Peer Review Report

News, analysis and commentary on Medical Staff credentialing, privileging, peer review and governance

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Peer Review Case Could Cost Defendants $70 Million

Judge Affirms Liability Of Hospital, Medical Staff Leaders

A Texas trial judge in March affirmed liability in what may be the largest jury verdict ever for allegedly abusive hospital peer review.

In August 2004, a jury had awarded Dr. Lawrence Poliner $366 million for a 1998 suspension of his cardiology privileges. Two months ago, the trial court reduced the potential award to $70 million on technical grounds but otherwise affirmed defendants' liability.

The verdict in *Poliner v. Texas Health Systems* found against Presbyterian Hospital of Dallas and three medical staff leaders who had participated in the suspension. Dr. Poliner claimed in his lawsuit that several of the individual defendants, his competitors at the hospital, "harbored animosity" toward him and conspired to bring about his suspension.

The suit also claimed that one of the defendants, Dr. James Knochel, participated in the conspiracy even though he was not a cardiologist. Plaintiff asserted that Dr. Knochel was a friend of the cardiologist defendants and abused his power as department chair to remove Poliner as a competitor. Defendants countered that they had quality of care concerns.

The jury sided with Dr. Poliner and awarded him damages on several theories, including defamation. The trial judge in his March 27, 2006 decision said that there was more than enough evidence to support Dr. Poliner's contention that he had been suspended without any quality of care concerns.

(See Poliner, page 6)

How do you stay out of peer review trouble?

See the **Commentary** on page 8. There are several steps you can take that will reduce the risk of a *Poliner*-like result.

In this Issue:

Part II in a Series: New JCAHO Requirements

Privilege Delineations Must Be Current, Specific

In the last issue of PEER REVIEW REPORT, I introduced three major JCAHO Medical Staff Standards changes on the horizon. They pertain to (1) clinical privilege delineations; (2) the credentialing process; and (3) continuous practitioner performance monitoring.

Today we'll take a closer look at the first of these, privileging.

Perhaps the most neglected Medical Staff (and board approved) document is the privilege delineation. There is a reason hospitals neglect

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Privilege Delineations . . . (cont'd)

them. JCAHO, up to now, has said very little that is clear about what they are, what they must contain and how you create them. With the proposed standards, JCAHO has moved these neglected children to the front of the line.

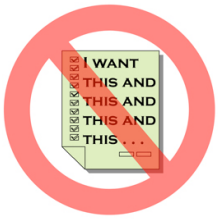
Let's clarify exactly what we are talking about. It is a piece of paper, created before the first applicant walks in the door, that describes a service the hospital has decided to provide to the public. There is one for each service the hospital offers. (OK, you can have a single long list, but most hospitals do each separately.) JCAHO—and consequently hospitals—have had a tendency to fuzz up the difference between creating and approving the privilege document on the one hand and granting or denying a request for the privilege on the other.

With JCAHO's proposed new privileging standards, it has moved these neglected children to the front of the line.

Many of the things that must be on this privilege paper and the way the contents are created will not shock some hospitals. But they will come as a rude awakening to many others.

First, JCAHO specifically emphasizes that each privilege must be setting-specific. Just because Dr. Jones is the most talented surgeon in the city does not mean your hospital is equipped to support everything he can do. If you can't support X Procedure, then he can't get X Procedure privileges at your hospital, no matter how good he is somewhere else.

Second, there must be a mechanism for assuring at all times that existing hospital resources can support each privilege. This dynamic requirement means that a hospital might have to change or eliminate a privilege if it lacks people, equipment or money to support it. Stifle the urge to say, "Well, yeah! Duh!" You'd be surprised how many hospitals don't even know where to look for their privileges, much less decide – on a structured, ongoing basis – whether they continuously match up with what they actually can and still do.



Third, the privilege document must contain the specific criteria that the hospital will use to determine whether an applicant qualifies to hold it. The new standard lists minimal criteria, such as licensure, specific training, data from use at other facilities among others. The "wish list" approach to privileging ("Tell us what you want to do, and we'll say yes or no.") is plainly out the window.

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Fourth, the new standards are now very clear that privileges are to be developed by the Medical Staff and then specifically approved by the board. This process is separate from the actual (later) request by an applicant for permission to perform those privileges.

You might argue that none of this is new. Those who have been diligent in JCAHO tealeaf reading might be right. Even if you have been diligent, here is what really *is* new:

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Privilege Delineations . . . (conclusion)

Under the new standards, you will have to monitor new and established surgeons for certain high-risk procedures.

