fifth Circuit made it plain that Poliner's claims of "bad motives or evil intent" and "anti-competitive motives" were completely disregarded in its "reasonable belief" analysis. App. 25a. The Fifth Circuit then concluded that HCQIA standards were met and granted defendants immunity as a matter of law. App. 16a-37a. Poliner petitions for certiorari.

REASON FOR GRANTING THE WRIT

This Court should grant certiorari because the Fifth Circuit, in deciding to grant HCQIA immunity as a matter of law, wholly disregarded subjective

motivations (an entire category of substantial evidence) in direct contravention of statutory language and clear Congressional intent.

A. This disregard is a gross misapplication of evidentiary standards set by law, clearly hinders the administration of HCQIA, and serves as a compelling reason to grant certiorari.

The existing judicial interpretation of the "reasonable belief" standard concludes that evidence of subjective motivations is wholly irrelevant when deciding a question of immunity. This interpretation has directly caused the circuit courts of appeal (here, the Fifth Circuit) to sanitize the facts of these cases to disregard evidence of subjective motivations (such as anticompetitive and political motives and personal dislike). This flies in the face of what Congress intended by its clear and unambiguous use of statutory language as well as in supporting legislative history. As a result, judicial findings in case after case demonstrate that no set of circumstances can ever result in rebuttal of the "reasonable belief" standard in the first and fourth prongs of the immunity analysis. The existing interpretation of the "reasonable belief" standard thwarts the concept of limited immunity and instead confers absolute immunity.

There are compelling reasons for the Court to accept this case. Pursuant to Supreme Court Rule 10(a), the Court should take this case because the Fifth Circuit "has so far departed from the accepted and usual course of judicial proceedings . . . as to call

for this Court's supervisory power." Further, according to Supreme Court Rule 10(c), the Court should grant certiorari because the Fifth Circuit "has decided an important question of federal law that has not been, but should be, settled by this Court."

Certiorari is appropriate when precedential decisions of the appellate courts as to the construction and interpretation of a federal statute might seriously hinder future administration of the statute. *See Fed. Trade Comm'n v. Am. Tobacco Co.*, 274 U.S. 543 (1927) (finding serious hinderance of future administration of the law was grave and sufficiently probable to justify issuance of writ, but ultimately controversy over FTC cease and desist order turned on a previously decided fact issue of no general importance). The Court also has power to review the correctness of judicial application of an evidentiary standard in the rare instance when the standard appears to have been misapprehended or grossly misapplied. *See Universal Camera Corp. v. N.L.R.B.*, 340 U.S. 474, 490-91 (1951) (correcting variant applications of the "substantial evidence" standard for reviewing evidentiary validity of NLRB findings and redefining the scope of judicial review of administrative actions).

As it stands, the Fifth Circuit completely disregards a precise category of evidence that Congress specified should factor into HCQIA immunity analysis. This constitutes a gross misapplication of the statute's express evidentiary standard. As a result, the Fifth Circuit and its sister circuits routinely usurp the jury's fact-finding role, render state immunity laws meaningless, and transform the qualified immunity carefully crafted by Congress into absolute immunity.

One can scarcely imagine a more serious hinderance to the future administration of HCQIA. This pressing conflict demands this Court's guidance.

B. The real facts of Poliner's case show the abuse of peer review.

Effective medical peer review is essential to the provision of quality medical care. *Patrick v. Burget*, 486 U.S. 94, 105 (1988). Poliner's case reveals an undeniable abuse of medical peer review for reasons unrelated to health care. Such abuse, if unchecked, can irreversibly harm or destroy the reputations and careers of physicians across this country. The decisions made in Poliner's peer review were tainted by anticompetitive and political motives and personal dislike-motives that Congress, in passing HCQIA, explicitly directed would be considered when reviewing the "reasonable belief" required under the immunity statute. The Fifth Circuit, by following the standards laid out by its sister circuit courts, has completely eliminated consideration of these subjective motives as irrelevant and immaterial. Poliner turns to this Court, for the sake of his profession, the health care system, and patients themselves, as the only authority that can restore the objective reasonableness analysis clearly intended by Congress.

The real and complete facts of Poliner's story are set forth in Appendix 184a-202a.[5] A careful review of

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[5] All reasonable inferences are drawn in favor of Poliner and all evidence favoring defendants that the jury is not required to believe has been disregarded. *See Reeves v. Sanderson Plumbing Prods., Inc.*, 530 U.S. 133, 150-51 (2000).

these facts-the evidence that the jury actually believed-provides an understanding of the complex factual circumstances of Poliner's peer review. These facts paint a very different picture from the sanitized version of the facts set forth by the Fifth Circuit's reversal opinion. App. 3a-12a. These facts show the interwoven anticompetitive and political motives of the defendants and others involved in Poliner's peer review whose opinions were sought out and relied upon by defendants. These facts show the overwhelming evidence that Poliner was personally disliked by many of his reviewers, especially Knochel. These facts were accepted by the jury, which heard and weighed the evidence and made determinations about credibility. Above all, these are the facts that Congress specifically intended would factor into the determination of "reasonable belief" under the first and fourth prongs of immunity.

The Fifth Circuit is forced by the judicial interpretation of its sister circuits to utterly ignore the standards for reviewing jury verdicts, as clearly shown by its selectively sanitized version of the facts. This is a direct result of the line of cases, starting with *Austin v. McNamara*, 979 F.2d 728 (9th Cir. 1992), holding that an entire category of evidence (evidence of "subjective motives") is wholly irrelevant to evaluating "reasonable belief." As a result, the Fifth Circuit fashioned a one-sided version of the events that creates the impression that Poliner was a dangerous doctor with whom Knochel dealt fairly and reasonably by letting him agree to short periods of "abeyance" of his cath lab privileges. The Poliner jury, however, unanimously rejected that misleading version of events, as they were absolutely entitled to do. When

the evidence wholly disregarded by the Fifth Circuit is factored back in, the jury's findings that defendants did not have a "reasonable belief" are amply supported. Restoring the Fifth Circuit's ability (and, indeed, its obligation) to consider evidence of subjective motivations will remedy this gross misinterpretation of clear statutory language and Congressional intent. The Court must return the analysis to that originally envisioned by Congress, so that what is now effectively absolute immunity will operate as the qualified immunity Congress intended. Physicians, patients, and the healthcare system as a whole depend on it.

C. The purpose stated by Congress shows that HCQIA immunity is qualified.

In 1986, Congress enacted HCQIA after recognizing nationwide problems of medical malpractice and the need to improve the quality of medical care by restricting the ability of incompetent physicians to move from state to state without disclosure or discovery of previous damaging or incompetent performance. 42 U.S.C. § 11101(1)-(3) (1995). Congress decided these problems were best remedied through effective professional peer review. *Id.* The express purpose of enacting HCQIA was 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. 99-903, at 1 (1986), as *reprinted in* 1986 U.S.C.C.A.N. 6384. Under the proposed bill, "hospitals and physicians that conduct peer review [would] be protected from damages in suits by physicians who lose their hospital privileges, provided the peer review actions [met] the due process

and other standards established in the bill." *Id*. Congress found that "the threat of private money damage liability under Federal laws, including treble damage liability under antitrust law, unreasonably discourages physicians from participating in effective professional review." 42 U.S.C. § 11101(4). Thus, Congress saw an "overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." *Id*. at (5).

The House Committee on Energy and Commerce (the "Committee") reported favorably on the bill and recommended it pass. H.R. Rep. No. 99-903, at 1 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384. To ensure that physicians would cooperate in a system of peer review intended to identify incompetent and unprofessional doctors, the Committee stated it was "essential to provide some legal immunity to doctors and hospitals that engage in peer review activities." *Id*. at 6385. "Many people in the medical field told the Subcommittee on Health and the Environment that the reporting system would inevitably result in an enormous increase in litigation because physicians facing disciplinary action will feel compelled to challenge vigorously any action taken against them. Based on recent experience, the Committee believed that many of those physicians would file antitrust lawsuits." *Id*. It noted that "doctors who are sufficiently fearful of the threat of litigation will simply not do meaningful peer review." *Id*. Thus, the Committee saw a "clear need to do something to provide protection for doctors engaging in peer review if [the National Practitioner Data Bank, a centralized system of physician reporting, also created by HCQIA] was to be workable." *Id*.

To achieve that end, the bill (which became HCQIA) provided "limited, but essential, immunity. Doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of the bill are protected from damages sought by a disciplined doctor. The bill protects innocent and often helpless consumers from abuses by bad doctors without insulating improper anticompetitive behavior from redress." *Id*. at 6385-86 (emphasis added). Clearly, Congress intended a limited immunity, and envisioned that at least one type of subjective motivation would be considered in deciding immunity—evidence of "improper anticompetitive behavior."

D. Congress used clear and plain language—"reasonable belief"—in the immunity standards.

HCQIA sets four requisites that must be met to qualify for immunity, two of these require a "reasonable belief." Congress specifically chose the language of these standards to craft an immunity that would strike a balance between encouraging proper peer review and accountability for money damages in the event of improper peer review. By its clear language, the standard contemplates subjective elements. The most compelling example is malice. Malice in the peer review context in Texas is defined as "the making of a statement with knowledge that it is false, or with reckless disregard of whether it is false. Reckless disregard means that a statement is made with a high degree of awareness of probable falsity." App. 132a-133a. The Poliner jury found that each of the defendants acted maliciously, and this

finding necessarily eliminates the presence of a reasonable belief. It defies logic that a "reasonable belief" can be judicially determined without consideration of all evidence regarding all the motivations in a defendant's mind, including the fact that a defendant acted with legal malice. "Belief" is "[a] conviction of the truth of a proposition existing subjectively in the mind . . . ." Black's Law Dictionary 106 (6th ed. 1991) (emphasis added).[6] Sanitizing "reasonable belief" to remove consideration of any subjective elements, especially malice, eliminates any and all meaning from the term "belief," and renders the statutory language chosen by Congress meaningless.

E. Congress rejected broad immunity to avoid shielding anticompetitive behavior and other abuse when state immunity laws were avoided.

The Committee believed "that the purposes of the bill require protection for persons engaging in professional review." H.R. Rep. No. 99-903, at 8-9 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6391. In support of this belief, the Committee stated "[u]nder current state law, most professional review activities are protected by immunity and confidentiality provisions. A small but growing number of recent

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[6] Although the more recent edition of Black's has significantly pared down the lengthy definition for "belief" set forth in the sixth edition, it still contains the same "subjective" component by defining "belief" as "a state of mind that regards the existence of something as likely or relatively certain." Black's Law Dictionary 164 (8th ed. 2004).

federal antitrust actions, however, have been used to override those protections. Because the [National Practitioner Data Bank] will most likely increase the volume of such suits, the Committee feels that some immunity for the peer review process is necessary." *Id*. It is obvious that Congress was aware of the various state immunity statutes that existed[7] and did not want to affect or diminish state immunity statutes crafted by their respective legislatures for the protection of their physician citizens.[8] It did, however, want to provide immunity where there seemed to be a particular gap being used to circumvent those state immunity protections—the antitrust lawsuit. So Congress crafted its own immunity standard to fill that gap.

The Committee first considered establishing a very broad protection from suit for professional review actions. *See* H.R. Rep. No. 99-903, at 9 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6391. However, "in response to concerns that such protection might be abused and serve as a shield for anti-competitive economic actions under the guise of quality controls," the Committee restricted the protection to provide immunity only from damages in private actions, and only for proper peer review. *Id*. A clearer statement regarding Congressional intent could not have been made—federal immunity was not designed to shield peer review motivated by "anti-competitive economic actions." Even this Court has recognized qualified

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[7] *See* note 17, *infra*.

[8] *See* §11115(a). However, this is exactly what has happened, as discussed in section H(3) below.

immunity is to be applied in the antitrust context. *Patrick v. Burget*, 486 U.S. at 105 n.8 ("Congress in fact insulated certain medical peer-review activities from antitrust liability in [HCQIA]. . . ." (emphasis added)).

F. Congressional intent supports a more objective "reasonable belief" standard but in no way eliminates consideration of subjective intent.

Initially, the Committee considered a "good faith" standard. H.R. Rep. No. 99-903, at 10, (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6392. However, there were concerns that "good faith" might be interpreted "as requiring only a test of the subjective state of mind of the physicians conducting the professional review action." *Id*. Thus, the Committee changed to a more objective "reasonable belief" standard, which appeared to be more restrictive than a "good faith" test.[9] *Id*. at 6392-93. "The Committee [intended] that this test be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." *Id*. at 6393. Congress focused the inquiry on the state of mind of the defendant at the time of the action, which must also be reasonable.

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[9] Thus, a defendant could not receive immunity for unreasonable behavior just because he claimed that he acted in "good faith." The belief would also have to be reasonable for immunity to be conferred.

Granted, the Committee believed that a more objective "reasonable belief" standard would be met "in the overwhelming majority of professional review actions." *Id*. Thus, a presumption to that effect was provided in the bill, "requiring a plaintiff to show by clear and convincing evidence[10] that no such reasonable belief existed at the time of the professional review action." *Id*. But the Committee's language also shows it recognized there would be at least some cases in which the "reasonable belief" standard would not be met.

Nothing in the "reasonable belief" test articulated by Congress precludes the consideration of factual evidence of a bias or improper motive in conjunction with other evidence about professional competence or patient care. Simply because Congress favored a "more objective" standard it does not follow that all subjective motives unrelated to health care are irrelevant in the analysis. After all, when HCQIA was enacted as part of Public Law 99-660, its title remained "Title IV – Encouraging Good Faith Professional Review Activities." Pub. L. No. 99-660, 100 Stat. 3743 (1986) (emphasis added). Aside from the title of the bill itself, Congress also stated its "intent that physicians receive fair and unbiased review to protect their reputations and medical practices." H.R. Rep. No. 99-903, at 11 (1986), *as reprinted* in 1986 U.S.C.C.A.N. 6384, 6393. Further, Congress specified that, "to ensure that reviews of

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[10] Although the proposed bill would have required plaintiff to provide "clear and convincing evidence" to rebut the presumption, the enacted statute adopted the less burdensome "preponderance of the evidence" test. *See* 42 U.S.C. § 11112(a).

physicians pertain only to quality of care . . . members of the hearing panel, or the hearing officer, cannot be in direct economic competition with the physician-respondent." *Id*. In the face of all this guidance, Congress would be stunned to know how HCQIA immunity has been recast.

G. Courts have transformed qualified immunity by wholly disregarding subjective intent.

Austin v. McNamara was the first case to conclude that subjective intent must be wholly eliminated from the analysis. In the *Austin* opinion, after citing much of the same language regarding the legislative history of HCQIA set forth above, the Ninth Circuit proclaimed (without any authority) that a physician's allegations of "animosity" and "hostility" are "irrelevant to the reasonableness standards of §11112(a). The test is an objective one, so bad faith is immaterial." *Austin v. McNamara*, 979 F.2d at 734. In direct contrast to the "more objective" test that Congress employed, the *Austin* court invented a highly simplistic test that turns a blind eye to bad faith, malice, or actual motive.[11]

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[11] The dissent in *Austin* points out the serious flaw in this holding, stating that "[e]vidence of motive and intent is relevant to show whether the defendants possessed a reasonable belief that the final revocation was warranted by the facts known. Moreover, the legislative history discussing the due process requirements of section 11112 makes clear that it is essential that 'physicians receive fair and unbiased review to protect their reputation and medical practices' (internal citations omitted). Any inquiry into

One by one, circuit courts of appeal have parroted this erroneous standard, which now supplants the actual standard for immunity as articulated by Congress. The illogical result is that there exists no category of evidence that can ever rebut the presumption that a defendant had a "reasonable belief." Thus, each and every case in which the "reasonable belief" prongs of immunity have been analyzed by a circuit court of appeals has been dismissed as a matter of law based on federal immunity.[12] The Poliner case was the only exception until the Fifth Circuit reversed.

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the reasonableness of the reviewers' beliefs should at least consider any evidence of bias or ulterior motive even though an objective standard ultimately applies." *Id.* at 741, n. 3.

[12] The Tenth Circuit is the only circuit court of appeals that has upheld a lower court's finding that the presumption of immunity under HCQIA was rebutted by plaintiff. In *Brown v. Presbyterian Healthcare Servs*., 101 F.3d 1324 (10th Cir. 1996), the court affirmed the district court's conclusion that Dr. Brown presented sufficient evidence for a reasonable jury to find that her peer review action was not taken after a "reasonable effort to obtain the facts of the matter" and, thus, defendants were not immune, as a matter of law, from damages stemming from the revocation of Dr. Brown's privileges. The analyses of both courts was focused on the third prong and did not address the nature of the "reasonable belief" test.

H. The resulting effects of the judicial misinterpretation clearly turn HCQIA on its head.

1. Effect—There exists no evidence that can be used to rebut presumption of HCQIA immunity.

The circuit courts of appeal have spent much time telling physicians what cannot be used to rebut the presumption of immunity, but are suspiciously silent as to how a physician could actually rebut the presumption.[13] The Fifth Circuit's decision in Poliner is a good example. Despite its claim that it considered the "totality of the circumstances" (App. 22a), the court plainly disregarded any and all evidence that could have conceivably rebutted the presumed immunity. Subjective motives are not considered—the erroneous exclusion of this entire category of evidence is the reason for this petition for certiorari. Another category of excluded evidence involves the departure from the medical staff bylaws (especially a knowing violation), which would seem a logical barometer for "reasonableness." Not so. The Fifth Circuit specifically states that evidence of a knowing violation

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[13] The one exception appears to be in cases where the physician plaintiff has failed to present evidence raising issues of malice and subjective motives not in the interest of patient care. For example, in *Mathews v. Lancaster Gen. Hosp.*, the Third Circuit determined that Dr. Mathews failed to rebut the first prong of HCQIA requirements because he did not present evidence that professional review action "was motivated by anything other than a reasonable belief that it would further quality health care." *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3d Cir. 1996).

of the medical staff bylaws does not "defeat" immunity and the overall analysis makes it plain that the Fifth Circuit did not even consider bylaws violations that knowingly occurred in evaluating "reasonable belief." App. 16a-37a. Other courts are no different. They consistently disregard or severely minimize evidence of the violation of medical staff bylaws.[14] Lastly, the Fifth Circuit dismissed Poliner's numerous expert opinions (another category of evidence), and stated that defendants' beliefs could not have been unreasonable despite the medical facts of the care given and the outlandish criticisms made of Poliner. App. 23a-24a. Other courts play this same game with their various analyses, rendering it impossible to imagine any set of circumstances where "reasonable belief" will not be found as a matter of law.

2. Effect—Courts now routinely usurp the fact-finding role of the jury.

Congress envisioned that, for most cases, HCQIA immunity would be determined by the courts as a matter of law before a jury trial. Congress stated "this

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[14] *See, e.g., Wieters v. Roper Hosp., Inc.*, 58 Fed.Appx. 40, 46 (4th Cir. 2003) (even if procedure strayed from letter of the bylaws, it still meets immunity requirements if it was "fair to the physician under the circumstances"); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469-70 (6th Cir. 2003) (even assuming bylaws were violated, notice and procedures complied with HCQIA's statutory "safe harbor"); *Bakare v. Pinnacle Health Hosp., Inc.*, 469 F.Supp.2d 272, 290 at n. 33 (M.D. Pa. 2006) ("court need not determine whether MEC followed the Bylaws"); *Wahi v. Charleston Area Med. Ctr.*, 453 F.Supp.2d 942, (S.D.W.Va. 2006) (failure to follow bylaws procedures did not render process inadequate under HCQIA).

[reasonable belief] standard will be met in the overwhelming majority of professional review actions." H.R. Rep. No. 99-903, at 10 (1986), *as reprinted in* 1986 U.S.C.C.A.N. 6384, 6393. For this "overwhelming majority," Congress specified a procedure for early judicial determination of immunity. Congress intended that HCQIA provisions "allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible." *See id.* at 6394. "The provisions would allow a court to make a determination that the defendant has or has not met the standards specified in [42 U.S.C. § 11112(a)]. The Committee intend[ed] that the court could so rule even though other issues in the case remain to be resolved. For example, a court might determine at an early stage of the litigation that the defendant has met the standards, even though the plaintiff might be able to demonstrate that the professional review action was otherwise improper. At that point, it would be in order for the court to rule on immunity." *Id*.

But the Committee observed that "[i]f the professional review actions being challenged fail to meet the standards of [§ 11112(a)], no immunity is provided and the suit can be tried without regard to the provisions of this bill." *Id*. at 6391. This crucial sentence supports the obvious conclusion that Congress envisioned cases in which immunity would not be decided as a matter of law. In these cases, the discrete fact issues underlying the four HCQIA standards would be determined by a jury.

Thus, at summary judgment, a court using a "somewhat unusual standard" given the rebuttable

presumption determines: "Might a reasonable jury, viewing the facts in the best light for [plaintiff], conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?" *Austin*, 979 F.2d at 734*; see also Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir.1994).

The Poliner trial court, at the summary judgment stage, could not have implemented this complex legal standard any more carefully or thoughtfully. App. 96a. The court stated:

> Dr. Poliner contends that he has raised material issues of fact as to whether Defendants were motivated by something other than a reasonable belief that their actions would further the care of the Hospital's patients. More specifically, Plaintiff alleges that the combination of the personal animosity toward him and the desire to eliminate an economic competitor resulted in a conspiracy to eliminate plaintiff from practicing at [the Hospital]. In making this examination, most courts have adopted an objective standard of reasonableness [citations omitted]. That is, the focus of this inquiry is not whether the defendants' initial concerns are ultimately proven to be medically sound. Rather, the objective inquiry focuses on whether the professional action taken against [Poliner] was taken "in the reasonable belief that the actions was in the furtherance of quality health care [citations omitted]."

App. 97a (emphasis added). Notably, the Poliner trial court did not disregard the evidence of personal animosity and anticompetitive motives as the Fifth Circuit later would; nowhere in the summary judgment opinion is any statement of law that this category of evidence is "irrelevant." Instead, as Congress intended, this category of evidence factored into the trial court's determination (using an "objective inquiry") that fact issues regarding "reasonable belief" were raised and needed to be determined by a jury. In stark contrast to the Fifth Circuit and its sister circuit courts, the Poliner trial court, in its summary judgment ruling, got it right.[15]

The Eleventh Circuit confirms that the Poliner trial court employed the correct procedure at summary judgment and in its subsequent instructions to the jury at trial. "If there are disputed subsidiary issues of fact concerning HCQIA immunity, such as whether the disciplined physician was given adequate notice of the charges and opportunity to be heard, the court may ask the jury to resolve subsidiary factual questions by responding to special interrogatories." *Bryan v. James E. Holmes Reg'l Med Ctr.*, 33 F.3d 1318, 1333 (11th Cir.1994). This observation would seemingly also

[15] At least one other federal district court appears to have also gotten it right. *See Islami v. Covenant Med. Ctr.*, 822 F.Supp. 1361 (N.D. Iowa 1992) (stating a jury can and should decide any discrete, disputed material fact issues essential to the final determination of immunity as a matter of law if that determination cannot be made at the summary judgment stage and finding that plaintiff raised a fact issue regarding the fairness and adequacy of the process in his peer review).

apply to the fact question of whether defendants had a "reasonable belief."[16]

In Poliner, the trial court gave the jury discrete factual questions to resolve and the jury answered the discrete factual questions as to each defendant, separately distinguishing the May 14 action from the May 29 action. App. 126a-132a. The jury found that, for each defendant, the "reasonable belief" standards in the first and fourth prongs were not met. The jury answered each of these factual questions in a way that allowed the trial court ultimately to determine that immunity could not be conferred on defendants as a matter of law. The Poliner case showed there was an actual route to achieving accountability for damage done to a career and reputation under the guise of medical peer review—the way Congress intended HCQIA to work. However, the Fifth Circuit's reversal drastically changes this. The complex process for determining qualified immunity under HCQIA (which, in at least some cases, requires jury fact finding) can now never operate as Congress intended. The Poliner case has turned from an example of the proper operation of immunity to proof of its utter failure.

3. Effect—Individual state laws are now rendered meaningless.

In addition to granting immunity, HCQIA expressly allows individual states to provide additional or

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[16] Determinations of "reasonableness" and "adequacy" are inherently fact-based inquiries. *See, e.g., Islami v. Covenant Med. Ctr.*, 822 F.Supp. 1361, 1377 (N.D. Iowa 1992).

greater protection to peer review activities. "Except as specifically provided in this subchapter, nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter." 42 U.S.C. § 11115(a). This Court has explicitly stated that "[t]he Act expressly provides that it does not change other 'immunities under law,' § 11115(a), including the state-action immunity, thus allowing States to immunize peer-review action that does not meet the federal standard." *Patrick v. Burget*, 486 U.S. at 105 n.8. Nothing in the legislative history indicates that Congress intended for HCQIA to completely preempt state law in this area. *See Zamaniam v. Christian Health Ministry*, No. 94-1781, 1994 WL 396179 at *2 (E.D. La. 1994) (not reported) (addressing plaintiff's jurisdictional argument based on complete preemption doctrine and finding no statutory evidence of congressional intent to preempt state peer review laws).

State peer review laws generally provide immunity except in situations of malice, fraud, or willful and wanton conduct.[17] For example, soon after HCQIA was

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[17] Thirty states currently have medical peer review immunity standards that are related to whether the defendants "acted without malice." *See* Ala. Code § 6-5-333 (2006); Ark. Code Ann. § 20-9-502 (2005); Cal. Health & Safety Code § 1370 (West 2003); Cal. Civ. Code § 43.7 (West 2003); Conn. Gen. Stat. Ann. § 19a-17b (West 2003); Del. Code Ann. tit. 24 § 1768 (2003); Ga. Code Ann. §§ 31-7-132, 31-7-141 (2001); Haw. Rev. Stat. § 663-

enacted in 1986, Texas (applicable in Poliner) enacted its own law to provide that peer review actions taken "without malice" are immune from liability.[18] From

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1.7 (2002); Iowa Code Ann. § 147.135 (West 2003); Kan. Stat. Ann. § 65-442 (2002); La. Rev. Stat. Ann. § 13:3715.3 (West 2002); Mich. Comp. Laws Ann. § 331.531 (West 2003); Miss. Code Ann. § 41-63-5 (2003); Mo. Ann. Stat. § 537.035 (West 2003); Mont. Code Ann. § 37-2-201 (2002); Neb. Rev. Stat. § 71-147.01 (2003); N.J. Stat. Ann § 2A:84A-22.10 (West 2003); N.Y. Educ. Law § 6527 (McKinney 2003); N.C. Gen. Stat. § 131E-95 (2003); N.D. Cent. Code § 23-34-06 (2003); Ohio Rev. Code Ann. §§ 2305.25, 2305.28 (West 2003); Pa. Stat. Ann. tit. 63, § 425.3 (West 2003); R.I. Gen. Laws §§ 5-37.3-7, 23-17-25 (2002); S.C. Code Ann. § 40-71-10 (Law Co-op. 2003); S.D. Codified Laws § 36-4-25 (2003); Tenn. Code Ann. § 63-6-219 (2003); Tex. Occ. Code Ann. § 160.010 (Vernon 2003); Utah Code Ann. §§ 58-13-4, 58-13-5 (2003); Vt. Stat. Ann. tit. 26, § 1442 (2002); Va. Code Ann. § 8.01-581.13 (Michie 2003); Wyo. Stat. Ann. §§ 35-17-103, 33-26-408 (Michie 2002). Twelve states have standards related to whether the defendants "acted in good faith." *See* Del. Code Ann. tit. 24 § 1768 (2003); Ind. Code Ann. §§ 34-30-15-15, 34-30-15-17 (West 2003); Kan. Stat. Ann. § 65-442 (2002); Mass. Gen. Laws Ann. ch. 111, § 203 (2003); Mo. Ann. Stat. § 537.035 (West 2003); N.H. Rev. Stat. Ann. §§ 329:17, 507:8-c (2002); Okla. Stat. Ann. tit. 63, §§ 1-1709, 1-1709.1 (West 2002); Or. Rev. Stat. § 41.675 (2002); Tenn. Code Ann. § 63-6-219 (2003); Utah Code Ann. §§ 58-13-4, 58-13-5 (2003); Va. Code Ann. § 8.01-581.13 (Michie 2003);Wis. Stat. Ann. § 146.37 (West 2003). Three states have standards related to whether the defendants "acted without fraud." *See* Ark. Code Ann. § 20-9-502 (Michie 2003); Fla. Stat. Ann. § 766.101 (West 2003); N.C. Gen. Stat. § 131E-95 (2003). And one state has standards related to whether the defendants acted "without willful and wanton misconduct." *See* 210 Ill. Comp. Stat. Ann. 85/10.2 (West 2003); 225 Ill. Comp. Stat. Ann. 60/5 (West 2003).

[18] Texas peer review immunity, enacted in 1987, provided immunity from civil liability for "a person, health-care entity, or medical peer review committee, that, without malice, participates

the language of the Texas statute and the case law interpreting it, it is clear Texas took the additional step of providing more protection to medical peer review than HCQIA. *Roe v. Walls Reg'l Hosp., Inc.*, 21 S.W.3d 647, 653 (Tex. App.—Waco 2000, no pet.) (citing *St Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 507 (Tex. 1997)). Qualified immunity under Texas state law can only be defeated by a showing that the defendant acted with actual malice. *Id*. If a plaintiff shows malice, the Texas legislature has made its intent known—it will protect its physician citizens from these peer review actions and allow those citizens to hold the responsible parties accountable through the remedy of civil damages.[19]

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in medical peer review actively or furnishes records, information, or assistance to a medical peer review committee or the board." *See* Tex.Rev.Civ. Stat. Ann. art. 4495b section 5.06(m) (repealed) (emphasis added). Texas's current immunity statute continues this "without malice" standard. TEX. OCC. CODE ANN. § 160.010(a)(1)-(3) (Vernon 2001) (emphasis added).

[19] The Fifth Circuit minimizes the remedy of civil damages in this context by stating "[t]he doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment." App. 28a. But the availability of such relief is no substitute for money damages otherwise available under federal or state law, particularly if there are financial consequences (such as lost earnings and damage to professional reputation). As this Court said in a case requiring backpay for a civil rights violation under Title VII: "If employers faced only the prospect of an injunctive order, they would have little incentive to shun practices of dubious legality. It is the reasonably certain prospect of a backpay award that "provide(s) the spur or catalyst which causes employers and unions to self-examine and to self-evaluate their employment practices and to endeavor to eliminate, so far as possible, the last vestiges of an unfortunate and

HCQIA immunity, as currently interpreted by the courts, completely overrides any state law that mandates accountability for peer review conducted with bad faith, malice, or intentional fraud. The ability to rebut the presumption of immunity under state law will always be stymied by the current "objective reasonableness" test under HCQIA. Thus, a peer review action can be taken maliciously and in bad faith as long as there is any kind of quality of care issue or professional competence issue that can be raised.[20] In essence, state laws enacted to protect physician citizens from malicious peer review are now meaningless. Although Congress stated an intent not to override state law, that is precisely what has occurred.

4. Effect—Absolute immunity has resulted.

The circuit courts of appeal refuse to consider bad motive—period. They do not even attempt to analyze the "totality of the circumstances," which necessarily includes the consideration of subjective motives along with possible legitimate motives. Instead, the circuit courts of appeal seize on any conceivable proper motive

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ignominious page in this country's history." *Albemarle Paper Co. v. Moody*, 422 U.S. 405, 417-18 (1975).

[20] Perhaps one of the most ridiculous statements illustrating this absurd result comes from an Ohio state court of appeals in *Cowett v. TCH Pediatrics, Inc.*—"[i]f a hospital rids itself of a doctor both because of health care concerns and because of financial/political concerns, HCQIA will give the hospital immunity from suit." *Cowett v. TCH Pediatrics, Inc.*, 7th Dist. No. 05 MA 138, 2006 Ohio-5269, at ¶23 (Ohio App. 2006) (emphasis in the original).

(true or not) as justification. The limited immunity envisioned by Congress is thus rendered an impossibility. Now that the courts have wholly and categorically disregarded such evidence, peer review is absolutely immune. Absolute immunity in the peer review context (where independent hospitals and health care entities and their participants receive absolute protection) is a grave error.[21] Even worse, as

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[21] This is especially true considering that these diffuse, separate entities conduct peer review independent from any state or federal governmental authority. There exist none of the hallmarks under which absolute immunity from civil liability has historically been applied. There are five contexts in which this Court has approved the application of absolute immunity from civil liability: (1) prosecutors performing prosecutorial acts (*see Imbler v. Pachtman*, 424 U.S. 409, 430-31 (1976)); (2) judges performing judicial tasks (*see Stump v. Sparkman*, 435 U.S. 349, 355 (1978)) and state officials or employees performing adjudicatory tasks (*see Olsen v. Idaho State Bd. of Med.*, 363 F.3d 916 (9th Cir. 2004)); (3) legislators performing legislative tasks (*see Bogan v. Scott-Harris*, 523 U.S. 44 (1998)); (4) police officers who testify as witnesses (*see Briscoe v. LaHue*, 460 U.S. 325 (1983)); and (5) the President of the United States for acts taken while in office (*see Nixon v. Fitzgerald*, 457 U.S. 731 (1982); *see also Clinton v. Jones*, 520 U.S. 681, 696 (1997)). In each of these contexts, unlike in medical peer review, the actors are government officials (most often elected) and not private individuals acting on behalf of a private organization. Additionally, the immunity is granted due to concerns that civil suits would be disruptive to the flow of government. *See, e.g., Spalding v. Vilas*, 161 U.S. 483, 498 (1896); *see also Pierson v. Ray*, 386 U.S. 547, 564 n. 4 (1967). Further, in these recognized instances absolute immunity is expressly limited by the Court to conduct undertaken in the exercise of certain, specific acts within the function of the actor's office. *See, e.g., Butz v. Economou*, 438 U.S. 478, 508-17 (1978); *Imbler v. Pachtman*, 424 U.S. 409, 430-31 (1976); *Spalding v. Vilas*, 161 U.S. 483, 498 (1896). Finally, these persons to whom the Court has extended absolute immunity plainly function in a governmental role such

it now stands, this absolute immunity exists under the guise of "qualified immunity," creating a false sense of security for physicians who must operate in this precarious and unforgiving environment.

I. The stakes are high and the consequences serious—for physicians and patients.

The current state of immunity for peer review is made more tragic by the high stakes involved. There are a myriad of interwoven reporting requirements under federal and state law that may be triggered when an adverse action is taken. State licensing boards that monitor any such events have the power to revoke a physician's license to practice medicine. An adverse action at just one hospital can result in a "domino effect" whereby other hospitals, health care entities, insurance companies and other third parties take action against a physician because of the original adverse action, or at least conduct their own investigations, thus putting a physician in peril of losing privileges elsewhere, and jeopardizing his ability to practice medicine anywhere.

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that they are presumed to be aware of applicable laws and reasonably conscious of the clearly established constitutional and statutory rights of individuals who are subject to their conduct. None of these hallmarks exist in a medical peer review conducted by individual physicians who may or may not understand, and are certainly not bound by, due process laws or evidentiary rules. Further, peer review proceedings (unlike judicial and prosecutorial proceedings) are ostensibly governed by medical staff bylaws, which are not subject to any uniformity or standard, can be vastly different from hospital to hospital, and may or may not co-exist with applicable law or even constitute an enforceable contract.

An equally tragic victim is the one in whose name peer review and its various immunities were originally created—the patient. If peer review is carried out because of malicious intent (anticompetitive, political, personal, or otherwise) and is protected nonetheless by HCQIA immunity, the goals of protecting patients and ensuring patient care (which should be the pre-eminent considerations in peer review) take on a subordinate position. Physicians subject to review are not judged on the basis of their medical competency, and privileges may be removed (with devastating and possibly career-ending ramifications) in spite of competency. Good doctors are denied the ability to practice medicine, and patient care suffers.

J. Compelling reasons exist for the Court to stop the derailment of HCQIA.

HCQIA has been derailed. If the Fifth Circuit had departed from its sister circuits on an important federal issue such as this, or if the circuits were evenly divided, the Court would likely step in and review the case. The fact that the serious departure came when the Ninth Circuit first weighed in on the interpretation of "reasonable belief" standard and got it wrong (and other courts either blindly followed or had no choice) does not decrease in any way the need for this Court to address this issue and correct this serious misinterpretation of the law. This conflict is crucial enough to physicians, patients, and the health care system as a whole to warrant certiorari. The Court is the last hope to get the statute back on track and allow immunity in medical peer review to operate as Congress intended.

Without the grant of certiorari by this Court, the courts will continue down the current path of judicial misinterpretation, providing, in effect, absolute immunity for medical peer review. As is the case now, there will never be circumstances under which the "reasonable belief" tests under HCQIA are not met as a matter of law, even where juries find clear evidence of malice and motives unrelated to health care and conclude that no reasonable belief exists—as was the case in Poliner.

CONCLUSION

The petition for certiorari should be granted.

Respectfully submitted,

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Dated: October 21, 2008

APPENDIX A

IN THE UNITED STATES COURT OF APPEALS FOR THE FIFTH CIRCUIT

No. 06-11235

[Filed July 23, 2008]

LAWRENCE R POLINER, MD; LAWRENCE R POLINER, MD, PA	)
Plaintiffs-Appellees	)
v.	)
TEXAS HEALTH SYSTEMS, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas; JAMES KNOCHEL, MD	)
Defendants-Appellants	)

Appeals from the United States District Court for the Northern District of Texas

Before KING, HIGGINBOTHAM, and SOUTHWICK, Circuit Judges.

PATRICK E. HIGGINBOTHAM, Circuit Judge:

This appeal brings to us a judgment awarding some $33 million, including prejudgment interest, against a major hospital and leading physician for alleged defamations. As we will explain, this extraordinary judgment rests on limited restrictions of Dr. Lawrence Poliner's privileges at Presbyterian Hospital over a period of fewer than twenty-nine days to investigate concerns involving his handling of several patients. This peer review, which was headed by Dr. James Knochel, led to a suspension of Poliner's cardiac catheterization lab and echocardiography privileges that lasted approximately five months. Poliner sued Knochel, Presbyterian, and other doctors involved in the peer review alleging various federal and state law violations. The district court found that the suspension enjoyed immunity from money damages under the federal Health Care Quality Improvement Act (HCQIA),[1] and granted a partial summary judgment. But the court concluded that whether the temporary restrictions of privileges during the investigation enjoyed immunity from money damages presented questions for a jury.

The case proceeded to trial solely on the temporary restrictions of privileges. The jury found for Poliner on his defamation claims.[2] Poliner was able to offer evidence at trial of actual loss of income of about $10,000-but was awarded more than $90 million in

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[1] *See* 42 U.S.C. § 11101 *et seq.*

[2] The jury also found for Poliner on his breach of contract business disparagement, interference with contractual relations and intentional infliction of emotional distress claims. Poliner elected to recover under the defamation theory after trial.

defamation damages, nearly all for mental anguish and injury to career. The jury also awarded $110 million in punitive damages. The district court ordered a remittitur of the damages and entered judgment against Defendants. We hold that Defendants are immune under the HCQIA from money damages for the temporary restrictions of Poliner's privileges. We reverse and render judgment for Defendants.

I. Facts and Proceedings Below

A.

On May 12, 1998, Patient 36 presented in Presbyterian's emergency room with chest pains, and he was referred to Dr. Lawrence Poliner, an interventional cardiologist who had a solo practice at Presbyterian Hospital. Diagnostic tests indicated that the patient was suffering from a heart attack, and that the patient's right coronary artery (RCA) was partially blocked. Poliner performed a procedure to open the artery. However, Poliner made a diagnostic mistake: the patient's left anterior descending artery (LAD) was completely blocked, and Poliner missed it. Another doctor, Dr. Tony Das, saw the LAD on a monitor in the control room. Poliner learned that he missed the LAD sometime after completing the procedure. Das spoke to him about the procedure and the LAD. Dr. Charles Levin, the director of the catheterization lab, heard that day that Poliner had performed an emergency procedure. He reviewed the patient's films, and then spoke with Poliner.

In an addendum to the chart, Poliner admitted that he missed the totally blocked LAD. He wrote that "[i]n

reviewing the films, it is apparent that the left anterior descending coronary artery is totally occluded," and that "[a]t the time that this study was done and visualizing the anatomy in the laboratory from the video, this was not apparent, but it is obvious from reviewing the films." Poliner indicated that he might have treated the LAD before the RCA had he seen it.

