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The *Poliner* Case: Required Reading for Healthcare Executives and Attorneys

William Mack Copeland, MS, JD, PhD, FACHE
Law Offices of William Mack Copeland LLC
Cincinnati, OH

On July 23, 2008, the Fifth Circuit reversed a very closely watched peer review case, *Poliner v. Texas Health Systems*,[1] a credentialing case out of the U.S. District Court for the Northern District of Texas involving a jury verdict awarding $366 million to a Dallas physician.[2] The federal district court later reduced the award to $22.5 million.[3] This contested peer review case was in its eighth year, with 558 separate docket entries—and, while there was a reduction in the award, the district court had sustained the majority of the earlier order that upheld the jury verdict.[4] The Fifth Circuit held that the hospital and the physician involved were immune under the Health Care Quality Improvement Act (HCQIA).

The case is important, not for its large damage award, but because it deals with many of the issues commonly found in credentialing cases, such as confidentiality of peer review records, the HCQIA immunity, state peer review statutes granting immunity, and damages. Both the district court and the appeals court decisions should be required reading for any attorney who practices in the medical staff arena, whether representing hospitals or physicians, serving as hearing officer, or as counsel to the hearing officer or hearing panel. The decisions are also excellent reference documents for individuals involved in the credentialing process or serving in executive positions in the hospital or medical staff. *Poliner v. Texas Health Systems* is a classic case of how *not* to impose a summary suspension.

Background

Lawrence R. Poliner, MD, is board certified in both internal medicine and cardiovascular diseases. In 1997, he held medical staff privileges, including catheterization laboratory (cath lab)

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—from a declaration of the American Bar Association

privileges, and was practicing cardiology at Presbyterian Hospital of Dallas, TX. On three separate occasions, after procedures in the cath lab, nurses filed Committee Event Report Forms with respect to Dr. Poliner's procedures. The hospital's Clinical Risk Review Committee received copies of these forms for appropriate action. The committee reviewed two of these cases and referred them to the Internal Medicine Department for further review. The other case was also referred to Internal Medicine after review. While these cases were still pending, Dr. Levin, director of the cath lab, reviewed another of Dr. Poliner's cases (patient number 36) and brought it to the attention of the chief of cardiology. Dr. Levin found "that Dr. Poliner performed an angioplasty on the wrong artery and missed a totally occluded left anterior descending coronary artery."[5] These issues were brought to the attention of Dr. Knochel, chair of internal medicine. Dr. Knochel then spoke to the hospital president, vice president of medical affairs, and in-house counsel. The district court describes what happened next:

> 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.[6]

The peer review process proceeded in a relatively normal fashion after this, with an ad hoc committee formed to review Dr. Poliner's cases. Finding substantial problems, the ad hoc committee referred the matter to the Internal Medicine Advisory Committee (IMAC). At its meeting on May 27, the IMAC recommended additional reviews by an outside reviewer; however, an outside reviewer was not available in time for a scheduled meeting with Dr. Poliner. The IMAC also recommended that the abeyance be extended as was provided in the bylaws. At Dr. Knochel's direction, a letter was hand-delivered to Dr. Poliner for his consent to the extension. Dr. Poliner was advised that the extension was investigational in nature with the ad hoc committee reviewing forty-four of his cases. The letter indicated that Dr. Poliner would have an opportunity to meet with the IMAC to respond to the ad hoc committee review. Dr. Knochel again told Dr. Poliner that the alternative to abeyance was suspension. On May 29, Dr. Poliner signed the extension request.

Dr. Poliner received only three days notice of this meeting in which he was to defend his cases. He requested a postponement for one day or at least to have it rescheduled from 8 a.m. to later in the day. Dr. Knochel denied this request.

The day after this meeting, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges. Dr. Knochel summarily suspended Dr. Poliner's cath lab and echocardiography privileges but allowed all other privileges to stay in place. Dr. Knochel told Dr. Poliner that he was entitled to an expedited hearing.