Like the criteria list for each privilege, the "organization" (more on this shortly) must decide which privileges, because of the risks, should require special "performance monitoring" and what that monitoring must consist of. The standards don't say where these criteria have to go, but the privilege document would seem a likely candidate.

Let's suppose your hospital authorizes a high-risk surgical procedure. You have two types of surgeons: Ones who are already doing that procedure at your hospital and new applicants you've never seen before. If your hospital requires performance monitoring, you have to monitor both types of surgeons. The methods may be different for each type (mentoring, proctoring, outcomes measurement, external review), but you have to do it and do it consistently.

Can you duck this simply by declaring none of your procedures are high-risk? Almost surely not. The standards require a process for deciding which privileges require performance monitoring. You can choose to monitor every privilege you have, or you can do a privilege-by privilege analysis to see which ones need it. If you can't prove you've even looked at them, your simple declaration probably won't get you very far.

Note that JCAHO frames all these new requirements (and some others we'll talk about in future issues) in terms of compliance by the "organization." Students of the Medical Staff Standards may see this as a significant shift from the old days, where the primary initiative was on the Medical Staff. This often led to anguished cries from administration, particularly when administration could not get the Medical Staff to start the ball rolling.

Because JCAHO imposes these new privileging requirements on the "organization," hospitals can no longer blame Medical Staffs for inaction. Both administration and physician leaders must get to work.

Although JCAHO has not necessarily backed off its belief that matters of this sort should start at the Medical Staff level, imposing these new requirements on "the organization" instead of the Medical Staff appears to give hospital administrations a wedge to get the job done if the Medical Staff sits on its hands. In the best of all worlds, the Medical Staff and administration cooperate. But there is now more room for the hospital to step in if the Medical Staff won't.

Beware, however; this cuts two ways. Hospitals can no longer blame Medical Staff inaction for failure to comply. So if your privileges do not meet the new standards, both administration and the Medical staff need to get to work.

In the next issue, we'll take up the changes that JCAHO will require in your credentialing process.

Legal Analysis: Are You Doing All That Is Required?

Incident Reports Require Special Handling

A lot of people think you can keep a hospital incident report out of litigation because it's confidential under Ohio's incident report confidentiality law.

If you haven't jumped through all the right hoops, however, disappointment awaits you.

When this Ohio statute went into effect in 2003, I said in PEER REVIEW REPORT that it had lurking within it some fairly strict requirements. First, the report has to be prepared for a peer review committee. Second, examination of incident reports has to be part of the committee's job.

Sure enough, recent cases have held that the statute means what it says. Courts have rejected confidentiality claims in several recent cases where the hospital failed to prove both requirements.

Let's look at a recent case, *Smith v. Manor Care of Canton, Inc.,* to see how this works.

The facts in *Smith* are simple. Smith's father died in the defendant nursing home from positional asphyxiation. His head had got caught between the bed's mattress and the bedrail.

The nursing home administrator asked the nurse involved to write out what happened. When the administrator got what she had written, she balled it up, tossed it in her desk drawer and told her to try again.

Why? Well, that's what plaintiff wanted to know. There were several other things plaintiff thought didn't smell right either. At deposition, the plaintiff's lawyer asked questions to find out. The nursing home's lawyer objected on the basis of the incident report statute. The plaintiff filed a motion to force some answers.

The trial judge up in Stark County ruled that the nurse had to answer the questions. The Court of Appeals affirmed.

Manor Care had produced no evidence that it even had a peer review committee, much less one of a defined size and membership. There was also no evidence that such a committee reviewed incidents as part of its work or that it did, in fact, review this incident. Finally, the court said – and this may be significant – there was no proof that any of this information was used *to assess the quality of care* at the nursing home.

The main point is: If you plan to claim confidentiality of any incident report, your reporting structure *must* include review by a peer review committee specifically empowered to do so.

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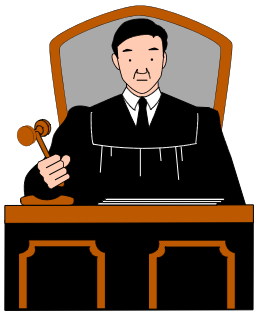

Sure enough, Ohio courts have held that the statute governing incident reports means what it says.

Incident Reports . . . (conclusion)

Peer review committees are not necessarily restricted to hospital review of doctors.

Some interesting unanswered questions remain, however.

Although the court said there was no proof that the information was used "to assess the quality of care" at the nursing home, the statute itself contains no such requirement. Nothing in the legislation requires that a committee prove what it did with the information, and wisely so: Such proof would violate the confidentiality of peer review committees. The court may have got itself a little too far afield on that point.

