PEER REVIEW 2006

Legal Developments in 2006

The Problem

- July 23, 2002
- Unhealthy Hospitals - 103,000 preventable deaths in 2000 - Chicago Tribune
- FYI
- The next time someone suggests that you to enter a clinical trial at a hospital, beware:
- "The number of people needlessly killed by hospital infections is unbelievable, but the public doesn't know anything about it. For years, we've just been quietly bundling the bodies of patients off to the morgue while infection rates get higher and higher." That's what Dr. Barry Farr, a leading infection-control expert told The Chicago Tribune.
- The Chicago Tribune's investigative series, UNHEALTHY HOSPITALS, penetrates the healthcare industry's long hidden facts about the rising rate of infection-related, preventable hospital deaths. This comprehensive analysis of 5, 810 hospitals nationwide, examined the records of 75 federal and state agencies, plus internal hospital files, patient databases and court cases around the nation. The Tribune calculated 103,000 deaths in 2000 from hospital grown infections--75% were preventable.

The Problem

- **In Hospital Deaths from Medical Errors at 195,000 per Year USA**
- Main Category: Medical Malpractice News
  Article Date: 09 Aug 2004 - 13:00pm (UK)

  An average of 195,000 people in the USA died due to potentially preventable, in-hospital medical errors in each of the years 2000, 2001 and 2002, according to a new study of 37 million patient records that was released today by HealthGrades, the healthcare quality company.

  The HealthGrades Patient Safety in American Hospitals study is the first to look at the mortality and economic impact of medical errors and injuries that occurred during Medicare hospital admissions nationwide from 2000 to 2002. The HealthGrades study applied the mortality and economic impact models developed by Dr. Chunliu Zhan and Dr. Marlene R. Miller in a research study published in the Journal of the American Medical Association (JAMA) in October of 2003. The Zhan and Miller study supported the Institute of Medicine's (IOM) 1999 report conclusion, which found that medical errors caused up to 98,000 deaths annually and should be considered a national epidemic.

The Problem

	Heath Care Costs (per patient/year)	Life Expectancy (in years)
• United States	$4,887	77.1 years
• Canada	$2,792	79.8 years
• Spain	$2,383	79.2 years
• Japan	$2,003	80.9 years

Source: World Heath Organization

The Problem

Country	Years of Healthy Living
▪ United States (males)	67.2 years
▪ Sweden (males)	71.9 years
▪ United States (females)	71.3 years
▪ Italy (females)	74.7 years
▪ San Marino (females)	75.9 years
▪ Iceland (males)	72.1 years

	Infant Mortality (per 1,000 births)
▪ United States	6.9
▪ Japan	3.2
▪ Sweden	3.4
▪ France	4.6
▪ Denmark	5.3

▪ Source: World Health Organization

How Good Are We?

Category	Where do we rank
Years of healthy living	29th Between Slovenia and Portugal
Overall quality of Health Care	37th Between Costa Rica and Slovenia
Spending on Health Care	1st

Source: World Health Organization

What do We Pay For?

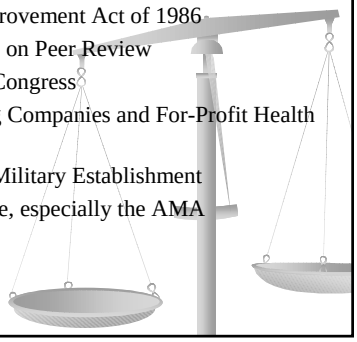
A General Motors Hummer with all of the bells and whistles

What do we get?

Ford Escort without options

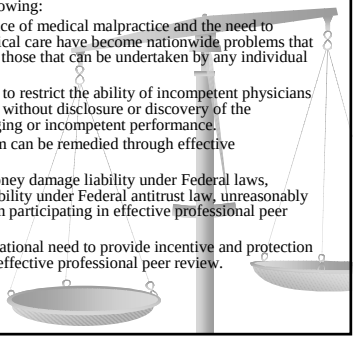
What Prevents Improvement in Health Care

- Health Quality Improvement Act of 1986
- The Courts Rulings on Peer Review
- The United States Congress
- Big Business (Drug Companies and For-Profit Health Care
- The United States Military Establishment
- Organized Medicine, especially the AMA



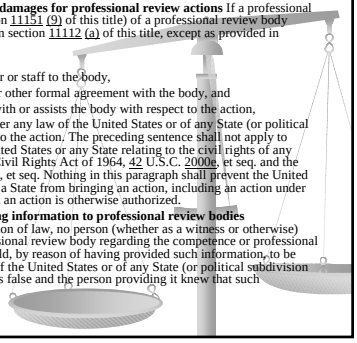
Health Care Quality Improvement Act of 1986

- The Congress finds the following:
- **(1)** The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
- **(2)** There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
- **(3)** This nationwide problem can be remedied through effective professional peer review.
- **(4)** The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
- **(5)** There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.



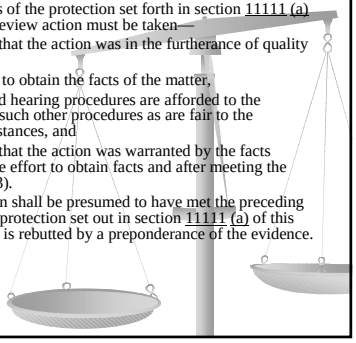
Health Care Quality Improvement Act of 1986

- **(a) In general (1) Limitation on damages for professional review actions** 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. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of title 15, where such an action is otherwise authorized.
- **(2) Protection for those providing information to professional review bodies** Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.