Patient 36 also suffered post-procedure complications. The patient suffered internal bleeding and eventually went into shock, deteriorating to the point that a critical care specialist, Dr. Kenney Weinmeister, was brought in. Weinmeister testified that the patient was suffering from "severe metabolic acidosis," which "was due to what we call hypovolemia or essentially blood loss so that he didn't have enough fluid in his vessels to maintain blood pressure, and that was due to a retroperitoneal hemorrhage or bleeding." The patient was, in his words, "near respiratory failure." Weinmeister testified that, had he not intervened, the patient could have died within an hour. Poliner was in the ICU a number of times following the patient's procedure. There were problems contacting Poliner, although at trial there was testimony that he tried to call the ICU several times but he could not get through. Poliner also sent his wife, who is a nurse, over to check on the patient. As the patient's condition deteriorated in the afternoon, Poliner was not present. There was evidence at trial that he had another procedure scheduled that afternoon, but the time line is not entirely clear. Dr. John Harper, the chief of cardiology, was told about Patient 36 on May 12, and he reviewed the patient's chart and films.

Dr. James Knochel, the chairman of the Internal Medicine Department (IMD), learned about Patient 36 from Das and Weinmeister the next day, May 13.[3] This, however, was not the first of Poliner's patients to come to Knochel's attention. Cardiology was part of the IMD, and four of Poliner's other patients-Patients 3, 9, 10, and 18-had been referred by the hospital's Clinical Risk Review Committee (CRRC) to Knochel and the Internal Medicine Advisory Committee (IMAC), which Knochel chaired, for review.[4]

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[3] The trial testimony is somewhat unclear about what exactly Knochel knew on May 13 about the post-procedure care Patient 36 received. Knochel and Weinmeister testified that they spoke about the patient. Weinmeister testified that he told Knochel about his concerns regarding Patient 36's post-procedure problems, while Knochel suggested in his testimony that he may not have been aware of all of the post-procedure problems.

[4] Generally, when an incident occurred at Presbyterian, including something relating to patient care, a Committee Event Report Form (CERF) would be completed. The CERF was sent to the hospital's risk management department for processing. If the event involved clinical issues, the CERF was forwarded to the CRRC. The CRRC would review the incident, and if the committee had concerns, it would forward the case to the relevant department for further review. When an incident involved the IMD, Knochel would receive the referral from CRRC, and the IMAC would assist in determining whether the patient had received acceptable care.

Poliner's care of Patients 3,[5] 9,[6] 10,[7] and 18[8]

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[5] In December 1997, Poliner treated Patient 3. The issue here was Poliner's decision to re-use a sheath site for a second procedure after the nurses expressed concern that the site may have been contaminated by urine and blood. Poliner wanted to preserve the other sheath site in case another procedure was required.

[6] Poliner treated Patient 9 in October 1997. The procedure performed by Poliner was not questioned, but other treatment decisions were. There were concerns about the amount of blood thinner ordered pre-procedure, as well as orders for additional blood thinner and another drug post-procedure. At approximately 2:00 a.m., the patient was experiencing stroke-like symptoms. A nurse called Poliner, and he ordered a platelet infusion. Poliner did not then return to Presbyterian to evaluate the patient, although there may have been little else he could have done at the time. Nor did he order a CT scan or request a neurological consult. Poliner returned to the hospital in the morning and requested the neurological consult. The patient subsequently had CT scans and underwent surgery later in the day. The case involved several nursing errors as well.

[7] Poliner performed a catheterization on Patient 10 in the fall of 1996. The patient had shellfish and Betadine allergies. There were concerns at the time that a shellfish allergy was predictive of an allergy to iodine-containing contrast dye that was used in catheterizations. The patient refused to be pretreated with Benadryl. Poliner decided to proceed with the procedure. The patient developed a rash, although it is unclear whether the contrast-dye in fact caused the rash. The primary concern was Poliner's decision to proceed with the procedure without any allergy pretreatment.

[8] Patient 18, an 88-year-old woman, presented in the emergency room with a heart attack in September 1997. She was referred to Poliner, and he decided to perform a catheterization. The patient died during the procedure. The primary issue was whether it was appropriate to attempt the procedure or whether she should have been treated medically.

involved different issues of varying degrees of concern, but in each case, his medical judgment had been questioned and, to some extent, criticized.[9] Although Patient 10 had been reviewed and cleared by the IMAC in March 1997, the other cases were of recent vintage. The CRRC referred Patients 3 and 18 to the IMD in early 1998. Knochel asked a cardiologist to review each case, and the IMAC considered the cases at the end of April. The CRRC referred Patient 9 to the IMD in April. Levin completed a review of the case sometime before May 13, although the IMAC had yet to take up the case. It was against this backdrop that Knochel learned of Patient 36. Knochel consulted with Harper, Levin, various hospital administrators and the members of the IMC on May 13, and decided that he would seek an abeyance—a temporary restriction—of Poliner's cath lab privileges to allow for an investigation as provided for in the Medical Staff bylaws.[10]

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[9] One other case discussed at trial involved a mistake Poliner made during a catheterization. Poliner accidentally threaded a catheter through Patient 39's vein instead of the artery. The primary concern was not that Poliner initially entered the vein by accident, but that it took him too long to realize the mistake; indeed, the catheter reached the patient's heart. The parties dispute whether this case factored into Knochel's decision, but for our purposes, it does not matter whether it, did or not.

[10] Presbyterian's Medical Staff bylaws provide that

> [w]henever the activities or professional conduct of any physician are of such concern that in the assessment of the department chairman, vice-chairman, or advisory committee, further evaluation of the activities or professional conduct is necessary, the department chairman, vice-chairman, or advisory committee may hold certain clinical privileges of the physician in abeyance for

Late on May 13, Knochel met with Poliner, Harper, and Levin, and asked Poliner to agree to the abeyance. When Poliner asked what his options were, Knochel told him that the alternative was suspension of his privileges.[11] The abeyance letter was delivered to Poliner the next afternoon, May 14, and Knochel asked Poliner to sign and return it by 5:00 p.m. The letter advised Poliner that Patient 36 was the catalyst, and that Patients 3, 9, and 18 had also been referred by the CRRC to the IMD. The letter explained that Knochel was going to appoint an ad hoc committee of cardiologists to conduct a review, and that Poliner would have the opportunity to meet with Knochel and the IMAC to respond to any concerns raised by the committee that could lead to corrective action prior to the action being taken. Poliner requested more time so he could consult a lawyer, but Knochel declined. Poliner signed the abeyance request. Poliner subsequently engaged legal counsel.

Knochel immediately appointed an ad hoc committee of six cardiologists to review a sample of Poliner's cases. The committee reviewed 44 cases, and

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> a period of up to fifteen (15) days (the initial action) while additional review is performed. Such action shall be known as Abeyance. The physician must agree to the abeyance prior to the taking of such action. If the physician does not agree to the abeyance, the department will proceed with the corrective action or suspension.

[11] The bylaws allow for a summary suspension of clinical privileges "when the acts of a practitioner through his lack of competence, impaired status, behavior or failure to care adequately for his patients constitutes a present danger to the health of his patients."

concluded that Poliner gave substandard care in more than half. The IMAC met on May 27, the thirteenth day of the abeyance, to consider the ad hoc committee report, and recommended conducting additional reviews of echocardiograms and obtaining an outside review. The IMAC also recommended extending the abeyance of Poliner's cath lab privileges as provided for in the bylaws.[12] Knochel had a letter hand delivered to Poliner requesting his consent to the extension. The letter advised Poliner that the extension was investigational in nature and that the ad hoc committee had reviewed 44 of his cases. The letter also stated that Poliner would have an opportunity to meet with the IMAC to respond to the ad hoc committee review. Knochel again told Poliner that the alternative to abeyance was a suspension. Poliner signed the extension request on May 29.

A meeting of the IMAC was scheduled for June 11. On June 8, Knochel sent Poliner a letter advising him of the June 11 meeting and asking him to attend the meeting. Knochel provided Poliner with a list of the patients that had been reviewed and the comments of the reviewers, and told him that the patient records would be available to him. Poliner requested that the June 11 meeting be delayed to allow him more time to review the patients' files, but his request was denied and the meeting was held as scheduled. The day after the meeting, June 12, the IMAC agreed unanimously

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[12] The bylaws provide, "The department chairman, vice-chairman or advisory committee may extend the abeyance for an additional fourteen (14) days."

that Poliner's cath lab and echocardiography privileges should be suspended.[13]

An addendum to the IMAC meeting minutes reflects the following concerns about Poliner: (1) poor clinical judgment; (2) inadequate skills, including angiocardiography and echocardiography; (3) unsatisfactory documentation of medical records; and (4) substandard patient care. Knochel accepted the recommendation of the IMAC and suspended Poliner's cath lab and echocardiography privileges on June 12.

On July 10, Poliner requested a hearing on the June 12 suspension. Although he had a right to an expedited hearing under the bylaws, and the letter informing Poliner of his suspension advised him so, Poliner did not request an expedited hearing.[14] The hospital notified Poliner on August 14 that a hearing

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[13] As will be seen, the district court later granted summary judgment to all defendants participating in this suspension of privileges after finding immunity under federal law. It was from this unchallenged grant of summary judgment that Poliner tacked to the argument that the temporary restriction of privileges during the investigation was distinct from the June 12 suspension.

[14] It is unclear from the bylaws whether the suspended physician must specifically request the expedited hearing or is entitled to it as of right. The bylaws state that, "a hearing for a practitioner who is under suspension which is then in effect shall be held as soon as arrangements may reasonably be made, but not later than ten (10) days from the date of receipt of such petitioner's request for hearing." The bylaws then provide, "A physician under suspension who requests an expedited hearing shall have waived his right to the 30-day hearing notice requirement." This uncertainty is of no moment.

had been set for September 14, and identified who would be on the Hearing Committee. On August 19, Poliner requested a continuance. On October 5, the hospital notified Poliner that the hearing had been rescheduled for the first week of November, as Poliner had apparently requested.

The hearing was held as re-scheduled, and on November 9, the Hearing Committee issued its recommendations. The Committee concluded that the June 12 suspension should be upheld based on the evidence that was available at the time of the suspension but that Poliner's privileges should be reinstated with a condition.[15] Presbyterian's Medical Board accepted the Committee's recommendations. Poliner appealed the Medical Board's decision to uphold the June 12 suspension to Presbyterian's

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[15] Specifically, the Hearing Committee recommended that "Poliner should be required to have a mandatory consultation with another cardiologist on staff who has interventional cardiology privileges in the Cardiac Cath Lab. Consultation should be for concurrence with documented indications for the selected procedure to be performed prior to the procedure." The pre-procedure consultation was to apply to the first 30 patients "for which intervention is contemplated," at which point Harper was to review those 30 cases and "make a recommendation to Dr. Knochel about Dr. Poliner's clinical performance before unrestricted privileges are to be granted." Approximately a month after the Medical Board approved this condition, it changed the condition from pre-procedure consultation to post-procedure review of the first 30 cases. This review was to be conducted by an outside reviewer, who would also review at least 30 other comparable cases from other cardiologists, ostensibly for the purpose of comparison. The outside reviewer's conclusions would be given to the cardiology chief who would then make a recommendation to Knochel for further action.

Committee on Professional Affairs (CPA). The appeal was limited to determining whether Poliner had substantially received the procedural due process provided for in the bylaws. The CPA determined he had, and Presbyterian's Board of Trustees upheld that decision.

B.

In May 2000, Poliner and his professional association sued Knochel, Harper, Levin, Presbyterian, and other doctors who had been involved in the peer review process. Poliner brought federal antitrust claims as well as state antitrust, Deceptive Trade Practices Act, and numerous tort claims. Defendants moved for summary judgment on, among other grounds, immunity under the HCQIA. On September 30, 2003, the district court issued its decision.

In analyzing HCQIA immunity, the district court concluded that there were two peer review actions, the May 14 abeyance and June 12 suspension. The court held, as to the May 14 abeyance, that fact questions precluded summary judgment. The court found a fact issue as to whether Knochel's threat to summarily suspend Poliner if he did not agree to the abeyance vitiated Poliner's consent. If Poliner had not freely agreed, the court reasoned that the abeyance was then in fact a summary suspension. If this was so, the court concluded that there were fact issues as to whether Defendants satisfied the HCQIA's standards. Thus, the court denied HCQIA immunity, as well as state law immunity, to Knochel, Harper, Levin, and Presbyterian.

The court ruled that the remaining defendants, who had served on the ad hoc committee and on the IMAC, were entitled to HCQIA and state law immunity. The court dismissed some of Poliner's claims but ruled that fact issues remained as to Poliner's remaining tort claims, including defamation, against Knochel, Harper, Levin, and Presbyterian.

The district court's summary judgment decision reshaped the case. As Poliner explained in his motion for leave to file a fourth amended complaint,

> The Court found that there was an issue of fact with respect to whether the May 14, 1998 Abeyance (the "Forced Abeyance") was in fact a de facto summary suspension. The Summary Judgment Ruling centers on the action of the Defendants in imposing the Forced Abeyance, shifting the majority of the focus of the case to the time period before and on May 14, 1998, when the Forced Abeyance was imposed. . . . Given the Summary Judgment Ruling and the Court's recent comments, it is clear that the focus of the case has shifted from an emphasis on the [June 12] Summary Suspension to an emphasis on the Forced Abeyance, a shift that the parties could not have reasonably foreseen. Now that such shift has occurred, Plaintiffs request leave to amend their Complaint for the purpose of conforming the complaint to the issues that the Court has indicated will be submitted to the jury.

Indeed, one of the amendments Poliner offered as an example in his motion was "add[ing] allegations

regarding the Forced Abeyance that will allow the jury to decide whether or not the Forced Abeyance, in reality, was a summary suspension."

In a subsequent order, dated July 7, 2004, the district court clarified that Poliner could not recover any damages from the June 12 suspension: "Based on the Court's finding that all of the participants in the June 12, 1998 suspension were entitled to immunity, the Court finds that Plaintiffs are not entitled to recover damages flowing from that suspension." The order also stated that, " [i]n light of this ruling, the propriety of the [ad hoc committee's] review and the IMAC's recommendation is no longer at issue. Accordingly, evidence of malice or the motive of any of the participants in the June 12, 1998 suspension is not relevant, nor is any evidence regarding the [ad hoc committee's] analysis of the patients' files examined."

C.

After four years of litigation, Poliner's trial theory tracked this new course: he was forced to agree to the abeyances, the consequence of which was that Knochel had summarily suspended him. This mattered, he said, because, under the Medical Staff bylaws, a summary suspension was allowed when a doctor posed a "present danger to the health of his patients," and he posed no such danger. Rather, Poliner suggested that he was suspended because his solo practice was a competitive threat to the dominant cardiology groups at Presbyterian, that Knochel "had it in for" him.

The trial evidence largely focused on the propriety of Poliner's treatment of Patients 3, 9, 10, 18, 39, and

especially 36, and whether the mistakes Poliner had made rendered him a "present danger." Consistent with the court's July 7 order, the jury was not told about the ad hoc committee's conclusions and the IMAC's responses, although the jury was told that there was an investigation, that Poliner was summarily suspended on July 12, and that after the November hearing, his privileges were reinstated.

During the charge conference, the district court raised the issue of whether the abeyance period involved one or two peer review actions, and eventually decided to charge the jury that the May 14 abeyance and the extension of the abeyance were separate peer review actions.

The case was submitted to the jury, which found for Poliner on all of his remaining claims. The jury awarded in aggregate more than $360 million in damages, $90 million of which were for the defamation claims. Almost all of the damages awarded were for mental anguish, injury to career, and punitive damages. Harper and Levin settled with Poliner after trial. Poliner elected to recover under his defamation theory against Knochel and Presbyterian. The district court remitted the defamation damages to $10.5 million for injury to career, $10.5 million for mental anguish, and $1.5 million in punitive damages, and further ordered prejudgment interest, which totals over $11 million. Defendants appealed. Poliner cross-appealed but subsequently dismissed his appeal.

II. Standard of Review

We review the denial of motion for judgment as a matter of law *de novo.*[16] A party is entitled to judgment as a matter of law when "a reasonable jury would not have a legally sufficient evidentiary basis to find for the party on that issue."[17] "In entertaining a Rule 50 motion for judgment as a matter of law the court must review all of the evidence in the record, draw all reasonable inferences in favor of the nonmoving party, and may not make credibility determinations or weigh the evidence."[18] "Nonetheless, '[i]f the facts and inferences point so strongly and overwhelmingly in favor of the moving party that the reviewing court believes that reasonable jurors could not have arrived at a contrary verdict, then we will conclude that the motion should have been granted.'"[19]

III. Health Care Quality Improvement Act

Congress passed the Health Care Quality Improvement Act because it was concerned about "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care," and because "[t]here is a national need to restrict the

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[16] *Palasota v. Haggar Clothing Co.,* 499 F.3d 474, 480 (5th Cir. 2007).

[17] Fed. R. Civ. P. 50(a).

[18] *Ellis v. Weasler Eng'g, Inc.,* 258 F.3d 386, 337 (5th Cir. 2001).

[19] *Dixon v. Wal-Mart Stores, Inc*., 330 F.3d 311, 313-314 (5th Cir. 2003) (quoting *Resolution Trust Corp. v. Cramer,* 6 F.3d 1102, 1109 (5th Cir. 1993)).

ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance."[20] Congress viewed peer review as an important component of remedying these problems, but recognized that lawsuits for money damages dampened the willingness of people to participate in peer review.[21] Accordingly, Congress "grant[ed] limited immunity from suits for money damages to participants in professional peer review actions."[22]

When a "professional review action" as defined by the statute meets certain standards, the HCQIA provides that participants in the peer review "shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action."[23] The statute establishes four requirements for immunity:

> For purposes of the protection set forth in section 11111(a) of this title, a professional

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[20] 42 U.S.C. § 11101(1), (2).

[21] *See Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F. 3d 25, 31 (1st Cir. 2002) ("Before passage of the HCQIA in 1986, threats of antitrust action and other lawsuits often deterred health care entities from conducting effective peer review.").

[22] *Mathews v. Lancaster Gen. Hosp.,* 87 F.3d 624, 632 (3d Cir. 1996).

[23] 42 U.S.C. § 11111(a); *see also id.* § 11151(9) (defining "professional review action"). The act includes exceptions for certain civil rights actions that are not at issue here. *See id.* § 11111(a).

> review action must be taken--
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> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).[24]

"The Act includes a presumption that a professional review [action] meets the standards for immunity, 'unless the presumption is rebutted by a preponderance of the evidence.'"[25] We agree with our sister circuits that the HCQIA's "reasonableness requirements were intended to create an objective standard of performance, rather than a subjective good faith standard."[26]

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[24] *Id.* § 11112(a).

[25] *Mathews,* 87 F.3d at 633 (quoting 42 U.S.C. § 11112(a)).

[26] *Bryan v. James E. Holmes Reg'l Med. Ctr.,* 33 F.3d 1318, 1323 (11th Cir. 1994); *see also Singh,* 308 F.3d at 32 ("Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards. We apply these objective standards here."

A.

HCQIA immunity extends to "professional review actions." The Act defines a "professional review action" in part as

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician.[27]

(citations omitted)); *Sugarbaker v. SSM Health Care,* 190 F.3d 905, 912 (8th Cir. 1999) ("Further, we have held that the reasonableness requirements contained in section 11112(a) necessitate an objective inquiry."); *Brown v. Presbyterian Healthcare Servs.,* 101 F.3d 1324, 1333 (10th Cir. 1996) ("Courts apply an objective standard in determining whether a peer review action was reasonable under 42 U.S.C. § 11112(a)."); *Mathews,* 87 F.3d at 635 ("We agree with our sister circuits that § 11112(a) imposes an objective standard."); *Smith v. Ricks,* 31 F.3d 1478, 1485 (9th Cir. 1994) (explaining that "the 'reasonableness' requirements of § 11112(a) were intended to create an objective standard, rather than a subjective standard"). We previously indicated in an unpublished opinion that the "reasonableness" requirements impose an objective standard. *See Doe v. La. Psychiatric Med. Ass'n,* No. 96-30232, 1996 WL 670414, at *3 (5th Cir. Oct. 28, 1996).

[27] 42 U.S.C. § 11151(9).

The jury was charged that the May 14 abeyance and the extension of the abeyance were both professional review actions. We agree.

Both restrictions on Poliner's cath lab privileges meet the substantive elements of this definition. While there could be no extension of the abeyance without the initial abeyance, the extension of the abeyance resulted from an independent decision that another period of restriction was needed. To put it differently, the May 14 abeyance and the extension, although imposing the same substantive restrictions, enjoyed distinct justification and in this sense independently limited Poliner's privileges.[28] Thus, we evaluate the abeyance and the extension separately for compliance with § 11112(a).

To be clear, the abeyances are temporary restrictions of privileges, and we use that terminology, which comes from the Medical Staff bylaws, in our discussion; but for the purposes of HCQIA immunity from money damages, what matters is that the restriction of privileges falls within the statute's definition of "peer review action," and what we

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[28] *Cf. Mathews,* 87 F.3d at 634 ("The definition of 'professional review action' encompasses decisions or recommendations by peer review bodies that directly curtail a physician's clinical privileges or impose some lesser sanction that may eventually affect a physician's privileges."); *Mathews v. Lancaster Gen. Hosp.,* 883 F. Supp. 1016, 1027 (E.D. Pa. 1995) (explaining that "the term 'professional review action' refers to the decision that results from a review of the facts obtained"); *Fobbs v. Holy Cross Health Sys. Corp.,* 789 F. Supp. 1054, 1065 (E.D. Cal. 1992) (explaining that the § 11112(a) standards "apply to discrete decisions, not to an ongoing course of conduct").

consider is whether these "peer review actions" satisfy the HCQIA's standards, and not whether the "abeyances" satisfy the bylaws.

We deal with one other preliminary matter now. The decision to extend the abeyance was made after the ad hoc committee reported the results of its review to Knochel and the IMAC; however, because of the district court's pre-trial order of July 7, the jury did not learn of this. This does not impede our consideration of the evidence because the district court's summary judgment and July 7 orders establish the relevant historical facts[29] and the propriety of the ad hoc committee review for HCQIA purposes. The district court found that the ad hoc committee members were entitled to HCQIA immunity, and more to the point, the ad hoc committee's review undergirded the grant of HCQIA immunity for the June 12 suspension. Neither of the orders has been challenged on appeal. They are the law of the case.

B.

We begin with whether each peer review action was taken "in the reasonable belief that the action was in the furtherance of quality health care." It is plain that they were by the controlling standards. Other circuits have explained, as relevant under the facts of this

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[29] It is not clear whether the committee concluded that Poliner gave substandard care in 26 or 29 cases. Some evidence and the district court's summary judgment order states that it was 29 cases, while the minutes from the IMAC meeting on May 27 list 26 cases. For our purposes, it makes no difference whether the number is 26 or 29.

case, that "[t]he 'reasonable belief standard of the HCQIA is satisfied if 'the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."[30] "[T]he Act does not require that the professional review result in an actual improvement of the quality of health care,"[31] nor does it require that the conclusions reached by the reviewers were in fact correct.[32] It bears emphasizing that "the good or bad faith of the reviewers is irrelevant";[33] rather it is an objective inquiry in which we consider the totality of the circumstances.[34]

It is indisputable that Poliner's treatment of Patient 36 raised serious questions about what had happened and why. Missing the LAD was a critical diagnostic error, made all the more troubling by the

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[30] *Meyers v. Columbia/HCA Healthcare Corp.,* 341 F.3d 461, 468 (6th Cir. 2003) (quoting *Bryan,* 33 F.3d at 1323).

[31] *Imperial v. Suburban Hosp. Ass'n, Inc.,* 37 F.3d 1026, 1030 (4th Cir. 1994); *see also Meyers,* 341 F.3d at 468 (same).

[32] *See Imperial,* 37 F.3d at 1030 ("But more importantly to the issue at hand, even if Imperial could show that these doctors reached an incorrect conclusion on a particular medical issue because of a lack of understanding, that does not meet the burden of contradicting the existence of a *reasonable belief* that they were furthering health care quality in participating in the peer review process.").

[33] *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 840 (3d Cir. 1999).

[34] *Imperial,* 37 F.3d at 1030.

fact that Das and Levin saw the LAD; indeed, Poliner described the LAD as obvious and clear in his addendum. The concerns that flow from the LAD are amplified by the problems with Poliner's other patients that had been brought to Knochel's attention. It was in relatively quick succession that Knochel was presented with separate cases that called into question Poliner's medical judgment. That Poliner had over 20 years of experience and an apparently clean record before these cases only serves to heighten the concern: why was this experienced physician now having these problems? On May 14, there was ample basis for concern.

The ad hoc committee's review, upon which the extension of the abeyance rested, speaks for itself. A group of six cardiologists reviewed 44 of Poliner's cases and concluded that he gave substandard care in more than half of the cases. We conclude that, as to both peer review actions, the belief that temporarily restricting Poliner's cath lab privileges during an investigation would further quality health care was objectively reasonable.

Poliner defends the jury's verdict by arguing that the evidence demonstrates that had Poliner "actually administered the purported 'care' demanded by the critics, he would have affirmatively *endangered* his patients." Setting aside the fact that the evidence is not so unequivocal, this argument suffers from two interrelated flaws. First, our inquiry focuses on the information available to Defendants when they made the critical decisions. Defendants did not have the

benefit of post-hoc expert analyses at that time.[35] Second, this focuses on whether Defendants' beliefs proved to be *right.* But the statute does not ask that question; rather it asks if the beliefs of Poliner's peers were objectively reasonable under the facts they had at the time.[36] If a doctor unhappy with peer review could defeat HCQIA immunity simply by later presenting the testimony of other doctors of a different view from the peer reviewers, or that his treatment decisions proved to be "right" in their view, HCQIA immunity would be a hollow shield.

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[35] *See Singh,* 308 F.3d at 41 (explaining that "[t]he appropriate 'inquiry is whether the decision was reasonable in light of the facts known at the time the decision was made, not in light of facts later discovered" (quoting *Sklaroff v. Allegheny Health Educ. Research Found.,* No. Civ. A. 95-4758, 1996 WL 383137, at *9 (E.D. Pa. July 8, 1996))): *Sugarbaker,* 190 F.3d at 916-17 (explaining that expert opinions prepared for litigation did not rebut the presumption because the opinions were not known at the time the peer review action was taken).

[36] *See Lee v. Trinity Lutheran Hosp.,* 408 F.3d 1064, 1071 (8th Cir. 2005) ("Even if Dr. Lee could show that 'the [peer review actions] reached an incorrect conclusion . . . [that] does not meet the burden of contradicting the existence of a reasonable belief that [the hospital] w[as] furthering health care quality.'" (quoting *Sugarbaker,* 190 F.3d at 916)): *Meyers,* 341 F.3d at 469 n.5 ("Our review, however, is not directed at whether each of the complaints were undisputedly true, but whether Defendants acted reasonably in considering and relying upon them."); *Sugarbaker,* 190 F.3d at 913 (explaining that such an argument "miss[es] the mark" because "[t]he focus of our inquiry is not whether the Executive Committee's initial concerns ultimately proved to be medically sound); *Mathews,* 87 F.3d at 636 n.9 ("While the conflicting reports raise an issue of fact as to whether Mathews provided acceptable care, they do not call into question whether the Board's decision in relying on the Wilson report was reasonable.").

Poliner's urging of purported bad motives or evil intent or that some hospital officials did not like him provides no succor. We have serious doubts that Poliner proved that the restrictions resulted from anti-competitive motives, and more to the point, the inquiry is, as we have explained, an objective one. Our sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity,[37] as do we.

C.

"The HCQIA does not require the ultimate decisionmaker to investigate a matter independently, but requires only a 'reasonable effort to obtain' the facts."[38] We consider "the totality of the process leading

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[37] *See, e.g.*, *Sugarbaker,* 190 F.3d at 914 ("In the HCQIA immunity context, the circuits that have considered the issue all agree that the subjective bias or bad faith motives of the peer reviewers is irrelevant."), *Mathews*, 87 F.3d at 635 (explaining that other circuits "have held that a defendants subjective bad faith is irrelevant under § 11112(a) and have upheld a finding of immunity if, on the basis of the record, the court could conclude that the professional review action would further quality health care"); *Bryan,* 33 F.3d at 1335 ("Moreover, Bryan's 'assertions of hostility do not support his position [that the Hospital is not entitled to the HCQIA's protections] because they are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial The real issue is the sufficiency of the basis for the [Hospital's] actions.'" (quoting *Austin v. McNamara,* 979 F.2d 728, 734 (9th Cir. 1992))).

[38] *Gabaldoni v. Wash. County Hosp. Ass'n,* 250 F.3d 255. 261 (4th (Cir. 2001).

up to" the professional review action.[39]

No reasonable jury could conclude that Defendants failed to make a "reasonable effort to obtain the facts." Prior to May 14, Patients 3, 9, and 18 had been reviewed by the CRRC, which identified the care issues involved and forwarded the cases to Knochel. Each of these cases was reviewed by a cardiologist for Knochel and the IMAC. As to Patient 36, Knochel spoke with Weinmeister, Das, Levin, and Harper. Levin reviewed the films and spoke with Poliner briefly about the case, while Harper reviewed the patient's chart and films. Das saw the LAD while the procedure was occurring and spoke with Poliner. Weinmeister had treated the patient post-procedure. And, as to the abeyance extension, Knochel relied on the review of 44 cases conducted by the ad hoc committee. As explained above, the district court's summary judgment established the propriety of the ad hoc committee review, and that remains unchallenged, for good reason. Knochel was entitled to rely on the information provided to him by the other doctors,[40] and there is nothing to suggest that the information was facially

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[39] *Mathews*, 87 F. 3d at 637; *see also Meyers*, 341 F.31 at 469 (same).

[40] *See Gabaldoni,* 250 F.3d at 261 (explaining that "it was permissible for the Board to rely on the reports and investigations of the various committees . . . in rendering its decision"); *Bryan,* 33 F.3d at 1335 (same).

flawed or otherwise so obviously deficient so as to render Defendants' reliance "unreasonable."[41]

Poliner urges that omissions in the investigation and Knochel's admission at trial that further investigation was necessary before Poliner's privileges could be summarily suspended-that is, there was insufficient evidence to denominate Poliner a "present danger" under the bylaws-support the jury's findings that a "reasonable effort" was lacking. As to the former, Poliner was entitled to a *reasonable* effort, not a perfect effort.[42]

Poliner's latter argument is unavailing because HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards. Provided that a peer review action as defined by the statute complies with those standards, a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages.[43]

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[41] *Cf. Brader,* 167 F.3d at 843 (explaining that "the reports of Diamond and Ochsner were not so obviously mistaken or inadequate as to make reliance on them unreasonable").

[42] *Singh,* 308 F.3d at 43.

[43] *See Meyers,* 341 F.3d at 469-70 (rejecting an argument that failure to comply with hospital bylaws defeated immunity because "even assuming LMH did violate the bylaws, the notice and procedures provided complied with the HCQIA's statutory 'safe harbor'"); *Ricks,* 31 F.3d at 1487 n.8 (rejecting an argument that violations of state law and professional organization guidelines defeat HCQIA immunity "because once the immunity provisions of the HCQIA are met, defendants 'shall not be liable in damages

It bears emphasizing that this does not mean that hospitals and peer review committees that comply with the HCQIA's requirements are free to violate the applicable bylaws and state law. The HCQIA does not gainsay the potential for abuse of the peer review process. To the contrary, Congress limited the reach of immunity to money damages. The doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment.[44] The immunity from money damages may work harsh outcomes in certain circumstances, but that results from Congress' decision that the system- wide benefit of robust peer review in rooting out incompetent physicians, protecting patients, and preventing malpractice outweighs those occasional harsh results; that giving physicians access to the courts to assure procedural protections while denying a remedy of money damages strikes the balance of remedies essential to Congress' objective of

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under any law of the United States or of any State' based on a professional review action" (quoting § 11111(a)(l))); *Bakare v. Pinnacle Health Hosps., Inc.,* 469 F. Supp. 2d 272, 290 n.33 (M.D. Pa. 2006) ("HCQIA immunity attaches when the reviewing body satisfies the requirements *under HCQIA,* regardless of its own policies and procedures.").

[44] *Sugarbaker*, 190 F.3d at 918; *see also Singh*, 308 F.3d at 44 ("HCQIA immunity only covers liability for damages. It does not shield covered defendants from suit and other forms of relief."); *Imperial*, 37 F.3d at 1031 (explaining that "the actual protection given by the Act is limited to damages"). To the extent we suggested otherwise in *Doe*, *see* 1996 WL 670414, at *4, we decline to follow, and are not bound by, that unpublished opinion, *see* 5th Cir. 47.5.4 (providing that "[u]npublished opinions issued on or after January 1, 1996, are not precedent").

vigorous peer review.[45] The doctor may not recover money damages, but can access the court for other relief preventive of an abusive peer review. It is no happenstance that this congressional push of peer review came in a period of widespread political efforts at the state level to achieve tort reform and protect medical doctors from the debilitating threat of money damages. It would have been quixotic at best If those efforts were accompanied by tolerance of money damages suits by doctors facing peer review-where tort reformers assured that discipline of doctors would be found.

D.

Section 11112(a)(3) imposes certain procedural requirements, namely that a peer review action is taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." Section 11112(b) provides a "safe harbor" set of procedures that, if given, means that the "health care entity is deemed to have met the adequate notice and hearing requirement." Finally, § 11112(c) provides,

> (c) Adequate procedures in investigations or health emergencies

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[45] *See Imperial*, 37 F.3d at 1028 ("To assure that hospitals and doctors cooperate with the system and engage in meaningful professional review, Congress found it essential to provide qualified immunity from damages actions for hospitals, doctors, and others who participate in the professional review process.").

> For purposes of section 11111(a) of this title, nothing in this section shall be construed as--
>
> (1) requiring the procedures referred to in subsection (a)(3) of this section--
>
> (A) where there is no adverse professional review action taken, or
>
> (B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or
>
> (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

The peer review actions satisfy the HCQIA's procedural requirements.

The May 14 restriction falls squarely within § 11112(c)(l)(B)'s scope. The abeyance was a restriction of privileges that was imposed to allow for an investigation to determine whether other action, such as a suspension, was necessary. Poliner urges that the provision does not apply because the restriction lasted for 15 days, one day longer than is permissible. We are not persuaded. The ad hoc committee completed its review and reported its results to Knochel and the

IMAC on May 27. Upon receipt of the ad hoc committee report, Defendants had an objectively reasonable basis to take another peer review action. The IMAC decided that same day that a further restriction of Poliner's privileges was necessary. For immunity purposes it is of no moment that they requested Poliner's consent to the extension of the abeyance on May 29, the purported fifteenth day, because the decision to further restrict his privileges was made within the required 14 days.

We conclude that the extension of the abeyance falls within § 11112(c)(2)'s curtilage,[46] and in any event, Defendants imposed the restriction after procedures that were fair to Poliner under the circumstances. The "emergency" provision requires only that a failure to act "may result in an imminent danger to the health of any individual." That the ad hoc committee concluded that Poliner gave substandard care in half of the cases reviewed, and considering the seriousness of the diagnostic error with Patient 36 and the serious risks that attend cardiac catheterizations, Defendants were fully warranted in concluding that failing to impose further temporary restrictions "may result" in an imminent danger. Poliner contends that this provision applies in "extraordinary cases in which a physician suddenly becomes impaired or grossly incompetent." Poliner cites no authority for this proposition, and the plain

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[46] The parties dispute whether § 11112(c)(2) relieves compliance with all of § 11112(a)'s standards or is limited to § 11112(a)(3)s "notice and hearing" requirement. We need not, and do not, wade into this dispute because we conclude that the extension of the abeyance satisfies the requirements of 11112(a)(1), (2), and (4).

language of the statute is not so limited. Moreover, authority from our sister circuits and the district courts conclude that the provision is not so narrow,[47] as

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[47] *See Sugarbaker,* 190 F.3d at 917 (indicating that the Executive Committee's decision to impose a "precautionary suspension" would fall under the emergency provision after a clinical review committee reviewed 24 of the doctor's patients and reported multiple areas of concern); *Brader,* 167 F.3d at 836-37, 842 (holding that a summary suspension of a surgeon's privileges to perform an operation fell under the emergency provision where a review of the mortality rates for the procedure at the hospital showed that the surgeon was responsible for half of the mortalities, and an outside reviewer reported numerous complications and instances of "poor surgical judgment"); *Johnson v. Christus Spohn,* No. C-06-138, 2008 WL 375417, at *12 (S.D. Tex. Feb. 8, 2008) ("Based on the purportedly negligent treatment of RM [who eventually died], the Court has little trouble finding Dr. Johnson's summary suspension was appropriately based on the reasonable belief he failed to care for a patient and thus may have represented an imminent danger to the health of an individual."); *Schindler v. Marshfield Clinic,* No. 05-C-705-C, 2006 WL 2944703, at *13 (W.D. Wisc. Oct. 12, 2006) (explaining that, where a surgeon "was performing surgery, a surgical instrument slipped and plaintiffs patient was rendered quadriplegic for an unspecified period of time," and the surgeon was temporarily suspended during an investigation, the emergency provision was "satisfied"); *Bakare,* 469 F. Supp. 2d at 282, 289 & n.31 (holding that the emergency provision applied to a precautionary suspension that was imposed after an outside reviewer reviewed ten of the plaintiffs cases and concluded that "beyond a reasonable degree of medical certainty [Dr. Bakare's] medical management falls below the established standards"): *Pfenninger v. Exempla, Inc.,* 116 F. Supp. 2d 1184, 1202 (D. Colo. 2000) (concluding that the emergency provision was applicable where "the Executive Committee found that Dr. Pfenninger had exercised poor judgment in three recent cases; that he had a history of similar problems, and that summary suspension was 'necessary to protect patients'").

does an unpublished decision from our court.[48]

Poliner received the "subsequent notice and hearing or other adequate procedures" that the provision contemplates. To the point, the district court ruled at summary judgment that, as to the June 12 suspension, Poliner received notice and hearing adequate to satisfy the HCQIA. That ruling, which has not been challenged, establishes that Poliner received adequate process for purposes of the "emergency" provision.

Our review confirms this, and further leads us to conclude that the extension was imposed "after such other procedures as are fair to the physician under the circumstances." The May 14 letter provided notice to Poliner of the peer review, which patient triggered it, the other patients then-of concern, that an ad hoc committee review would be taken and a general description of how that review would be conducted, and finally that Poliner would have "an opportunity to meet with the PMAC] and me in person to respond to or clarify any clinical concerns that could result in a recommendation for corrective action prior to that action being taken." Poliner and his lawyer knew what was happening and why before the extension.

The ad hoc committee's conclusions justify Defendants' decision to impose another period of the

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[48] *See Payne v. Harris Methodist HEB,* No. 01-10212, 2002 WL 1396969, at *1 n. 1 (5th Cir. June 7, 2002) (holding, in considering the emergency provision, that "[g]iven the serious allegations of incompetence made against Payne, we agree with the district court that the hospital was permitted to suspend him temporarily while sorting out the truth of the allegations").

same restrictions without immediately giving a hearing. The committee review raised serious problems with Poliner's cases, and rather than acting precipitously, Defendants sought out further information. It is difficult to conceive of a meaningfully different response from Defendants. Upon receipt of the ad hoc committee's review, it would have been untenable to restore full privileges while a hearing was scheduled and Poliner was given time to prepare. Had Defendants immediately held a hearing, there would have been no opportunity for Poliner to review the cases at issue, and we have no doubt that we would be considering whether such a hearing was "fair." Further informing our analysis is the fact that Poliner had engaged counsel prior to the extension of the abeyance. It bears emphasizing that the restriction on privileges was temporary in nature and limited in scope, tailored to the objective facts before the hospital officials. Poliner received "fair" procedures under these circumstances.

Once the decision was made, Poliner was quickly notified that the extension was needed, given further details of the ad hoc committee review, and told again that he would have an opportunity to address the IMAC. Ten days after extending the restrictions, a date for a hearing was set and Poliner was notified of the hearing, told which patients had been reviewed and the concerns in those cases, and given access to the patient records. The hearing, in which Poliner personally participated, was promptly held on June 11.