Another point frequently missed but suggested in *Smith* is this:

"Peer review committees" are not necessarily restricted to hospital review of doctors.

It is true that most peer review committees are established at hospitals to review medical staff members, mostly MDs and DOs. But the 2003 Ohio law is not restricted and allows broadly defined "health care entities" to review "health care providers." The statute says providers could be *individuals or entities.*

So it is clear that the nursing home in *Smith* could have had a peer review committee to review all health care givers there. Since Ohio has not said who can serve on the committee, nothing would stop non-physicians from membership. The administrator and director of nursing would probably do.

The follow-on questions of whether a hospital or other entity might have multiple peer review committees, how they might work and what purposes they might serve are well beyond the scope of this article.

Suffice it to say that peer review committees to review all health care givers can be extremely useful positive improvement vehicles – and they are essential to the protection of incident reports in Ohio.

Poliner (continued from page 1)

The difficulties described in the suit arose shortly after Dr. Poliner joined Presbyterian's staff in 1997.

Dr. Poliner, a 1969 Cornell Medical School graduate, was boarded in both internal medicine and cardiovascular diseases in the 1970s. According to Dr. Chris Rangle, a physician who worked with Dr. Poliner at other facilities, Dr. Poliner was director of the cardiac catheter lab at another Dallas hospital, on the faculty of Southwestern Medical School and Baylor College

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Poliner (continued)

of Medicine and a consultant for NASA. Dr. Poliner's lawyer, Charla Aldous, added in a *Lawyers Weekly USA* article on the case that Dr. Poliner had never been named in a malpractice suit.

Trouble began at Presbyterian almost immediately. According to Dr. Poliner's lawyer, his competitor-defendants all disliked him. "It's all a big boy's club and Dr. Poliner didn't belong," his lawyer said. Even defendant Dr. Knochel, Dr. Poliner's internal medicine department chair, admitted during trial that no one liked Dr. Poliner.

Within months after becoming a medical staff member in 1997, nurses began filing reports of alleged errors by Dr. Poliner. These reports were under review in May 1998. On May 12, defendant Dr. Charles Levin, director of the cardiac catheter lab, found a questionable case and brought it to the attention of defendant Dr. John Harper, chief of cardiology, on May 13. Both Levin and Harper were competitors of Poliner. That same day, they went to Dr. Knochel with their concerns about the case.

The following day, May 14, Dr. Knochel called a meeting with Dr. Poliner for 2 PM. Drs. Levin and Harper were present. Dr. Knochel demanded that Dr. Poliner voluntarily "accept abeyance" of all his cath lab procedures so that Dr. Knochel could review Dr. Poliner's cases. If Dr. Poliner refused voluntary abeyance, Dr. Knochel said he would suspend him. Dr. Poliner was not permitted to discuss any of the cases and was directed not to consult an attorney. Dr. Knochel gave Dr. Poliner three hours to decide. Dr. Poliner agreed to abeyance.

The judge and jury later found that the choice of abeyance or suspension was the equivalent of a suspension. The Court's opinion in March noted that Dr. Knochel had admitted at trial that he did not have enough information to conclude Dr. Poliner was a danger to patients. The judge said there was ample evidence at trial to conclude that defendants' actions were not reasonably related to providing quality care.

Subsequent meetings, committees and boards met, with the end result that Dr. Poliner's care was found to be appropriate. The hospital, however, refused to withdraw the suspension from his record. That, according to his lawyer, was the defendants' final undoing. "The jury was just so angry at the hospital that they wouldn't admit they had made a mistake and they were so arrogant," said attorney Aldous.

She added that if the hospital had removed the suspension from Dr. Poliner's record, he never would have sued. According to the *Lawyers Weekly* account, Ms. Aldous said:

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"The jury was just so angry at the hospital that they wouldn't admit they had made a mistake and they were so arrogant."

Charla Aldous, attorney for Dr. Poliner

There was ample evidence at trial to conclude that the defendants' actions were not reasonably related to providing quality care.

Poliner (Conclusion)

"Our case was about intangibles. We really hit hard on the fact that your reputation and your integrity and your character are really about all you have in life. Larry Poliner loves cardiology and he loves practicing cardiology. They took that away from him without even letting him speak for 10 minutes."

The case is far from over. Texas court rules require the parties to mediate. If they fail to settle the case, the judge may still require Dr. Poliner to accept a number lower than $70 million as a condition for entering final judgment. Defendants also have the right to appeal.

Patient handoffs are a significant source of patient safety incidents. The Rx: clear face-to-face communication and accurate medical records.