Dr. Poliner requested a hearing but not an expedited one. The hearing proceeded as scheduled and the Hearing Committee recommended Dr. Poliner's privileges be restored with conditions. The Hearing Committee also found that the summary suspension was justified based on evidence available at the time. The hospital's Medical Board upheld the recommendation of the Hearing Committee.

Dr. Poliner then requested an appeal of the summary suspension—but was advised that, pursuant to the hospital's bylaws, appeal was limited to a determination of whether he had been substantially provided due process. The appeal committee found that due process was adequate and told Dr. Poliner that it did not have authority to set aside the summary suspension. The hospital's Board of Trustees upheld the appeal committee.

The following year, Dr. Poliner filed suit in federal court[7] against the hospital, Dr. Knochel, and several other physicians alleging antitrust violations, violation of due process, business disparagement, slander and libel, tortious interference with business and prospective advantage, violation of the Deceptive Trade Practices Act, and intentional infliction of mental anguish and emotional distress. He also requested a temporary restraining order, temporary injunction and permanent injunction, declaratory relief that immunity under the HCQIA and the Texas Medical Practice Act did not apply, and declaratory relief that the two acts are unconstitutional.[8]

The Summary Judgment Proceeding

In the summary judgment proceeding, the court dismissed the antitrust claims,[9] as well as all charges against physicians other than Knochel, Harper, and Levin. The court found that the HCQIA protected the dismissed physicians. Regarding Knochel, Harper, Levin, and the hospital, the court found "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."[10]

Another interesting finding in the summary judgment proceeding was that the hospital's bylaws, not the medical staff bylaws, created a contract between the hospital and the physicians and provided contractual due process rights. Therefore, the court denied summary judgment for the hospital on the breach of contract claims.[11]

In addition, the court denied summary judgment to Knochel, Harper, Levin, and the hospital on the other state law claims. The court found that actual malice was a fact issue with regard to these defendants, indicating that there was evidence that these

defendants "violated their own bylaws as well as the HCQIA in summarily suspending Dr. Poliner's privileges."[12] Dr. Poliner subsequently settled with Drs. Harper and Levin,[13] and the case went to trial with Dr. Knochel and the hospital as the only defendants.

The Jury Decision

The jury handed down a unanimous verdict on August 27, 2004, finding that defendants acted with actual malice and without justification or privilege. The jury award for compensatory and exemplary damages was $366,210,159.30.[14] Based on the evidence, the jury concluded that:

1. The action to suspend Dr. Poliner's cardiac cath lab privileges was not undertaken in the reasonable belief that the action furthered quality healthcare; Dr. Knochel testified that he did not have enough information to assess whether Dr. Poliner posed a present danger to his patients;[15]
2. The action lacked good faith and was taken with malice;[16]
3. There was not adequate notice and hearing procedures afforded Dr. Poliner; the only option he was offered was the abeyance, and he was not allowed to consult with an attorney before accepting the abeyance; in addition, defendants would not discuss patient cases with him;[17] and
4. There was not a reasonable effort to obtain the facts of the matter.[18]

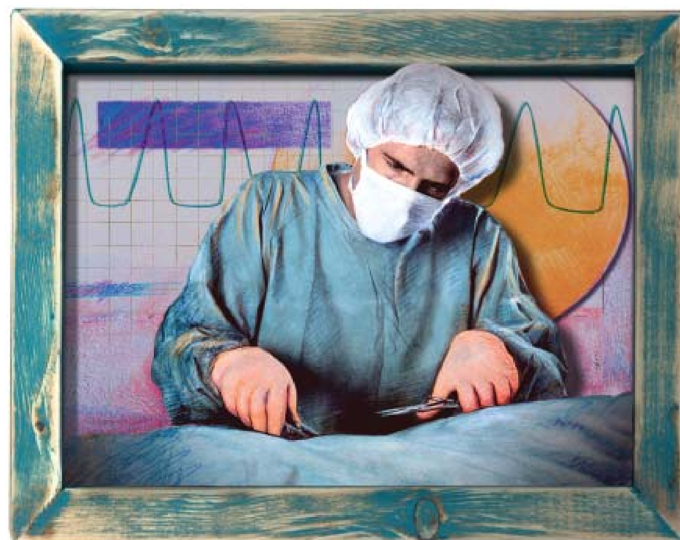
On September 18, 2006, the district court determined that the award was excessive and reduced it to $22,542,206.20, $21 million in actual damages and $1,542,106.20 in punitive damages.[19] The court subsequently granted a settlement credit for the settlement with Drs. Levin and Harper and set the award at $21,000,000.00 in non-economic actual damages, $7,894.92 in lost wages and $1,542,106.20 in punitive damages, for a total award of $22,550,001.12.[20]