This case demonstrates how the process provisions of the HCQIA work in tandem: legitimate concerns lead to temporary restrictions and an investigation; an

investigation reveals that a doctor may in fact be a danger; and in response, the hospital continues to limit the physician's privileges. The hearing process is allowed to play out unencumbered by the fears and urgency that would necessarily obtain if the physician were midstream returned to full privileges during the few days necessary for a fully informed and considered decision resting on all the facts and a process in which the physician has had an opportunity to confront the facts and give his explanations. The interplay of these provisions may work hardships on individual physicians, but the provisions reflect Congress' balancing of the signscant interests of the physician and "the public health ramifications of allowing incompetent physicians to practice while the slow wheels of justice grind."[49] Defendants satisfied the notice and hearing requirements, and no reasonable jury could conclude otherwise.

E.

Finally, we consider whether each peer review action was taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts." "Our analysis under § 11112(a)(4) closely tracks our analysis under § 11112(a)(l)."[50] In both instances, the temporary restrictions were "tailored to address the health care

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[49] *Rogers v. Columbia/HCA of Cent. La., Inc.,* 971 F. Supp. 229, 236 (W.D. La. 1997).

[50] *Brader,* 167 F.3d at 843; *see also Meyers,* 341 F.3d at 471 (same); *Singh,* 308 F.3d at 38 n. 13 (same); *Sugarbaker,* 190 F.3d at 916 (same).

concerns" that had been raised[51] –procedures in the cath lab–leaving untouched Poliner's other privileges. Nor was the information relayed to Knochel "so obviously mistaken or inadequate as to make reliance on [it] unreasonable."[52] There was an objectively reasonable basis for concluding that temporarily restricting Poliner's privileges during the course of the investigation was warranted by the facts then known, and for essentially the reasons given above, we hold that Defendants satisfy this prong.

To allow an attack years later upon the ultimate "truth of judgments made by peer reviewers supported by objective evidence would drain all meaning from the statute. The congressional grant of immunity accepts that few physicians would be willing to serve on peer review committees under such a threat; as our sister circuit explains, "'the intent of [the HCQIA] was not to disturb, but to reinforce, the preexisting reluctance of courts to substitute their judgment on the merits for that of health care professionals and of the governing bodies of hospitals in an area within their expertise.'"[53] At the least, it is not our role to re-weigh this judgment and balancing of interests by Congress.

IV. Conclusion

Not only has Poliner failed to rebut the statutory presumption that the peer review actions were taken

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[51] *Mathews*, 87 F.3d at 638.

[52] *Id.*

[53] *Lee*, 408 F.3d at 1073 (quoting *Bryan.* 33 F.3d at 1337).

in compliance with the statutory standards, the evidence independently demonstrates that the peer review actions met the statutory requirements. Because Defendants are immune under the HCQIA, we have no occasion to consider Defendants' other substantial arguments that we must reverse and render judgment based on state law immunity[54] and because Poliner failed to prove the substantive elements of his claims. One of the largest difficulties lies in causation, that is, whether Poliner proved that any of the purported damages were caused by the abeyance and abeyance extension as opposed to the June 12 suspension that was immunized before trial. Nor need we reach the compelling arguments that, at the very least, we would have to reverse and remand for a new trial because of the jury's excessive verdict[55] and manifest trial errors.

We REVERSE the judgment of the district court and RENDER judgment for Defendants.

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[54] *See* Tex. Occ. Cock -Ann. § 160.010.

[55] *See Wells v. Dallas Indep. Sch. Dist.,* 793 F.2d 679, 683-84 (5th Cir. 1986) (explaining that "when an award is 'so exaggerated as to indicate bias, passion, prejudice, corruption, or other improper motive,' remittitur is inadequate and the only proper remedy is a new trial" (quoting *Caldarera v. E. Airlines, Inc*., 705 F.2d 778, 784 (5th Cir. 1983))).

APPENDIX B

IN THE UNITED STATES DISTRICT COURT FOR THE NORTHERN DISTRICT OF TEXAS DALLAS DIVISION

CIVIL ACTION NO. 3:00-CV-1007-P

[Filed October 13, 2006]

LAWRENCE R. POLINER, M.D. and LAWRENCE R. POLINER, M.D., P.A., Plaintiffs,	)
v.	)
TEXAS HEALTH SYSTEMS, a Texas non-profit corporation, d/b/a PRESBYTERIAN HOSPITAL OF DALLAS, and JAMES KNOCHEL, M.D., Defendants.	)

AMENDED MEMORANDUM OPINION AND ORDER

Now before the Court are (1) Defendants' Texas Health Systems (Presbyterian Hospital of Dallas) and James Knochel, M.D.'s Motion for Remittitur, filed September 16, 2005; (2) Defendants Texas Health Systems (Presbyterian Hospital of Dallas) and James Knochel, M.D.'s Motion for a New Trial, filed

September 16, 2005; (3) Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses and Costs; and (4) Defendants' motion for settlement credit, filed May 26, 2006[1] After careful consideration of the Parties' briefing and the applicable law, the Court hereby DENIES Defendants' Motion for a New Trial, GRANTS in PART Defendants' Motion for Remittitur, DENIES in part as MOOT and DENIES in part as premature Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses and Costs, and DENIES Defendants' motion for settlement credit.

MOTION FOR NEW TRIAL

A. ERRONEOUS EXCLUSION OF EVIDENCE AT TRIAL.

In their Motion for a New Trial,[2] Defendants Texas

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[1] In its Order dated March 26, 2006, the Court denied in part Defendants' Motion for a New Trial. The remainder of that motion - that portion concerning damages - will be considered herein.

[2] Local Rule 7.1(d) requires that a motion be accompanied by a brief that sets forth the movant's contentions of facts and/or law, and argument and authorities. As Defendants are aware, motions shall concisely articulate the grounds therefor, whereas the brief is to contain the statement of facts, legal theories, legal arguments, and legal analysis. The brief should contain all the information the Court needs to make its determination (with the exception of evidence.) Local Rule 7.2(c) states that a brief must not exceed twenty-five pages. Defendants filed a twenty-one page brief along with a fifty-five page motion for a new trial. Certainly, a fifty-five page motion is not a concise articulation of the ground therefor. Defendants' attempt to present fifty-five pages of facts

Health Systems (Presbyterian Hospital of Dallas) ("Presbyterian" or "the Hospital") and James Knochel, M.D. ("Knochel") (collectively,"Defendants") argue that the Court's erroneous admission and exclusion of certain evidence warrants reversal and a new trial. (Defs.' Br. at 16-17.) Specifically, Defendants argue that the Court erroneously excluded evidence establishing that in November 1998, the Hearing Committee upheld Dr. Poliner's June 1998 summary suspension and found it justified. (*citing* Trial Tr. Vol. 9 at 2099-2103; Defs.' App. at 95.)

At the summary judgment stage, the Court found as a matter of law that the June 1998 suspension was lawful and dismissed several defendants from the case on that basis. Consequently, the theory of the case narrowed to the single issue of whether the May 1998 suspension/abeyance was lawful. Because the jury was only to consider whether the circumstances surrounding the May abeyance/suspension gave rise to a cause of action and damages, the Court ruled that the fact that the Hearing Committee upheld the June summary suspension in November was deemed irrelevant and inadmissible.

The Court rejects Defendants' conclusory argument that the Court's decision to exclude such evidence was harmful error. Defendants offer no valid legal basis for reversing the ruling and therefore the Court declines to do so.

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and legal discussion in a motion is clearly an impermissible effort to circumvent the page limits.

B. JURY CHARGE ERROR.

Defendants also argue they are entitled to a new trial because of several errors in the jury charge. First, Defendants argue that the Court erred in refusing to ask the jury to apportion the damages among each defendant. Defendants maintain that Section 33.003 of the Texas Civil Practices and Remedies Code, which is the Proportionate Responsibility Statute, mandates that the jury shall determine the percentage of responsibility of each defendant. (Defs.' Br. at 18.)Defendants conclude that "[b]ecause of the jury's failure to apportion damages, it is impossible to determine whether the jury intended to apportion damages according to the amounts awarded, or awarded damages against each defendant for the same injury." (Defs.' Br. at 18-19.)

Section 33.003 provides that

> [t]he trier of fact, as to each cause of action asserted, shall determine the percentage of responsibility, stated in whole numbers, for the following persons with respect to each person's causing or contributing to cause in any way the harm for which recovery of damages is sought, whether by negligent act or omission, by any defective or unreasonably dangerous product, by other conduct or activity that violates an applicable legal standard, or by any combination of these: (1) each claimant; (2) each defendant; (3) each settling person; and (4) each responsible third party . . .

Tex. Civ. Prac. & Rem. Code § 33.003 (Vernon 1997

Supp. 2005). Although Defendants did request an apportionment question in the jury charge, Defendants did not provide the Court with any legal authority supporting their request. (Trial Tr. Vol. 10 at 2389-90.) They never cited to the Texas Proportionate Liability Statute or any other legal source.

In the Court's Charge to the Jury, the Court specifically instructed the jury to consider each defendant separately and not to include damages as to one defendant in assessing damages against any other defendant. (*See* Jury Question No. 11.) The jury charge listed each defendant separately and provided blanks next to each defendant's name for each element of recovery (*e.g.*, loss of earnings, injury to career and reputation, mental anguish). The fact that the jury returned a verdict with different amounts for each defendant with respect to injury to career/reputation and mental anguish indicates that the jury apportioned the responsibility for the damages among the several defendants. Because the jury did apportion the damages among the defendants, the Court finds there was no harmful error.

With respect to loss of earnings, the evidence at trial established that Plaintiffs' lost earnings amount was $10,526.55. (*See* Trial Tr. Vol. 11 at 2544.) The jury entered that entire amount next to each defendant's name. The fact that the jury returned a verdict with the same amount for each defendant with respect to lost earnings indicates that the jury believed that each defendant's conduct proximately caused Plaintiffs to lose the entire lost earnings amount and that all defendants should be held liable for that amount. The Court concludes that the jury intended to

hold all Defendants responsible for one lost earnings amount, and consequently there is no harmful error.[3]

Defendants also argue that a new trial is required because the jury was not asked to apportion the damages between Plaintiffs Dr. Poliner and his Professional Association. (Defs.' Br. at 13.) They cite to section 71.010 of the Texas Civil Practices and Remedies Code which states that damages shall be divided by the jury among the individuals who are entitled to recovery. (Defs.'Br. at 13.)

Defendants did not request apportionment among Plaintiffs at any time during trial, in any motion, or at the jury charge conference. Not only has this argument been waived, it is disingenuous and wholly without merit. Chapter 71 of the Texas Civil Practices and Remedies Code is Texas' Wrongful Death Statute and Section 71.010 applies only in wrongful death cases.

Second, Defendants argue that the Court erred in failing to include an agency issue or instruction in the jury charge explaining that Presbyterian can only be liable through its agents and employees. (Defs.' Br. at 19.)[4] They go on to state in a conclusory fashion that

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[3] Because the defendants cannot be held jointly and severally liable for this amount, the Court hereby assesses $5263.28 against Dr. Knochel and $2631.64 against Presbyterian. These amounts were calculated in accordance with the ratio used by the Jury to assess the actual non-economic damages. The Court considers the settlement amounts paid by Drs. Levin and Harper to include their portion of the economic damages owed.

[4] This issue, while unrelated to damages, was not resolved in the Court's March 26, 2006 Order.

"Plaintiffs failed to establish that the acts of [Dr. Knochel] fell within the scope of [Dr. Knochel's] general authority and were in furtherance of Presbyterian's business and for the accomplishment of the object for which [Dr. Knochel] was hired." (Defs.' Br. at 19.) The Court disagrees.

First, the jury charge did include an agency instruction in not one, but two instances. (*See* Court's Charge to the Jury at 2, 47.) Second, the evidence at trial established unequivocally that Dr. Knochel's unlawful conduct fell within the scope of his authority and was in furtherance of Presbyterian's business and for the accomplishment of the object for which Dr. Knochel was hired. In fact, there was no evidence to the contrary. Moreover, the jury's finding of liability against the Hospital was appropriate in light of the testimony and conduct of the Hospital's Vice-President for Medical Staff Affairs and its President, who supported Dr. Knochel's conduct at the time it occurred and at trial. Those administrators testified that they believed Dr. Knochel acted fairly and appropriately under the circumstances.

Defendants also argue they are entitled to a new trial because the Court erred by submitting the same damages elements multiple times, thereby presenting the danger of multiple recoveries. (Defs.' Br. at 19.) To the extent Defendants are arguing that the Court erred by submitting a damages question to the jury for each of the different causes of action, such as breach of contract, defamation, tortious interference, etc., that issue is moot because the one-satisfaction rule limits Plaintiffs' recovery to one claim. Additionally, the jury was specifically instructed to consider each defendant

separately with respect to damages, thereby obviating the risk of a double recovery. The hospital administrators were consulted and agreed with the summary suspension decision and with the procedure utilized. By its verdict, the jury found Dr. Knochel the most culpable of the defendants, then the Hospital, and lastly, Drs. Levin and Harper.

For these reasons, the remainder of Defendants' Motion for a New Trial is hereby DENIED.[5]

MOTION FOR REMITTITUR

A. BACKGROUND

In an order dated March 27, 2006, this Court held that the one-satisfaction rule requires Plaintiffs to elect one of their alternative claims for entry of judgment. Accordingly, per Plaintiffs' request, the Court entered judgment on Plaintiffs' defamation claim.[6]

The jury awarded Dr. Poliner $90,010,526.55 in actual damages as compensation for the defamatory

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[5] The issue of whether the damage awards are excessive is addressed herein as part of the Court's discussion concerning remittur.

[6] Because Plaintiffs elected for judgment on their defamation claim rather than their breach of contract claim, Plaintiffs' Post-trial Petition for Attorneys' Fees, Expenses, and Costs is hereby denied with respect to Plaintiffs' recovery of attorneys' fees. However, as the prevailing party, Plaintiffs are entitled to recover their costs. See Fed. R. Civ. P. 54(d)(1). Upon entry of judgment, Plaintiffs are entitled to resubmit their bill of costs.

statements made against him by Defendants Knochel, Harper, Levin and Presbyterian. The Jury Charge specifically instructed the jurors to consider each defendant separately and not to include damages as to one defendant in assessing damages against any other defendant. (*See* Jury Question No. 11.)

With respect to Dr. Knochel, the jury awarded Dr. Poliner $10,526.55 in economic damages,$20 million in mental anguish damages and $20 million in injury to reputation and career damages. With respect to Presbyterian, the jury awarded Dr. Poliner $10,526.55 in economic damages, $15 million in mental anguish damages and $15 million in injury to reputation and career damages. The jury also found that Plaintiffs were entitled to recover exemplary damages in the amount of $110 million. The jury held Dr. Knochel responsible for $40 million and Presbyterian responsible for $50 million of that amount.

B. LEGAL PRINCIPLES FOR REMITTITUR.

In their Motion for a New Trial, Defendants argue that the actual and exemplary damages found by the jury are unsupportable and excessive such that a new trial is warranted. In the alternative, Defendants argue in their Motion for Remittitur that the jury's award of $70,010,526.55 in actual damages against Dr. Knochel and Presbyterian is excessive and contrary to right reason, thereby necessitating a remittitur.

There is a strong presumption in favor of affirming a jury award of damages. *See Hughes v. Ford Motor Co.*, 204 F. Supp. 2d 958, 964 (N.D. Miss. 2002). The court may not reverse a jury verdict for excessiveness

except on the "strongest of showings." *Caldarera v. Eastern Airlines, Inc.*,705 F.2d 778, 784 (5th Cir. 1983). The jury's award is not to be disturbed unless it is entirely disproportionate to the injury sustained. *See id.* Yet, when a jury's award exceeds the bounds of any reasonable recovery, the court must grant a remittitur. *See id.* Decisions on motions for new trial and remittitur are committed to the sound discretion of the trial court. *See Westbrook v.General Tire and Rubber Co.*, 754 F.2d 1233, 1241 (5th Cir. 1985); *Hughes*, 204 F. Supp. 2d at 964.

Trial courts should employ remittitur for those verdicts that are so large as to be contrary to right reason, whereas a new trial should be ordered when the jury's damage award was infected by passion or prejudice. *See Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 683-84 (5th Cir. 1986); *Smith v. City of Seven Points*, 608 F. Supp. 458, 463 (E.D. Tex. 1985). If the court believes that a remittitur is more appropriate, it must first offer the plaintiff a choice between accepting a reduction in damages or proceeding with a new trial. *See Smith*, 608 F. Supp. at 463.

In reducing the level of damages, the court may not simply substitute its opinion concerning the proper amount for that of the jury. *See id.* The rules governing remittitur vary by jurisdiction. They may be provided for specifically in a statute or court rules, or developed through case law. Texas courts determine the size of the remittitur in accordance with the judge-made "maximum recovery rule," which prescribes that the verdict must be reduced to the maximum amount the jury could properly have awarded. *See Caldarera*, 705 F.2d at 784. The court "will decline to reduce damages

where the amount awarded is not disproportionate to at least one factually similar case from the relevant jurisdiction." *Lebron v. United States*, 279 F.3d 321, 326 (5th Cir. 2002). The maximum recovery rule does not limit an award to the highest amount previously entered in the jurisdiction, but instead does not become operative unless the award exceeds 133% of the highest previous recovery in the relevant jurisdiction for a factually similar case. *See id.* Because the facts of each case are different, prior damages awards are not always controlling; the rule does not apply when unique facts or circumstances are present that are not reflected within the controlling caselaw. *See id.*

If a new trial is warranted and if it is clear that the issue of damages is independent of those issues relating to liability, the new trial, if any, may be limited to the question of damages. *See Smith,* 608 F. Supp. at 465.

C. REMITTITUR/NEW TRIAL ANALYSIS.

When deciding whether it is appropriate to set either a remittitur or a new trial, the Court must resolve several issues: First, was the verdict excessive? Second, if the verdict was excessive, was the jury motivated by passion or prejudice? Third, if the verdict was excessive, but was not motivated by passion or prejudice, what was the maximum amount the jury could have awarded given the evidence submitted and the applicable law? And finally, how much should the damages be reduced in order to set a proposed remittitur?

1. Excessiveness of Verdict.

The first issue the Court must resolve is whether the verdict was excessive. With respect to economic damages, the evidence at trial reflected a total lost earning amount of $10,526.55. The jury verdict held each defendant responsible for $10,526.55, thereby indicating that the jury believed each defendant's conduct proximately caused Plaintiffs to lose the entire lost earnings amount. The Court concludes that the jury intended to hold all Defendants responsible for one lost earnings amount. This amount is not excessive.

The jury also awarded Dr. Poliner $35 million for injury to his reputation/career. Although it is difficult to calculate an amount to fairly and reasonably compensate someone for the damage to their career/reputation, the law requires juries to do so. Dr. Poliner's career was decimated by Defendants' actions. The evidence at trial established that Dr. Poliner had an impressive and unblemished career in cardiology prior to these events. Dr. Poliner attended college at Notre Dame University and studied medicine at Cornell Medical School. After doing his residency in Colorado and spending some time in the United States Air Force, Dr. Poliner went into a fellowship program at University of Texas Southwestern Medical School in cardiology, where he eventually became a faculty member. After spending some years in academia at University of Texas Southwestern Medical School and at Baylor College of Medicine, Dr. Poliner was recruited to head a heart institute in Kansas. He spent many years practicing in Kansas and spent some time practicing cardiology in Indiana. In 1996, Dr. Poliner

moved to Dallas to practice medicine with a large physicians' group. He left that group in June 1997 and began his own cardiology practice with privileges at Presbyterian. According to the testimony at trial, Dr. Poliner had never had his medical license questioned, had never been asked to agree to an abeyance, and had never been sued for malpractice.

While working in Dallas at Presbyterian, Dr. Poliner practiced emergency cardiac medicine and, in an effort to build up his private practice, was relying almost solely on emergency room physician referrals for his business. While at Presbyterian, his referral base grew steadily and he was doing a large volume of work in the cath lab.

After being labeled by Defendants as a "dangerous doctor," the emergency room doctors stopped referring patients to him, lest they be blamed for sending a patient to an unsafe doctor. Consequently, Dr. Poliner was unable to sustain any kind of practice at Presbyterian. Although he had courtesy privileges at Medical City Dallas, his referral practice had dried up.

While there is no doubt that Dr. Poliner's evidence established that he suffered a massive injury to his reputation/career, there was no evidence that he suffered damages in the amount of $35 million. That amount is not reasonable and is excessive.

The jury also awarded Dr. Poliner $35 million for mental anguish suffered by Knochel's and Presbyterian's tortious conduct. Mental anguish is recoverable when it causes a substantial disruption in daily routine or a high degree of mental pain and

distress. *See Bently v. Bunton*, 94 S.W.3d 561, 606 (Tex. 2002). Dr. Poliner testified that the ordeal and the ensuing litigation caused him to lose sleep, cost him time with his family, caused him to spend innumerable hours with lawyers and work on the lawsuit, disrupted his family life, distressed his children, and cost him his career. He explained that people in the medical community viewed him with disdain and he suffered great embarrassment and humiliation. Dr. Poliner's wife (who worked with Dr. Poliner) testified that Dr. Poliner's life and personality changed dramatically as a result of this ordeal. She testified that following the abeyance, he worked day and night on this matter- reviewing records, consulting with doctors for their testimony at his hospital hearing(s), making copies of documents, and hiring others to help. She testified that Dr. Poliner was no longer a confident physician who enjoyed his profession, his family, and his life. She testified that this experience made Dr. Poliner and the mood of their entire family anxious and sad.

The record leaves no doubt that Dr. Poliner suffered mental anguish as a result of Defendants' statements. Although the humiliation and mental anguish suffered by Dr. Poliner are abstract and speculative elements of damages that are not susceptible to precise calculation, the Court finds that $35 million is not a rational amount of damages based on the evidence.

The jury's punitive damage award against Defendants Knochel and Presbyterian totaled $90 million. At trial, the jury heard Dr. Knochel testify that he did not have enough information to assess whether Dr. Poliner posed a present danger to his

patients at the time he asked Dr. Poliner to agree to the abeyance. Dr. Knochel threatened Dr. Poliner with suspension of his privileges if Dr. Poliner refused to sign the abeyance letter, even though "[w]e didn't determine that [Dr. Poliner] was a present threat to his patients at that particular point. That is why we asked for an abeyance to investigate it to see if he was in fact dangerous to his patients." Dr. Knochel was prepared to suspend Dr. Poliner's privileges despite the fact that he did not know whether Dr. Poliner posed a present danger to his patients. The Hospital's representative testified that this procedure was"appropriate and sanctioned." This evidence supports the jury's finding that the suspension was not undertaken in the reasonable belief that Dr. Poliner posed a present danger to the health of his patients and was in violation of the Hospital bylaws. The jury also heard Dr. Knochel testify that he informed Dr. Poliner that Dr. Poliner must agree to an abeyance of his cath lab privileges or Dr.Knochel would terminate all his hospital privileges immediately. Dr. Knochel did not offer Dr. Poliner any other options that may have been less severe. The Hospital's representative testified that this threat was "acceptable for an abeyance procedure." There was also evidence that Dr. Knochel told Dr. Poliner that he was not permitted to consult an attorney. Additionally, Dr. Poliner's medical experts testified that no reasonable hospital could have taken the action it did against Dr. Poliner except by knowingly or recklessly disregarding the medical evidence. Furthermore, there was evidence at trial that none of the Defendants would discuss the patient cases with Dr. Poliner prior to his summary suspension and that they did not provide Dr. Poliner with an opportunity to be heard or any hearing of any kind

prior to his summary suspension. Although this type of malicious conduct can warrant the imposition of punitive damages, the Court finds that $90 million is excessive.

2. Jury Motivation.

Having determined that $160 million is an excessive verdict based on the evidence presented, the Court must now determine whether the jury was motivated by passion and prejudice in arriving at the total. *See Smith v. City of Seven Points*, 608 F. Supp. 458, 463 (E.D. Tex. 1985). When an award is so exaggerated as to indicate bias, prejudice, corruption, or improper motive, the only proper remedy is a new trial. *Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 683-84 (5th Cir. 1986). In the alternative, if the Court determines that the verdict was contrary to right reason, but was not the product of passion or prejudice, Plaintiffs will be offered the choice between remittitur or a new trial.

Resolution of this issue requires great reliance on the discretion of the trial court. *See Smith*,608 F. Supp. at 463. Based on the judge's observation of the trial, he or she must determine whether the jury was impassioned or prejudiced against the defendants. *See id.*

There is no doubt that the size of this award clearly reflects the jury's desire to punish these Defendants and to compensate Dr. Poliner for the loss of his career. The fact that Dr. Poliner, his witnesses, and his counsel may have become emotional at times during the trial does not establish that the jurors' damages

assessment was infected by passion or prejudice. Rather, after presiding over the trial, listening to the testimony, and observing the jurors, the Court concludes that their desire to punish Defendants and to compensate Dr. Poliner for the loss of his career was a product of reason - not emotion - resulting from a rational deduction that such action was necessary to compensate Dr. Poliner and to effect change in Defendants' conduct in the future.

Dr. Poliner presented himself as a committed and dedicated doctor who was good at and enjoyed his profession. He was respected by his peers and had accumulated an impressive and unblemished career. Defendants came across as arrogant, uncaring, and completely unconcerned with damaging Dr. Poliner's career. The law is obviously written to encourage hospitals and doctors to engage in peer review to correct or eliminate dangerous doctors. However, the law does not encourage callous attempts to find dangerous doctors without concern for doctors' careers and in violation of the hospital's own bylaws and fundamental rules of fairness.

There was nothing in the jurors' behavior to indicate that they were predisposed to Plaintiffs. In light of this conclusion, the Court finds that a remittitur is appropriate.

3. Application of the Maximum Recovery Rule.

Having determined that remittitur is appropriate, the Court must determine whether the Maximum Recovery Rule applies in this case. As stated *supra*, because the facts of each case are different, prior

damages awards are not always controlling; the rule does not apply when unique facts or circumstances are present that are not reflected within the controlling caselaw. *See Lebron v. United States*, 279 F.3d 321, 326 (5th Cir. 2002).

Defendants direct the Court's attention to several cases involving medical peer review/suspension of physician staff privileges as well as some defamation cases. Of the cases cited by Defendants, the most analogous is *Rea v. Hosp. Corp. of Am.*, 892 F. Supp. 821 (N.D. Tex. 1993) (Solis, J.). In *Rea,* the court awarded damages for tortious interference with business relations claims involving two physicians' ten-month suspensions of hospital privileges. The court awarded the plaintiffs $197,928.00 in lost earnings damages and $200,000 in punitive damages.

Rea and this case do have some similarities - both cases involved physicians who were initially suspended, but ultimately reinstated. Both cases involved defendant hospitals that failed to follow their own bylaws and failed to give the plaintiffs fair notice and opportunity to be heard. Both cases involved personality clashes between the defendants and the plaintiff physicians. Both cases found that the defendants acted with malice in making their peer review decisions.

Yet this case differs from *Rea* - as well as from the other cases cited by Defendants - in some very key respects. First, this case involves a physician whose career was decimated by Defendants' actions. Dr. Poliner practiced emergency cardiac medicine and relied almost solely on emergency room physician

referrals for his business. After being labeled a "dangerous doctor," emergency room doctors stopped referring patients to him, lest they be blamed for sending a patient to an unsafe doctor. Consequently, Dr. Poliner was unable to sustain any kind of practice at Presbyterian. Additionally, because Dr. Poliner did not perform unique services that were in high demand, he was unable to take his expertise to another location. For these reasons, the jury awarded Dr. Poliner a significant amount for damage to career/reputation.

By contrast, in *Rea* the physicians had clinics and privileges at other hospitals in the vicinity and could transfer their work/patients elsewhere in the area. The type of medicine practiced by the physicians in *Rea* was unique and of a non-emergency nature. These doctors had no competition in the area; if a patient wanted the medicine they practiced, the patient went to them. Furthermore, they were not dependent on referrals for their practice. There was no evidence in *Rea* that the defendants' tortious conduct affected the plaintiffs' careers.

Also in *Rea,* the parties agreed to a bench trial whereas in this case there is a jury verdict to consider. Because of the strong presumption in favor of affirming jury awards, the Court will try to give effect to the jury's verdict while keeping in mind that the jury's job was to fairly and reasonably compensate Plaintiffs. *See Bently v. Bunton*, 94 S.W.3d 561, 606 (Tex. 2002).

After reviewing the cases cited by Defendants and after conducting its own research, the Court concludes that the Maximum Recovery Rule does not apply in

this case because this case involves unique facts and circumstances that are not reflected within the controlling case law.

4. Calculation of Damages.

Because of the unique facts of this case, the Court must identify the maximum verdict supported by the evidence. *See Smith v. City of Seven Points*, 608 F. Supp. 458, 465 (E.D. Tex.1985). Compensatory and punitive damages will be considered separately. *See id.*

a. *Punitive Damages.*

With regard to punitive damages, Defendants argue that the statutory punitive damages cap established by Section 41.008(b) of the Texas Civil Practices and Remedies Code applies in this case. Plaintiffs respond that they are entitled to an uncapped award of exemplary damages because section 41.008(c)(11) of the Texas Civil Practices and Remedies Code does not limit the amount of punitive damages where a defendant used deception to secure the execution of a document.

Section 41.008(b) states that "exemplary damages awarded against a defendant may not exceed an amount equal to the greater of: (1)(A) two times the amount of economic damages; plus(B) an amount equal to any non economic damages found by the jury, not to exceed $750,000; or (2) $200,000." Tex. Civ. Prac. & Rem. Code § 41.008(b) (Vernon 1997 & Supp. 2005). Section 41.008(c) states that the punitive damages cap does not apply to a cause of action "based on conduct described as a felony in the following sections of the

Penal Code . . . (11) Section 32.46 (securing execution of document by deception)". Tex. Civ. Prac. & Rem. Code Ann. § 41.008(11) (Vernon 1997 & Supp. 2005). At trial, Dr. Knochel testified that he informed Dr. Poliner that Dr. Poliner must agree to a "voluntary" abeyance of his cath lab privileges or Dr. Knochel would terminate all of Dr. Poliner's hospital privileges immediately. Although Dr. Knochel used coercion and duress to convince Dr. Poliner to sign the abeyance letter and acted in violation of the Hospital's bylaws, there was no evidence or finding that he used deception. (*See* Jury Question No. 2.) Thus, Dr. Knochel's conduct could not have constituted a Penal Code violation under Section 32.46. Further, the cause of action for which Plaintiffs seek recovery - defamation - is not a claim based on securing a document by deception. Rather, it is a claim based on the publication of a false statement that harmed Plaintiffs' reputation. For these reasons, the Court concludes that the punitive damages cap applies in this case and therefore, Plaintiffs' punitive damage award is limited to $750,000 plus two times the amount of economic damages against each Defendant.

b. *Actual Damages.*

As noted earlier, nearly all of the actual injury suffered by Plaintiffs falls into a nebulous and intangible category that cannot be precisely calculated. It is difficult to place a price on mental anguish, humiliation and a career/reputation. The evidence presented did cast some light on the degree of injury suffered as a result of Defendants' statements. As stated *supra*, Dr. Poliner's career and reputation were obliterated by Defendants' actions. And Dr. Poliner

and his family have endured significant mental anguish. In light of these and other considerations, and after carefully reviewing the trial transcript and the briefing presented, the Court hereby concludes that the maximum possible recovery for Plaintiff's injuries caused by Dr. Knochel's defamatory statements is $6,000,000 for injury to career and reputation and $6,000,000 for mental anguish. Likewise, the Court hereby concludes that the maximum possible recovery for Plaintiff's injuries caused by Presbyterian's defamatory statements is $4,500,000 for injury to career and reputation and $4,500,000 for mental anguish.

MOTION FOR SETTLEMENT CREDIT

Defendants argue in their motion for settlement credit that because Plaintiffs suffered one injury, Defendants are entitled to a settlement credit in the amount of the settlement(s) between Plaintiffs and Drs. Harper and Levin. Defendants cite to the Court's March 26, 2006 Order analyzing the one-satisfaction rule, wherein the Court held that Defendants' unlawful conduct resulted in but one single injury to Plaintiffs. However, as this Order explained herein, the jury was instructed when considering damage amounts to consider each defendant separately and the jury did so with respect to non-economic actual and punitive damages, as indicated by their assessment of different damage amounts against each defendant. Each award represented each defendant's separate contribution to Plaintiffs' single injury, with the single exception of lost earnings. The non-economic and punitive damages awarded against Dr. Knochel and Presbyterian are entirely separate from those amounts awarded against

Drs. Harper and Levin, which have been settled. Therefore, no settlement credit will be given except with respect to economic damages, and Defendants' motion is hereby DENIED in PART.

With respect to economic damages, the Court hereby issues a settlement credit for amounts paid by Drs. Levin and Harper. Rather than hold Dr. Knochel and Presbyterian responsible for the entire $10,526.55 in lost earnings, the Court hereby assesses $5263.28 against Dr. Knochel and $2631.64 against Presbyterian. These amounts were calculated using the four defendants' actual non-economic damages ratio. Drs. Levin and Harper's portion of the economic damages award was paid in their settlement amount.

CONCLUSION

In conclusion, the Court finds that the maximum recovery shown by the evidence in this case against Defendants Dr. Knochel and Presbyterian is $21 million in non-economic actual damages,$7894.92 in lost earnings, and $1,542,106.20 in punitive damages. It is therefore ordered that if Plaintiff agrees to a reduction in actual and punitive damages against Defendants to $22,550,001.12,then Defendants' Motion for New Trial will be DENIED and judgment will be entered in Plaintiffs' favor.

Plaintiffs must indicate acceptance of the remittitur in writing within ten (10) days from the date of this order. If Plaintiffs fail to do so, a new trial limited to the issue of damages will be scheduled.

It is SO ORDERED, this 13th day of October 2006.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

IN THE UNITED STATES DISTRICT COURT
NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

NO. 3:00-CV-1007-P

[Filed October 13, 2006]

LAWRENCE R. POLINER, M.D., and LAWRENCE R. POLINER, M.D., P.A.,	)
Plaintiffs,	)
v.	)
TEXAS HEALTH SYSTEMS, A TEXAS NON-PROFIT CORPORATION d/b/a PRESBYTERIAN HOSPITAL OF DALLAS; JAMES KNOCHEL, M.D.; CHARLES LEVIN, M.D.; and JOHN HARPER, M.D.,	)
Defendants.	)

FINAL JUDGMENT

Pursuant to the Court's Memorandum Opinion and Orders of September 30, 2003, July 7, 2004, March 27, 2006, and October 13, 2006 and the jury verdict returned on August 27, 2004, the Court issues this Final Judgment as follows:

1. Plaintiffs Lawrence R. Poliner, M.D. and Lawrence R. Poliner, M.D., P.A. (collectively, "Plaintiffs") are awarded $22,550,001.12 on

their defamation claim against Defendants Texas Health Systems d/b/a Presbyterian Hospital of Dallas ("Presbyterian Hospital of Dallas") and Dr. James Knochel, M.D. ("Dr. Knochel").

2. Judgment is entered against Dr. Knochel as follows:

   a) $6 million for injury to Dr. Poliner's career;
   b) $6 million for Dr. Poliner's mental anguish;
   c) $5263.28 for economic loss; and
   d) $771,053.10 for punitive damages.

3. Judgment is entered against Presbyterian Hospital of Dallas as follows:

   a) $4.5 million for injury to Dr. Poliner's career;
   b) $4.5 million for Dr. Poliner's mental anguish;
   c) $2631.64 for economic loss; and
   d) $771,053.10 for punitive damages.

4. Plaintiffs take nothing from any Defendants based on Plaintiffs' antitrust claims.

5. Plaintiffs take nothing from any Defendants based on Plaintiffs' Deceptive Trade Practices Act claims.

6. Plaintiffs take nothing from any Defendants based on Dr. Poliner's June 12, 1998 suspension.

7. Plaintiffs take nothing from any of their claims against defendants Charles Harris, M.D., Anthony Das, M.D., David Musselman, M.D., Robert Brockie, M.D., Jorge Cherif, M.D., Steven Meyer, M.D., and Martin Berk, M.D.

8. Costs are assessed against Plaintiffs insofar as those costs were incurred defending those Defendants listed in Paragraph 7.

9. Costs are assessed against Defendants James Knochel, M.D. and Presbyterian Hospital of Dallas insofar as those costs were incurred prosecuting Plaintiffs' claims against said Defendants.

10. Prejudgment interest shall be awarded at the rate of 8.25% beginning from the date suit was filed through the date of judgment.

11. Postjudgment interest shall be awarded at the rate of 4.90% beginning from the day after the date of judgment until the judgment is satisfied.

IT IS SO ORDERED.

Signed this 13th day of October 2006.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

APPENDIX C

IN THE UNITED STATES DISTRICT FOR THE NORTHERN DISTRICT OF DALLAS DIVISION

CIVIL ACTION NO. 3-00-CV-1007-P

[Filed July 7, 2004]

LAWRENCE R. POLINER, M.D., and LAWRENCE R. POLINER, M.D., P.A.,	)
Plaintiffs,	)
v.	)
TEXAS HEALTH SYSTEMS, ET AL.,	)
Defendants.	)

ORDER

Now before the Court are Defendants' Request for Findings and Rulings . . . Regarding Scope of Issues to be Tried and Evidence Relevant thereto, filed on March 2, 2004, and Plaintiffs' Cross-Motion for Clarification ("Cross-Motion"), filed March 9, 2004. After careful consideration of the Parties' briefs and the applicable law, the Court GRANTS Defendants' Motion and DENIES Plaintiffs' Cross-Motion.

In their motions, the Parties request clarification of the Court's Memorandum Opinion and Order issued on September 30, 2003 ("Order") regarding the scope of the issues to be tried and the relevant evidence. The Parties disagree as to whether the Court's Order permits Plaintiffs to seek damages flowing from the June 12, 1998 suspension of Dr. Poliner's privileges. Although the Court and the attorneys previously discussed this issue at status conferences held on February 26, 2004, and April 2, 2004, the Court has not yet made a definitive ruling on the issue. Based on the Court's finding that all of the participants in the June 12, 1998 suspension were entitled to immunity, the Court finds that Plaintiffs are not entitled to recover damages flowing from that suspension.

Two separate professional review actions were at issue in this case: (1) the decision to suspend Dr. Poliner's privileges on May 14, 1998, and (2) the IMAC recommendation after review of the AHC's report to suspend Dr. Poliner's privileges on June 12, 1998. *See Mathews v. Lancaster Gen. Hosp.*, 883 F. Supp. 1016, 1028 (E.D. Pa. 1995)(explaining that an initial suspension of a doctor's privileges and a subsequent hearing to review that decision are two separate professional review actions). The Court analyzed each professional review action to determine whether it met the requirements of 42 U.S.C. § 11112(a). In its Order, the Court found that the participants in the June 12, 1998 suspension satisfied the elements of § 11112(a). The Court also determined that Plaintiffs had not produced sufficient evidence to warrant a finding that the participants in the June 12 suspension acted with malice. The Court concluded that the participants in the June 12 suspension were therefore entitled to

immunity, and summary judgment was granted in favor of all of the defendants with respect to the June 12 suspension. With respect to the professional review action on May 14, 1998, the Court determined that factual issues existed as to whether the action was a suspension or an abeyance and as to whether Defendants Knochel, Levin, and Harper acted with malice.

The crux of Plaintiffs' argument is that while the Court's Order precludes them from recovering from the participants in the June 12, 1998 suspension, it does not preclude them from recovering from the remaining Defendants based on the decisions made by the participants in the June 12, 1998 suspension. According to Plaintiffs, the Court's Order "did not make any factual findings with respect to the propriety of the peer review proceedings that occurred after the abeyance on May 14, 1998," and "only serves to preclude Plaintiffs' recovery from the Dismissed Defendants based on immunity." (Pls.' Cross-Mot. at 2, 4.) As such, Plaintiffs argue that they should be allowed to pursue damages flowing from the June 12, 1998 suspension.