Quick Hits:

- The Ohio legislature has approved a measure that will **require all Ohio hospitals to report cost and quality data** to the Ohio Department of Health. ODH will then make that information public on its website so that consumers can compare hospital performance. **Substitute House Bill 197** now goes to Governor Taft for signature. The bill may be signed into law by the time you read this.

- A Louisiana **jury returned verdicts May 26 in favor of Kadlec Medical Center** in its groundbreaking suit **against Lakeview Regional Medical Center**. The suit, reported in the last issue, alleged that Lakeview had failed to tell Kadlec about the drug problems of an anesthesiologist who moved from Lakeview (in Louisiana) to Kadlec (in Washington state). Kadlec wrote asking for credentialing information; Lakeview provided an incomplete response. After getting Kadlec staff privileges, the anesthesiologist, Dr. Lee Berry, seriously injured a Kadlec patient. Kadlec sued to get Lakeville to pay the damages. The jury found that Lakeview had both negligently and intentionally misrepresented what it knew about Dr. Berry. It also found against two of Dr. Berry's former partners, who had each written favorable recommendations despite knowing of Dr. Berry's drug problems.

- Two recent separate studies confirm that **patient handoffs are a significant source of patient safety incidents**. The studies appear in the December 2005 issues of *Quality and Safety in Health Care* and *Academic Medicine*. One study noted that other high-risk handoffs, like those used in air traffic control, are repetitively practiced. Not so in medicine, where wide variations occur because of poor communication skills and lack of training. The results are confusion, unnecessary and suboptimal care. Both studies confirm the **critical role of clear face-to-face communication between caregivers and legible, relevant and accurate entries in the medical records**. National Patient Safety Goal 2E for 2006 stresses the need for a standardized approach to handoffs, including the opportunity to ask and respond to questions.

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Commentary

Don't Miss The Real Message In *Poliner*

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The *Poliner* case headlined in this issue probably frustrates a lot of you.

The so-called experts say, "Do peer review, and you'll produce better care." The more strident voices threaten, "If you don't police your own, we'll get the government to come in and do it for you." Uh oh. Be afraid. Be very afraid.

So along comes a case like *Poliner*, where the hospital does peer review – and gets spanked. Damned if you do, damned if you don't, right?

No. The key here is doing peer review properly. If you think simply doing peer review poses unacceptable hazards, you've missed the lessons that *Poliner* teaches: Don't use competitors. Don't let bad blood or politics into the process. Get independent assessments. If you goofed, admit it and reverse the damage while there's still time. Arrogance costs money.

You may say this case is an aberration, but we know better. What's out of place is that the hospital in this one got stung. Most other cases end with pre-trial dismissal because there was some connection to improving health care. Here the hospital broke all the rules above, and now may pay dearly. Like airplane accidents, peer review verdicts come from not just one but multiple mistakes.

Rich Setterberg

So what can you do to hedge against this happening to your organization?

- Get competitors out of the process. Yes, it is often necessary to consult with competing surgeons on a surgical error, but stop there. Make sure your written process forbids any of them from making a decision, even at early stages.
- Exercise suspension power jointly. Many medical staff bylaws allow a single medical staff officer to suspend. Consider adding the CEO or her designee as one of the persons who must agree. It's her hospital, and she'll pay if some department head abuses his power for personal reasons. Cumbersome? Not in real life. Extra protection? Yes.
- Build in independent review. Many processes don't resort to an outside reviewer until a lot of damage is done. Start earlier. This should be even easier in systems, where a sharing structure might allow one affiliate to turn to another for help.
- Enforce the "imminent danger" rule. Suspensions are OK without a hearing as long as there is an imminent danger to the health of any individual. Pay closer attention to this standard, particularly the word "imminent."
- Avoid politics. Easy to state, hard to do. If there is bad blood between a physician leader and a physician, ask the leader to step aside in favor of a more neutral alternative.
- Admit mistakes. If you stop the train early enough, you can turn a hasty, poor decision into a (mostly) non-event. All successful plaintiff cases I've seen involved stubborn hospitals in denial all the way up to the angry jury verdict against them.

The lesson of *Poliner* is not "Don't do peer review." Instead, it's "Do it right."

Richard A. Setterberg Co., L.P.A. publishes and distributes **PEER REVIEW REPORT** free to inform clients and others about issues and developments concerning medical staff matters. It is not legal advice. For further information on issues or topics in this newsletter as they may apply to particular facts, please contact the editor at (513) 733-1759 or rascolpa@cinci.rr.com.

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