The Appeals Court Decision

On July 23, 2008, the appeals court reversed the district court and ruled in favor of the hospital and the defendant physician. This decision is very instructive because the court provides a great deal of insight into how the courts construe the HCQIA.

Finding that the defendants were entitled to immunity under the HCQIA with regard to the abeyance and the extension of the abeyance, the appeals court stated:

> The jury was charged that the May 14 abeyance and the extension of the abeyance were both professional review actions. We agree. . . .
>
> 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 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 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.[21]



Regarding whether the actions were taken in the reasonable belief that they were in furtherance of quality healthcare, the appeals court, quoting *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 468 (6th Cir. 2003) and *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994), stated:

> [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. . . . [T]he Act does not require that the professional review result in an actual improvement of the quality of health care," nor does it require that the conclusions reached by the reviewers were, in fact correct. It bears emphasizing that "the good or bad faith of the reviewers is irrelevant rather

> it is an objective inquiry in which we consider the totality of the circumstances. . . ."
>
> 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. [22]

Regarding the contention by Dr. Poliner that the restriction on his privileges resulted from anticompetitive motives, the appeals court indicated that "[o]ur sister circuits have roundly rejected the argument that such subjective motivations overcome HCQIA immunity, as do we."[23]

The appeals court found that no reasonable jury could conclude that defendants failed to make a reasonable effort to obtain the facts.

> [A]s to the abeyance extension, Knochel relied on the review of 44 cases conducted by the ad hoc committee. . . . Knochel was entitled to rely on the information provided to him by the other doctors, and there is nothing to suggest that the information was facially flawed or otherwise so obviously deficient so as to render Defendants' reliance unreasonable. . . . [T]he [HCQIA] 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.[24]

Citing § 11112(c) of the HCQIA, the appeals court found that the actions taken by the defendants satisfy the procedural requirements of the Act: "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."[25] Dr. Poliner had argued that defendants did not comply because the restriction lasted fifteen days, one day longer than permissible: "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."[26]

Citing the emergency provision of § 11112(c)(2), the appeals court found that the extension of the abeyance falls within these parameters, because "[t]he 'emergency' provision requires only that a failure to act may result in an imminent danger to the health of any individual. . . . Defendants were fully warranted in concluding that failing to impose further temporary restrictions 'may result' in an imminent danger."[27]

The court concluded that the actions taken by the defendants were taken in the reasonable belief that the action was warranted by the facts known at the time:

> 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)(1)." In both instances, the temporary restrictions were "tailored to address the health care concerns" that had been raised—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." 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." At the least, it is not our role to re-weigh this judgment and balancing of interests by Congress.[28]

This case shows how important following one's bylaws, state peer review laws and the HCQIA is. It also provides a good reference guide for physicians' counsel to review what steps the hospital and its medical staff must accomplish prior to imposing a summary suspension, or any other peer review action for that matter.