To support their arguments, Plaintiffs point to the fact that the Court cannot make any fact findings in a summary judgment proceeding. The Court agrees with Plaintiffs that the Court's Order did not make any findings of fact. However, the Order determined, in accordance with Federal Rule of Civil Procedure 56, that no issue of material fact existed with respect to the June 12, 1998 suspension to warrant submission to a jury. Plaintiffs' attempt to inject the propriety of the

June 12, 1998 suspension before the jury is simply an attempt to circumvent the Court's Order.

Because the Court has determined that the June 12, 1998 suspension was carried out in accordance with federal and state statutes, those statutes prohibit the recovery of any damages resulting from that suspension. Allowing Plaintiffs to recover damages for the June 12, 1998 suspension would allow Plaintiffs to recover damages without showing that the suspension violated the Health Care Quality Improvement Act and without showing that the June 12, 1998 suspension was carried out with malice. This is contrary to the language and purposes of the immunity statutes, and therefore, the Court finds that Plaintiffs are not entitled to recover damages flowing from Dr. Poliner's June 12, 1998 suspension.

In light of this ruling, the propriety of the AHC's review and the IMAC's recommendation is no longer at issue. Accordingly, evidence of malice or the motive of any of the participants in the June 12, 1998 suspension is not relevant, nor is any evidence regarding the AHC's analysis of the patients' files examined.

For the reasons set forth above, the Court GRANTS Defendants' motion for clarification regarding the scope of the issues to be tried and DENIES Plaintiffs' Cross-Motion.

IT IS SO ORDERED.

Signed this 7th day of July 2004.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

APPENDIX D

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

No. 3:00-CV-1007-P

[Filed September 30, 2003]

LAWRENCE R. POLINER, M.D., Plaintiff,	)
v.	)
TEXAS HEALTH SYSTEMS, A TEXAS NON-PROFIT CORPORATION D/B/A PRESBYTERIAN HOSPITAL OF DALLAS; JAMES KNOCHEL, M.D.; CHARLES HARRIS, M.D.; ANTHONY DAS, M.D.; CHARLES LEVIN, M.D.; DAVID MUSSELMAN, M.D.; JOHN HARPER, M.D.; ROBERT BROCKIE, M.D.; JORGE CHERIF, M.D.; STEVEN MEYER, M.D.; AND MARTIN BERK, M.D., Defendants.	)

MEMORANDUM OPINION AND ORDER

Now before the Court are the following:

1. Defendants' Motion for Summary Judgment, with brief in support and appendix, filed May 15, 2002;

2. Plaintiff's Response to Defendants' Motion for Summary Judgment, with brief in support and appendix, filed June 11, 2002;

3. Defendants' Reply to Plaintiff's Response to Defendants' Motion for Summary Judgment and Brief in Support, filed June 26, 2002;

4. Defendants' Objections to Plaintiff's Summary Judgment Evidence, filed June 26, 2002 and December 5, 2002;

5. Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions and Brief in Support, filed June 11, 2002;

6. Defendants' Response to Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions, Motion to Strike, Motion for Protective Order and Brief in Support, filed June 18, 2002;

7. Defendants' Response to Plaintiff's Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions, Motion

to Strike, Motion for Protective Order and Brief in Support, filed June 19, 2002;[1]

8. Plaintiff's Reply to Defendants' Response to Motion for Leave to Supplement Response to Defendants' Motion for Summary Judgment and to Take Additional Depositions and Brief in Support, with appendix, filed July 3, 2002;

9. Plaintiff's Response to Defendants' Motion to Strike and for Protective Order and Brief in Support, filed July 8, 2002;

10. Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic and Brief in Support, filed June 17, 2002;

11. Plaintiff's Response to Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic, and Brief in Support, filed June 28, 2002;

12. Defendants' Motion to Quash and for Protective Order Regarding Plaintiff's Notice of Intention to Take Oral Deposition of Dr. Morton Kern and Brief in Support Thereof, filed June 19, 2002;

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[1] The Court notes that Defendants' Response and Motion to Strike and for Protective Order is a duplicate of Defendants' previous filing on June 18, 2002, listed above as item number 6. As such, the Court DENIES this motion as MOOT.

13. Plaintiff's Response to Defendants' Motion to Quash and for Protective Order Regarding Plaintiff's Notice of Intention to Take Oral Deposition of Dr. Morton Kern and Brief in Support, filed June 28, 2002;

14. Defendants' Reply to Plaintiff's Response to Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic and Defendants' Reply to Plaintiff's Response to Defendants' Motion to Quash and for Protective Order and Brief in Support, filed July 2, 2002.

15. Plaintiff's Supplemental Response to Defendants' Motion for Summary Judgment filed on November 20, 2002;

16. Defendants' reply to Supplemental Response filed on December 5, 2002, and;

17. Plaintiff's Motion to Amend Complaint filed on July 11, 2002;

18. Defendants' response to plaintiff's Motion to Amend Complaint filed on July 31, 2002;

19. Plaintiff's reply to defendant's response to plaintiff's Motion to Amend Complaint filed on August 15, 2002.

After a thorough review of the evidence, the pleadings, the parties' briefs, and the applicable law, for the reasons set forth below, the Court is of the opinion that (1) Defendant's Motion for Summary

Judgment should be GRANTED in part, and DENIED in part; (2) Defendants' Objections to Plaintiff's Summary Judgment Evidence (Docket entries nos. 171 and 232) should be DENIED as MOOT, except where noted otherwise; (3) Plaintiff's Motion for Leave to Supplement Response and to Take Additional Depositions (Docket entry no. 147) should be DENIED; (4) Defendants' Motion to Strike and for Protective Order (Docket entries nos. 164 and 166) should be DENIED; (5) Defendants' Motion to Limit the Number of Experts Designated on the Same or Similar Topic (Docket entry no. 163) should be DENIED; (6) Defendants' Motion to Quash and for Protective Order Regarding Dr. Morton Kern (Docket entry no. 165) should be DENIED as MOOT; and (7) Plaintiff's Motion to Amend Complaint (Docket entry no. 198) is GRANTED.

INTRODUCTION

Plaintiff Lawrence R. Poliner, M.D., ("Dr. Poliner") filed this suit before the Court against Texas Health Systems d/b/a Presbyterian Hospital of Dallas (hereinafter "Hospital" or "PHD"), and Doctors James Knochel, Charles Harris, Anthony Das, Charles Levin, David Musselman, John Harper, Robert Brockie, Jorge Cherif, Steven Meyer, and Martin Berk (collectively "Defendants"), for claims arising out of a peer review which resulted in a suspension of Plaintiff's cardiac cath lab and echocardiography privileges at the Hospital for part of 1998. Specifically, Dr. Poliner alleges that the Defendants, by participating in the suspension of his privileges: (1) entered into a combination and conspiracy in violation of Sections 1 and 2 of the Sherman Act and Section 4 of the Clayton

Act (all Defendants); (2) engaged in an unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983 (all Defendants); (3) breached his contractual due process rights created under the Hospital's Bylaws (Hospital only); (4) caused business disparagement, slander and libel (all Defendants); (5) caused tortious interference with business (all Defendants); (6) caused tortious interference with prospective advantage (all Defendants); (7) violated the Deceptive Trade Practices Act (all Defendants); and (8) caused intentional infliction of mental anguish and emotional distress (all Defendants). *See generally* Third Am. Compl. In his remaining counts, Plaintiff's other requested relief includes: (9) an application for temporary restraining order, temporary injunction and permanent injunction (Hospital only); (10) a request for declaratory relief that Defendants' actions are not entitled to immunity under either the Health Care Quality Improvement Act ("HCQIA") or the Texas Medical Practice Act (all Defendants); and (11) a request for declaratory relief that the HCQIA and the Texas Medical Practice Act are unconstitutional as enacted. *See* Id.

Meanwhile, Defendants have moved for summary judgment on each count on the grounds that: (a) Texas law does not recognize a cause of action for suspension of hospital privileges; (b) neither the Texas Medical Practice Act, nor HCQIA creates a private cause of action for temporary suspension of hospital privileges; (c) the HCQIA and the Texas Peer Review statutes immunize the peer review activity of Defendants from liability; (d) Plaintiff's antitrust allegations, even if taken as true, (i) preclude a finding of an unreasonable restraint of trade within the ambit of the antitrust

laws, (ii) are barred by the intraenterprise immunity doctrine, (iii) there is no effect on interstate commerce as a matter of law, and (iv) Presbyterian does not possess the requisite market power within the relevant market to give rise to liability; (e) there is no evidence of any contract between Plaintiff and Defendants; (f) Plaintiff can produce no evidence of any prospective contracts between Plaintiff and third parties that were affected by the alleged interference; (g) Plaintiff's business disparagement, slander and libel claims are barred by the one-year statute of limitations and are based on statements protected by privilege; (h) Defendants are entitled to summary judgment on Plaintiff's claims for intentional infliction of mental anguish and emotional distress; (i) Defendants are entitled to summary judgment on Plaintiff's claims for alleged violation of Texas Deceptive Trade Practices Act; (j) Plaintiff's request for injunctive relief fails as a matter of law due to the existence of an adequate remedy at law; and (k) Plaintiff's request for declaratory judgment fails to plead a complaint that is remediable by declaratory judgment, and it merely encompasses previously pleaded claims in order to create a basis for an award of attorney's fees. *See generally* Defs.' Mot. Summ. J. at 3-4. Each of these arguments will be considered in turn.

BACKGROUND

Dr. Poliner received his medical degree from Cornell University School of Medicine in 1969, and completed his residency in Internal Medicine at the University of Colorado in 1972. He became board certified in internal medicine in 1972 and in cardiovascular diseases in 1977. Dr. Poliner first

applied for privileges at PHD in May 1996. He was granted temporary privileges in June 1996, and formally appointed to the hospital staff in January 1997. The first year of Dr. Poliner's appointment to the medical staff at PHD was provisional, and in July 1997, Dr. Poliner applied for reappointment to the medical staff. He was granted reappointment at PHD in October 1997.

On September 29, 1997, a nurse in the Cardiac Catheterization Lab ("Cath Lab") filled out a Committee Event Report Form ("CERF") on Dr. Poliner with respect to patient no. 18. This patient died following a procedure on the patient by Dr. Poliner in the cath lab. The CERF was referred to the hospital's Clinical Risk Review Committee ("CRRC"). On October 29, 1997, another nurse in the cath lab filed a CERF on Dr. Poliner with respect to patient no. 9. Patient no. 9 suffered a stroke following a cath lab procedure by Dr. Poliner. The nurse's report indicated a concern that the patient developed chest pain and signs of a stroke after the cath lab procedure. Although he was informed of the patient's symptoms, Dr. Poliner did not go to see the patient until the following day. This report was also referred to the CRRC. On December 18, 1997, a nurse in the cath lab filled out a CERF on Dr. Poliner with respect to patient no. 3. The CERF concerned Dr. Poliner's alleged use of a contaminated sheath and was also referred to the CRRC. On January 12, 1998, the CRRC took up discussion of the referrals concerning patients nos. 3 and 18. Among the functions of the CRRC is to refer identified issues of patient care concerns to the appropriate department or committee. Following review of the cases involving patients nos. 3 and 18,

the CRRC decided to refer both cases to the hospital's Internal Medicine Department for further review. The issues the CRRC identified with respect to patient no. 18 included whether the patient met the criteria for the procedure performed by Dr. Poliner, "evaluation of the cardiologist's procedural technique", and "evaluation of practitioner trends particularly with complications during interventional cardiac procedures." In the Internal Medicine Department, review of the cases was assigned to the Internal Medicine Advisory Committee ("IMAC"). IMAC was a PHD committee with responsibility for reviewing cases where quality of patient care concerns were raised involving doctors in the Internal Medicine Department. Cardiology was part of the Internal Medicine Department at PHD. The CERF report concerning patient no. 9 was taken up by the CRRC on April 13, 1998, and the CRRC subsequently decided to refer that case to the IMAC for further review. Issues identified by the CRRC with respect to patient no. 9 again included "evaluation of practitioner trends particularly complications with or following interventional cardiac procedures" and "evaluation of the overall medical management of the patient." IMAC review of the cases involving patients nos. 3, 9, and 18 was still pending when a case involving patient no. 36 was brought to the attention of Dr. John Harper by Dr. Charles Levin on May 13, 1998. Dr. Levin was director of the cath lab on May 12, 1998, and part of his duties involved occasional review of emergency cases. Dr. Poliner had performed an emergency angioplasty on patient no. 36 on May 12, and Dr. Levin reviewed the film of the procedure. Upon review of the film, Dr. Levin concluded that Dr. Poliner performed the angioplasty on the wrong artery and missed a totally

occluded left anterior descending coronary artery. Dr. Levin considered this error potentially life threatening to the patient. Dr. Levin informed Dr. Harper, then Chief of Cardiology, on May 13, 1998 of his findings with respect to patient no. 36. Dr. Knochel, Chairman of the Department of Internal Medicine, was also informed about patient no. 36 on May 13, 1998. Dr. Knochel testified that in addition to the missed occluded artery, he had also received complaints from nurses who were concerned that Dr. Poliner had not paid adequate attention to the needs of patient no. 36 once the patient had been transferred to the floor from the cath lab. In light of the events concerning patient no. 36 and the other reports concerning Dr. Poliner which were then under review, Dr. Knochel spoke to Mark Merrill, President of PHD, Bruce Bougeno, Vice-President of Medical Staff Affairs, and George Pearson, in-house counsel for PHD. Dr. Knochel asked plaintiff to accept abeyance of all procedures in the cath lab until an ad hoc committee appointed by Knochel could review plaintiff's cath lab cases. Drs. Levin and Harper were present at the meeting between Knochel and plaintiff. According to plaintiff, he was given an abeyance letter after 2:00 p.m. on May 14, 1998 and told to sign and return it by 5:00 p.m. that day or his privileges would be immediately suspended. Plaintiff alleges he was not told about patient no. 36, was not given an opportunity to defend himself against the accusations, and was not told which of his patients were going to be reviewed by the ad hoc committee. Plaintiff was told not to consult an attorney before deciding whether to sign the abeyance letter. Plaintiff signed and returned the abeyance letter agreeing to an abeyance. The abeyance of plaintiff's cath lab privileges did not extend to plaintiff's admission and

consultation privileges at the hospital. Dr. Knochel then appointed six doctors, all cardiologists at PHD, to the ad hoc committee ("AHC"): Dr. Robert Brockie, Dr. Jorge Cheirif, Dr. Anthony Das, Dr. Charles Harris, Dr. Steven Meyer, and Dr. William Reardon. All members of the ACH except Dr. Reardon are named defendants in this suit. The AHC met on May 20, 1998 and reviewed forty-four (44) of plaintiff's cases. All but two of the cases reviewed by the AHC were selected by the medical staff office at PHD or selected at random. Two of the cases selected for review by the AHC were selected because of concerns which had been raised regarding those patients. After reviewing the cases, the AHC concluded that substandard care was rendered in twenty-nine (29) of the cases. The IMAC then met on May 27, 1998 to consider the report of the AHC. The members of the IMAC were Dr. David Musselman, Dr. Steven Rinner, Dr. Lyle Kaliser, and Dr. William Harvey with Dr. Knochel serving as chairman. Dr. Musselman was the only cardiologist on the committee, and is the only member of the IMAC named by Dr. Poliner as a defendant in this case. The IMAC recommended that additional reviews of echocardiograms be performed and that an outside reviewer be asked to review the cases. The IMAC further recommended extending the abeyance for two weeks to allow time for the echocadiogram reviews and for the outside review. By letter of May 29, 1998, plaintiff was asked, and he agreed, to extend the abeyance until June 12, 1998. Defendants assert that an outside reviewer could not be found who could perform the necessary reviews in time for the hearing. On June 8, 1998, Dr. Knochel sent plaintiff a letter advising him of an IMAC meeting on June 11, 1998 as part of the peer review process. The meeting was

scheduled from 8:00 a.m. to 9:00 a.m. Plaintiff was provided a list of patients whose cases had been reviewed and informed that the records pertaining to those cases would be made available for plaintiff's review. On June 10, 1998, plaintiff sent Dr. Knochel a letter requesting a postponement of the IMAC hearing until June 12 or until the afternoon of June 11. Dr. Poliner stated he needed more time to review all of the material necessary. By letter of June 10, 1998, Dr. Knochel refused Dr. Poliner's request for a delay. The IMAC meeting proceeded as scheduled, and Dr. Poliner was given one hour to present his response to the concerns raised about his patient care. On June 12, 1998, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges and identified the following specific concerns: (1) poor clinical judgment; (2) inadequate skills, including angiocardiography and echocardiography; (3) unsatisfactory documentation of medical records; and (4) substandard patient care. After obtaining the recommendations of the IMAC, Dr. Knochel summarily suspended Dr. Poliner's cath lab and echocardiography privileges and informed Dr. Poliner of his decision by letter dated June 12, 1998. Dr. Knochel's letter further advised Dr. Poliner that the suspension did not extend to admission and consultation privileges or to any privilege not performed in the Cardiac Cath Lab or echocardiograms at PHD. Dr. Poliner was also advised that he was entitled to an expedited hearing concerning his suspension in accordance with PHD's Medical Staff By-Laws. On July 10, 1998, Dr. Poliner wrote Mark Merrill, President of PHD, and requested a hearing concerning the suspension of his privileges. The letter did not request an expedited hearing. Mr. Merrill informed Dr. Poliner by letter of August 14, 1998, that

a hearing before a Hearing Committee of PHD's Medical Staff was scheduled for September 14, 1998 at 6:00 p.m. The letter also identified the five members of the Hearing Committee. On August 19, 1998, plaintiff's counsel requested a continuance of the hearing due to a scheduling conflict of his co-counsel. By letter of October 5, 1998, Mr. Merrill informed Dr. Poliner that the hearing was continued until November 3, 1998 at 6:00 p.m. and on November 4, 1998. Dr. Poliner objected generally that the Hearing Committee did not include any cardiologists but did not object to any of the individual members of the committee. Dr. Poliner also acknowledges that he was not in direct competition with any of the members of the Hearing Committee. A hearing was held on November 3, 4, and 5, 1998. On November 9, 1998, the Hearing Committee issued its report. The Hearing Committee recommended unanimously that Dr. Poliner's privileges should be restored with conditions, and found unanimously that the summary suspension of Dr. Poliner's privileges was justified based on the evidence available at the time. On November 18, 1998, the hospital's Medical Board met and accepted the recommendation of the Hearing Committee. Dr. Poliner was informed of the Medical Board's decision by letter of November 20, 1998. By letter of January 15, 1999, Dr. Poliner advised Mr. Merrill that he wished to appeal to the hospital's Committee on Professional Affairs ("COPA") the summary suspension of his privileges on June 12, 1998. Dr. Poliner expressed concern that, although his privileges had been restored, the presence of the summary suspension on his record would continue to be harmful to him. Dr. Poliner was advised that, pursuant to the hospital's by-laws, his appeal was limited to a determination of

whether Dr. Poliner had been substantially provided with the procedural due process provided in the by-laws. COPA met on March 2, 1999 to consider Dr. Poliner's appeal. COPA ultimately found that Dr. Poliner had been afforded procedural due process during the peer review process and that it did not have the authority to set aside the summary suspension of privileges. On June 7, 1999, the hospital's Board of Trustees upheld the decision of COPA. None of the individual defendants in this suit were on the hearing committee or COPA. Plaintiff then filed this suit on May 11, 2000.

DISCUSSION

I. Summary Judgment Standard

Summary judgment shall be rendered when the pleadings, depositions, answers to interrogatories and admissions on file, together with affidavits, if any, show that there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed. R. Civ. P. 56(c); *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). All evidence and the reasonable inferences to be drawn therefrom must be viewed in the light most favorable to the party opposing the motion. *United States v. Diebold, Inc.*, 369 U.S. 654, 655 (1962).

The moving party bears the burden of informing the district court of the basis for its belief that there is an absence of a genuine issue for trial, and of identifying those portions of the record that demonstrate such an absence. *Celotex*, 477 U.S. at 323. Once the moving party has made an initial showing, the party opposing

the motion must come forward with competent summary judgment evidence of the existence of a genuine fact issue. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 586 (1986). The party defending against the motion for summary judgment cannot defeat the motion unless he provides specific facts that show the case presents a genuine issue of material fact, such that a reasonable jury might return a verdict in his favor. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). Mere assertions of a factual dispute unsupported by probative evidence will not prevent summary judgment. *Id.* at 248-50; *Abbot v. Equity Group, Inc.*, 2 F.3d 613, 619 (5th Cir. 1993). In other words, conclusory statements, speculation and unsubstantiated assertions will not suffice to defeat a motion for summary judgment. *Douglass v. United Servs. Auto. Ass'n*, 79 F.3d 1415, 1429 (5th Cir. 1996) (en banc). If the nonmoving party fails to make a showing sufficient to establish the existence of an element essential to its case, and on which he bears the burden of proof at trial, summary judgment must be granted. *Celotex*, 477 US. at 322-23. The Court will not, in the absence of any proof, assume that the nonmoving party could or would prove the essential facts necessary to support a judgment in favor of the nonmovant. *See Little v. Liquid Air Corp.*, 37 F.3d 1069, 1075-1076 (5th Cir. 1994).

Finally, the Court has no duty to search the record for triable issues. *Ragas v. Tennessee Gas Pipeline Co.*, 136 F.3d 455, 458 (5th Cir. 1998). "The party opposing summary judgment is required to identify specific evidence in the record and to articulate the precise manner in which the evidence supports his or her claim." *Id.* A party may not rely upon "unsubstantiated

assertions" as competent summary judgment evidence. *Id.*

II. The Antitrust Claim

Dr. Poliner alleges that by participating in the suspension of his privileges the Defendants: (1) entered into a combination and conspiracy in violation of Sections 1 and 2 of the Sherman Act and Section 4 of the Clayton Act; and (2) engaged in an unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983. The same elements are required to establish a violation of the Texas Free Enterprise and Anti-Trust Act and the comparable sections of the Sherman Act. Further the Texas statute is to be read in harmony with the Sherman Act. Thus, the Court will examine these claims together. *See Nafrawi v. Hendrick Med. Ctr.*, 676 F. Supp. 770, 774 (N.D. Tex. 1987) (citing Tex. Bus. & Com. Code Ann. § 15.05(a) (Vernon 1997)).

The Fifth Circuit has previously observed that the Sherman Act "does not purport to afford remedies for all torts committed by or against persons engaged in interstate commerce." *Kiepfer, M.D. v. Beller*, 944 F.2d 1213, 1221 (5th Cir. 1991) (citing *Larry R. George Sales Co. v. Cool Attic Corp.*, 587 F.2d 266, 272 (5th Cir. 1979). "The limited scope of the antitrust laws results from the fact that they are intended to protect *competition*, not necessarily *competitors*." *Id*. Thus, as an initial matter, an antitrust plaintiff must show not just that the defendants' actions injured him, but that they unreasonably restrained competition. *Id.* ("[f]ederal courts have consistently held that Section 1 of the Sherman Act prohibits only unreasonable

restraint of trade; in the ordinary case, alleged violations are judged by a 'rule of reason'").

Section 1 of the Sherman Antitrust Act forbids contracts, combinations, or conspiracies in restraint of trade or commerce. 15 U.S.C. § 1. To prevail on a section 1 claim, plaintiff must show that the defendants (1) engaged in a conspiracy, (2) that produced some anti-competitive effect, (3) in the relevant market. *Johnson, D.O. v. Hosp. Corp. of Am.*, 95 F.3d 383, 392 (5th Cir. 1996). Section 1 applies only to concerted action; unilateral conduct is excluded from its purview. *Id.*

The Court finds that Plaintiff has failed to establish that the suspension of his privileges was the result of anti-competitive concerted action on the part of the Defendants. Courts have cautioned that "[i]f the claim is one that simply makes no economic sense, respondents must come forward with more persuasive evidence to support their claim than otherwise would be necessary." *Johnson*, 95 F.3d at 393. Plaintiff contends that the AHC was made up of his competitors. Plaintiff asserts that over seventy percent of all cardiology procedures at PHD were performed by two groups, the North Texas Heart Center ("NTHC") and the Cardiology and Internal Medicine Association ("CIMA"). Plaintiff maintains that these two groups made up the AHC and wanted to eliminate plaintiff as a competitor. However, three of the six doctors on the AHC were not members of either NTHC or CIMA. These three doctors were independent doctors as was plaintiff. Apart from his general assertions, plaintiff has not presented any evidence of concerted anti-competitive action by the cardiologists at PHD.

Further plaintiff offers no explanation as to why the independent doctors on the AHC had any motive to eliminate plaintiff as a competitor. These doctors were in the same circumstances as plaintiff in that they were competing with the two large groups at PHD. Nor does plaintiff offer any explanation for why the two large cardiology groups did not turn their anti-competitive designs on these other independent doctors. The Court finds that there is no evidence that any of the individual doctor Defendants stood to benefit economically from the suspension of Plaintiff's privileges here. *See Rea, M.D. v. Hosp. Corp. of Am.*, 892 F. Supp. 821, 825 (N.D. Tex. 1993). Monitoring the competence of physicians through peer review is clearly in the public interest, and revocation or suspension of a physician's privileges because of legitimate concerns about the quality of patient care that he rendered is obviously a lawful objective. *Willman, M.D. v. Heartland Hosp. East*, 34 F.3d 605, 610 (8th Cir. 1994). Thus, plaintiff has not shown any anti-competitive conspiracy.

Nevertheless, even assuming the established proof of a conspiracy to suspend his privileges plaintiff must still show harm to competition sufficient to demonstrate a Section 1 violation because of the suspension of his cardiac cath lab and echocardiography privileges at the Hospital for part of 1998. *See Doctor's Hosp. of Jefferson, Inc. v. Southeast Med. Alliance, Inc.*, 123 F.3d 301 (5th Cir. 1997). To prove a Section 1 violation, plaintiff must show that defendants' activities caused an injury to competition. *Id.* at 307.

Dr. Poliner has not presented evidence that affiliation with the NTHC or CIMA was necessary to compete in the marketplace or that the suspension of his privileges somehow reflected injury to competition generally. Although the Court assumes for present purposes that Plaintiff was damaged as a result of his suspension and that Defendants intended to harm Dr. Poliner by suspending his privileges, Plaintiff cannot show that it rendered him unable to compete. At the time of his suspension, Plaintiff continued to have privileges at other hospitals in the area. The summary judgment evidence shows that plaintiff had full staff privileges at five other hospitals and courtesy privileges at two other hospitals at the time of his summary suspension. (Plf. App., Vol. 4, at 2428-29). Further, the number of providers available to the ultimate consumers was not reduced. Thus, the ability of purchasers to choose health care providers was unchanged as Dr. Poliner's services remained available to consumers at other health care facilities. Therefore, in the absence of any anticompetitive effect in any market, the Court holds that a jury could not properly find that Defendants' actions violated Section 1 of the Sherman Act.

Section 2 of the Sherman Act prohibits the monopolization or attempted monopolization of any part of interstate trade or commerce. 15 U.S.C. § 2. To prove monopolization, the plaintiff must demonstrate that the defendant had both the capacity and the intent to monopolize. *Seidenstein, M.D. v. Nat'l Medical Enter., Inc.*, 769 F. 2d 1100, 1105-1106 (5th Cir. 1985). In addition, to establish Section 2 violations premised on attempt and conspiracy to monopolize, a plaintiff must define the relevant market. *Doctor's*

Hosp. of Jefferson, 123 F.3d at 311. "To define a market is to identify producers that provide customers of a defendant firm (or firms) with alternative sources for the defendant's product or services." *Id.* The relevant product and geographic markets must reflect the realities of competition. *Id.*

Defendants here urge that the relevant market urged by Dr. Poliner and his experts is too narrowly drawn as it consists only of Defendant Hospital. The Court agrees. Notably, "every court that has addressed this issue has held or suggested that, absent an allegation that the hospital is the only one serving a particular area or offers a unique set of services, a physician may not limit the relevant geographic market to a single hospital." *Ginzberg, M.D. v. Memorial Healthcare Systems, Inc.,* 993 F. Supp. 998, 1013 (S.D. Tex. 1997). Defendants' expert opines that the relevant market is a seventeen county area around Dallas-Ft. Worth from which PHD attracted its cardiology patients. The court notes that all but two of the seventeen counties from which PHD drew its cardiology patients are north of Dallas. One county, Kaufman, is east and slightly southeast of Dallas, and the other, Henderson is southeast. (Def. App., Vol. 2, at 1065, 1076). Thus, an argument could be made that the realty of competition is that PHD draws its patients from Dallas County and areas to the north of Dallas County. The court finds that the relevant product market is, at least, the provision of inpatient invasive cardiology procedures. The relevant market is at least the City of Dallas north of Interstate 30, or north of downtown.

As noted above, Dr. Poliner had privileges at other hospitals after his privileges were suspended at PHD.[2] Plaintiff's summary judgment evidence establishes that he was able to treat some of his patients at other hospitals following his suspension at PHD. In establishing a Section 2 violation, plaintiff must present evidence concerning where the ultimate consumers of the relevant medical services could go for alternative services. *Doctor's Hospital* of *Jefferson v. Southeast Medical Alliance Inc.*, 123 F.3d at 311. Plaintiff has failed to produce any evidence that ultimate consumers of the relevant medical services could not turn to hospitals other than PHD to obtain the services. To the contrary, the evidence shows that consumers could and did utilize other hospitals after plaintiff lost his privileges at PHD. Although plaintiff's expert presents evidence that the two primary cardiology groups at PHD increased their share of business following plaintiff's suspension of privileges, plaintiff offers no evidence that PHD or the defendant doctors increased their business in the larger relevant market. Thus, because plaintiff's proposed relevant market is too narrow, evidence of what happened at PHD following plaintiff's suspension is not sufficient to establish that defendants had market power in the relevant market. That is, plaintiff has not shown that defendants had the ability or opportunity to dominate or to attempt to monopolize the larger relevant market outside PHD. *Id.* Therefore, plaintiff has failed to

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[2] The summary judgment evidence shows that PHD was the second largest provider of cardiology services in the Dallas-Ft. Worth area. (Def. App., Vol. 2 at 1067). Besides PHD, plaintiff had privileges at the third and eighth largest providers of cardiology services in the same area. (Plf. App., Vol. 4, at 2428-29).

establish that a fact issue exists with respect to his Sherman Act, Section 2 claim.

Defendants' motion for summary judgment is granted with respect to all of plaintiff's antitrust claims.

III. Procedural Rights Under the Medical Bylaws

Under Texas law, an important distinction exists between (a) medical bylaws, which are bylaws created by the medical staff to control the governance of the medical professionals with privileges at the hospital, and (b) hospital bylaws, which are a set of bylaws created by the hospital itself and adopted by its governing board. *See Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438 (Tex. Civ. App.- Texarkana 1994, writ denied). Under the former, it is generally understood that rights promulgated by *medical staff bylaws* are considered incapable of creating an enforceable contract between the hospital and its physicians. *See Weary v. Baylor Univ. Hosp.*, 360 S.W.2d 895, 897-898 (Tex. Civ. App.- Waco 1962, writ ref'd n.r.e.); *see also Stephen, M.D. v. Baylor Medical Ctr. at Garland*, 20 S.W.3d 880, 887 (Tex. Civ. App.- Dallas 2000, no writ). However, under the latter, procedural rights prescribed under *hospital bylaws* may constitute contractual rights between the physicians and the adopting hospital. *See Gonzalez*, 880 S.W.2d at 438-39; *see also Stephen*, 20 S.W.3d at 887. Federal courts applying Texas law have adhered to this view. *See Monroe v. AMI Hosp. of Tex., Inc.*, 877 F. Supp. 1022, 1029 n.5 (S.D. Tex. 1994) ("This court notes, however, under Texas law, a hospital's medical

staff bylaws do not constitute a contract between a hospital and its medical staff members").

PHD's bylaws provide that the "Medical/Dental Staffs' Bylaws shall provide a process for denying, withdrawing or qualifying staff privileges, which provides procedural due process for the member." PHD's Bylaws, Art. Eleven, § 11.04. In turn, the medical staffs' bylaws provide that summary suspension of privileges can be made when the conduct of the physician "constitutes a present danger to the health of his patients." Medical Staffs' Bylaws, Art. VIII - Part C: Section 2(a). PHD argues that because the Board of Trustees of the hospital retain the final authority with respect to suspensions, the medical staffs' bylaws do not create contractual rights for members of the staff. The court disagrees. The court finds that the hospital bylaws in this case are similar to the bylaws in *Gonzalez v. Sun Jacinto Methodist Hospital*, 880 S.W.2d 436 (Tex.-Texarkana 1994). In *Gonzalez*, the hospital bylaws provided that when a staff member's privileges were to be suspended or terminated the member was entitled to a hearing before the Medical Staff. The bylaws further provided that the hearing "shall be conducted formally under procedures adopted by the Board of Directors and contained in the Medical Staff Bylaws, Rules and Regulations to assure due process and afford full opportunity for the presentation of all pertinent information." In the present case, the hospital bylaws directed that the process for suspension of members' privileges was to by provided by the Medical Staffs' bylaws and were to provide for procedural due process for the member. As in *Gonzalez*, the bylaws of the PHD medical staff were subject to approval of the Board of

Trustees of PHD and were to provide procedural due process for the staff members. PHD Bylaws, Art. Eleven, §§ 11.02 & 11.04. Thus, the court finds that the hospital bylaws in the present case provided contractual procedural due process rights. As discussed below, the court has determined that there are fact issues as to whether defendant PHD breached its contractual obligations to insure procedural due process for plaintiff. Hence, PHD's motion for summary judgment is denied with respect to plaintiff's breach of contract claim.

IV. State Law Claims

As described above, Dr. Polinar brings several state law claims against all of the defendants. The defendants assert they are entitled to summary judgment on all of plaintiff's state law claims based upon immunity under the Healthcare Quality Improvement Act ("HCQIA"), 42 U.S.C. § 11111 *et seq.,* and the Texas Peer Review Immunity Statutes, Tex. Occ. Code Ann. § 160.001 *et seq.* These arguments will be addressed below.

A. The Healthcare Quality Improvement Act

The HCQIA was enacted to provide for effective peer review and interstate monitoring of incompetent physicians, and also to provide qualified immunity for peer review participants. *Austin v. McNamara, M.D.*, 979 F.2d 728, 733 (9th Cir. 1992). In furtherance of the latter goal, the HCQIA states that if a "professional

review action[3] of a professional review body[4] meets certain [specified] standards, then (A) the professional review body, (B) any person acting as a member or staff to the body, (C) any person under contract or other formal agreement with the body, and (D) any person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or any State . . . with respect to the action." *See* 42 U.S.C. § 11111(a) (2001).

In order for immunity to apply under the HCQIA, the professional review action must be taken:

(1) in the reasonable belief that the action was in furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

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[3] A "professional review action" means "an action or recommendation of a professional body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. *See* 42 U.S.C. § 11151(9).

[4] A "professional review body" means "an activity of a health care entity with respect to an individual physician -

(A) to determine whether the physician may have clinical privilege with respect to, or membership in, the entity;

(B) to determine the scope or condition of such privileges or membership; or

(C) to change or modify such privileges or membership.

See 42 U.S.C. § 11151(10).

> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3) [above].

See 42 U.S.C. § 11112(a). The Act also 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. *See* Id.; *see also Brader v. Allegheny Gen. Hosp.,* 167 F.3d 832, 839 (3rd Cir. 1999).

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." *Brader*, 167 F.3d at 839. With the purpose of the HCQIA and its burden allocations in mind, the Court shall now examine Plaintiff's specific arguments as to why immunity should not attach to Defendants for the peer review actions taken against him.

1. Reasonable Belief that the Action Furthered Quality Health Care

Dr. Poliner contends that he has raised material issues of fact as to whether Defendants were motivated by something other than a reasonable belief that their actions would further the care of the Hospital's patients. More specifically, Plaintiff alleges that the combination of the personal animosity toward him and the desire to eliminate an economic competitor resulted in a conspiracy to eliminate plaintiff from practicing at PHD. In making this examination, most courts have adopted an objective standard of reasonableness. *See Brader*, 167 F.3d at 839; *see also Sugarbaker, M.D. v. SSM Health Care*, 190 F.3d 905, 912-913 (8th Cir. 1999) *cert. denied.* 528 U.S. 1137 (2000); *Mathews, M.D. v. Lancaster Gen. Hosp.*, 87 F.3d 624, 635 (3rd Cir. 1996); *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F. 3d 1026, 1030 (4th Cir. 1994); *Egan v. Athol Memorial Hosp.*, 971 F. Supp. 37, 42 (D. Mass 1997), *affirmed* 134 F.3d 361 (1st Cir. 1998). That is, the focus of this inquiry is not whether the defendants' initial concerns are ultimately proven to be medically sound. Rather, the objective inquiry focuses on whether the professional action taken against plaintiff was taken "in the reasonable belief that the action was in the furtherance of quality health care." *See Sugarbaker*, 190 F.3d at 913.

In this case, the court finds that the summary judgment evidence creates a fact issue as to whether Dr. Poliner was summarily suspended on May 14, 1998. Defendants maintain that plaintiff agreed to an abeyance as provided in the hospital by-laws. However, the hospital by-laws require that the physician must

agree to the abeyance. Art. VIII, Part C: Section 3(a). Dr. Poliner maintains he was told by Dr. Knochel that if he did not agree to the abeyance, plaintiff's privileges would be summarily suspended. Dr. Knochel testified in his deposition that he told plaintiff that the only alternative to the abeyance was suspension. Thus, there is a fact issue as to whether plaintiff agreed to an abeyance or was instead summarily suspended. Assuming for summary judgment purposes that the abeyance was instead a summary suspension, the court must then determine whether that action was taken in accordance with the HCQIA. The HCQIA provides that the requirement of adequate notice and hearing procedures do not preclude immediate suspension of privileges subject to subsequent notice and hearing "where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 1112(c)(2). PHD's Medical Staff by-laws provide summary suspensions may be made when the acts of a physician "present a danger to the health of this patients . . . ." However, the HCQIA does require that summary suspensions be made only after a reasonable effort to obtain the facts of the matter. At the time he offered plaintiff the abeyance, Dr. Knochel knew of the ongoing investigations by the IMAC and of the incident in the cath lab on May 12, 1998. However, Dr. Knochel could not have made the decision to summarily suspend Dr. Poliner on the basis of the complaints then before the IMAC. Those complaints were initially made in September, October and December 1997 and were still under investigation in May 1998. Thus, those complaints could not have been considered by Defendants as "constituting an imminent danger to the health" of plaintiff's patients. Defendants also knew of the May 12 incident in the

emergency room concerning patient no. 36. However, before suspending plaintiff, defendants had not received the report from the IMAC, did not talk to Dr. Poliner about any specific complaints, and did not offer plaintiff the opportunity to give his side of the story and to address the concerns defendants had about plaintiff's conduct. Thus, if plaintiff was summarily suspended on May 14, 1998, the court finds there are fact issues as to whether defendants Levin, Harper, Knochel, and PHD: (1) acted in the reasonable belief that their action was in furtherance of quality health care; (2) acted after a reasonable effort to obtain the facts of the matter after procedures that were fair to Dr. Poliner under the circumstances; (3) reasonably believed immediate suspension was necessary because failure to act may have resulted in an imminent danger to the health of any person; and (4) acted with actual malice. Thus, defendants' Knochel, Levin, Harper, and PHD's motion for summary judgment is denied on the basis of immunity under the HCQIA.

Defendants Charles Harris, Anthony Das, David Musselman, Robert Brockie, Jorge Cheirif, Steven Meyer, and Martin Berk were sued by plaintiff because of their roles on the AHC or IMAC committee or because they participated in reviewing plaintiff's care of his patients. The court finds these defendants are entitled to summary judgment on the basis of the immunity provided by the HCQIA and the Texas Peer Review Immunity Statutes. As set forth above, the evidence establishes that the first documented review of plaintiff occurred after a nurse in the cath lab filled out a CERF against Dr. Poliner on September 29, 1997. Three CERFs were filed against Dr. Poliner by nurses in the cath lab in September, October, and

December 1997. By hospital policy, the CERFs were referred to the hospital's Clinical Risk Review Committee ("CRRC"). None of the defendants named in this suit were members of the CRRC. The CRRC reviewed two of the CERFs on January 12, 1998, identified several concerns with Dr. Poliner's patient care in the two cases, and referred the cases to the Internal Medicine Department for further review. The CRRC took up review of the CERF with respect to patient no. 9 on April 13, 1998, and that case was also referred to Internal Medicine Department. All three cases were then referred to the IMAC, the committee charged with investigating patient care concerns within the Internal Medicine Department. The IMAC was still reviewing the three cases involving Dr. Poliner when the May 12, 1998 incident involving patient no. 36 occurred. After obtaining the abeyance from plaintiff, Dr. Knochel appointed an Ad Hoc Committee ("AHC") composed of six cardiologists to review plaintiff's cath lab and echocardiogram privileges. The AHC was the hospital committee that performed the most thorough review of plaintiff's cases. Plaintiff asserts that the reviews were less than thorough and that the written reviews completed by the reviewing defendants were "so egregious that they are prima facie evidence of malice and intent to harm." (Plf.'s Brief in Resp. to Mot. For S.J. at 3). Plaintiff further argues that there is no evidence to establish that he was a danger to his patients at the time of his summary suspension on June 12, 1998. Plaintiff supports his argument with the testimony of several retained experts. After reviewing forty-four (44) of plaintiff's cases, the AHC concluded that plaintiff rendered substandard care in twenty-nine (29) of the cases. The IMAC then met to discuss the report of the

AHC. The IMAC was composed of several doctors only one of whom was a cardiologist. Thus, most of the members of the IMAC were not direct competitors of Dr. Poliner. The IMAC met and reviewed the report of the AHC and subsequently met and heard from Dr. Poliner. After hearing from the AHC and from Dr. Poliner, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges on June 12, 1998. Following plaintiff's appeal of his suspension, the Hearing Committee heard evidence over portions of three days. The Hearing Committee recommended restoration of Dr. Poliner's privileges, but also concluded that the suspension of Dr. Poliner's privileges was justified under the circumstances then existing. Dr. Poliner has agreed that the members of the hearing committee were not his competitors. In sum, the record establishes that the CRRC, the IMAC, and the hearing committee all had concerns with some of Dr. Poliner's practices. The overwhelming majority of the doctors on those committee were not competitors of Dr. Poliner. The recommendations of the AHC and the IMAC were made only after review of some of plaintiff's files and after hearing from plaintiff. The court cannot overlook this evidence in favor of plaintiff's personal beliefs and the opinions of hired experts. Moreover, there is no evidence in the record that any of the doctors on the CRRC, the IMAC or the hearing committee had any personal animosity towards plaintiff. Plaintiff's evidence of malice as to these defendants consists of instances where the defendants disagree with a finding or course of treatment followed by plaintiff after review of the patients' files. The court does not find this evidence sufficient to raise a fact issue of malice with respect to these defendants. These defendants were doing what

is customary in peer review processes, and plaintiff has not presented sufficient evidence to overcome the immunity conferred by the HCQIA.

2. Reasonable Fact Gathering

In order to qualify for HCQIA immunity, Defendants must also have made a reasonable effort to obtain the relevant facts. *See* 42 U.S.C. § 11112(a)(2). In assessing this issue, the Court must consider whether the totality of the process leading up to plaintiff's summary suspension evidenced a reasonable effort to obtain the facts of the matter. *See Matthews*, 87 F. 3d at 637; *see also Brader*, 167 F.3d at 831.

With respect to defendants Knochel, Harper, Levin and PHD, for the reasons stated above the court finds that their actions in summarily suspending plaintiff on May 14, 1998 were not made after a reasonable effort to obtain the facts in the case.

Plaintiff asserts here that the reviews conducted by the AHC were biased, incomplete, and filled with errors. Thus, plaintiff concludes those defendants did not make reasonable efforts to obtain the facts in this case. For reasons stated above, the court disagrees. Plaintiff's conclusion is drawn largely from the testimony of his experts. However, some of plaintiff's own experts acknowledged errors made by plaintiff. Additionally, plaintiff's arguments ignore that other doctors in the hospital, who were not direct competitors of plaintiff and who have not been shown to have had any ill will toward plaintiff, expressed concern with plaintiff's patient care. Plaintiff maintains that some of the personnel in the cath lab

were upset with him because of the emergency nature of his practice, and because some believed that cases plaintiff treated as emergencies were not really emergencies. However, apart from this general speculation, plaintiff provides no evidence that the specific complaints made by the cath lab nurses were motivated by ill will. More importantly, there has been no showing that the CRRC's referrals to the IMAC of the three CERFs filed against plaintiff were motivated by ill will. The CRRC's referral of the complaints to the Internal Medicine Department indicates that legitimate concerns about patient care were involved. None of the members of the CRRC are defendants in this case. None of the doctors on the CRRC were direct competitors of plaintiff, and none have been shown to have had any animosity against plaintiff. Similarly, only one member of the IMAC could be seen as a direct competitor of plaintiff. There is no evidence that the other members of the IMAC had animosity against plaintiff. Yet these doctors, after reviewing the report from the AHC and after hearing from plaintiff, recommended unanimously that plaintiff's privileges be suspended. The same is true of the Hearing Committee that heard plaintiff's appeal of his suspension. Although the committee recommended that plaintiff's privileges be restored, the committee also found that the summary suspension of plaintiff's privileges was proper under the evidence known at the time.

On the record as a whole, the court finds that the actions taken by Defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk, were sufficient to constitute a "reasonable effort to obtain the facts."

3. Adequate Notice and Hearing

Plaintiff maintains that he was not afforded adequate notice and hearing procedures in accordance with the HCQIA. Plaintiff complains that he was given only one hour to review the cases with IMAC, and that he was never given the opportunity to meet with the AHC who conducted the reviews. Plaintiff also complains that only one cardiologist was on the IMAC. However, plaintiff has not shown that the absence of cardiologists on the IMAC rendered the peer review process fundamentally unfair to him. Additionally, the court notes that there were no cardiologists on the Hearing Committee that recommended restoring plaintiff's privileges. The HCQIA requires that "adequate notice and hearing procedures" be afforded to the physician involved. 42 U.S.C. § 111112(a)(3). However, the HCQIA also provides that the notice and hearing requirements of the statute do not "preclude an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c). Plaintiff, relying on his testimony and the testimony of his experts, asserts that the defendants cannot show that imminent danger to any of his patients existed at the time of his summary suspension. For the reasons stated above, the court finds there is a fact issue with respect to plaintiff's summary suspension on May 14 1998.

However, the court finds that the actions of the AHC and the IMAC were taken after adequate notice to plaintiff and after a hearing. Plaintiff complains

that he was given insufficient time to respond to twenty-nine complex cases before the IMAC. However, prior to the hearing with the IMAC, plaintiff was given a list of the cases with which the IMAC had concerns. Plaintiff was then provided access to all of the records pertaining to those cases. Additionally, the letter of abeyance given to plaintiff on May 14, 1998 identified concerns with plaintiff's treatment of patients nos. 3, 9, 18, and 36. The immediate danger to patient safety concerns resulted from Dr. Poliner's treatment of patient no. 36. Although the abeyance letter did not specify the concerns with those patients, plaintiff had notice of concerns with those cases for almost four weeks prior to the hearing before the IMAC. Dr. Steven Rinner, an internist on the IMAC, identified the case of patient no. 36 as the one that concerned him the most and the reason that Dr. Rinner considered plaintiff a danger to his patients. The court cannot find on the record of this case that the proceedings of the AHC and the IMAC were such that plaintiff was not given a meaningful opportunity to address the concerns raised against him. Dr. Poliner requested additional time from Dr. Knochel to respond to the issues raised, and Dr. Knochel denied the request. However, there is no evidence that plaintiff asked the IMAC for additional time to respond or informed the IMAC that he had been given insufficient time to respond to the concerns raised about his patient care. On the record as a whole, the court concludes that Plaintiff was afforded adequate notice and hearing as required under the HCQIA with respect to the actions of the AHC and the IMAC. Accordingly, the defendant doctors on those committees are entitled to immunity, and summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie,

Cheirif, Meyer, and Berk as to all of plaintiff's state law claims against these defendants.

B. Texas Peer Review Immunity Statutes

In addition to the immunities granted by the HCQIA, the Act itself allows individual states to provide even further protection to medical peer review activities. *See Roe v. Walls Regional Hosp., Inc.*, 21 S.W.3d 647, 652 (Tex. Civ. App.- Waco 2000). Specifically, the HCQIA provides that: "nothing in this subchapter shall be construed as changing the liabilities or immunities under law or as preempting or overriding any State law which provides incentives, immunities, or protection for those engaged in a professional review action that is in addition to or greater than that provided by this subchapter." 42 U.S.C. § 11115(a); *see also St. Luke's Episcopal Hosp. v. Agbor*, 952 S.W.2d 503, 507 (Tex. 1997) ("even if the Federal Act does not apply . . . this provision specifically allows states to implement their own initiatives to provide greater immunities in professional review actions than those the Federal Act provides").

To this end, the Texas Legislature in 1987 enacted section 5.06 of the Texas Medical Practice Act ("TMPA"), which under section 5.06 provided:

> (*l*) A cause of action does not accrue against the members, agents, or employees of a medical peer review committee or against the health-care entity from any act, statement, determination or recommendation made, or act

> reported, without malice, in the course of peer review as defined by this Act.
> (m) A person, health-care entity, or medical peer review committee, that, without malice, participates in medical peer review actively or furnishes records, information, or assistance to a medical peer review committee or the board is immune from any civil liability arising from such an act.

See Roe, 21 S.W.3d at 653 (*citing* Tex. Rev. Civ. Stat. Ann. art. 4495b § 5.06(*l*), (m) (repealed)). Thereafter, in 1989, the Texas Legislature enacted sections 161.031-161.033 of the Health and Safety Code, extending peer review immunity to members of a "medical committee":

> A member of a medical committee is not liable for damages to a person for an action taken or recommendation made within the scope of the functions of the committee if the committee member acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to the committee member.

See Roe, 21 S.W.3d at 65 *(citing* Tex. Health & Safety Code Ann. § 161.033 (Vernon 1992).

Currently codified in the Texas Occupations Code, immunity from civil liability is provided to:

> (1) a person who, in good faith, reports or furnishes information to a medical peer review committee or the board;

> (2) a member, employee or agent of the board, a medical peer review committee, or a medical organization district or local intervenor, who takes an action or makes a recommendation within the scope of the functions of the board, committee, or intervenor program, *if that member, employee, agent, or intervenor acts without malice and in the reasonable belief that the action or recommendation is warranted by the facts known to that person;* and
> (3) a member or employee of the board or any person who assists the board in carrying out its duties or functions provided by law.

Tex. Occ. Code Ann. § 160.010 (a) (Vernon 2001) (emphasis added). As such, Texas has clearly taken the additional step of providing for more protection to the activity of medical peer reviews than those which the HCQIA provides. *See Roe,* 21 S.W.3d at 653 (citing *Agbor,* 952 S.W.2d at 507). Thus, the qualified immunity from liability conferred by these statutes to defendants can be defeated only by a showing that they acted with actual malice. *See Id.* The court now turns to the issue of whether plaintiff has provided summary judgment evidence raising a genuine issue of material fact on the question of malice.

C. Malice

In the context of the Texas peer review immunity statutes, actual malice is the standard by which defendants' conduct is measured. *Johnson v. Hospital Corp. of America,* 95 F.3d 383, 395 (5th Cir. 1996). Actual malice means "the making of a statement with knowledge that it is false, or with reckless disregard of

whether it is true." *Duffy v. Leading Edge Products, Inc.*, 44 F.3d 308 at 313 (5th Cir. 1995) (internal citations and quotations omitted). "Reckless disregard" means that a statement is made with "a high degree of awareness of probable falsity." *Id.* When a qualified privilege is asserted as an affirmative defense, which the defendants have done, whether the statements are true is of no moment, unless there is clear evidence of actual malice. A plaintiff must show that the defendant acted with actual malice in order to overcome the affirmative defense of qualified privilege. *ContiCommodity Services, Inc. v. Ragan,* 63 F.3d 438, at 443 (5th Cir. 1995). If a fact question exists whether a statement or comment was made with actual malice, that statement automatically loses qualified privilege status, and summary judgment would be inappropriate. *See Bozéé v. Branstetter,* 912 F.2d 801, 807 (5th Cir. 1990). In the context of the summary judgment motion, plaintiff must raise a fact issue of actual malice rather than defendants prove the absence of malice. *Duffy v. Leading Edge,* 44 F.3d at 314. "Negligence, lack of investigation, or failure to act as a reasonably prudent person are insufficient to show actual malice." *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.)). However, inadequate investigation coupled with the presence of ulterior motives may be sufficient to raise a fact issue as to actual malice. *Id.* at 315.

In the present case, there is not simply a claim of inadequate investigation, but a complete failure to investigate and to gather all of the facts from both sides before Dr. Knochel summarily suspended plaintiff's privileges by telling plaintiff to sign the

abeyance letter or face immediate suspension. Viewing the summary judgment in light most favorable to plaintiff, there is evidence that defendants Knochel, Harper, Levin, and PHD violated their own bylaws as well as the HCQIA in summarily suspending Dr. Poliner's privileges. Additionally, plaintiff presents evidence that some of the defendants involved in the summary suspension of May 14 harbored animosity against plaintiff. Thus, the court finds that a fact issue exists with respect to whether defendants Knochel, Harper, Levin and PHD acted with actual malice. These defendants' motion for summary judgment on the basis of immunity conferred by the Texas peer review statutes is denied.

With respect to defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk, the court finds plaintiff has failed to raise an issue of malice, and summary judgment is granted in favor of these defendants as to all of plaintiff's state law claims against them.

VII. Interference with Contractual Relations

Plaintiff brings a related claim against all the Defendants for the wrongful and intentional interference with his business and contractual relationships with his existing and prospective patients. *See* Pl.'s Third Amend. Compl. at ¶¶ 123-127. To recover for tortious interference with an existing contract, the plaintiff must prove: (1) the existence of a contract subject to interference, (2) the act of interference was willful and intentional, (3) such intentional act was a proximate cause of plaintiff's damage and (4) actual damage or loss occurred. *See*

Johnson v. Hospital Corp. of America, 95 F.3d 383, 394 (5th Cir. 1996) (citing *Victoria Bank & Trust Co. v. Brady*, 811 S.W.2d 931, 939 (Tex. 1991). Having determined that fact issues exist with respect to whether defendants Knochel, Levin, Harper and PHD acted with malice, the court denies these defendants' motion on the grounds that their conduct was privileged or protected by the peer review immunity statutes. Additionally, there is a fact issue as to whether defendants wrongfully suspended plaintiff's privileges. If the jury finds that defendants wrongfully suspended plaintiff's privileges, this would satisfy the independent tort requirement of *Wal-Mart Stores, Inc. v. Sturges*, 52 S.W.3d 711 (Tex. 2001). Defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk's motion for summary judgment as to plaintiff's tortious interference with business claim is granted since plaintiff has not established a fact issue that these defendants acted with malice.

VIII. Defamation and Business Disparagement Claims

Defendants move for summary judgment on the grounds that the personal defamation claims are barred by the one year statute of limitations. With respect to the business disparagement claims, defendants assert that the allegedly defamatory statements were true and the statements were entitled to a qualified privilege. To sustain a claim involving statements that enjoy a qualified privilege, plaintiff must show that defendants' publication of the statements was motivated by actual malice at the times the statements were made.

Plaintiff concedes that the personal defamation claims are subject to a one year statute of limitations. However, Plaintiff maintains that each publication of the statements gives rise to a separate cause of action. *Carr v. Mobile Video Tapes, Inc.*, 893 S.W.2d 613, 619 (Tex. App.- Corpus Christi 1995, no writ). Additionally, plaintiff alleges that he was forced to publish his suspension of privileges when he has applied or reapplied for privileges and to state agencies and to third party payors. Texas courts recognize the narrow category of cases of self-compelled defamation. *Purcell v. Seguin State Bank and Trust Co.* 999 F.2d 950, 959 (5th Cir. 1993). Plaintiff presents evidence of publication within one year of the filing of this suit. Defendants' Knochel, Levin, Harper and PHD's motion for summary judgment as to plaintiff's personal defamation claims is denied.

With respect to the business disparagement claims, the court has previously found that a fact issue exists as to whether defendants acted with actual malice. Thus, even if the statements enjoy a qualified privilege, the existence of a fact issue on the issue of actual malice precludes summary judgment for these defendants on this claim. Defendants also contend that the statements concerning Dr. Poliner's suspension were true. However, the court has determined that a fact issue exists as to whether defendants suspended plaintiff because of a belief of an imminent danger to plaintiff's patients or for other reasons. Hence, defendants' Knochel, Levin, Harper and PHD's motion for summary judgment with respect to plaintiff's business disparagement claims is denied. Summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk on

plaintiff's personal defamation and business disparagement claims.

IX. INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

To recover on a claim of Intentional Infliction of Emotional Distress, a plaintiff must establish that 1) the defendant acted intentionally or recklessly, 2) the conduct was "extreme and outrageous", 3) the actions of the defendant caused plaintiff emotional distress, and 4) the resulting emotional distress was severe. *Twyman v. Twyman,* 855 S.W.2d 619, 621-22 (Tex. 1993). Whether a defendant's conduct is extreme and outrageous is a question of law. *Brewerton v. Dalrymple*, 997 S.W.2d 212, 216 (Tex. 1999). The fact that a defendant's conduct is tortious or otherwise wrongful does not, standing alone, necessarily render it extreme and outrageous. *id.* To be extreme and outrageous, a defendant's conduct must be "so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized community." *GTE Southwest, Inc. v. Bruce,* 998 S.W.2d 605, 611 (Tex. 1999).

Because the court has found that a fact issue exists as to whether defendants Knochel, Levin, Harper, and PHD acted with actual malice, summary judgment is denied as to these defendants on plaintiff's intentional infliction of emotional distress claim. However, summary judgment is granted in favor of defendants Harris, Das, Musselman, Brockie, Cheirif, Meyer, and Berk on this claim.

X. Deceptive Trade Practices Act Claims

Defendants move for summary judgment on plaintiff's Texas Deceptive Trade Practices Act claim on the grounds that plaintiff is not a consumer under the TDPA. A "consumer" under the TDPA is someone who sought or acquired, by purchase or lease, goods or services. *Amstadt v. U.S. Brass Corp.,* 919 S.W.2d 644, 649 (Tex. 1996). The summary judgment evidence does not establish that plaintiff is consumer of the hospital with respect to his privileges at the hospital. Clearly, plaintiff was not a consumer with respect to the individual defendants in this case. Summary judgment is granted in favor of all defendants on plaintiff's TDPA claim.

XI. Miscellaneous Motions

Plaintiff filed a motion to amend complaint on July 11, 2002 seeking to include as a plaintiff in this case Lawrence Poliner, M.D., P.A., a sub-chapter S corporation organized under the laws of the State of Texas wholly owned by Dr. Poliner. Defendants object to the amendment asserting the amendment is untimely and prejudicial to defendants. Federal Rule of Civil Procedure 15(a) provides for amendment by leave of court and requires that leave be freely granted when justice requires. Plaintiff's proposed amendment does not add new claims or theories of recovery. It appears that defendants have known of the existence of the P.A. for some time, and the court does not find that allowing the amendment will cause prejudice to defendant. Plaintiff's motion to amend complaint is GRANTED.

Defendants' objections to plaintiff's summary judgment evidence and plaintiff's supplemental summary judgment evidence are DENIED as moot except where the court finds it necessary to rule on a specific objection in deciding this motion for summary judgment. Defendants also filed a motion to limit the number of expert witnesses. In light of the court's rulings on this motion for summary judgment, the testimony of some of these experts may no longer be necessary. Accordingly, defendants' motion is DENIED at this time. The court, however, cautions the parties about presenting unnecessary, cumulative evidence. The court will revisit the issue of limiting the number of expert witnesses at the pretrial conference, or by motion, if raised by the parties. However, any ruling limiting the number of experts will not be on the basis of when depositions of the experts were taken.

So Ordered.

Signed this 30th day of September 2003.

/s/Jorge A. Solis
Jorge A. Solis
United States District Judge

APPENDIX E

IN THE UNITED STATES DISTRICT COURT
FOR THE NORTHERN DISTRICT OF TEXAS
DALLAS DIVISION

CIVIL ACTION NO. 3-00-CV-1007-P

[Filed August 26, 2004]

LAWRENCE R. POLINER, M.D., and LAWRENCE R. POLINER, M.D., P.A.,	)
Plaintiffs,	)
v.	)
TEXAS HEALTH SYSTEMS, A TEXAS NON-PROFIT CORPORATION, d/d/a PRESBYTERIAN HOSPITAL OF DALLAS; JAMES KNOCHEL, M.D., CHARLES LEVIN, M.D.; and JOHN HARPER, M.D.,	)
Defendants.	)

COURT'S CHARGE TO THE JURY

MEMBERS OF THE JURY:

Now that you have heard all of the evidence, it becomes my duty to give you the instructions of the Court concerning the law applicable to this case.

It is your duty as jurors to follow the law as I shall state it to you, and to apply that law to the facts as you find them from the evidence in the case. You are not to single out one instruction alone as stating the law, but must consider the instructions as a whole. Neither are you to be concerned with the wisdom of any rule of rule stated by me.

Regardless of any opinion you may have as to what the law is or ought to be, it would be a violation of your sworn duty to base a verdict upon any view of the law other than that given in the instructions of the Court, just as it would also be a violation of your sworn duty, as judges of the facts, to base a verdict upon anything other than the evidencc in the case.

In deciding the facts of this case, you must not be swayed by bias or prejudice or favor as to any party. A corporation and all other persons are equal before the law and must be treated as equals in a court of justice. Our system of law does not permit jurors to be governed by prejudice or sympathy or public opinion. Both the parties and the public expect that you will carefully and impartially consider all of the evidence in the case, follow the law as stated by the Court in these instructions, and reach a just verdict regardless of the consequences.

A corporation is responsible for the acts of its officers, agents, or employees that are done within the scope of their authority delegated to them by the

corporation, or within the scope of their duties as employees of the corporation. An "employee" is a person in the service of another with the understanding, express or implied, that such other person has the right to direct the details of the work and not merely the result sought to be accomplished. A party is an "agent" of another party if the party acts with the other party's authority. Authority for another to act for a party must arise from the party's agreement that the other act on behalf and for the benefit of the party. If a party so authorizes another to perform an act, that other party is also authorized to do whatever else is proper, usual, and necessary to perform the act expressly authorized.

As stated earlier, it is your duty to determine the facts, and in so doing you must consider only the evidence I have admitted in the case. The term "evidence" includes the sworn testimony of the witnesses, the exhibits admitted in the record, and stipulated facts. Stipulated facts must be accepted as proven facts. Any evidence as to which an objection was sustained by the Court and any evidence ordered stricken by the Court, must be entirely disregarded.

Remember that any statements, objections or arguments made by the lawyers are not evidence in the case. The function of the lawyers is to point out those things that are most significant or most helpful to their side of the case, and in so doing, to call your attention to certain facts or inferences that might otherwise escape your notice. In the final analysis, however, it is your own recollection and interpretation of the evidence that controls in the case. What the lawyers say is not binding upon you.

Generally speaking, there are two types of evidence which a jury may consider in properly finding the truth as to the facts in this case. One is "direct" evidence – such as testimony of an eyewitness. The other is "indirect" or "circumstantial" evidence – the proof of a chain of circumstances which points to the existence or nonexistence of certain facts. As a general rule, the law makes no distinction between direct and circumstantial evidence, but simply requires that the jury find the facts from a preponderance of all the evidence, both direct and circumstantial.

So, while you should consider only the evidence in the case, you are permitted to draw such reasonable inferences from the testimony and exhibits as you feel are justified in the light of common experience. In other words, you may make deductions and reach conclusions which reason and common sense lead you to draw from the facts which have been established by the testimony and evidence in the case.

Now, I have said that you must consider all of the evidence. This does not mean, however, that you must accept all of the evidence as true or accurate. You are the sole judges of the credibility or "believability" of each witness and the weight to be given to his or her testimony. In weighing the testimony of a witness, you should consider his or her relationship to Plaintiff or to Defendant; his or her interest, if any, in the outcome of the case; his or her manner of testifying; his or her opportunity to observe or acquire knowledge concerning the facts about which he or she testified; his or her candor; fairness and intelligence; and the extent to which he or she has been supported or contradicted by other credible evidence. You may, in

short, accept or reject the testimony of any witness in whole or in part.

Also, the weight of the evidence is not necessarily determined by the number of witnesses testifying as to the existence or nonexistence of any fact. You may find that the testimony of a smaller number of witnesses as to any fact is more credible than the testimony of a larger number of witnesses to the contrary.

During the trial of this case, certain testimony has been read to you by way of depositions, consisting of sworn answers to questions asked of the witnesses in advance of trial. Such testimony is entitled to the same consideration and is to be judged as to credibility, and weighed, and otherwise considered by the jury in the same way, insofar as possible, as if the witness had been present and had given from the witness stand the same testimony as given in the deposition.

I will instruct you as to which party has the burden of proof on each essential element of its claim in the case. The party having the burden of proof on each issue of fact must prove that fact by a "preponderance of the evidence." A preponderance of the evidence means such evidence as, when considered and compared with that opposed to it, has more convincing force and produces in your minds a belief that what is sought to be proved is more likely true than not true. In other words, to establish a claim by a preponderance of the evidence merely means to prove that the claim is more likely so than not so.

In determining whether any fact in issue has been proved by a preponderance of the evidence, you the

jury may consider the testimony of all the witnesses, regardless of who may have called them, and all the exhibits received in evidence, regardless of who may have introduced them. If the proof should fail to establish any essential element of Plaintiffs' claim by a preponderance of the evidence, the jury should find for Defendants as to that claim. If the proof should fail to establish by a preponderance of the evidence any essential element of a defense raised by the Defendants, the jury should find for the Plaintiffs as to that defense.

A witness may be "impeached" or discredited by contradictory evidence, by a showing that he or she testified falsely concerning a material matter, or by evidence that at some other time be or she said or did something, or failed to say or do something, which is inconsistent with the witness' present testimony.

If you believe that any witness has been so impeached, it is in your exclusive province to give the testimony of that wittness such credibility or weight, if any, as you think it deserves.

In answering the questions which I will submit to you, answer "yes" or "no" unless otherwise instructed. A "yes" answer must be based on a preponderance of the evidence. If you do not find that a preponderance of the evidence supports a "yes" answer, then answer "no."

You should not interpret the fact that I have given instructions about Plaintiffs' damages as an indication in any way that I believe that Plaintiffs should, or should not, win this case.

After I have completed reading these instructions and reviewing the verdict form and jury questions with you, counsel will have the opportunity to make their closing arguments.

Your verdict must represent the considered judgment of each juror. In order to return a verdict, it is necessary that all members of the jury agree to each question. You therefore may not enter into an agreement to be bound by a majority or any vote other than a unanimous one.

Remember at all times that you are not partisans. Rather, you are judges – judges of the facts. Your sole interest is to seek the truth from the evidence in the case.

Upon retiring to the jury room, you should first select one juror to act as your presiding officer who will preside over your deliberations and will be your spokesperson here in Court. A verdict form has been prepared for your convenience. Your presiding officer will sign in the space provided below after you have reached your verdict.

If, during your deliberations, you wish to communicate with the Court, you should do so only in writing by a note handed to the Deputy Marshal and signed by the presiding officer. During your deliberations, you will set your own work schedule, deciding for yourselves when and how frequently you wish to recess and for how long.

After you have reached your verdict, you will return these instructions together with your written answers

to the questions that I will submit to you. Do not reveal your answers until such time as you are discharged, unless otherwise directed by me.

Date: August 26th, 2004.

/s/
JORGE A. SOLIS
UNITED STATES DISTRICT JUDGE

HEALTH CARE QUALITY IMPROVEMENT ACT ("HCQIA")

HCQIA was passed by Congress to improve the quality of medical care by encouraging physicians to identify and discipline physicians who are incompetent or who engage in unprofessional behavior. This process is referred to as peer review. As you are aware, this lawsuit arises from Plaintiffs' claim that the Defendants misused the peer review process when his privileges were suspended on May 14, 1998 and on May 29, 1998.

Plaintiffs claim that the Defendants' actions on or before May 14, 1998 and on May 29, 1998 were in reality a suspension of his privileges because he only signed the abeyance under the threat of immediate suspension of all of his privileges. Defendants claim that Dr. Poliner voluntarily agreed to accept the abeyance.

HCQIA provides that an immediate suspension or restriction of clinical privileges may be made, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action

may result in an imminent danger to the health of any individual. The Presbyterian Medical Staff Bylaws provide that when the acts of a practitioner through his lack of competence, or failure to care adequately for his patients constitutes a present danger to the health of his patients, all or any of the clinical privileges of a practitioner may be summarily suspended. Under the law, Defendants had the legal right to suspend or to threaten to suspend Dr. Poliner's privileges on May 14, 1998 and on May 29, 1998 if the failure to take such an action may have resulted in an imminent danger to the health of any individual or if Dr. Poliner constituted a present danger to the health of his patients. In determining whether the Defendants are entitled to the immunity afforded by the HCQIA, you must only consider the events and actions that occurred on or before May 14, 1998 and May 29, 1998.

QUESTION NO. 1

Plaintiff has the burden of proof on this question. Do you find by a preponderance of the evidence that the Defendants did not have a reasonable belief on or before May 14, 1998 or May 29, 1998 that Dr. Poliner posed an imminent danger to the health of any individual or that Dr. Poliner constituted a present danger to the health of his patients?

Answer "Yes, the Defendants did not have a reasonable belief" or "No, the Defendants did have a reasonable belief".

James Knochel, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes

May 29, 1998 ANSWER: Yes

If you have answered "No" as to all Defendants in Question No. 1, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions. If you have answered "Yes" as to any Defendant in Question No. 1, proceed to the section entitled Abeyance and answer Question No. 2.

ABEYANCE

The Medical Staff Bylaws provide that in order to constitute an abeyance, the action affecting Dr. Poliner's privileges must be agreed to by him. If you find by a preponderance of the evidence that Dr. Poliner's agreement to the May 14, 1998 letter or to the May 29, 1998 letter was caused by duress, if any,

imposed by the Defendants, you may not find that Dr. Poliner agreed to the abeyance. Duress is the mental, physical, or economic coercion of another, causing that party to act contrary to his or her free will and interest.

QUESTION NO. 2

Do you find by a preponderance of the evidence that Dr. Poliner did not agree to the abeyance on May 14, 1998 or on May 29, 1998?

Answer "Yes, Dr. Poliner did not agree to the abeyance" or "No, Dr. Poliner did agree to the abeyance" as to May 14, 1998.

ANSWER: Yes

Answer "Answer "Yes, Dr. Poliner did not agree to the abeyance" or "No, Dr. Poliner did agree to the abeyance" as to May 29, 1998.

ANSWER: Yes

Proceed to the section entitled HCQIA Immunity and answer Question No. 3.

HCQIA IMMUMITY

The HCQIA provides that if a professional review action meets the standards set forth below, then the professional review body, any person acting as a member or staff to the body, any person under a contract or other formal agreement with the body, and any person who participates with or assists the body

with respect to the action, shall not be liable in damages under any law of the United States or of any State with respect to the action. Specifically, a professional review action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

A "professional review action" is an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. You are instructed that the actions of Defendants with respect to the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and May 29, 1998 were "professional review actions" pursuant to the provisions of federal law cited above.

A "professional review activity" is an activity of a health care entity with respect to an individual physician –

> (a) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
> (b) to determine the scope or conditions of such privileges or membership, or
> (c) to change or modify such privileges or membership.

A "professional review body" is a health care entity and the governing body or any committee of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professionnl review activity.

To satisfy the first element, you must be satisfied that Defendants, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients.

In determining whether the Defendants made a reasonable effort to obtain the facts of the matter, you must consider the totality of the process leading up to the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and on May 29, 1998.

QUESTION NO. 3

Do you find by a preponderance of the evidence that the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and on May 29, 1998 was not undertaken:

(1) in the reasonable belief that the action was in the furtherance of quality health care?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(2) after a reasonable effort to obtain the facts of the matter?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Presbyterian Hospital

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

(4) and in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)?

Answer "Yes, it was not undertaken" or "No, it was undertaken" as to each Defendant.

James Knochel, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

Charles Levin, M.D.

May 14, 1998 ANSWER: Yes
May 29, 1998 ANSWER: Yes

John Harper, M.D.

May 14, 1998	ANSWER: Yes
May 29, 1998	ANSWER: Yes

Presbyterian Hospital

May 14, 1998	ANSWER: Yes
May 29, 1998	ANSWER: Yes

If you have answered "Yes, it was not undertaken" to any Defendant as to any part of Question No. 3, proceed to the section entitled Texas Peer Review Immunity Statutes and answer Question No. 4. If you have answered "No, it was undertaken" as to each Defendant as to all parts of Question No. 3, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

TEXAS PEER REVIEW IMMUMTY STATUTES

In addition to the requirements of HCQIA, Texas law provides that a person, in good faith or without malice, who reports or furnishes information to a medical peer review committee, is immune from civil liability. Texas law further provides immunity from civil liability to a member of a medical peer review committee who takes an action within the scope of the functions of the committee, if that employee or agent acts without malice and in the reasonable belief that the action is warranted by the facts known to that person.

Malice is the making of a statement with knowledge that it is false, or with reckless disregard of

whether it is false. Reckless disregard means that a statement is made with a high degree of awareness of probable falsity.

You are instructed that the actions of the Defendants in connection with May 14, 1998 and May 29, 1998 were actions taken in the course of medical peer review as provided by Texas state law described above.

QUESTION NO. 4

Do you find by a preponderance of the evidence that any of the following Defendants took an action within the scope of the functions of a medical peer review committee, with malice and not in the reasonable belief that the action was warranted by the facts known to that person?

Answer "Yes, Defendant acted with malice and not in the reasonable belief" or "No, Defendant acted without malice and in the reasonable belief" as to each Defendant.

James Knochel, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

Do you find by a preponderance of the evidence that any of the following Defendants, with malice and not

in good faith, reported or furnished information to a medical peer review committee?

Answer "Yes, Defendant acted with malice and not in good faith" or "No, Defendant acted without malice and in good faith" as to each Defendant.

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

If you have answered "Yes" as to any Defendant listed in Question No. 4, proceed to the section entitled Release and answer Question No. 5. If you have answered "No" as to all Defendants listed in Question No. 4, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

RELEASE

Defendants claim that Dr. Poliner released any claims he had against Defendants by virtue of the language in Dr. Poliner's Application for Appointment. Dr. Poliner's Application for Appointment signed on May 30, 1996 extends immunity to, releases, and holds harmless from any and all liability Presbyterian Hospital, its representatives, and its Medical Staff for summary suspensions made in good faith and without malice.

QUESTION NO. 5

Defendants have the burden of proof on this question. Do you find by a preponderance of the evidence that the Defendants' suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 and May 29, 1998 were made in good faith and without malice, and thus, effectively released Defendants from all claims asserted by Plaintiffs?

Answer "Yes" or "No".

May 14, 1998 ANSWER: No

May 29, 1998 ANSWER: No

If you have answered "Yes" to Question No. 5, proceed to the last page entitled Certificate, sign the verdict form, and do not answer my further questions. If you have answered "No" to Question No. 5, proceed to the section entitled Breach of Contract Damages and answer Question No. 6.

BREACH OF CONTRACT DAMAGES

Answer Question No. 6 only if you have answered "Yes" as to any Defendant in Questions No. 1 and 2.

QUESTION NO. 6

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his damages, if any, that resulted from Presbyterian Hospital's failure to comply with its Bylaws?

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

Answer in dollars md cents for damages, if any

loss of earnings Answer: 30,000,000.00

Proceed to the section entitled Defamation and answer Question No. 7.

DEFAMATION

Defamation is a defamatory statement orally communicated or published to a third person without legal excuse. Defamation is divided into two categories: libel and slander. Libel is the publication of a written statement without legal excuse, whereas slander is the publication of an oral statement without legal excuse.

In order to recover on his claim of defamation, Dr. Poliner must prove by a preponderance of the evidence that Defendants published a defamatory statement concerning Dr. Poliner. A defamatory statement is one in which the words tend to damage a person's reputation, exposing him or her to public hatred, contempt, ridicule, or financial injury, or deterring third persons from associating or dealing with him.

A statement is published if it is communicated orally, in writing, or in print to some third person

capable of understanding their defamatory import and in such a way that the third person did so understand. A defamatory statement can be published by conduct. A statement is published by conduct when the communication is made and understood without words. To be actionable in defamation, a statement must contain an assertion of an objectively verifiable fact. Self-publication occurs when the plaintiff communicates a defamatory statement to a third party. An exception to the rule that the defendant must publish a statement exists when a reasonably prudent person would have expected that the plaintiff would communicate the defamatory statement to a third party.

QUESTION NO. 7

Do you find by a preponderance of the evidence that any of the following Defendants published a defamatory statement referring to Dr. Poliner in connection with the suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 7, proceed to answer Question No. 8. If you have answered "No" as to all Defendants in Question No. 7, proceed to the section entitled Business Disparagement and answer Question No. 12.

QUESTION NO. 8

Defendants have the burden of proof on this question. With respect to the defamatory statements found in Question No. 7, do you find by a preponderance of the evidence that all such defamatory statements were true?

Answer "Yes" or "No".

ANSWER: No

If you have answered "No" to Question No. 8, proceed to answer Question No. 9. If you have answered "Yes" to Question No. 8, proceed to the section entitled Business Disparagement and answer Question No. 12.

DEFAMATION PER SE

Defamation *per se* consists of defamatory statements so obviously hurtful to the person aggrieved that they require no proof of their injurious character to make them actionable. To maintain a claim for defamation *per se*, the defamatory statement must involve the imputation of serious misconduct or impropriety (such as the commission of a crime), or that the statement must affect a person injuriously in his or her office, profession, or occupation.

QUESTION NO. 9

Do you find by a preponderance of the evidence that any of the following Defendants published a statement referring to Dr. Poliner that was defamatory *per se* in connection with the peer review action taken on or before May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

Regardless of whether you have answered "Yes" or "No" to Question No. 9, proceed to answer Question No. 10.

QUALIFIED PRIVILEGE

As a defense to libel or slander, a qualified privilege extends to communications made in good faith on a subject in which the author has an interest or duty to another person having a corresponding interest or duty. The qualified privilege is lost, however, if the defamatory statement is in any degree actuated by malice. Malice is publication with the knowledge that the communication was false or with reckless disregard for whether it was false.

QUESTION NO. 10

Question No. 10(A) Defendant has the burden of proof on this question. With respect to each of the statements found by you in response to Question No. 7, do you find by the preponderance of the evidence that any of the Defendants had an interest or duty to another person having a corresponding interest or duty regarding the peer review action taken on May 14, 1998 or May 29, 1998?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: No

Charles Levin, M.D.

ANSWER: No

John Harper, M.D.

ANSWER: No

Presbyterian Hospital

ANSWER: No

If you have answered "Yes" as to any Defendant in Question No. 10(A), proceed to answer Question No. 10(B) with respect to such Defendant(s). If you have answered "No" as to all of the Defendants in Question No. 10(A), proceed answer Question No. 11.

Question No. 10(B) Plaintiff has the burden of proof on this question. With respect to the statements identified by you in Question 10(A), do you find by a preponderance of the evidence that Defendants made such statements with malice?

James Knochel, M.D.

ANSWER: _____

Charles Levin, M.D.

ANSWER: _____

John Harper, M.D.

ANSWER: _____

Presbyterian Hospital

ANSWER: _____

If you have answered "Yes" as to any Defendant in Question No 10(B), proceed to answer Question No. 11 with respect to such Defendant(s). If you have answered "No" as to all of the Defendants in Question No. 10, proceed to the section entitled Business Disparagement and answer Question No. 12.

DEFAMATION DAMAGES

If you answered "Yes" to Question 9 as to any Defendant, then Dr. Poliner is presumed to have suffered general damages and you may estimate the amount of general damages without additional evidence. General damages may include injury to career and reputation and mental anguish. If you answered "No" to Question 9, then Dr. Poliner is not presumed to have suffered general damages, and you must assess what damages were proximately caused by such defamatory statements. In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and/or May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

"Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

QUESTION NO. 11

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his damages, if any, proximately caused by any such defamatory statements?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant.

Answer in dollars and cents as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 20,000,000.00

mental anguish
ANSWER: 20,000,000.00

Charles Levin, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

John Harper, M.D.