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1 *Poliner v. Texas Health Sys.*, No. 06-11235 (5th Cir. July 23, 2008).
2 *Poliner v. Texas Health Systems*, U.S. Dist. LEXIS 13125 (N.D. Tex. Mar. 27, 2006). (Referenced herein as Doc. 488).
3 *Poliner v. Texas Health Systems*, 2006 U.S. Dist. LEXIS 66819 (N.D. Tex. Sept. 18, 2006) (Referenced herein as Doc. 483); *Poliner v. Texas Health Systems*, 239 F.R.D. 468, 239 F.R.D. 468; 2006 U.S. Dist. LEXIS 74569 (N. Dist. TX Oct. 13, 2006). (Referenced herein as Doc. 494).
4 *See also* the court's September 2003 summary judgment order, *Poliner v. Texas Health Systems*, 2003 U.S. Dist. LEXIS 17162 (N.D. Tex. Sept. 30, 2003). (Referenced herein as Doc. 238).
5 Doc. 238 at 7.
6 *Id.* at 7 and 8.
7 *Id.* at 8-11.
8 *Id.* at 4.
9 *Id.* at 13.
10 *Id.* at 31.
11 *Id.* at 19.
12 *Id.* at 31.
13 Doc. 494 at 8.
14 Doc. 483 at 3.
15 *Id.* at 7-8.
16 *Id.* at 10.
17 *Id.* at 9.
18 *Id.*
19 Doc. 238 at 9.
20 Doc. 494 at 9.
21 *Poliner v. Texas Health Sys.*, No. 06-11235 (5th Cir. July 23, 2008) at 16. (Citations ommitted.)
22 *Id.* at 16-17. (Citations omitted.)
23 *Id.* at 19. (Citations omitted.)
24 *Id.* at 20. (Citations omitted.)
25 *Id.* at 22-23.
26 *Id.* at 23.
27 *Id.*
28 *Id.* at 27. (Citations omitted.)

PRACTICE GROUPS

Chair's Column

Michael A. Cassidy
Tucker Arensberg PC
Pittsburgh, PA

The Medical Staff Credentialing and Peer Review Practice Group (MSCPR PG) has had an active start for its new program year. The vice chairs and responsibilities for the current year are as follows:

- **Keith Shiner** of Reed Smith (kshiner@reedsmith.com)—Website;
- **Patricia Hofstra** of Duane Morris (phofstra@duanemorris.com)—Membership and Affinity Group Development;
- **Michael Callahan** of Katten Muchin (michael.callahan@kattenlaw.com)—Educational Programs and MS1.20 Task Force Development;
- **Tim Adelman** of Adelman Sheff and Smith (tadelman@hospitallaw.com)—Research and Peer Review Toolkit; and
- **Steve Kleinman** of Schottenstein Zox & Dunn (skleinman@szd.com)—Publications and Emergency Preparedness Taskforce.

MSCPR PG has already been active in cosponsoring two educational programs—"A New Battleground: The Clash Between Peer Review Protection and Civil Rights Claims," at which Maria Danaher of the Pittsburgh office of Ogletree Deakins and Maria Abrahamsen of Dykema Gossett co-presented with Rob Niccolini of McGuire Woods as moderator, and "*Poliner* Postmortem: Implications for Hospitals and Medical Staff Members," at which Bill Hinnant of Medicolegal Consultants and Jeff Moseley of Buerger co-presented, with yours truly as the Moderator.

Steve Kleinman has been active in the publications area. This is the third newsletter produced under Steve's leadership, and the November 2008 edition of AHLA *Health Lawyers News* will present a feature article entitled "Collision Course: The Intersection of Employment Cases and Peer Review Information" by Maria Danaher. Michael Callahan has been active in discussions with Sidney Welch of the Physician Organizations PG and Brian Gradle of the Hospital and Health Systems PG discussing plans to establish a task force to deal with the expected revision of The Joint Commission MS1.20 Hospital Accreditation Standards. Tim Adelman is working with the Healthcare Liability and Litigation PG to establish a Peer Review Toolkit, which is intended to include not only the decisions but a brief bank for credentialing decisions.

We look forward to a very productive year and invite your participation in the upcoming programs, but also we invite you to submit articles for this newsletter—which you can do by contacting Steve Kleinman.