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

Presbyterian Hospital

loss of earnings
ANSWER: 10,526.55

injury to career and reputation
ANSWER: 15,000,000.00

mental anguish
ANSWER: 15,000,000.00

Proceed to the section entitled Business Disparagement and answer Question No. 12.

BUSINESS DISPARAGEMENT

Whereas an action for defamation protects the personal reputation of nn injured person, an action for business disparagement protects the economic interests of the injured party against lost earnings. To recover on a claim of business disparagement, Lawrence Poliner, M.D., P.A. must pxove the following:

(1) that a Defendant published a false, disparaging statement;
(2) that the statement concerned the economic interests of Lawrence Poliner, M.D., P.A.; and

(3) that the statement was made with knowledge of the falsity of the disparaging statement or with reckless disregard concerning its falsity, or with spite, ill will, and evil motive, or intending to interfere in the economic interests of the Lawrence Poliner, M.D., P.A.

A statement is disparaging if it is understood to cast doubt upon the quality of another's land, chattels or intangible things, or upon the existence or extent of his or her property in them, and the publisher intends the statement to cast the doubt, or the recipient's understanding of it as casting the doubt was reasonable.

Reckless disregard means that a statement is made with a high degree of awareness of probable falsity.

A statement is published if it is communicated orally, in writing, or in print to some third person capable of understanding their defamatory import and in such a way that the third person did so understand. A defamatory statement can be published by conduct. A statement is published by conduct when the communication is made and understood without words. To be actionable in defamation, a statement must contain an assertion of an objectively verifiable fact Self-publication occurs when the plaintiff communicates a defamatory statement to a third party. An exception to the rule that the defendant must publish a statement exists when a reasonably prudent person would have expected that the plaintiff would communicate the defamatory statement to a third party.

Plaintiffs must establish lost earnings that have been realized, and the communication must play a substantial part in inducing others not to deal with Lawrence Poliner, M.D., P.A. with the result that special damage, in the form of lost earnings, is established.

QUESTION NO. 12

Did any of the Defendants with malice publish a disparaging statement regarding Lawrence Poliner, M.D., P.A.'s economic interests in connection with the suspension of Dr. Poliner's cardiac catheterization privileges on or before May 14, 1998 or May 29, 1998 that were false?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 12, proceed to answer Question No. 13. If you have answered "No" as to all the Defendants listed in Question No. 12, proceed to the section entitled Interference with Contractual Relations and answer Question No. 14.

BUSINESS DISPARAGEMENT DAMAGES

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 13

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Lawrence Poliner, M.D., P.A. for its damages, if any, that resulted from any such disparaging statements caused by Defendants?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant. Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings ANSWER: 1,000,000.00

Charles Levin, M.D.

loss of earnings ANSWER: 1,000,000.00

John Harper, M.D.

loss of earnings ANSWER: 1,000,000.00

Presbyterian Hospital

loss of earnings ANSWER: 1,000,000.00

Proceed to the section entitled Interference with Contractual Relations and answer Question No. 14.

INTERFERENCE WITH CONTRACTUAL RELATIONS

To recover for tortious interference with an existing contract, Plaintiffs must prove: (1) the existence of a contract subject to interference, (2) the act of interference was willful and intentional, (3) such intentional act was a proximate cause of Plaintiffs' damage and (4) actual damage or loss occurred.

Any such contract does not have to be in writing.

If the interference was merely an incidental result of conduct the Defendant(s) was engaging in for another purpose, the interference may be considered unintentional. "Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

To recover for wrongful interference with prospective contracts, Plaintiffs must prove: (1) there was a reasonable probability that Plaintiffs would have entered into the contracts; (2) that Defendants intentionally prevented the contractual relations from occurring with the purpose of harming Plaintiffs; and (3) that Defendants conduct was independently tortious or wrongful.

Any such contract does not have to be in writing.

QUESTION NO. 14

As of May 14, 1998, did Plaintiffs have existing contracts with patients, health care plans, insurance companies, referral physicians, third party payors, hospitals other than Presbyterian Hospital, or medical instructions?

Answer "Yes" or "No".

ANSWER: Yes

If you have answered "Yes" to Question No. 14, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18. If you have answered "No" to Question No. 14, proceed to the section entitled Justification and answer Question No. 16.

QUESTION NO. 15

Do you find by a preponderance of the evidence that any of the Defendants intentionally interfered with Plaintiffs' existing and prospective contracts with patients, health care plans, insurance companies, referral physicians, third party payors, hospitals other than Presbyterian Hospital, or medical institutions?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

Charles Levin, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

John Harper, M.D.

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

Presbyterian Hospital

Existing contracts ANSWER: Yes

Prospective contracts ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question No. 15, proceed to answer Question No. 16. If you have answered "No" as to all Defendants in Question No. 15, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18.

JUSTIFICATlON DEFENSE

A party is justified in interfering with another's contract if it exercises its own legal rights or a good faith claim to a colorable legal right, even though that claim ultimately proves to be mistaken. Defendants have the burden to prove that the interference was justified.

QUESTION NO. 16

Defendant has the burden of proof on this question. Did any of the Defendants interfere because they had a good-faith belief that they had a right to do so?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: No

Charles Levin, M.D.

ANSWER: No

John Harper, M.D.

ANSWER: No

Presbyterian Hospital

ANSWER: No

If you have answered "Yes" to Question No. 16, proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18. If you have answered "No" to Question No. 16, proceed to answer Question No. 17 only with respect to the Defendants to which you answered "No".

INTERFERENCE WITH CONTRACTUAL RELATIONS DAMAGES

Plaintiffs must show actual damage or loss was proximately caused by the alleged interference. "Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

In answering this question, you may only consider damages, if any, proximately caused by the Defendants' interference occurring on or before May 14, 1998 and May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 17

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Plaintiffs for their damages, if any, proximately caused by such interference?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing

damages against any other Defendant. Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 20,000,000.00

mental anguish
ANSWER: 20,000,000.00

Charles Levin, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

John Harper, M.D.

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 5,000,000.00

mental anguish
ANSWER: 5,000,000.00

Presbyterian Hospital

loss of earnings
ANSWER: 37,000.00

injury to career and reputation
ANSWER: 15,000,000.00

mental anguish
ANSWER: 15,000,000.00

Proceed to the section entitled Intentional Infliction of Emotional Distress and answer Question No. 18.

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS

Intentional infliction of emotional distress occurs when a defendant acts intentionally or recklessly with extreme and outrageous conduct to cause the plaintiff emotional distress and the emotional distress suffered by the plaintiff was severe.

Conduct is intentional if the defendant desires to cause the consequences of his/its act or believes that the consequences are substantially certain to result from the act.

Conduct is reckless if the defendant knows or has reason to know of facts that create a high degree of risk of harm to another and deliberately proceeds to act in conscious disregard of or indifference to the risk.

"Extreme and outrageous conduct" occurs only where the conduct has been so outrageous in character, and so extreme in degree, as to go beyond all possible bounds of decency, and to be regarded as atrocious, and utterly intolerable in a civilized society.

QUESTION NO. 18

Did any of the Defendants intentionally inflict severe emotional distress on Dr. Poliner?

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" to Question No. 18, proceed to answer Question No. 19. If you have answered "No" to Question No. 18, proceed to the section entitled Exemplary Damages and answer Question No. 20.

INTENTIONAL INFLICTION OF EMOTIONAL DISTRESS DAMAGES

"Proximate cause" means that cause which, in a natural and continuous sequence, produces an event, and without which cause such event would not have occurred. In order to be a proximate cause, the act or omission complained of must be such that a person using ordinary care would have foreseen that the event, or some similar event, might reasonably result therefrom. There may be more than one proximate cause of an event.

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and on May 29, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998. Do not add any amount for interest on damages, if any.

QUESTION NO. 19

What sum of money, if any, if paid now in cash, would fairly and reasonably compensate Dr. Poliner for his emotional distress, if any, proximately caused by Defendants?

Consider the elements of damages listed below and none other. Consider each element separately and do not include damages for one element in any other element. Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant.

Answer in dollars and cents for damages as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

loss of earnings	ANSWER: 10,526.55
mental anguish	ANSWER: 20,000,000.00

Charles Levin, M.D.

loss of earnings	ANSWER: -0-
mental anguish	ANSWER: 1,000,000.00

John Harper, M.D.

loss of earnings	ANSWER: -0-
mental anguish	ANSWER: 1,000,000.00

Presbyterian Hospital

loss of earnings	ANSWER: 10,526.55
mental anguish	ANSWER: 20,000,000.00

Proceed to the sectian entitled Exemplary Damages and answer Question No. 20.

EXEMPLARY DAMAGES

"Exemplary damages" means an amount that you may in your discretion award as a penalty or by way of punishment.

For purposes of this question only, "malice" means:

(a) a specific intent by any of the following to cause substantial injury to Dr. Poliner; or

(b) an act or omission by any of the following,

(i) which, when viewed objectively from the standpoint of any of the following at the time of its occurrence, involved an extreme degree of risk, considering the probability and magnitude of the potential harm to others; and

(ii) of which any of the following had actual, subjective awareness of the risk involved, but nevertheless proceeded with conscious indifference to the rights, safety, or welfare of others.

QUESTION NO. 20

Do you find by clear and convincing evidence that the harm caused by any of the Defendants resulted from malice?

Clear and convincing evidence requires a greater degree of persuasion than the preponderance of the

evidence standard; however, proof to an absolute certainty is not required.

Answer "Yes" or "No" as to each Defendant you answered "Yes" to in Question No. 4.

James Knochel, M.D.

ANSWER: Yes

Charles Levin, M.D.

ANSWER: Yes

John Harper, M.D.

ANSWER: Yes

Presbyterian Hospital

ANSWER: Yes

If you have answered "Yes" as to any Defendant in Question 20, then answer Question No. 21. Otherwise, proceed to the last page entitled Certificate, sign the verdict form, and do not answer any further questions.

QUESTION NO. 21

In answering this question, you may only consider damages, if any, that resulted from the actions of Defendants occurring on or before May 14, 1998 and May 28, 1998. You may not, however, consider damages that stem from any action taken on or after June 12, 1998.

Factors to consider in awarding exemplary damages, if any, are –

a. The nature of the wrong.

b. The character of the conduct involved.

c. The degree of culpability of each Defendant.

d. The situation and sensibilities of the parties concerned.

e. The extent to which such conduct offends a public sense of justice and propriety.

f. The net worth of the Defendants.

Exemplary damages can be assessed against Presbyterian Hospital as a principal because of an agent by an agent, but only if:

a. Presbyterian authorized the doing and the manner of the act; or

b. the agent was unfit and Presbyterian was reckless in employing him; or

c. the agent was employed in a managerial capacity and was acting in the scope of employment with Presbyterian Hospital; or

d. Presbyterian Hospital or a manager of Presbyterian Hospital ratified or approved the act.

What sum of money, if any, if paid now in cash, should be assessed against any of the Defendants and awarded to Plaintiffs as exemplary damages, if any, for the conduct found in response to Question 20?

Consider each Defendant separately and do not include damages as to one Defendant in assessing damages against any other Defendant. Answer only as to the Defendants which you answered "Yes" to in Question 4.

James Knochel, M.D.	$40,000,000.00
Charles Levin, M.D.	$10,000,000.00
John Harper, M.D.	$10,000,000.00
Presbyterian Hospital	$50,000,000.00

CERTIFICATE

We, the jury, have answered the above and foregoing questions as herein indicated, and herewith return same into court as our verdict.

DATE: August 27, 2004

BY: /s/_____
PRESIDING OFFICER OF THE JURY

APPENDIX F

In the
UNITED STATES COURT OF APPEALS
for the Fifth Circuit

No. 06-11235

[Filed October 4, 2007]

Lawrence R. Poliner, MD; Lawrence R. Poliner, MD, PA,	)
Plaintiffs-Appellees-Cross-Appellants,	)
v.	)
Texas Health Systems, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas; James Knochel, MD,	)
Defendants-Appellants-Cross-Appellees.	)

Appeal from the United States District Court
for the Northern District of Texas
Honorable Jorge A. Solis,
United States District Judge

APPELLEES' BRIEF

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CERTIFICATE OF INTERESTED PERSONS

No. 06-11235; *Lawrence R. Poliner, MD; Lawrence R. Poliner, MD, PA v. Texas Health Systems, a Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas; James Knochel, MD*

The undersigned counsel of record certifies that the following listed persons and entities as described in the fourth sentence of 5TH CIR. R. 28.2.1 have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

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/s/
Jeffrey S. Levinger
Attorney of Record for
Plaintiffs-Appellees

STATEMENT REGARDING ORAL ARGUMENT

Appellees believe that oral argument may be useful in this case, but not for the reasons stated in Appellants' "statement regarding oral argument." Contrary to their characterizations (Br. at vii), the legal questions involved in this case are not especially "substantial," and the evidence, the verdict, and the numerous opinions below belie Appellants' one-sided version of the facts. This case turns more on the facts than the law. It involves a physician whose career and reputation were destroyed by a so-called "peer review" in which Appellants used the threat of an immediate suspension they knew they could not lawfully impose to coerce his "agreement" to an "abeyance" of his privileges. In so doing, Appellants permanently tarnished the physician's career and reputation, and succeeded in their goal of driving him out of the hospital. Given the volume of pleadings, the length of the trial record, and the detail of the trial court's opinions, oral argument is likely to aid the Court's decisional process.

TABLE OF CONTENTS

TABLE OF AUTHORITIES

Cases

Statutes

Rules

Other Authorities

ABBREVIATIONS AND RECORD REFERENCES

Abbreviations

"The Hospital" refers to defendant Texas Health Systems, a Texas Non-Profit Corporation, d/b/a Presbyterian Hospital of Dallas.

"CIMA" refers to Cardiology and Internal Medicine Associates.

"CSANT" refers to Cardiothoracic Surgery Associates of North Texas.

"NTHC" refers to North Texas Heart Center.

"Defendants" refers collectively to the Hospital and James Knochel, MD.

"HCQIA" refers to the Health Care Quality Improvement Act, 42 U.S.C. § 11101, *et seq*.

Record References

Trial testimony and hearing testimony are denoted by a number, which refers to the volume of the Reporter's Record that the testimony appears in, followed by "RR" and a number, which refers to the page number appearing in the upper right hand corner of the page.

Pleadings, motions, and other court papers are denoted by "CR" followed by a number, which refers to the bates-stamp on the bottom right hand corner of the page. These documents were digitally imaged and filed on CD-ROM by the clerk.

Pleadings, motions, appendices, sealed filings, and other court papers that were not digitally imaged and are not included on the CD-ROM are denoted by "Doc.," which refers to the docket entry number listed on the trial court docket sheet appearing at CR0001, followed by a number, which refers to the document's own page number.

"PX" refers to the exhibits of plaintiffs Lawrence R. Poliner, MD and Lawrence Poliner, MD, PA.

"DX" refers to the exhibits of defendants Texas Health Systems, d/b/a Presbyterian Hospital of Dallas and James Knochel.

STATEMENT OF THE ISSUES

1. Was there sufficient evidence to support the jury's finding of duress, which was based on Defendants' threat of unlawful action to coerce Poliner into signing two abeyance letters that he had no obligation to accept? Further, can Defendants use the unpreserved and inapplicable defenses of estoppel and ratification to excuse their imposition of duress?

2. Was there sufficient evidence to support the jury's findings that Defendants' actions did not satisfy the requirements for HCQIA immunity?

3. Was there sufficient evidence to support the jury's findings that Defendants acted with actual malice and thus were not entitled to immunity under the Texas medical peer review statute?

4. Was there sufficient evidence to support the jury's findings that Defendants defamed Poliner, including by republishing defamatory *per se* statements within the limitations period?

5. Was there sufficient evidence that would support the rendition of judgment based on the jury's alternative findings of tortious interference and breach of contract?

6. Did the trial court correctly exercise its discretion in denying Defendants' motion for new trial, which erroneously contended that the damages verdict was the product of "passion and prejudice" and that certain evidence should have been admitted or excluded?

7. Should the trial court's exercise of discretion in ordering a substantial remittitur of the actual damages be left undisturbed, and did the trial court correctly reject Defendants' effort to compare the damages here to the different damages in an unrelated case in contravention of the "maximum recovery rule"?

STATEMENT OF THE CASE

Poliner and his professional association sued Knochel, the Hospital, and others for maliciously using a sham peer-review process to falsely label him as a dangerous doctor -- actions that Defendants knew would eliminate his solo cardiology practice at the Hospital and ruin his unblemished reputation. (CR0076) Poliner's suit, which asserted an antitrust claim and various state law causes of action, attacked primarily three actions by Defendants:

- Knochel's threat on May 14, 1998 to immediately suspend Poliner (an action reserved under the governing bylaws for physicians who constitute a present danger) if Poliner did not agree to an abeyance of his privileges in the catheterization lab (an action that could not be imposed under the bylaws without the physician's agreement).

- Knochel's threat on May 29, 1998 to immediately terminate Poliner without any opportunity for a hearing if Poliner did not agree to extend the abeyance to June 12.

- The decision to summarily suspend all of Poliner's privileges on June 12, 1998.

(CR0090-91, 0098-99, 2639-50, 3589)

After extensive discovery, Defendants moved for summary judgment claiming they were immune from damages under the federal HCQIA and the Texas medical peer review statute. (CR1337-1400) In response, Poliner presented extensive summary judgment evidence from twelve different experts that Defendants' actions were based on false and malicious criticisms of Poliner's work, were biased and pretextual, and were undertaken after woefully inadequate investigation, notice, and hearing. (Doc. 151 at 1-665) Despite this evidence, the trial court granted summary judgment in part on September 30, 2003, holding that the June 1998 suspension was entitled to statutory immunity. (CR2613, 2616, 2620) The court also dismissed Poliner's antitrust and DTPA claims (CR2600-05, 2623), but determined that fact issues existed as to whether the actions taken against Poliner on May 14 and May 29 were entitled to immunity (CR2607, 2611, 2619-21).[1]

Following a two-week trial that focused primarily on the May 14 and May 29 actions taken by Knochel, the Hospital, and two other defendant doctors, the jury unanimously found in Poliner's favor on every question

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[1] Poliner filed a cross-appeal to preserve his right to challenge the adverse portions of the September 2003 order (CR7265-67), but has opted to omit those issues from this brief in order to streamline the appeal and limit consideration to the jury's verdict and the final judgment.

submitted. (CR4443-91) Although the actual and exemplary damage figures in the verdict totaled over $366 million, Poliner recognized that the awards overlapped and thus sought actual damages of approximately $70 million and exemplary damages of $90 million against Knochel and the Hospital (the other two defendants having settled). (CR5373-74) Defendants filed extensive motions for JMOL and for new trial. (CR4859-4921, 5988-6078)

In a series of lengthy opinions and orders, the trial court ruled that: (1) Defendants had waived a number of their arguments by not raising them at trial; (2) the evidence supported the jury's findings that Defendants were not entitled to immunity;[2] (3) sufficient evidence supported the jury's findings of contract breach, defamation, and tortious interference, and judgment would be rendered on the defamation claim; (4) there was sufficient evidence that the damages awarded to Poliner resulted from the May actions (as opposed to the immune June action); (5) Defendants were not entitled to a new trial based on alleged trial errors or claims of jury passion and prejudice; (6) the awards of actual damages for injury to career/reputation and mental anguish were nonetheless excessive and should be remitted to a total of $21 million; and (7) exemplary damages should be statutorily capped at $750,000 against each Defendant. (CR6515-49, 6645-63, 7268-73, 6664-66, 7274-76) Poliner accepted the remittitur

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[2] Defendants erroneously contend that the court based its immunity rulings on a finding that Defendants had breached the bylaws. (Br. at 6-7 & n.4) The court did not so rule, but as discussed further below, the bylaws are nevertheless relevant to the immunity analysis.

(CR6623-26), and the court rendered an amended final judgment consistent with its previous opinions (CR7274-76).

STATEMENT OF FACTS

Although Defendants pay lip service to the proper standard for reviewing jury verdicts (Br. at 27), they utterly ignore those standards in their recitation of the "facts." Instead of discussing the evidence in the light most favorable to the jury's verdict, Defendants have fashioned a sensationalized and one-sided version of the events -- scripted to create the impression that Poliner was a dangerous doctor whom Knochel dealt with fairly and reasonably by letting him agree to a short "Abeyance" of his cath lab privileges. The jury, however, unanimously rejected that misleading version of the story, and the evidence amply supported its findings. In fact, the evidence showed that Knochel used the threat of an immediate suspension of all of Poliner's privileges -- an action Knochel admitted he lacked any factual basis to take -- to coerce the "Abeyance" and falsely label Poliner as a dangerous doctor. This abuse of the peer-review process immediately and irreversibly destroyed the impeccable reputation and career that Poliner had built in over 20 years of practice. Thus, far from "gut[ting]" the HCQIA or the related Texas immunity statutes (Br. at 9), the judgment below simply confirms that to be immune, peer review must be honest and legitimate.

Poliner was and is a committed, dedicated, and skilled medical doctor. (CR6657-58) A specialist in interventional cardiology, Poliner graduated from Cornell Medical School in 1969 and completed his

internship and residency at the University of Colorado in 1972. (PX-2; 5RR1114) After serving two years in the Air Force, he completed a cardiology fellowship at the University of Texas Southwestern Medical School in 1976, and then devoted nearly a decade to teaching cardiology at both Southwestern and Baylor University Medical School. (5RR1115, 1121, 1123-26; PX-2) He subsequently entered private practice, first joining a heart institute in Wichita, Kansas, and later working with a large cardiology group in Indiana that was developing new techniques. (5RR1128, 1190-91, 1196) Despite having performed thousands of diagnostic catheterizations and angioplasties during those years -- including high-risk procedures involving acutely-ill patients -- Poliner had never lost a patient in the cath lab, had never been sued for malpractice, and was uniformly acclaimed to be a good doctor. (5RR1126-27, 1194-95)

In 1996, a group known as CSANT recruited Poliner to move to Dallas and work at the Hospital. (5RR1196-98) He applied for privileges (PX 15), and after undergoing rigorous scrutiny, was appointed to the Hospital's medical staff and approved to perform cardiac catheterizations, angioplasties, and insertions of stents (2RR347-48; PX-33, 35). As a member of CSANT, Poliner did not directly compete with either of the two dominant cardiology groups at the Hospital -- NTHC or CIMA -- which drew patients primarily from the Dallas area. (5RR1198-99) Instead, he treated patients in outlying areas in northeast Texas and southern Oklahoma, and brought them to the Hospital only if they needed more extensive treatment in the cath lab. (5RR1198)

With only one exception, Poliner practiced without incident while he was associated with CSANT from June 1996 through May 1997. (5RR1199) The one exception involved Patient 10, an Oklahoma nurse who was sent to Poliner by her personal physician in November 1996 for a cardiac catheterization. (2RR353-54; 5RR1211-12; PX-501) Before the procedure, the patient said she was allergic to shellfish and Betadine. (5RR1212-13) Although these allergies do not indicate an allergy to the contrast dye used in catheterizations -- and Patient 10 did not reveal any such allergy -- Poliner offered to give her Benadryl as a preventative measure, which she refused. (3RR649, 672-78; 4RR899; 5RR1213-14) Poliner then proceeded with the catheterization, and although it was a complete success, Patient 10 later developed a rash that was promptly and effectively treated. (2RR359; 5RR1202-03; PX-52, 501) No one was able to say whether the rash was caused by the contrast dye. (6RR1377, 1415)

Nearly three months later, the Internal Medicine Advisory Committee ("IMAC") -- the peer-review body headed by Knochel, a Hospital employee and the chair of its internal medicine department (2RR293) -- reviewed the case of Patient 10 and asked Poliner to explain what had happened (5RR1200; DX-21). Poliner did so, and the IMAC cleared the case on March 10, 1997. (5RR1201-02; PX-52, 501) Knochel nonetheless contended that Poliner should not have gone forward with any procedure on Patient 10 once he learned she was allergic to anything (2RR356-58; 5RR1214-15; PX-53) -- ignoring the facts that the patient's physician had sent her to Poliner with acute coronary symptoms that needed prompt treatment and

that the risk of allergic reactions to contrast dye was only four in one million (2RR352-53; 5RR1203, 1212-15). Further ignoring Patient 10's charts, Knochel falsely told Poliner that "there is no statement in the record explaining why a cardiac catheterization should have been performed." (2RR356; PX-53) According to Knochel, Poliner did not respond positively to these unfounded criticisms regarding Patient 10 (2RR356), and that response contributed to Knochel's opinion that Poliner was unfriendly, argumentative, disagreeable, and ungrateful (2RR366).

In June 1997, tired of the travel required by CSANT, Poliner and his wife decided that he should open his own solo practice at the Hospital. (5RR1208) This placed him in competition with the other cardiology groups there, including NTHC and CIMA. (1RR228-30; 4RR819-20; 5RR1209) Just as Poliner began to get his solo practice off the ground, however, Knochel and Dr. Charles Levin, the director of the cath lab and a member of CIMA, put up an unexpected road block. (4RR811-13, 822-23; PX-54) Even though Poliner had been credentialed to perform (and was performing) procedures in the Hospital's cath lab for many months while he was with CSANT (4RR826-28; PX-33, 35), Levin was told by either Knochel or the medical staff office that the documentation allowing Poliner to perform certain cath lab procedures was now inadequate, and he made Poliner cancel a scheduled procedure (4RR822-23). But Knochel and Levin could only temporarily disrupt Poliner's cath lab privileges. (4RR823) After the IMAC and Knochel reviewed Poliner's medical records and other data relating to his diagnostic and interventional procedures, even Knochel had to admit to Levin that "Dr. Poliner is

qualified to perform these procedures." (4RR826-28; PX-54)

Over the following months, Poliner built his practice by obtaining referrals of acutely-ill coronary patients from the emergency room and directly from other physicians at the Hospital. (5RR1209; 6RR1277-78) By the fall of 1997, Poliner ranked fifth or sixth out of 20 doctors in the number of procedures performed in the cath lab. (7RR1661) This thriving practice placed him in serious competition with NTHC and CIMA, and produced friction with some cath lab nurses who were unaccustomed to the long hours he was working. (6RR1298-99; 9RR2147) Having previously been unable to eliminate Poliner's solo practice through pretextual "documentation" issues, Knochel, the Hospital, and Poliner's competitors instead launched a secret campaign, conducted entirely without Poliner's knowledge, to eliminate his privileges, ruin his practice, and destroy his reputation -- all under the guise of "peer review."

Between late September and mid-December 1997, three of Poliner's cath lab cases came under question. (2RR374, 418, 424)[3] In contrast to the give-and-take

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[3] Although Defendants now discuss a fourth case involving Poliner's treatment of Patient 39 in January 1998 (Br. at 13), Defendants conceded at trial that this case did not form the basis of their May 1998 actions toward Poliner that are at issue here (2RR373; PX-83). Moreover, far from being a "rookie mistake" -- as one of the former defendants in this case self-servingly described Poliner's insertion of a catheter through Patient 39's vein instead of an artery (3RR646) -- Poliner's cardiology experts testified that even experienced cardiologists occasionally enter a patient's vein instead of the artery (3RR702; 4RR922).

discussions involved in the review of Patient 10's case, the reviews of these three cases were performed entirely in secret -- so much so that Poliner was not even told the reviews were ongoing, much less consulted for his input. (6RR1299-1300) Had Poliner at least been consulted, he would have offered legitimate explanations for all of his actions, inactions, or decisions in treating all three acutely-ill patients. (6RR1304) Indeed, even the one-sided information Knochel and the Hospital developed gave them no basis for concluding -- as they ultimately did on May 13, 1998 -- that Poliner presented a danger to his patients and therefore needed to be immediately suspended. (2RR361-62, 449-50)

The first case at issue involved Patient 18, an 88-year old woman who died on September 28, 1997 while Poliner was performing an emergency catheterization in an effort to save her life. (4RR916; 6RR1264-67) Although Knochel (a nephrologist by training) believed that Poliner should not have performed the procedure at all (6RR1266), the facts belie that conclusion. Patient 18 was a heavy smoker with vascular disease, and was suffering an acute heart attack when she was admitted to the emergency room. (6RR1265, 1378-79) After Poliner informed Patient 18 of her options and the risks of a catheterization, she consented to the procedure. (6RR1265-66) The procedure turned out to be very complex as a result of her ongoing heart attack and calcified arteries, and she died from the heart attack Poliner was trying to treat -- not from the

procedure itself. (6RR1385-86; 7RR1559-62)[4] Several months later, the Hospital's Mortality and Morbidity Review Committee analyzed the case and determined that it would not be referred for further review. (PX-68) Poliner firmly believed (and two cardiology experts later confirmed) that Patient 18 likely would have died had Poliner not performed the procedure. (4RR916; 6RR1265-66, 1378)

The second case involved Patient 9, an elderly man who suffered a stroke from bleeding in the brain the day after Poliner successfully reopened a heart-attack vessel on October 27, 1997. (2RR374; 5RR1215, 1226; PX-61) Knochel believed that the procedure itself "was fine," but that Poliner thereafter had abandoned the patient by not coming to the ICU in the middle of the night when the patient developed complications. (2RR376-77) The facts, however, portray a very different picture. Following the successful procedure, Poliner ordered a complete blood count within three hours -- a vital test for any coronary patient who has received blood thinning and anti-clotting medications. (6RR1242-44) But in this case, the Hospital staff delayed several hours in taking the blood count, and when Poliner later was informed that the patient's platelet count was abnormally low, he immediately stopped the medicines in order to reduce the risk of

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[4] Indeed, in a report Knochel requested, Dr. Charles Harris stated that "the catheterization and angioplasty were carried out in a satisfactory manner." (PX-88) Harris's report, however, made several misstatements about the timing of various events. (*Compare* PX-88 *with* 8RR1790-94)

bleeding. (6RR1253-54)[5] At 2:30 a.m., a nurse called Poliner at home to report that the patient was slurring his speech. (6RR1257-58) Poliner correctly recognized that the patient was bleeding in the brain, and he ordered the nurse to immediately administer platelets to stop the bleeding. (6RR1258-59) Although Poliner, as a caring physician, wished in hindsight that he had personally come to the Hospital at 2:30 a.m. to be with his patient, he remained convinced (and a cardiology expert confirmed) that ordering platelets was "all that could be done" and that anything else he might have considered (like sending the patient for a diagnostic CT scan or to surgery) would have only endangered Patient 9 by moving him and causing more bleeding. (4RR909; 6RR1259-62, 1367-68) Indeed, it was not until the end of the next day that Patient 9 became stable enough for a neurosurgeon to successfully perform surgery. (2RR392; 3RR600; 6RR1263-64)

The third case that Defendants seized upon involved Patient 3, a 74-year old acutely-ill man on whom Poliner performed a catheterization on December 16, 1997. (6RR1346) When the patient was later returned to the cath lab for an angioplasty, Poliner learned that the gauze dressing originally covering the sheath in the patient's groin area had become soiled with urine before the nurses had

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[5] Citing to a handwritten report of Dr. Charles Levin, Defendants now contend that Poliner "had given higher doses of blood thinning medication than recommended." (Br. at 12, citing PX-59) But three expert cardiologists dismissed that criticism, noting that the dosages Poliner gave were standard (or at least reasonable) at the time he performed the procedure in 1997. (3RR685-87; 4RR902-06; 6RR1357-62)

changed it. (5RR1171-72, 1177-78) Poliner examined the groin site, found no infection, exchanged the original sheath for a new one, and successfully performed the angioplasty. (2RR421; 5RR1168, 1173-74, 1178)[6] Although a nurse and a competitor of Poliner later took the position that Poliner should have used the other groin site for the angioplasty (2RR421-22; PX-75), Poliner had decided at the time not to do so because he needed to preserve that site in case he had to install a balloon pump (5RR1175-76). The balloon pump could "stay in the body for some days" and thus required "a fresh site" that "was clean and had been uncontaminated." (5RR1176) Two cardiology experts confirmed that Poliner's judgment was reasonable (4RR917-18; 6RR1347-52), and an advisory board at the Hospital ultimately cleared the case after determining that "there were no untoward effects" (PX-79; 6RR1274-75) -- thus corroborating Poliner's initial conclusion that there was no infection.

By May 1998, still unbeknownst to Poliner, the cases involving Patients 18, 9, and 3 had been under review for five months, and still no committee had found those cases to involve substandard care. (2RR374-75, 422; 6RR1272) Thus, the three cases did not provide Knochel and the Hospital any justification for impairing Poliner's privileges -- let alone taking the dramatic step of immediately suspending him.

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[6] The initial reports of the Clinical Risk Review Committee inaccurately stated that Poliner had re-used the original sheath when he performed the angioplasty. (DX-23, 35) Dr. Rivera's handwritten review correctly stated that the sheath was exchanged but nonetheless made several erroneous assertions, including that the groin site was infected. (PX-75; 6RR1351)

(2RR374-75, 418, 423-25) On May 12, 1998, however, Defendants finally got the pretext they had been looking for following an event in the cath lab involving Poliner's treatment of Patient 36 -- an event that was first questioned by Levin, the director of the cath lab, a competitor at CIMA, and one of the persons who had unsuccessfully tried to disrupt Poliner's privileges the previous year. (4RR811; 6RR1298)

Patient 36 was a 46-year old male who was sent to the cath lab after treatment in the emergency room did not relieve his severe chest pain. (5RR1279; DX-179) Poliner correctly determined from the EKG and a catheterization that the undersurface of the patient's heart "was not moving normally" due to blockages in the right coronary artery (RCA); he also noted that there was disease in the left anterior descending artery (LAD) that supplied blood to the front of the heart, but correctly determined that this portion "was working well" because it was being supplied with blood by a collateral artery. (5RR1160-61, 1164; 6RR1284, 1395) Accordingly, Poliner worked on the patient's RCA and installed five stents -- a lengthy and complex procedure -- which immediately relieved the patient's chest pain. (6RR1279-80, 1286, 1395-96)

Despite the success of the procedure, Poliner learned later that day that he had missed a total occlusion in a part of the LAD. (6RR1298-99; DX-177) "Amazed and disconcerted" by this admitted mistake -- something he had never done in over 20 years of practice -- Poliner overreacted and hastily dictated an addendum to his initial report stating that if he had seen the occlusion in the LAD, he would have worked on it before the RCA. (5RR1163; DX-177) On deeper

reflection, however, Poliner remained convinced (and three nationally-known cardiology experts later confirmed) that the RCA was the cause of the patient's problems, that even if Poliner had known of the LAD he would have been correct in repairing the RCA first, and that he in fact would have endangered the patient by starting with the LAD. (3RR708 [Wharton]; 4RR931-32 [Kern]; 5RR1160-64, 7RR1590 [Poliner]; 6RR1392 [DeMaio]) Indeed, although another cardiologist, Dr. Tony Das, had contemporaneously observed Poliner's work on Patient 36's RCA and noticed on the monitor that the LAD was occluded, Das said nothing to Poliner at the time because he felt that Poliner was not endangering the patient by fixing the RCA first. (2RR481-82)[7]

After the procedure, Poliner accompanied Patient 36 to an overflow ICU (opened specifically for that patient) where trained ICU nurses were to administer the red blood cells that Poliner had ordered and to monitor the sheath that was still in the patient's groin. (6RR1285-86; 9RR2040-41) Although Defendants' brief now attacks Poliner for his alleged "post-procedure neglect of Patient 36" (Br. at 17), that attack is irrelevant because Knochel was not aware of any such

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[7] Defendants' brief ignores all this testimony and instead relies extensively on the opinions of their own hired expert, Rick Lange, to support their claim that Poliner misdiagnosed the source of the patient's problems and therefore worked on the wrong artery. (Br. at 14, citing 8RR1760-65) But given the contrary testimony of Doctors Wharton, Kern, DeMaio, Poliner, and Das, the jury was entitled to discredit Lange's faulty opinions. In fact, Lange was forced to admit that Patient 36's LAD did not have to be repaired until three years later. (8RR1846)

allegations at the time of his decisions about Poliner on May 13 (2RR428). In any event, the facts belie the allegation. Far from "fail[ing] to respond to numerous pages from nursing staff" (Br. at 15, 35), Poliner in fact personally saw the patient several times (9RR2042-43), and then "made multiple calls" to the ICU but could not get through on the telephone (7RR1665). Tied up in another procedure, Poliner sent his wife -- a nurse Ph.D. who worked in his office -- to the ICU to see Patient 36. (6RR1297; 7RR1665-66) There, Mrs. Poliner observed that Patient 36's head was significantly elevated (7RR1667-68) -- a position that can create bleeding problems at the site of the sheath in the groin (6RR1288-89). Indeed, around 2 or 3 p.m., Patient 36 began to experience breathing difficulties arising from excessive bleeding in his abdominal muscles. (9RR2020; DX-179) Dr. Selma Swafford, Patient 36's attending physician, promptly called in Dr. Kenney Weinmeister, a pulmonary and critical care specialist responsible for the care of ICU patients, to deal with the emergency. (9RR2018-20; DX-179) Weinmeister was able to stabilize Patient 36. (9RR2025)[8]

Later that day, Levin told Poliner that he knew about the missed LAD "and that the case would have

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[8] As they do with Lange, Defendants rely extensively on Weinmeister's testimony to create the false impression that Poliner's lack of responsiveness nearly allowed Patient 36 to die. (Br. at 15-16, citing 9RR2020-27) But the jury was entitled to discredit Weinmeister's undocumented opinions, especially given his admissions that he had no recollection of Patient 36 just a few weeks before the trial (9RR2032-33), and that he had never filed a written complaint about Poliner's care (9RR2051).

to be reviewed." (6RR1298) Levin, however, made no effort to obtain Poliner's explanation or to seek an outside review. (6RR1298-99; 8RR1774) Instead, Levin promptly reported the incident to Dr. John Harper, the chief of cardiology and a member of NTHC (4RR846), and Das reported it to Knochel on the morning of May 13 (2RR396-97). Knochel immediately took advantage of the opportunity -- with the Hospital's acquiescence -- to destroy Poliner's career and reputation.

With nothing more to go on than incomplete reports regarding Patient 36, and the inconclusive but ongoing internal reviews concerning the long-ago completed treatment of Patients 18, 9, and 3, Knochel decided that Poliner's privileges in the cath lab should be placed in "abeyance" -- an action that could not be taken under the medical staff bylaws unless Poliner first agreed. (1RR189-91; 2RR256-57; PX-220 at 73) Although the bylaws further provided that a doctor who did not agree to an abeyance would be subjected to either "corrective action" or "suspension" (1RR189-91; PX-220 at 73), Knochel did not consider offering the option of "corrective action" to Poliner (2RR256-57, 364-65). That measure would have: (1) given Poliner an opportunity to interview with an investigating committee; (2) allowed for a variety of milder measures such as education, training, or the proctoring of his cases; and (3) required a full hearing under article IX of the bylaws before his privileges could actually be restricted or suspended. (6RR1447-48; PX-220 at 71-72, 76-79) Instead of corrective action, Knochel determined that the only other option he would offer Poliner would be the immediate suspension of all his privileges (2RR256-57, 364-65) -- a drastic step that

the bylaws permitted *only* if the physician were so impaired or incompetent that he "constitute[d] a present danger to the health of his patients" (1RR206-07; PX-220 at 73).

Significantly, despite deciding on May 13 that suspension would be the only option for Poliner other than abeyance, Knochel did not have sufficient information to make the requisite finding that Poliner was a present danger to the health of his patients -- *and Knochel admitted as much at trial*. (2RR361-62, 449-50) The admitted lack of information, however, did not stop Knochel from presenting his two-option approach to the Hospital's president (Mark Merrill), its vice-president for medical staff affairs (Bruce Bougeno), and its in-house attorney (George Pearson). (2RR256-57, 402-06, 412; PX-80) Although Knochel claimed he "would have backed off" his decision if these Hospital employees had objected (2RR444), they did not object but in fact "acquiesced" and "agreed" to his plan (2RR403-04). Thus armed with "the sanction of the [H]ospital," Knochel summoned Poliner to a meeting at 5:00 p.m. on May 13. (2RR404; 6RR1299) Knochel told Poliner that Harper and Levin would be in attendance, but otherwise refused to tell Poliner what the meeting would be about. (6RR1299)

At the 5:00 p.m. meeting, Knochel told Poliner, in the presence of Harper and Levin, that Poliner had to sign a letter accepting an abeyance of his privileges to practice in the cath lab. (6RR1299-1300; PX-80) When Poliner asked why Knochel was making this request, Knochel refused to discuss any of Poliner's cases and did not let him provide any explanations. (6RR1300; 7RR1507; PX-80) Further, when Poliner asked what

his options were, Knochel said that he could agree to the abeyance or else Knochel would terminate "all hospital privileges" and Poliner would be "off the staff" immediately. (2RR363-64; 6RR1300-01; 7RR1508; PX-80) Knochel did not mention the option of corrective action, he did not inform Poliner about his rights to a hearing, and he did not explain or provide a copy of the bylaws. (6RR1301) Poliner returned to his office feeling "scared," "devastated," and in "disbelief" of what Knochel had said. (6RR1301-02)

Around 3:00 p.m. on May 14, Knochel's assistant delivered to Poliner the letter requesting his agreement to the abeyance of his cath lab privileges. (6RR1302; PX-80, 83) The letter referred to Poliner's treatment of Patient 36 and informed him, for the first time, that his treatment of Patients 18, 9, and 3 was also currently under review. (PX-83) Poliner called Knochel and asked if he could have an attorney review the letter; Knochel replied that "he didn't have an attorney so [Poliner] couldn't have an attorney," and gave Poliner an immediate deadline to "[s]ign this letter right now and get it back down to the office or your privileges are gone." (2RR415-16; 6RR1302; 7RR1511-13) Based on Knochel's "ultimatum to do the abeyance or my privileges were finished," Poliner "was forced" to sign the letter and deliver it to Knochel. (6RR1302; 7RR1509) Knochel promptly sent a memo to six of the Hospital's cardiologists informing them that Poliner "has accepted abeyance" of his cath lab privileges, and appointing them to an ad hoc committee tasked with reviewing Poliner's cases during the preceding 18 months. (6RR1303; PX-82)

The news that Poliner had been banned from working in the cath lab, and the false statement that Poliner had agreed to the abeyance, quickly spread throughout the Hospital, and the consequences were immediate and devastating. (6RR1304-05, 1312) Before the abeyance that Knochel coerced, Poliner's reputation was impeccable, his patient and referral base was growing, and he was busy in the cath lab. (6RR1278, 1305) But immediately after the forced abeyance on May 14, Poliner's referral base from the other doctors "was gone. The phones stopped ringing. The practice was gone . . . I didn't have any patients after that. There were no referrals." (6RR1305, 1312) One of Poliner's key referral sources, Dr. Marty Cohen, confirmed that he had concerns about sending any of his patients to Poliner after hearing in May 1998 "that Doctor Poliner was having problems around the hospital." (3RR799-800, 803-05) Cohen's concerns were representative of those of any referral physician, who "would have to think at least five times before you would refer a patient" to a cardiologist whose privileges had been taken away. (6RR1342 [DeMaio])

When Poliner's referral sources told him that "my reputation was being destroyed," Poliner justifiably became concerned that he was being "labeled as a dangerous doctor" to whom "nobody would refer patients." (6RR1312) Poliner thus wrote a letter to Knochel on May 21 informing him "that there have already been some breaches of confidentiality of this matter" and warning that "[t]he rumors alone can have swift, direct and devastating economic effects on my reputation and practice that will be irreparable." (6RR1304; PX-87) When Knochel responded by asking Poliner to "describe the breeches [sic] of

confidentiality" (PX-86), Poliner stated that he did not want "to involve my referral sources in this matter," but that those sources had expressed concern "that there should be a rapid resolution of this issue because it has been injurious to my reputation" (6RR1312; PX-90). The forced abeyance "devastated" Poliner and his family, "destroyed [his] life," damaged his health, and forever "affected his entire persona." (5RR1103; 6RR1301-02, 1311-12; 7RR1606, 1672, 1677-78)[9]

Still, Knochel and the Hospital were not through with Poliner. Instead of providing him the rapid resolution he so desperately needed, they opted to prolong their actions. On May 29, the last day of the 15-day period that the bylaws allowed for an abeyance (PX-220 at 73), Knochel wrote to Poliner seeking his acquiescence to a fourteen-day extension to June 12 (6RR1309-10; PX-92). Although Poliner by that time had contacted a lawyer named Chris Sharp, he had no opportunity to even consult with Sharp because Knochel again threatened to terminate all of Poliner's privileges with no opportunity to defend himself unless he signed the May 29 extension letter immediately. (6RR1310; 7RR1516-17, 1521) Recognizing that Knochel's threat would mean his "career was over,"

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[9] Defendants try to downplay these injuries by noting that "Poliner maintained privileges at several other hospitals." (Br. at 22) But even though at least two other hospitals had granted limited privileges to Poliner, his practice was almost exclusively at the Hospital -- the location of his office, his staff, his referral base, and the cath lab. (6RR1305; 7RR1655-56, 1661-62) And significantly, Poliner would have had to tell these other hospitals about the actions Defendants took against him. (4RR1068; 6RR1345; PX-208)

Poliner had no choice but to sign the letter extending the abeyance to June 12. (6RR1310; PX-92)

During the 29-day abeyance period, Knochel and his hand-picked committee apparently reviewed 44 of Poliner's cases (PX-92), and reported their findings to the IMAC (Doc. 150 at p. 46). Poliner was given only one hour on June 11 to meet with the IMAC and explain the quality of his care. (Doc. 150 at p. 48) The next day, the IMAC made official what Knochel had twice threatened when it recommended that Knochel immediately suspend Poliner's catheterization privileges (and now his echocardiography privileges as well). (6RR1310) Convinced that he had rendered the best care possible for his critically-ill patients, Poliner requested a hearing, retained attorney Michael Logan, and asked several prominent cardiologists from around the country to review the medical records and opine about the quality of his care. (Doc. 150 at p. 58-59) In November 1998, following a three-day evidentiary hearing, a committee appointed by the Hospital's medical board recommended that Poliner's privileges be reinstated. (2RR368; 6RR1310-11)

Despite this reinstatement, Poliner's practice at the Hospital "was in fact ruined," and he was forced to move his office to Medical City Dallas and attempt to rebuild his practice there. (6RR1311-13, 1472) But even after moving, the damage to Poliner's career and reputation stemming from the forced abeyance and being falsely labeled a dangerous doctor persisted. Every time Poliner submitted an application to a hospital or HMO, he had to disclose (with appropriate explanations) that his privileges previously had been "restricted" as a result of the forced abeyance.

(4RR1066-68; 6RR1315-17, 1329-30, 1345-46; PX-207, 208) In response to various requests for references, Knochel also reported -- even as late as January 2000 -- that Poliner's privileges at the Hospital had been limited or restricted. (2RR439; 4RR1086; 7RR1638-39; PX-169, 171) The continuing adverse effects of the abeyance were consistent with the expectations of Poliner's peer-review expert that "to have this sort of thing happen would be an injury that would be irreparable, irreversible, and permanent, and that forever after Doctor Poliner's reputation as an invasive cardiologist would be in question because of what had happened." (4RR1016) Like a "surgeon who can't work in the operating room," an interventional cardiologist who loses the privilege to work in the cath lab -- even temporarily -- "is marked as a person who can't function in what he does." (4RR986-87)

To Poliner, the actions of Knochel and the Hospital meant that "all the things I worked for for many years over a long period of time in gaining experience in cardiology are just gone as a result of this." (6RR1327; *see also* 6RR1311-12) For his part, Knochel had no remorse or regret about what happened to Poliner, rationalizing his behavior with such denials as "I didn't do it. He did." (2RR443) Indeed, even though Poliner had not practiced at the Hospital for nearly four years by the time of trial in August 2004, Knochel still insisted that Poliner was a dangerous doctor who should not be practicing cardiology anywhere. (2RR349)

SUMMARY OF THE ARGUMENT

Defendants' entire brief rests on the false premise that Poliner, aided by the jury and the trial court, "recast" the "agreed Abeyance" as an "involuntary suspension," and then "leveraged" that "transformation" into a false and defamatory statement that Poliner was a dangerous doctor. (Br. at 24-25) This straw-man argument mischaracterizes the evidence. In fact, Knochel himself created that "transformation" by making two threats to immediately suspend or terminate Poliner (an action reserved under the bylaws for physicians who constitute a present danger) if Poliner did not "agree" to the abeyance (as the bylaws required). Knochel's threat of immediate suspension, however, was unlawful and malicious because he *knew* the facts did not support the requisite finding that Poliner was a danger. The "abeyance" was therefore coerced through duress, and without it the Defendants would not have been able to destroy Poliner's career and reputation. When the evidence is thus accurately characterized, Defendants' obstacles in overturning the jury's adverse findings and the court's substantially remitted judgment become insurmountable.

To begin with, there was ample evidence to support the jury's findings that the abeyance letters were obtained by duress -- specifically, Knochel's threat to do an act he had no legal right to do, in order to coerce Poliner's agreement to a damaging alternative Poliner had no legal obligation to accept. The evidence also supports the jury's findings that Defendants did not comply with *any* of the standards for HCQIA immunity, especially given their failure to provide

Poliner any opportunity for notice and hearing, and their admitted lack of belief that the immediate suspension Knochel threatened was warranted. For these and other reasons, Defendants also acted with the actual malice that prevents them from claiming immunity under the Texas peer review statute.

Defendants are also incorrect that the defamation verdict "rested on false premises and impermissibly stacked inferences." (Br. at 25) There was abundant evidence that Defendants -- through their threats, words, actions, and factual omissions -- published the false and defamatory message that Poliner not only was a dangerous doctor, but also admitted to being dangerous by "agreeing" to restrict his own privileges. The actual malice that accompanied Defendants' words and conduct is manifest. And the evidence amply supports the jury's verdicts on the alternative theories of contract breach and tortious interference with existing and prospective contracts, and the judgment below can be affirmed (in its entirety or as modified) based on any of those claims.

Finally, Defendants' shotgun-style requests for a new trial or further remittitur are as meritless as they are sparse. The trial court correctly found that the damage awards were not the product of "passion and prejudice," and it correctly exercised its discretion in admitting the testimony of Dr. Dunn and excluding one portion of an irrelevant and cumulative defense exhibit. And the court's substantial remittitur of the awards for mental anguish and loss of career/reputation should not be reduced any further, particularly given the overwhelming evidence of loss

and the absence of any comparable case by which to apply the "maximum recovery rule."

ARGUMENT

I. Standards of Review.

Although Defendants attempt to minimize the effect of the applicable standards of review in this appeal (Br. at 27-28), those standards are highly deferential to the jury's verdict and the trial court's rulings. In attacking the sufficiency of the evidence supporting the verdict, Defendants face a daunting task because the Court's "standard of review with respect to a jury verdict is especially deferential." *Flowers v. Southern Reg'l Physicians Servs.*, 247 F.3d 229, 235 (5th Cir. 2001). Reviewing the record as a whole and drawing "all reasonable inferences most favorable to the [verdict]," the Court will affirm if there is "evidence of such quality and weight that reasonable and fair-minded [jurors] in the exercise of impartial judgment might reach difficult conclusions." *Boeing Co. v. Shipman*, 411 F.2d 365, 374-75 (5th Cir. 1969) (en banc). In conducting this review, the Court will "disregard all evidence favorable to the moving party that the jury is not required to believe." *Evans v. Ford Motor Co.*, 484 F.3d 329, 334 (5th Cir. 2007).

The denial of a motion for new trial based on the lower court's conduct of the trial (here, the admission or exclusion of evidence and the claim of alleged "passion and prejudice") is reviewed for abuse of discretion. *Pryor v. Trane Co.*, 138 F.3d 1024, 1026 (5th Cir. 1998). And where, as here, the trial court has already exercised its discretion and *granted* remittitur

of a damages award, the scope of this Court's review is "even narrower than usual." *See, e.g.*, *Stapleton v. Kawasaki Heavy Indus., Inc.*, 608 F.2d 571, 574 n.7 (5th Cir. 1979). Thus, the standard Defendants cite for reviewing the *denial* of a motion for remittitur (Br. at 27-28) is inapplicable.

II. The Evidence Supports the Jury's Finding that Poliner Was Forced to Sign the May 14 and May 29 Abeyance Letters Under Duress.

Correctly recognizing that the so-called "Abeyance" could not be imposed under the bylaws unless Poliner first agreed to it (PX-220 at 73), the trial court instructed the jury in Question No. 2 -- with the parties' consent (10RR2291-92) -- to determine whether Poliner's alleged agreement to the May 14 and May 29 abeyance letters "was caused by duress, if any, imposed by the Defendants" (CR4451). In now attacking the jury's findings that "Poliner did not agree to the abeyance" on either date, Defendants misapply the law of duress to a self-serving and discredited version of the facts. Defendants then compound that error by invoking two purported defenses -- estoppel and ratification -- that were not preserved and, in any event, are inapplicable as a matter of law and fact.

In Texas, duress involves (1) "improper or unlawful conduct or threat of improper or unlawful conduct" (2) that "is intended to and does interfere with another person's exercise of free will and judgment." *Dallas County Cmty. Coll. v. Bolton*, 185 S.W.3d 868, 878-79 (Tex. 2005). The first element typically involves "a threat to do some act which the threatening party has no legal right to do." *Id*. at 879 (citation omitted). The

second element occurs when the threatened act causes the party to whom it is directed "to do that which he would not otherwise do, and which he was not legally bound to do." *Shurtleff v. Giller*, 527 S.W.2d 214, 216 (Tex. Civ. App. -- Waco 1975, no writ). These principles expose the folly of Defendants' initial contention that Poliner merely faced "two options he did not like -- Abeyance and suspension." (Br. at 28)

The evidence is undisputed that on two separate occasions Knochel threatened to suspend or terminate all of Poliner's privileges immediately if he did not agree to two abeyances of his cath lab privileges. (2RR363-64; 6RR1301, 1310; 7RR1508, 1516-17; PX-80) It is also undisputed that Knochel had no legal right to carry out these threats because a suspension could be imposed under the bylaws only if the doctor "constitute[d] a present danger to the health of his patients" (PX-220 at 73), and Knochel admitted he lacked the factual basis to reach any such conclusion about Poliner (2RR361-62, 409, 449-50). And the evidence was overwhelming, if not undisputed, that those unlawful threats caused Poliner to act contrary to his free will by signing two letters that he would not otherwise have signed and that he was not legally bound to accept. (6RR1301-03, 1310; 7RR1515-17, 1523) Indeed, although Poliner had contacted a lawyer by May 29 (as Defendants point out), Knochel still was able to overcome Poliner's free will by again threatening to terminate all of his hospital privileges with no opportunity to defend himself unless he immediately signed the May 29 extension letter. (6RR1310; 7RR1516-17, 1521) These facts are entirely absent in the handful of duress cases Defendants now cite. (Br. at 28-29)

Defendants cannot overcome this evidence and the jury's findings by suggesting that Poliner was merely trying to "avoid [an] unfavorable alternative" and that he in fact "benefited from the Abeyance." (Br. at 29) These characterizations are at odds with the facts. The threatened suspension was an "alternative" Defendants had no legal right to impose and would have meant that Poliner's "career was over" (6RR1310), while the abeyance of his cath lab privileges was still a reputation-ruining event that Poliner was not legally bound to accept and was far worse than the unoffered alternatives of corrective action or an IMAC review (4RR986-89, 1013; 6RR1342-43). Nor can Defendants avoid the duress finding by arguing that "Poliner never informed [them] that he was secretly not agreeing to the Abeyance or that his agreement was withdrawn." (Br. at 29) A contemporaneous complaint about the coercive acts is not an element of duress, and the absence of such a complaint is not a defense to duress.[10] The jury here was entitled to conclude that any complaint by Poliner about coercion (or any attempt to withdraw the signed letters) would have only triggered the threatened suspension that caused Poliner's duress in the first place.[11]

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[10] The one case Defendants cite to support their argument, *Copeland v. Alsobrook*, 3 S.W.3d 598 (Tex. App. -- San Antonio 1999, pet. denied), did not involve duress, and stands only for the inapposite proposition that the meeting of minds necessary to form a contract must be based on what the parties said and not on their subjective state of minds. *Id*. at 604.

[11] Defendants' observation that "Poliner maintained privileges at several other hospitals" (Br. at 30) is similarly irrelevant under the facts and the law. Poliner practiced almost exclusively at the

Finally, the doctrines of "estoppel" and "ratification" that Defendants attempt to invoke (Br. at 30-31) are both unpreserved and inapplicable. They are unpreserved because Defendants failed to include them in their initial motion for JMOL (CR4401-20) or to ask that they be submitted to the jury (Doc. 327, ex. I). The doctrines are also inapplicable as a matter of law and fact. As Defendants' own cases reveal, the doctrine of "estoppel by contract" simply does not apply when, as here, the contract on which the claim of estoppel is based was "void, annulled, or set aside in some way." *Coffey v. Singer Asset Finance Co., L.L.C.*, 223 S.W.3d 559, 569 (Tex. App. -- Dallas 2007, no pet.) (duress not at issue). This principle reflects the common-sense rationale that a party cannot be "estopped" from disavowing a contract that was procured in the first instance by duress. For the same reason, "equitable estoppel" cannot override the existence of duress, which was not at issue in the one estoppel case Defendants cite. *See Stable Energy, L.P. v. Newberry*, 999 S.W.2d 538, 547-48 (Tex. App. -- Austin 1999, pet. denied). And "ratification" will not arise if the threat giving rise to the duress continues in existence, as it indisputably did here when Knochel threatened Poliner with immediate suspension on both May 14 and May 29. *Cf. Pace Concerts, Inc. v. Smith*, 990 F.2d 626, 1993 WL 117811, at *4 (5th Cir. 1993) (unpublished) (contract was signed *after* threat giving

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Hospital, and a suspension would have doomed his career no matter where else he held privileges. (6RR1310) Moreover, Texas courts have long held that the threat to terminate an employee unless he complies with the employer's demand will constitute duress, *see, e.g.*, *Shurtleff*, 527 S.W.2d at 216, even though the threatened employee could seek employment elsewhere.

rise to alleged duress had ceased to have any coercive effect).

III. The Evidence Supports the Jury's Findings that Defendants Are Not Entitled to Immunity.

The court below placed the burden on Poliner to overcome Defendants' claims for qualified immunity under both the HCQIA and the Texas peer review statute. (CR4450, 4454, 4458) The jury unanimously found that Poliner discharged his burden by proving that Defendants violated *every* requirement for immunity, and the evidence overwhelmingly supported its findings.

A. The HCQIA Does Not Protect Defendants' Actions.

Under the HCQIA, Poliner could rebut the statutory "presumption" of immunity by establishing that Defendants' "professional review actions" on May 14 and May 29 did not satisfy just *one* of the four requirements for immunity enumerated in 42 U.S.C. § 11112(a). *See Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 (10th Cir. 1996). Poliner more than met that burden by establishing -- as the jury found in response to Question No. 3 -- that Defendants' actions did not satisfy *any* of the four requirements. (CR4454-56) In now attacking these findings, Defendants and their amici set up an entirely false test -- one that assumes the professional review action to be evaluated under the HCQIA is merely an "Abeyance," voluntarily obtained and legitimately imposed. (Br. at 31-37) That argument ignores the

evidence, the charge, the verdict, and the post-trial rulings below.

Contrary to the premise of Defendants' argument, the professional review action to be evaluated under the HCQIA requirements is not the "Abeyance" alone -- it is Knochel's decision to immediately suspend all of Poliner's privileges if he did not accept an abeyance of his cath lab privileges, and Knochel's threats on May 14 and May 29 to do just that unless Poliner promptly signed the abeyance letters. This broader view of the actions that must be evaluated under the HCQIA is compelled by the statutory definition of "professional review action," which includes any "action or recommendation . . . which is taken or made in the conduct of professional review activity . . . which affects (or may affect) adversely the clinical privileges . . . of the physician." 42 U.S.C. § 11151(9). Moreover, this broader evaluation of Defendants' actions is compelled by the court's charge, which defined "professional review actions" as "the suspension of Dr. Poliner's cardiac catheterization lab privileges on May 14, 1998 and May 29, 1998," and asked the jury to determine whether this "suspension" was undertaken in compliance with the HCQIA standards. (CR4452-54)

When the professional review action at issue is thus properly characterized, and when all the evidence is viewed in the light most favorable to the jury's answers to Question No. 3, there can be no question that Poliner rebutted all (and certainly at least one) of the four requirements for HCQIA immunity. And for similar reasons, Defendants cannot rely on the so-called "emergency" provision in § 11112(c)(2) to salvage

their immunity claim. Indeed, given Defendants' extraordinary abuses of the peer-review process in this case, any other result would impermissibly transform the *qualified* immunity intended by Congress into *absolute* immunity. *See Brown*, 101 F.3d at 1334 n.9.

1. Defendants had no reasonable belief that their actions furthered quality heath care.

There was ample evidence to support the jury's findings in Question No. 3(1) that the actions taken against Poliner on May 14 and May 29 were not "in the furtherance of quality health care," and that Knochel and the Hospital could not have had a "reasonable belief" that they were. *See* 42 U.S.C. § 11112(a)(1). In each of the five medical cases Knochel and others criticized, the evidence demonstrated that if Poliner had actually administered the purported "care" demanded by the critics, he would have affirmatively *endangered* his patients. As the evidence showed, a reasonable person in Knochel's position would (or should) have known that:

- Patient 10 would have been placed in danger if Poliner had sent her back to Oklahoma without treatment merely to avoid the unlikely risk of a rash from her shellfish allergy. (2RR353-56; 5RR1211-12)

- Patient 18 likely would have died from her heart attack if Poliner had done nothing, instead of at least attempting cardiac intervention. (4RR916; 6RR1265-66)

- Patient 3 could have been harmed if Poliner had put the new sheath in the other groin and then later needed that groin site for a balloon pump. (5RR1175-76; 6RR1351-52)

- Patient 9 would have been endangered from further bleeding in the brain if Poliner had sent the patient off for a CT scan or to surgery in the middle of the night. (4RR909; 6RR1259-62, 1367-68)

- Patient 36 would have been placed at great risk if Poliner had worked first on the LAD instead of the RCA. (3RR708; 4RR931-32; 5RR1160-64; 6RR1392; 7RR1590)

Based on this evidence, the jury was entitled to conclude -- as it plainly did -- that Defendants were not operating under a reasonable belief that their actions were furthering *quality* health care. To the contrary, the evidence supported a finding that Defendants were trying to further an impermissible agenda that was entirely unrelated to health care. *See Boczar v. Manatee Hospitals & Health Systems, Inc.*, 993 F.2d 1514, 1518 (11th Cir. 1993) ("Fabricating damaging incidents or purposeful overreacting would be conduct that no reasonable medical practitioner or hospital could believe to be part of legitimate peer review."). Indeed, if Defendants had truly been interested in furthering the "objective medical concerns" required under § 11112(a)(1), *see Sugarbaker v. SSM Health Care*, 190 F.3d 905, 913 (8th Cir. 1999), they at least would have been willing to listen to Poliner's explanations regarding the care he administered.

2. Defendants made no reasonable effort to obtain the facts.

There was also abundant evidence supporting the jury's findings in Question No. 3(2) that the actions against Poliner on May 14 and May 29 were not taken "after a reasonable effort to obtain the facts of the matter." 42 U.S.C. § 11112(a)(2). Even though Knochel was prepared to suspend Poliner immediately on both dates (and used that threat to coerce an abeyance), neither he nor the Hospital had done any of the fact-gathering that a reasonable peer reviewer would ordinarily undertake before imposing such a drastic measure. Both Knochel and Merrill admitted that they did not have enough information to make the requisite finding that Poliner posed a present danger to his patients before deciding that he would be immediately suspended if he did not acquiesce in an abeyance. (1RR215; 2RR361-62, 449-50) Indeed, Knochel readily acknowledged that "files needed to be reviewed . . . people needed to be spoken to." (2RR409, 449)

Under § 11112(a)(2), however, those types of fact-gathering efforts should have been undertaken before, not after, Defendants decided that Poliner should be suspended. Instead, at the time Defendants decided Poliner's fate:

- the reviews of the cases involving Patients 3, 9, and 18 were still ongoing, and no one had even bothered to ask Poliner about these cases. (2RR422; 6RR1272)

- Knochel had not even looked at the files of Patient 9 despite claiming that this case was significant to his decision. (2RR373, 379)

- Knochel refused to hear Poliner's explanation of his treatment on Patient 36 and admitted that the case needed to be "investigated . . . more," despite claiming that this case was also significant to his decision. (2RR409, 413)

- Knochel failed to ask Das why he had allowed Poliner to continue working on Patient 36's RCA despite Das's contemporaneous observation that the LAD was occluded. (2RR397, 487-88)

- No one had reviewed the available database that would have revealed Poliner's consistently high level of patient care. (3RR546; 7RR1623)

Taken together, these omissions were more than sufficient for the jury to find that Defendants did not make "a reasonable effort to obtain the facts" before deciding that suspension was an appropriate remedy for Poliner. *See Brown*, 101 F.3d at 1334 (jury entitled to find that panel's review of only two charts before revoking physician's privileges was "unreasonably restrictive and not taken after a 'reasonable effort to obtain the facts.'").

3. Defendants provided inadequate notice and hearing.

Defendants initially are wrong in contending that "[n]otice and hearing were not required" for their actions against Poliner. (Br. at 35) The HCQIA provides that such procedures are not required for "a suspension or restriction of clinical privileges, for a period of *not longer than 14 days* . . . ." 42 U.S.C. § 11112(c)(1)(B) (emphasis added). This provision does not apply here because the initial suspension of Poliner began on May 14 and ended *fifteen days* later on May 29. (PX-82, 92) And while that period alone is sufficient to take Defendants' actions outside of § 11112(c)(1)(B), Defendants' demand that Poliner extend the suspension for an additional fourteen days to June 12 renders the provision's inapplicability even more obvious.

Defendants thus had to comply with the notice and hearing requirement under § 11112(a)(3), and ample evidence supported the jury's finding in Question No. 3(3) that their actions against Poliner were not undertaken "after adequate notice and hearing procedures" or "after such other procedures as are fair . . . under the circumstances." 42 U.S.C. § 11112(a)(3). Specifically:

- Knochel demanded that Poliner appear at the May 13 meeting but refused to tell him what the meeting would be about. (6RR1299-1300)

- At this meeting, Knochel refused to discuss any of Poliner's cases and did not let Poliner give any explanations. (6RR1300; 7RR1507)

- Harper and Levin also refused to let Poliner discuss his treatment of Patient 36. (3RR574-75, 651-52; 4RR847, 851)

- Knochel did not mention the option of corrective action, he did not inform Poliner about his rights to a hearing, and he did not explain or provide a copy of the bylaws. (6RR1301)

- Until May 14, Defendants did not tell Poliner that his treatment of Patients 3, 9, and 18 had even been under review. (PX-83; 6RR1299-1300)

- Knochel refused to let Poliner discuss or have an attorney review the May 14 letter (which Poliner received at 3:00 p.m.), and instead gave Poliner an immediate deadline to "[s]ign this letter right now and get it back down to the office or your privileges are gone." (2RR415-16; 6RR1302; 7RR1511-13)

- Defendants hindered Poliner's ability to review the charts from the four cases identified in the May 14 letter (PX-87) and refused to hear his viewpoint (2RR393, 413; 3RR651-52; 4RR851; 6RR1300).

- On May 29, when Knochel demanded that Poliner extend the abeyance period for an

> additional fourteen days, Knochel again threatened to terminate Poliner immediately and falsely stated that Poliner would have no opportunity to defend himself. (6RR1310; 7RR1516-17, 1521)

Multiple experts confirmed the obvious -- that Poliner received inadequate notice, was given no opportunity to be heard, and was the victim of a fundamentally unfair and unreasonable process. (3RR791; 4RR933-35, 992-94, 1015; 6RR1446-47) Accordingly, the evidence overwhelmingly established Defendants' violation of § 11112(a)(3).

4. Defendants had no reasonable belief that their actions were warranted by the facts.

Finally, ample evidence supported the jury's answer to Question No. 3(4) that Defendants' actions against Poliner were not undertaken "in the reasonable belief that the action was warranted by the facts known after such reasonable efforts to obtain facts and after meeting the requirement of [§ 11112(a)(3)]." 42 U.S.C. § 11112(a)(4). As demonstrated above, Defendants did not meet the requirement of § 11112(a)(3). They also did not have a "reasonable belief" on May 14 that the actions they took against Poliner were "warranted" by the known facts. Even though Knochel was prepared to suspend Poliner immediately -- and threatened just that -- both Knochel and Merrill admitted that they did not have enough information to make the requisite finding under the controlling bylaws that Poliner constituted a present danger to the health of his patients. (1RR206-07, 215; 2RR361-62, 449-50; PX-220

at 73) Knochel further acknowledged that he "probably [would] not" have suspended Poliner on May 14 on the basis of Patient 36 "[w]ith what I had in hand right on that day . . . until we investigated it more." (2RR409) By their own admissions, Defendants thus lacked *any* belief -- let alone the "reasonable belief" required by § 11112(a)(4) -- that the decision and threat to immediately suspend Poliner on May 14 were warranted by the known facts.[12]

Nor did Defendants have a reasonable belief on May 29 that immediately suspending all of Poliner's privileges was warranted by the known facts. Although Defendants now argue that by May 29 an ad hoc committee "had found a pattern of substandard care in over half of Poliner's cases" (Br. at 36), Defendants' only citation for that proposition is from the "background" section of the trial court's September 2003 summary judgment order (CR2596). In fact, there was no evidence at trial of the ad hoc committee's findings, Knochel's knowledge of any such findings, or even the notion that a claim of "substandard care" could warrant a finding that the doctor is a "present danger." To the contrary, the trial record was replete with evidence that Poliner was not a present danger, that no reasonable person could have believed that he was, and that a suspension thus was utterly

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[12] Contrary to the suggestion of Defendants and their amici allies, this conclusion does not "confus[e] HCQIA immunity standards with language in the Medical Staff Bylaws." (Br. at 7 n.4) Rather, it merely evaluates the reasonableness of Defendants' actions (as required by the HCQIA) in light of Defendants' own standards for determining when such actions are warranted (as established by the bylaws).

unwarranted. (3RR673-74, 714-19; 4RR898, 933, 1015; 6RR1336, 1338-40, 1342, 1400) Poliner therefore disproved Defendants' compliance with § 11112(a)(4).

5. Defendants cannot resurrect immunity through the HCQIA's "emergency" provision.

Having failed to satisfy any of the four requirements for immunity under § 11112(a), Defendants cannot resurrect their claim of immunity by invoking the HCQIA's so-called "emergency" provision, which allows "an immediate suspension or restriction of clinical privileges" if failing to do so "may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2). To begin with, § 11112(c)(2) is *not* -- contrary to the unsupported contention of Defendants and their amici -- "a second, independent provision which immunizes Defendants" even if they have failed to satisfy § 11112(a). (Br. at 36) Section 11112(c)(2) is merely an exception allowing the notice and hearing required under § 11112(a)(3) to be provided after the fact; it does not substitute for the other requirements of § 11112(a), including the need to have a reasonable belief that the action is warranted by the facts. *See* H.R.REP. NO. 99-903, *reprinted in* 1986 U.S.C.C.A.N. 6384, 6394 (describing emergency provision as an "exception[]" to "due process" that still requires a showing of "reasonable belief"); *Payne v. Harris Methodist H.E.B.*, 2001 WL 252185, at *3 (N.D. Tex. Jan. 31, 2001) (court analyzes all four requirements under § 11112(a); § 11112(c)(2) is relevant only to notice and hearing requirement).

In any event, regardless of whether § 11112(c)(2) is an exception to due process or a second basis for immunity, the evidence amply supported the jury's finding in Question No. 1 that Poliner did *not* pose "an imminent danger to the health of any individual" on either May 14 or May 29.[13] The HCQIA's emergency procedure is plainly intended for extraordinary cases in which a physician suddenly becomes impaired or grossly incompetent. The evidence here overwhelmingly disproved any such exigent circumstances. In the cases involving Patients 3, 9, and 18, Poliner's treatment had long since ended, reviews were still ongoing (although various committees had cleared cases 3 and 18), and no one had ever hinted that Poliner's work in the cath lab might pose an "imminent danger" to anyone. And while Poliner did miss part of an occluded LAD on Patient 36, he had never done that before in over 20 years of practice, Das was unconcerned when he contemporaneously observed Poliner's work on the RCA, and fixing the RCA immediately relieved the patient's symptoms. Based on Knochel's admission that he had not yet determined that Poliner posed a danger to his patients (2RR361-62, 449-50), and given the testimony from four experts that no one reasonably

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[13] While Question No. 1 did not place the statutory word "may" before the "imminent danger" language (CR4450), the court's accompanying instruction precisely tracked the statutory language (CR4449: "Under the law, Defendants had the legal right to suspend or to threaten to suspend Dr. Poliner's privileges on May 14, 1998 and on May 29, 1998 if the failure to take such an action may have resulted in imminent danger to the health of any individual . . . ."). Defendants did not object to the question or the instruction, but in fact endorsed them. (10RR2244-45)

could have so determined (3RR673-64; 4RR1015; 6RR1338-39, 1340, 1342, 1400), the jury was more than entitled to reject the only contrary evidence that Defendants can now muster -- the discredited testimony of Weinmeister and the self-serving testimony of former defendants Levin and Harper (Br. at 37). *See Brown*, 101 F.3d at 1334 n.9 (noting jury's responsibility in HCQIA cases to weigh conflicting expert opinions).

B. The Texas Peer Review Statute Does Not Protect Defendants' Actions.

After rejecting Defendants' claim of immunity under the HCQIA, the jury further found in Question No. 4 that Defendants were not entitled to immunity under the Texas peer review statute because they "took an action" against Poliner that was "with malice and not in the reasonable belief that the action was warranted by the facts known." (CR4458)[14] In attacking the finding of malice, Defendants again set up a false test to which they apply their own view of the evidence. Under the correct standard, the action

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[14] Although Defendants now complain that the court's definition of actual malice in the instruction to Question No. 4 focused on "making a statement" rather than "taking an action" (Br. at 37 n.9), the former was consistent with the facts, and the question itself asked whether Defendants "took an action" with malice (CR4458). Contrary to Defendants' further complaint (Br. at 38 n.11), the court's additional requirement in Question No. 4 that Defendants have "a reasonable belief that the action was warranted by the facts known" comes directly from the statute, *see* TEX. OCC. CODE ANN. § 160.010(a)(2), and was disproved by the same evidence that disproved the identical requirement in 42 U.S.C. § 11112(a)(4).

that must be tested for malice is not a legitimately obtained and freely agreed "Abeyance"; it is Knochel's decision to immediately suspend Poliner if he did not accept an abeyance, and Knochel's threats to carry out that suspension unless Poliner promptly signed the abeyance letters. This characterization of the relevant actions is not, as Defendants describe it, a "litigation invention" involving a "transformation of the agreed Abeyance into an involuntary suspension." (Br. at 40 n.12) If any "transformation" occurred, it was caused by Knochel himself in coercing the abeyance through the only means he knew would be effective -- threatening to impose a suspension that he knew the facts did not warrant. That act alone demonstrates actual malice.

As the trial court properly instructed the jury, actual malice exists when a statement is made with knowledge that it is false or with reckless disregard of whether it is false. (CR4457) Reckless disregard is a subjective standard that focuses on the conduct and state of mind of the defendant, *see Bentley v. Bunton*, 94 S.W.3d 561, 591 (Tex. 2001), and it occurs when the actor "entertain[s] serious doubts" or has a "subjective awareness of probable falsity." *Seidenstein v. National Med. Enterprises, Inc.*, 769 F.2d 1100, 1104 (5th Cir. 1985) (citations omitted). Because the actor's state of mind is at issue, actual malice "can -- indeed, must usually -- be proved by circumstantial evidence." *Bentley*, 94 S.W.3d at 596. Evidence that may support a finding of actual malice includes a "lack of care" or an "injurious motive" in making a statement, a statement "made on information that is obviously dubious," or "a purposeful avoidance of the truth." *Id.*; *see also Duffy v. Leading Edge Products, Inc.*, 44 F.3d 308, 315 n.10

(5th Cir. 1995) (inadequate investigation coupled with evidence of ulterior motive can establish actual malice). Thus, in *Frank B. Hall & Co. v. Buck*, 678 S.W.2d 612, 620-21 (Tex. App. -- Houston [14th Dist.] 1984, writ ref'd n.r.e.), evidence that the defendant's manager had a "strained" relationship with the plaintiff and "harbored animosity" toward him was sufficient to support the jury's finding that the statements at issue were made with actual malice.

Applying these principles under the proper standard of review, there is more than sufficient direct *and* circumstantial evidence to support the jury's findings that Knochel and the Hospital (both directly and through Knochel) acted with actual malice toward Poliner. Knochel had an intense dislike of Poliner (2RR366), and when Poliner began a solo practice in competition with the dominant cardiology groups at the Hospital, Knochel sided with those groups in trying to eliminate Poliner's privileges (1RR228-30; 2RR361-62; 4RR819-20; 5RR1209). When he failed to oust Poliner through the pretext of "inadequate documentation," Knochel authorized reviews of three cases in which the criticisms against Poliner were demonstrably exaggerated or manufactured. (*See* pp. 11-15, 38-39) Then, following the incident involving Patient 36, Knochel decided that Poliner would be immediately suspended -- an action reserved for only dangerous doctors -- if Poliner did not agree to put his cath lab privileges in abeyance. (2RR256-57, 364-65) But significantly, Knochel did not believe at the time that Poliner in fact constituted a present danger to his patients (2RR361-62, 365, 449-50), nor did he even profess to have such a belief. And the Hospital's president, Merrill, acquiesced in Knochel's decision

even though he likewise lacked any basis to believe that Poliner posed a danger. (1RR215-17; 2RR403-04)

Although this evidence alone is sufficient to support the jury's finding of actual malice, other evidence corroborates that finding. By refusing to even listen to Poliner's explanation about any of the cases at issue -- despite acknowledging that "files needed to be reviewed" and "people needed to be spoken to" (2RR450) -- Knochel purposefully avoided facts that would have rebutted any claim that Poliner was a dangerous doctor. Further demonstrating his animosity and ulterior motive in trying to eliminate Poliner and injure Poliner's reputation, Knochel refused to let Poliner confer with a lawyer, failed to inform him of the less severe options (such as corrective action or IMAC review) that should have been available to him, and misleadingly told Poliner he could be terminated without any opportunity to defend himself. (*See* pp. 20-22, 24-25, 42-43) Based on this conduct, four experts on cardiology and peer review testified that no one could have taken these actions against Poliner except by knowingly or recklessly disregarding the truth about Poliner's medical care. (3RR714-19, 790; 4RR898, 933, 935, 1015; 6RR1338-40, 1342, 1400, 1440) This and other evidence amply supports the finding of actual malice, which prevents Defendants from claiming state-law immunity.

IV. The Evidence Supports the Jury's Findings that Defendants Defamed Poliner.

Starting with the unsupported assertion that the Hospital cannot be liable for damages because only Knochel "said anything about the Abeyance" (Br. at

40), Defendants' shotgun attack on the jury's defamation findings continues their pattern of misapplying the law to an erroneous view of the evidence. Defendants' initial proposition is wrong because the Hospital is vicariously liable for the defamatory statements of Knochel (a Hospital employee and a department chairman), which coupled with the Hospital's own acquiescence and ratification, support a separate award of damages against the Hospital. (*See* pp. 81-83) The remainder of Defendants' arguments -- relating to the concepts of publication, truth, privilege, and limitations -- are equally flawed.

A. Defendants Published Statements that Were Defamatory *Per Se* and Were False.

The evidence demonstrates that Defendants were responsible for publishing at least five categories of false and defamatory *per se* statements about Poliner. Any one of them supports the jury's answers to Question Nos. 7-9 and the judgment below.[15]

(1) On May 13, 1998, Knochel published a statement to Levin, Harper, Merrill, and several other

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[15] Defendants' footnote contention that the court somehow "doom[ed]" the judgment by not submitting separate questions on each defamatory statement (Br. at 41 n.13) is wrong under Texas law. *See, e.g.*, *Columbia Med. Ctr. of Las Colinas v. Bush*, 122 S.W.3d 835, 859-60 (Tex. App. -- Fort Worth 2003, pet. denied). In any event, it was not preserved by a proper objection or requested question. (*See* 10RR2413: requesting only that jury be *instructed* about each defamatory statement, not that separate *questions* be submitted).

Hospital employees that Poliner's treatment of his patients would warrant his immediate suspension if he did not agree to an abeyance of his cath lab privileges. Because the bylaws allowed the immediate suspension of only those doctors who constituted a present danger to their patients, Knochel's statement conveyed the obvious and defamatory meaning that Poliner was a dangerous doctor. *See Turner v. KTRK Television, Inc.*, 38 S.W.3d 103, 114 (Tex. 2000) ("[A]n allegedly defamatory publication should be construed as a whole in light of the surrounding circumstances based upon how a person of ordinary intelligence would perceive it."); *Golden Bear Distrib. Sys. v. Chase Revel, Inc.*, 708 F.2d 944, 948-49 (5th Cir. 1983) (ordinary reader could interpret article to accuse plaintiff of fraud). Defendants failed to meet their burden of proving that this defamatory *per se* statement was true. Indeed, there was abundant evidence that Poliner was not a dangerous doctor, and at the time even Knochel did not believe that Poliner was dangerous. (2RR361-62, 449-50; 3RR673-64; 4RR935-36; 6RR1338-42)

(2) On May 14, 1998, Knochel sent a memo to six cardiologists at the Hospital stating that Poliner had "accepted abeyance" of his cath lab privileges. (PX-82) This statement was not "literally and substantially true," as Defendants conclusorily state. (Br. at 44) To the contrary, it was false because it failed to disclose that Knochel had coerced Poliner's alleged acceptance by threatening an immediate suspension that Knochel had no legal right to impose. *See Turner*, 38 S.W.3d at 114 ("[A] publication can convey a false and defamatory meaning by omitting or juxtaposing facts, even though all the [publication's] individual statements considered in isolation were literally true

or non-defamatory."). And the statement was defamatory *per se* because it conveyed the false and damaging meaning that Poliner had admitted his own deficiencies by volunteering to give up his cath lab privileges at least temporarily. *Id*. ("publication's meaning depends on its effect on an ordinary person's perception"). Nothing, of course, was further from the truth.

(3) Defendants' conduct of barring Poliner from the cath lab also constituted actionable defamation. As the trial court correctly instructed the jury, publication "by conduct" occurs when the communication to another "is made and understood without words." (CR4461) *See Reicheneder v. Skaggs Drug Ctr.*, 421 F.2d 307, 312 (5th Cir. 1970); *Marshall Field Stores, Inc. v. Gardner*, 859 S.W.2d 391, 396, 399 (Tex. App. -- Houston [1st Dist.] 1993, writ dism'd w.o.j.) (recognizing doctrine of "publication by conduct" but not applying it because jury charge was limited to "defamatory words").[16] Here, from the very moment

[16] Defendants acknowledged at trial that "conduct can constitute a defamation." (10RR2249) In now citing *Accubanc Mortgage Corp. v. Drummonds*, 938 S.W.2d 135, 150 (Tex. App. -- Fort Worth 1996, writ denied), for the proposition that "the very act of firing an employee" does not communicate the "words" required for defamation, Defendants ignore other Texas cases recognizing defamation by conduct. They also disregard the distinguishing fact in *Drummonds* that the employer never said anything about the reasons for the firing, which itself (unlike the suspension of a doctor) has no stated standards that would necessarily convey a defamatory meaning. *Id*. at 149. Equally inapposite is *Randall's Food Markets, Inc. v. Johnson*, 891 S.W.2d 640, 646 (Tex. 1995);

when Poliner was wrongly barred from the cath lab, the medical community understood that act to mean that Poliner had serious problems as a doctor. (3RR803-05; 6RR1309, 1312, 1344-45; PX-87, 90) Indeed, belying the fine distinction Defendants now try to draw between "the fact of Abeyance" and "suspension" (Br. at 43), two medical experts testified that physicians view these two rarely-imposed measures as "the same thing" -- namely, a statement that the affected doctor is a danger to his patients. (4RR1013-14; 6RR1344-45; *see also* 6RR1329-30) In Poliner's case, however, that statement was demonstrably false.

(4) In December 1999 and January 2000, long after Poliner's privileges were reinstated, Knochel responded to another hospital's inquiry about Poliner by twice reporting that Poliner's privileges had to be temporarily restricted. (2RR439; 4RR1086; 7RR1638-39; PX-169, 171) These statements conveyed a false meaning -- that Poliner was doing something seriously wrong -- by omitting to disclose material facts -- that the temporary restrictions had been coercively obtained and wrongfully imposed. *See Turner*, 38 S.W.3d at 114-15.

(5) In numerous applications to hospitals and HMOs, Poliner was repeatedly compelled to self-publish (with appropriate explanations) that his privileges had been "restricted" as a result of his forced

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as the *Turner* court observed, the statements in *Randall's* presented a "true account of events" and involved no omission or misleading presentation. *Turner*, 38 S.W.3d at 115.

abeyance. (4RR1066-68; 6RR1313-17, 1324, 1329-30, 1345-46; PX-207, 208) Defendants knew or should have known that Poliner would have to do so. (2RR439-43) Contrary to Defendants' contention (Br. at 47 n.18), the jury was instructed to consider self-publication (CR4461), Poliner relied on self-publication in his post-verdict briefs (CR6122-24), and Texas courts recognize the doctrine. *See Purcell v. Seguin State Bank & Trust Co.*, 999 F.2d 950, 959 (5th Cir. 1993).

B. Defendants' Defamation Was Not Qualifiedly Privileged.

In response to Question No. 10(A), the jury rejected Defendants' claim of "qualified privilege" by finding that they did not communicate their defamatory statements to other persons "having a corresponding interest or duty regarding the peer review action taken" on May 14 or May 29. (CR4466) Even assuming that the six prospective ad hoc committee members to whom Knochel communicated on May 14 had the requisite "corresponding interest or duty," no one else did -- including Levin and Harper (who were not on any peer review committee), Poliner's referral sources at the Hospital, or the other hospital to which Knochel falsely reported long after the reinstatement of Poliner's privileges. Thus, Defendants failed to conclusively establish a qualified privilege.

In addition, although the jury did not have to answer Question No. 10(B) -- asking whether the privilege (if found) was lost because the defamatory statements were made with actual malice -- the jury did find actual malice in the materially identical

Question No. 4, and there was ample evidence to support its findings.[17] The entire act of barring Poliner from the cath lab, and every statement about that act, were actuated by actual malice. As discussed above, Defendants' words and acts labeled Poliner as a dangerous doctor, even though Defendants did not believe at the time that he in fact constituted a present danger. (*See* pp. 49-51, 53-56) Further, even though Knochel knew he had threatened Poliner with a suspension that he also knew lacked any factual basis, he failed to disclose these facts in his May 14 memo to create a false impression that Poliner had "accepted" an abeyance. *See Huckabee v. Time Warner Entm't Co.*, 19 S.W.3d 413, 426 (Tex. 2000) (knowing omission of a critical fact to create a false impression raises inference that defendant acted with actual malice). And Knochel again acted with actual malice in December 1999 and January 2000, when he failed to disclose that the restriction on Poliner's privileges initially had been coerced and later had been eliminated. This evidence fully supports the finding of actual malice.

C. The Defamation Claim Is Not Barred by Limitations.

Defendants' seven-sentence argument about the statute of limitations ignores the trial court's three opinions thoroughly analyzing and then rejecting that

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[17] Other than their own *ipse dixit* (Br. at 45 n.17), Defendants offer no legal or logical reason why the jury's finding of actual malice in Question No. 4 would have to be repeated in the answer to Question No. 10(B) to overcome the defamation qualified privilege, just as it overcame the Texas peer review immunity.

defense. (CR2621, 6540-44, 7269-70) As the court correctly held, Defendants republished the defamatory statements in December 1999 and January 2000 (shortly before Poliner filed suit on May 11, 2000), and thus limitations does not bar Poliner's defamation claim. (*Id*.) Further, these republications are actionable, and they plainly referred to the unlawful restrictions in May 1998 rather than the allegedly immune restriction in June 1998. (4RR1086-87; PX-169, 171) In any event, as the court below correctly held, Defendants waived any arguments to the contrary by not timely raising them. (CR6541-44, 7269-70)[18]

V. Judgment Can Be Rendered on the Alternative Tort and Contract Claims.

Although the judgment below should be affirmed based on the defamation verdict, it also can be upheld on the alternative verdicts for tortious interference and breach of contract. *See DSC Communications Corp. v. Next Level Communications*, 107 F.3d 322, 327 (5th Cir. 1997) (affirming judgment on alternative verdict

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[18] There is also no merit to Defendants' cursory footnote argument that Poliner cannot recover damages from the 1998 defamation by proving republication within the limitations period. The one case they cite for that proposition, *Akin v. Santa Clara Land Co.*, 34 S.W.3d 334, 340-41 (Tex. App. -- San Antonio, 2000, pet. denied), says nothing about the recoverability of damages when, as here, limitations has been defeated by actionable republications. The rule Defendants propose also makes no sense when, as here, the republished statements relate directly back to the 1998 statements and the resulting damages are continuing, intangible, and not susceptible to precise temporal apportionment.

for misappropriation even though judgment based on usurpation verdict was vacated).[19]

A. The Evidence Supports the Jury's Findings of Tortious Interference.

In response to Question Nos. 14-17, the jury found that Defendants interfered with Poliner's contractual relationships (both existing and prospective), that the interference was not justified, and that Poliner was entitled to damages of the same type and amounts as the defamation damages. (CR4475-82) As the trial court found, sufficient evidence supported these findings, and thus the tortious interference claim constitutes an alternative basis for affirming the judgment. (CR6544-47)

Under *Keipfer v. Beller*, 944 F.2d 1213 (5th Cir. 1991) -- which Poliner and the trial court cited but which Defendants ignore -- there is ample evidence to support the findings that Defendants tortiously interfered with Poliner's practice. Like the doctor in *Keipfer*, *id.* at 1220, Poliner enjoyed a thriving practice that grew from physician and patient referrals. (6RR1277-78, 1305; 7RR1661) But Defendants intentionally destroyed that practice and Poliner's reputation by forcing Poliner to agree to the "abeyance" under duress, unjustifiably barring him from the cath lab, and publishing the false statement that he was a dangerous doctor. (*See* pp. 22-27, 76-78) These acts

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[19] Because the court below did not address the additional verdicts for business disparagement and intentional infliction of emotional distress, Poliner does not rely on them here.

interfered with Poliner's relationships with his referral sources, other hospitals, and health plans, and as a direct result, Poliner's reputation was ruined and he suffered significant mental anguish. (4RR1068-69; *see* pp. 22-27, 78-79) This evidence closely mirrors the facts in *Keipfer* and fully supports the jury's findings of liability for tortious interference and its damage awards for injury to career and reputation and for mental anguish (as reduced by the trial court). *Keipfer*, 944 F.2d at 1220.[20]

Defendants are also incorrect that the claim of tortious interference required Poliner to specifically identify "patients whose procedures had to be rescheduled or who fired Poliner." (Br. at 48) Rather, as this Court recognized in *Keipfer*, an interference with a doctor's general referral practice is sufficient to support a claim for tortious interference with prospective contracts. *Keipfer*, 944 F.2d at 1220; *see also Richardson-Eagle, Inc. v. William M. Mercer, Inc.*, 213 S.W.3d 469, 476 (Tex. App. -- Houston [1st Dist.] 2006, no pet.) (tortious interference with prospective contractual or business relations requires proof only

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[20] Contrary to Defendants' contention (Br. at 59 n.27), damages for injury to career/reputation, as well as damages for mental anguish, are recoverable in Texas under a claim of tortious interference, just as they are recoverable under defamation. *See, e.g.*, *Browning-Ferris, Inc. v. Reyna*, 852 S.W.2d 540, 549 (Tex. App. -- San Antonio 1992) (listing "emotional distress or actual harm to reputation" among damages available for tortious interference) (citing RESTATEMENT (SECOND) OF TORTS §744A(1)(c) (1977), *rev'd on other grounds*, 865 S.W.2d 925 (Tex. 1993). The one case Defendants cite, *American National Petroleum Co. v. Transcontinental Gas Pipe Line Corp.*, 798 S.W.2d 274, 278 (Tex. 1990), does not discuss these damages.

that the contracts or relations be "reasonably probable" under the circumstances).

Nor is there any merit to Defendants' premise that the tortious interference claim rests solely on defamation. (Br. at 48) For tortious interference with prospective contracts, a plaintiff need only prove an independently tortious or wrongful act. *Wal-Mart Stores, Inc. v. Sturges*, 52 S.W.3d 711, 726 (Tex. 2001). In addition to Defendants' defamatory conduct, Defendants' coercive conduct in obtaining Poliner's agreement to the abeyance through duress satisfies this element because duress is both wrongful and an actionable tort. *See, e.g., State Nat'l Bank v. Farah Mfg. Co.*, 678 S.W2d 661, 683 (Tex. App. -- El Paso 1984, writ dism'd by agr.). Thus, the tortious interference claim is not grounded exclusively in defamation.

Finally, as the trial court held, Defendants waived their defense of justification (CR6546 n.10) and, in any event, they failed to establish it (CR4479). With regard to interference with prospective contracts, justification is a defense "only to the extent" it is a defense to "the independent tortiousness of the defendant's conduct." *Sturges*, 52 S.W.3d at 727. Because there is no justification defense to duress (or defamation), this potential defense to an interference claim is unavailable to Defendants as a matter of law. *See id.*; *Prudential Ins. Co. of Am. v. Financial Review Servs., Inc.*, 29 S.W.3d 74, 81 (Tex. 2000). Further, Defendants had no legal right to, or good-faith belief that they could, interfere with Poliner's existing

contracts by securing the abeyance of Poliner's privileges through the unlawful threat of suspension.[21]

B. The Evidence Supports the Jury's Findings of Breach of Contract.

Alternatively, the Court may affirm the judgment as modified based on the breach of contract claim by Poliner's professional association. As a preliminary matter, Defendants are wrong in suggesting that the trial court could not correct the unobjected-to omission of the P.A. from the breach of contract damages question. (Br. at 49) Even the case Defendants cite, *Geosearch, Inc. v. Howell Petroleum Corp.*, 819 F.2d 521 (5th Cir. 1987), notes that a trial court "may correct clerical errors in a verdict," which is all the court did here. *Id.* at 527 (citing FED. R. CIV. P. 60(a)). (CR6533)

Defendants are also incorrect that the evidence does not support this claim. As the trial court correctly ruled (CR2605-07, 6528-29), section 11.04 of the Hospital bylaws creates an enforceable contract with physicians by incorporating the medical staff bylaws' procedural due process requirements for restricting

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[21] This stands in stark contrast to *Patel v. Midland Memorial Hospital & Medical Center*, 298 F.3d 333, 347 (5th Cir. 2002), cited by Defendants (Br. at 48-49), where the defendants' interference with the plaintiff-physician's business relationships was justified because it was undertaken under a peer-review process involving careful investigation and unmarked by any acts of coercion or duress.

physician privileges.[22] Because the Hospital bylaws thus provide the means by which the Hospital may curtail physician privileges, and impose an affirmative duty of compliance on the Hospital, they constitute an enforceable contract. *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438-39 (Tex. App. -- Texarkana 1994, writ denied).

Sufficient evidence also supports the jury's findings that the Hospital breached its contract:

- In response to Question No. 1, the jury found that Defendants lacked a reasonable belief that Poliner posed a "present danger" to his patients. By allowing Poliner to be threatened with summary suspension without this reasonable belief, the Hospital breached Art. VIII--Part C: § 3(a) of the medical staff bylaws, as incorporated into the Hospital's bylaws.

- In response to Question No. 2, the jury found that Defendants obtained the abeyances by duress. In so doing, the Hospital breached Art. VIII--Part C: § 2(a) of the medical staff

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[22] Specifically, section 11.04 provides that "[t]he Medical/Dental Staffs' Bylaws shall provide a process for denying, withdrawing or qualifying staff privileges, which provides procedural due process for the member." (PX-223 at 13) By contrast, the hospital bylaws in the cases Defendants cite had no such provision. *Stephan v. Baylor Med. Ctr.*, 20 S.W.3d 880, 887-88 (Tex. App. -- Dallas 2000, no writ); *Van v. Anderson*, 199 F. Supp.2d 550, 562-63 (N.D. Tex. 2002).

bylaws, which permits the Hospital to abate privileges only if the physician agrees.

- In response to Question No. 3(3), the jury found that Defendants failed to provide adequate notice and hearing, thus violating section 11.04 of the Hospital's bylaws.

Finally, Ruth Poliner's testimony regarding the P.A.'s lost earnings was sufficient to support an award of $10,526.55. Mrs. Poliner described the data she relied on and the method she used to calculate that figure -- and the Hospital objected to neither. (11RR2460-66) This competent evidence, based on objective facts and data, was sufficient to establish the P.A.'s lost earnings with "reasonable certainty." *Texas Instruments, Inc. v. Teletron Energy Mgmt., Inc.*, 877 S.W.2d 276, 278-79 (Tex. 1994). And an award of the requested $1,902,371.68 in attorney's fees is similarly allowed under the law and the supporting proof. (CR4652-74)

C. The Tort Damages Were Caused by the May 1998 Actions.

Defendants end their discussion of Poliner's other causes of action by switching gears and asserting that Poliner did not introduce evidence of damages that were "caused exclusively" by their May 1998 actions, as opposed to their June 1998 actions (which were found to be immune). (Br. at 53-54) This argument disregards the jury charge, the evidence, and basic principles of tort causation.

To begin with, the trial court instructed the jury to consider only those damages that resulted from the actions in May 1998, and not from any action on or after June 12, 1998. (CR4460, 4462, 4469, 4474, 4480, 4485) The court also noted, however, that it did *not* instruct the jury "that the scope or extent of Plaintiffs' injury and/or damages must be limited to a particular time period." (CR6547-48) Because "juries are presumed to follow their instructions" and Defendants have offered "no valid basis for disregarding that established presumption," the Court should reject Defendants' invitation to assume that the jury awarded damages that resulted from the June suspension rather than the May forced abeyances. *Gray v. Lynn*, 6 F.3d 265, 271 (5th Cir. 1993) (citations omitted).

Moreover, the evidence demonstrated that Poliner's tort damages (mental anguish and injury to career/reputation) began immediately after the forced abeyance of May 14. (6RR1301-02, 1311-12; *see* pp. 22-24) Poliner learned from other physicians "at the very onset" that his reputation "was being destroyed." (6RR1312) Consequently, his referrals stopped immediately (6RR1305) and his practice was already "gone" (6RR1311). Indeed, the very next day after the May 14 forced abeyance, Poliner received a phone call from Dr. Marty Cohen, one of his referring physicians, who had learned of the abeyance; thereafter, Cohen stopped referring patients to Poliner. (3RR803-05; CR6540)[23]

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[23] That the cessation of Dr. Cohen's referrals did not begin until June 1998 does not mean, as Defendants suggest (Br. at 23), that

Largely disregarding this evidence, Defendants instead contend that any damages Poliner sustained after June 1998 could not have been attributable "exclusively" to the May 1998 actions and thus cannot satisfy the causation element. (Br. at 22-23, 53-54) This argument has two fundamental defects. First, there is no requirement that the May actions have been the "exclusive" cause of Poliner's damages; as the trial court correctly instructed the jury, there can be more than one proximate cause of an event. (CR4468, 4480) Defendants themselves acknowledge that the May actions need only have been a "substantial factor" in causing Poliner's damages (Br. at 53), a requirement that the evidence satisfies.

Second, the fact that Poliner's damages continued long after May 1998 and thus "post-dated" the June suspension (*id.*) does not mean that the May actions were no longer a "substantial factor" in causing the damages. To the contrary, but for Defendants' unlawful actions in May 1998 that resulted in banning Poliner from the cath lab, Defendants would not have been able to summarily suspend Poliner at all (much less in a manner that any court would have immunized under the law).[24] And even if the June suspension *also*

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the May abeyances did not proximately cause Cohen to stop the referrals. In fact, Cohen testified that the abeyances did affect his decision to do so. (3RR805)

[24] If Knochel had merely asked for Poliner's agreement to the abeyance without making any unlawful threats, Poliner would have declined and thus would have been faced with either corrective action or suspension under the bylaws. Knochel could not have lawfully imposed a suspension, and under corrective action, Poliner could not have been suspended without first being

contributed to Poliner's damages, that does not sever the causal link between the May forced abeyances and the resulting damages. This result is consistent with the jury charge, which, as noted above, focused the jury on damages resulting only from the May actions but did not limit "the scope or extent of Plaintiffs' injury and/or damages . . . to a particular time period." (CR6547-48)

VI. Defendants Are Not Entitled to a New Trial

The trial court correctly rejected Defendants' request for a new trial based on the sufficiency of the evidence (Br. at 54 n. 22) because, as discussed above, the evidence overwhelmingly supported the verdict. *See Lane v. R.A. Sims, Jr., Inc.*, 241 F.3d 439, 444 (5th Cir. 2001). The court also acted well within its discretion in refusing a new trial based on Defendants' three additional complaints.

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heard by the same committee that ultimately vindicated him in November 1998. If Knochel had not spoken with Poliner but instead had assembled an ad hoc committee to review Poliner's cases, the committee would have taken weeks to make any recommendation. In the meantime, of course, Poliner would have been successfully treating patients in the cath lab on a regular basis (as he had done for the previous 20 years), thus making it impossible for any committee to conclude, reasonably and in good faith, that he constituted an imminent or present danger.

A. The Trial Court Correctly Determined that the Verdict Was Not the Product of Passion and Prejudice.

Defendants' first basis for a new trial -- that the size of the jury's awards alone evinces improper "passion and prejudice" -- is wrong as a matter of law and fact. (Br. at 54-55) As the Court held in *Edwards v. Sears, Roebuck & Co.*, 512 F.2d 276, 282 (5th Cir. 1975), "[a] jury's finding as to liability can be binding even though its monetary award is found to be excessive or even improperly influenced -- our deference to and faith in the jury system demands at least this much." While this Court on rare occasions has held that an award is so excessive that remittitur is an inadequate remedy, *see Wells v. Dallas Indep. Sch. Dist.*, 793 F.2d 679, 684 (5th Cir. 1984), that result is "not applicable" where a trial court expressly finds that the reduced award was "well supported by the evidence" and "was the product of reason, not passion." *Cimino v. Raymark Indus., Inc.*, 151 F.3d 297, 324 (5th Cir. 1998) (distinguishing *Wells*). The court below made these very findings based on its careful "observation of the trial." (CR6657) Specifically, the court found that "[t]here was nothing in the jurors' behavior to indicate that they were predisposed to Plaintiffs," and that the total award of actual and punitive damages, though excessive and subject to reduction, "was a product of reason -- not emotion -- resulting from a rational deduction [by the jury] that such action was necessary to compensate Dr.

Poliner and to effect change in Defendants' conduct in the future." (CR6657)[25]

Defendants cannot overcome these adverse findings by providing a list of alleged "overt plays to passion and prejudice." (Br. at 55 & n.23) This list is particularly unimpressive because the alleged "overt plays" are merely the ordinary incidents of any hard-fought and hotly-contested trial. Indeed, Defendants failed to object to virtually all of these comments at the time they were made, thereby waiving any complaint and belying Defendants' exaggerated contentions on appeal. (*See* 1RR132, 170, 219, 233; 3RR617, 659; 4RR843, 853; 7RR1673; 11RR2477, 2489, 2490-91, 2492-93, 2544-45) *Colburn v. Bunge-Towing, Inc.*, 883 F.2d 372, 376 (5th Cir. 1989). And the fact that Poliner's counsel were occasionally "warned" about their comments (Br. at 55 & n.25) shows only that the trial court exercised firm control over the courtroom in successfully eliminating any undue "passion and prejudice." *See, e.g.*, *Brown v. Parker Drilling Offshore Corp.*, 410 F.3d 166, 180-81 (5th Cir. 2005).[26] In short, the court correctly exercised its broad discretion in

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[25] The court did not, as Defendants imply, find that the jury's actual damages award "was meant to punish." (Br. at 56) In stating that "[t]here is no doubt that the size of this award clearly reflects the jury's desire to punish these Defendants and to compensate Dr. Poliner for the loss of his career," the court was addressing both the punitive and compensatory awards, respectively. (CR6657)

[26] The court also instructed the jury that "prejudice or sympathy" must not influence their decision (CR4444), and there is no basis for concluding that the jury disregarded that admonition. *Gray*, 6 F.3d at 271.

concluding that the jury's verdict was not motivated by passion and prejudice.

B. The Trial Court Correctly Exercised Its Discretion in Excluding the Hearing Committee's Endorsement of the June 1998 Suspension.

Contrary to Defendants' argument (Br. at 56-57), the trial court properly exercised its discretion in excluding the hearing committee's November 1998 letter, which reinstated Poliner but noted that the June 1998 suspension was justified "based on the evidence available to [Knochel] at the time." (DX-95) It is well-settled that a trial court has discretion to exclude evidence that is irrelevant or cumulative. FED. R. EVID. 401, 403. Here, the court correctly determined before trial that the hearing committee's self-serving endorsement of the June suspension was "irrelevant," given that Poliner was not permitted under the court's immunity ruling to attack the June suspension to which the letter referred. (PT-Hrg. 30-31, 34) Defendants' counsel even acknowledged that she "under[stood]" the basis for that ruling. (*Id.* at 34) Counsel was more concerned with being able to admit into evidence the letter's conditions on Poliner's reinstatement (*id.*), but the jury ultimately learned about these conditions through testimony and exhibits (3RR664; 7RR1470-72; PX-171).

Moreover, the statements in the letter about the June suspension were cumulative of other evidence the jury heard. For example, Harper volunteered that "[t]he committee recommended reinstatement of [Poliner's] privileges with monitoring, and

authenticated that they believed the action that had been taken for his summary suspension was justified." (3RR664) This testimony virtually duplicated the contents of the letter. (DX-95) Indeed, in sustaining Poliner's objection to the letter when Defendants finally attempted to offer it toward the end of the trial, the court told Defendants' counsel, "I think you have in what you need to get in." (9RR2102) Based on the irrelevant and duplicative contents of DX-95, the trial court correctly exercised its discretion in excluding it.

C. The Trial Court Correctly Exercised Its Discretion in Admitting Dr. Dunn's Testimony.

Defendants' handful of perfunctory attacks on the testimony of Poliner's expert, Dr. John Dunn (Br. at 57-58), fails to establish that the trial court abused its discretion in allowing that testimony. *See Hodges v. Mack Trucks, Inc.*, 474 F.3d 188, 194 (5th Cir. 2006). Far from constituting "unhelpful, baseless legal conclusions" (Br. at 57), Dunn's testimony regarding the standards for a reasonable peer-review process, the degree to which Defendants deviated from that process, and the impact of Defendants' actions on Poliner's career (4RR965-1089) assisted the jury's understanding of the specialized and inscrutable world of medicine that is far beyond the average juror's experience. *See, e.g.*, *Brown*, 101 F.3d at 1333-34 (expert testified regarding propriety of peer-review procedures); *Bryan v. James E. Holmes Reg'l Med. Ctr.*, 33 F.3d 1318, 1331 n.22 (11th Cir. 1994) (same).

There is also no merit to Defendants' mischaracterization of Dunn's testimony as simply

"reading Defendants' minds." (Br. at 57) Defendants' inapposite cases notwithstanding,[27] experts are allowed to testify to the ultimate issue at trial, FED. R. EVID. 704, including the presence of actual malice based on (among other facts) the failure to comply with professional standards. *See, e.g.*, *Suzuki Motor Corp. v. Consumers Union of U.S.*, 330 F.3d 1110, 1137 n.14 (9th Cir. 2003); *Bressler v. Fortune Magazine*, 971 F.2d 1226, 1228 (6th Cir. 1992).[28] And when the expert testifies about such subjects, there is no requirement, as Defendants suggest (Br. at 57-58), that the testimony be susceptible to testing methods applicable to scientific expert testimony. *See, e.g.*, *Pipitone v. Biomatrix, Inc.*, 288 F.3d 239, 247 (5th Cir. 2002).

Moreover, Dunn's testimony largely duplicated other evidence and thus could not have given rise to harmful error. *See, e.g.*, *Snyder v. Whittaker Corp.*, 839 F.2d 1085, 1090 (5th Cir. 1988). For example, like Dunn (4RR992-94, 1013, 1015-16), DeMaio also testified that Poliner was not a danger to his patients, that Defendants' procedure in obtaining the abeyances was unfair, that the actions taken against Poliner were unwarranted, that an abeyance is as damaging to a

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[27] *Brueggemeyer v. American Broadcasting Cos., Inc.*, 684 F. Supp. 452, 463-66 (N.D. Tex. 1988), and *Freedom Newspapers of Texas v. Cantu*, 168 S.W.3d 847, 858-59 & n.48 (Tex. 2005) both involved "expert journalists" whose opinions lacked sufficient support and, in the case of *Brueggemeyer*, invoked an incorrect legal standard.

[28] Contrary to Defendants' claim (Br. at 58), Dunn also testified under the correct definition of actual malice (4RR1014-15). By erroneously arguing that the HCQIA "required no notice and hearing" (Br. at 58), Defendants simply disagree with Dunn's correct conclusions to the contrary.

doctor's career as a suspension, and that the damage to Poliner's reputation was irreparable (6RR1336, 1338-45, 1400, 1446).[29]

VII. Further Remittitur Is Not Necessary or Appropriate.

Although the trial court reduced Poliner's damage awards for injury to career/reputation and mental anguish from $70 million to $21 million, Defendants now seek either greater reduction or outright vacatur. (Br. at 58-61) But such relief is neither necessary nor appropriate. Measured against the highly deferential standard of review that applies when a trial court has already granted remittitur, the court below did not abuse its discretion in setting damages at their present amounts. The court also correctly concluded that the "maximum recovery rule" did not require further reduction. And far from creating any duplicative recovery, the greatly reduced separate damages against the Hospital are appropriate given the Hospital's independent liability for its ratification of Knochel's actions.

A. The Trial Court's Exercise of Discretion in Setting a Reduced Amount of Actual Damages Should Not be Second-Guessed.

Defendants are incorrect in contending that no evidence supported the damage awards, as reduced by

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[29] Wharton (3RR714-19), Kern (4RR898, 933), Merrill (1RR215), and Knochel himself (2RR449-50) also duplicated portions of Dunn's testimony.

the trial court, for injury to career/reputation and mental anguish. (Br. at 59-60) This Court will not reverse a jury's damages verdict for excessiveness except on "the strongest of showings." *Caldarera v. Eastern Airlines, Inc.*, 705 F.2d 778, 784 (5th Cir. 1983). As a preliminary matter, juries are accorded "especially broad leeway" in awarding damages that are not readily quantifiable, such as injury to reputation and mental anguish. *Seidman v. American Airlines, Inc.*, 923 F.2d 1134, 1141 (5th Cir. 1991); *see also Bentley*, 94 S.W.3d at 605. This deference is magnified here, where the trial court has already reduced the jury's damage awards by remittitur to less than one-third of their original size. *Stapleton*, 608 F.2d at 574 n.7 ("Where the trial court has invoked its discretion in granting a remittitur, our scope of review is even narrower than usual.").

Defendants ignore this highly deferential standard of review and instead offer a one-sided view of the evidence in a light most favorable to their own argument. (*See* Br. at 22-23, 53-54, 59) Because Defendants' statements were defamatory *per se*, the existence of damages for injury to career/reputation and mental anguish are presumed without requiring specific evidence of harm. *See, e.g.*, *Bentley*, 94 S.W.3d at 604. But whether this Court considers the statements to be defamatory *per se* or *per quod*, the record amply supports both the fact and amount of damages as reduced by the trial court.

Injury to Career/Reputation. The court acted within its broad discretion in reducing the total award for injury to career and reputation to $10.5 million. *See, e.g.*, *Beaumont v. Basham*, 205 S.W.3d 608, 620-21

(Tex. App. -- Beaumont 2006, no pet.) (affirming award for injury to reputation that banker had established during career, based on reactions and "whispering" in banking community).[30] Before the events of May 1998, Poliner enjoyed a distinguished and unblemished career. (5RR1126-27, 1194-95; CR6653) His practice at the cath lab, which depended almost exclusively on referrals from other doctors, was thriving. (6RR1277-78, 1305; 7RR1661) As soon as Poliner was forced to put his cath lab privileges in abeyance, however, his referrals "dried up" and his practice "was gone." (6RR1303, 1305-11) The jury heard testimony that a loss of such privileges will permanently and irreparably ruin a physician's reputation. (4RR985, 1015-16; 6RR1342, 1345-46, 1444) Other physicians would no longer refer patients to a doctor, such as Poliner, who had been marked with a "scarlet letter" in this way. (3RR799; 6RR1342) Not only was Poliner unable to sustain any kind of practice at the Hospital (CR6654), but he was also precluded from teaching (6RR1324-27) and was rejected when he applied to work elsewhere (6RR1328-29). This and other evidence entitled the jury to conclude that Defendants' actions irreparably and permanently destroyed the sterling reputation and career that Poliner had built.

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[30] Defendants' suggestion that the trial court did not reduce the awards further because of its "apparent disapproval of and desire to punish Defendants rather than actual compensation for any injury" (Br. at 59, citing RE11:6658) is inaccurate and misconstrues the court's order. In observing that "Defendants came across as arrogant, uncaring, and completely unconcerned with damaging Dr. Poliner's career," the court was summarizing its view of the evidence and the jury's reaction to it in awarding both actual and punitive damages. (CR6657-58)

In light of the enormity and permanence of this injury, and given the reality that a doctor's reputation is a priceless asset, the amount of the awards for injury to career and reputation should not be further reduced.

Mental Anguish. Similarly, the trial court's reduced awards totaling $10.5 million for mental anguish should not be further reduced. An award of mental anguish damages will be affirmed if the evidence demonstrates "the nature, duration, and severity of [plaintiffs'] anguish, thus establishing a substantial disruption in the plaintiffs' daily routine." *Parkway v. Woodruff*, 901 S.W.2d 434, 444 (Tex. 1995). Such evidence includes humiliation, family discord, shame, loss of self-esteem, and physical symptoms such as sleeping difficulties. *See, e.g.*, *Wyler Indus. Works, Inc. v. Garcia*, 999 S.W.2d 494, 509 (Tex. App. -- El Paso 1999, no pet.). Because considerations of mental anguish are "particularly within the jury's province," the jury has "broad discretion" to fix the amount of such damages. *Marvelli v. Alston*, 100 S.W.3d 460, 482 (Tex. App. -- Fort Worth 2003, pet. denied).

Poliner and his wife offered substantial evidence that, as a direct result of Defendants' conduct in May 1998, he experienced a severe and long-lasting disruption of his personal life. He was "devastated" by the experience (6RR1301) and changed from "a relaxed, busy person trying to make his practice grow, to an intense, saddened person" (7RR1676). He largely abandoned the family activities he once enjoyed, such as swimming and skiing with his children and taking walks with his wife, and instead spent countless hours pouring over patient records and the accusations

against him. (7RR1653, 1671-73) The children "lost" their parents and the family "just became sad," marked by tension and melancholy. (7RR1676) Poliner experienced intense humiliation at being branded a dangerous doctor, and felt "like an outcast" in the medical community. (6RR1302, 7RR1605-06) He also began to suffer from elevated blood pressure and lost sleep. (7RR1671, 1677-78) Based on this and other evidence, the trial court acted well within its discretion in fixing the mental anguish awards at their present levels.

B. The Trial Court Correctly Determined that the Maximum Recovery Rule Does Not Apply Here.

Defendants' argument that the remitted damages should have been further reduced -- based simply on a comparison with one other case involving suspended physicians -- is premised on a misconception of the "maximum recovery rule" and ignores the unique circumstances of this case. (Br. at 60-61) Despite Defendants' suggestion to the contrary, "[a]n appellate court may not determine excessiveness by comparing verdicts in similar cases, but rather must review each case on its own facts." *Moore v. Angela MV*, 353 F.3d 376, 384 (5th Cir. 2003). While comparisons to damage awards in analogous cases "provide an objective frame of reference," they do "not control [this Court's] assessment of individual circumstances." *Id*. at 384 & n.8. Moreover, a departure from prior awards is appropriate "if unique facts are present that are not reflected within the controlling caselaw." *Douglass v. Delta Air Lines, Inc.*, 897 F.2d 1336, 1339 (5th Cir. 1990).

Based on these principles, the court below correctly rejected Defendants' invitation to reduce these damage awards roughly to the level of the lost earnings damages in *Rea v. Hospital Corp. of America*, 892 F. Supp. 821 (N.D. Tex. 1994). As the court noted, despite superficial similarities, *Rea* differs in "some very key respects." (CR6618) First, the physicians in *Rea* did not rely on referrals for their business, as Poliner did, and thus did not suffer the same "decimation" to their businesses, and concomitant mental anguish, by being suspended. (*Id.*) Second, the two cases involve distinct elements of damages: in *Rea*, the district court awarded damages only for "lost earnings," and not for other injuries such as mental anguish or the devastation to a career and reputation. *Rea*, 892 F. Supp. at 832. Comparing the awards in this case, which compensated Poliner for injury to reputation/career and mental anguish, to the award in *Rea*, which concerned only lost earnings under an entirely different set of facts, is an inappropriate exercise under this Court's precedent. *See Vogler v. Blackmore*, 352 F.3d 150, 157-58 (5th Cir. 2003) (declining to apply maximum recovery rule); *Moore*, 353 F.3d at 384-85; *Douglass*, 897 F.2d at 1345. The trial court was therefore correct in finding the maximum recovery rule to be inapplicable.[31]

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[31] In a footnote, Defendants argue that these awards also violate unspecified "constitutional guarantees" and that "[f]urther remittitur of actual damages requires re-examination of punitive damages." (Br. at 61 n.29) Defendants, however, have waived these conclusory arguments by inadequately briefing them on appeal. *See, e.g.*, *Shell Offshore, Inc. v. Office of Workers' Comp. Programs*, 122 F.3d 312, 317 (5th Cir. 1997).

C. The Evidence Supports the Separate Damage Awards Against the Hospital.

Finally, Defendants wrongly contend that the damage awards against the Hospital are "duplicative" of the awards against Knochel and lack independent evidentiary support. (Br. at 61) The claim of "duplication" fails for the basic reason that the court instructed the jury to "[c]onsider each Defendant separately" and not to "include damages as to one Defendant in assessing damages against any other Defendant." (CR4469) Because "juries are presumed to follow their instructions," *Gray*, 6 F.3d at 271, and the jury here obviously did so by assessing different damage amounts against the Hospital and Knochel (*see* CR6649-50, 7272), the Court should reject the unfounded notion that the jury awarded the same damages against the Hospital as it did against Knochel.

Moreover, the separate damage awards against the Hospital flow from the separate liability findings against it, and are supportable because of its vicarious liability for the actions of Knochel and others. *See Knutson v. Morton Foods, Inc.*, 603 S.W.2d 805, 807 (Tex. 1980) ("plaintiff could separately sue an employee and his employer and recover from both of them, so long as he did not recover more than one satisfaction"). The awards are also supportable because of the Hospital's acquiescence in and ratification of those actions. *See Prunty v. Arkansas Freightways, Inc.*, 16 F.3d 649, 652-53 & n.12 (5th Cir. 1994) (principal with knowledge of the facts may be independently liable for damages based on its agent's tortious acts that it adopts or fails to repudiate). Here, Knochel informed

the Hospital's president and others about his two-option approach to Poliner (*i.e.*, accept an abeyance or be suspended), and while Knochel claimed he would have "backed off" his decision if any of them had objected, they did not object but in fact "acquiesced" and "agreed" to his plan. (2RR256-57, 402-06, 412) Although the Hospital's president lacked any information that Poliner was a dangerous doctor, he also failed to take any corrective action after learning that Knochel's threat was carried out. (1RR202) *See Prunty*, 16 F.3d at 652-55. Based on the Hospital's independent actions, the jury was more than justified in awarding Poliner separate damages against the Hospital for his injury to career/reputation and mental anguish.

CONCLUSION

The amended final judgment should be affirmed in its entirety or, alternatively, affirmed as modified (as set forth in part V(B)).

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/s/
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[Certificate of Service and Certificate of Compliance Omitted in this Appendix]