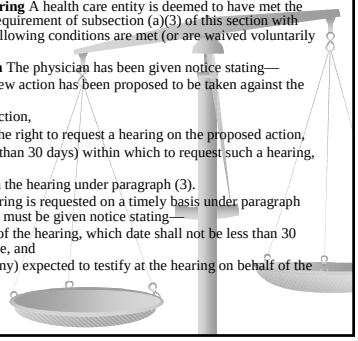
Health Care Quality Improvement Act of 1986
"The 4 prongs"

- **(a) In general** 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 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 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.



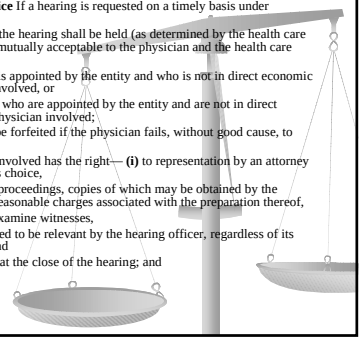
Health Care Quality Improvement Act of 1986

- **(b) Adequate notice and hearing** A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):
- **(1) Notice of proposed action** The physician has been given notice stating—
- **(A) (i)** that a professional review action has been proposed to be taken against the physician,
- **(ii)** reasons for the proposed action,
- **(B) (i)** that the physician has the right to request a hearing on the proposed action,
- **(ii)** any time limit (of not less than 30 days) within which to request such a hearing, and
- **(C)** a summary of the rights in the hearing under paragraph (3).
- **(2) Notice of hearing** If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating—
- **(A)** the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and
- **(B)** a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.



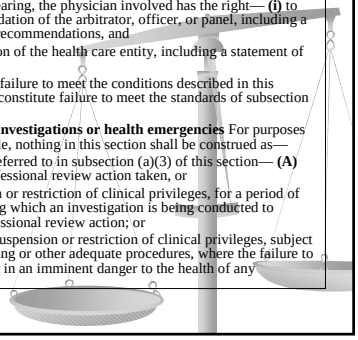
Health Care Quality Improvement Act of 1986

- **(3) Conduct of hearing and notice** If a hearing is requested on a timely basis under paragraph (1)(B)—
- **(A)** subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)— **(i)** before an arbitrator mutually acceptable to the physician and the health care entity,
- **(ii)** before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or
- **(iii)** before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;
- **(B)** the right to the hearing may be forfeited if the physician fails, without good cause, to appear;
- **(C)** in the hearing the physician involved has the right— **(i)** to representation by an attorney or other person of the physician's choice,
- **(ii)** to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,
- **(iii)** to call, examine, and cross-examine witnesses,
- **(iv)** to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and
- **(v)** to submit a written statement at the close of the hearing; and



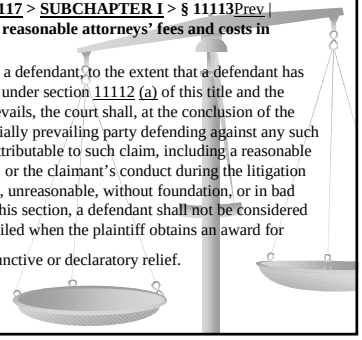
Health Care Quality Improvement Act of 1986

- **(D)** upon completion of the hearing, the physician involved has the right— **(i)** to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and
- **(ii)** to receive a written decision of the health care entity, including a statement of the basis for the decision.
- A professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section.
- **(c) Adequate procedures in investigations or health emergencies** 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.



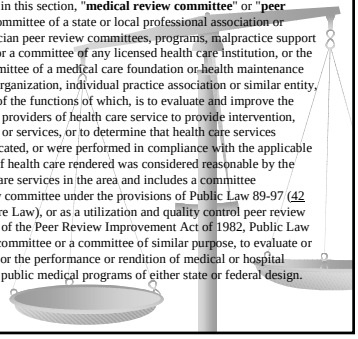
Health Care Quality Improvement Act of 1986

- **TITLE 42 > CHAPTER 117 > SUBCHAPTER I > § 11113**Prev | Next**§ 11113. Payment of reasonable attorneys' fees and costs in defense of suit**
- In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112 (a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against any such claim the cost of the suit attributable to such claim, including a reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.



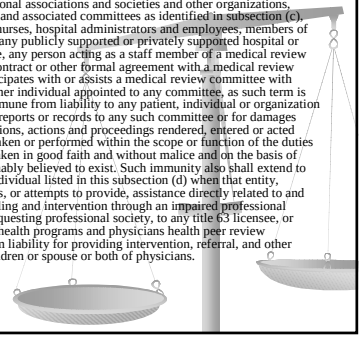
The State Statutes

- **T. C. A. § 63-6-219** (c) As used in this section, "**medical review committee**" or "**peer review committee**" means **any** committee of a state or local professional association or society, including impaired physician peer review committees, programs, malpractice support groups and their staff personnel, or a committee of any licensed health care institution, or the medical staff thereof, or any committee of a medical care foundation or health maintenance organization, preferred provider organization, individual practice association or similar entity, the function of which, or one (1) of the functions of which, is to evaluate and improve the quality of health care rendered by providers of health care service to provide intervention, support, or rehabilitative referrals or services, or to determine that health care services rendered were professionally indicated, or were performed in compliance with the applicable standard of care, or that the cost of health care rendered was considered reasonable by the providers of professional health care services in the area and includes a committee functioning as a utilization review committee under the provisions of Public Law 89-97 (42 U.S.C. §§ 1395-1395pp) (Medicare Law), or as a utilization and quality control peer review organization under the provisions of the Peer Review Improvement Act of 1982, Public Law 97-248, §§ 141-150, or a similar committee or a committee of similar purpose, to evaluate or review the diagnosis or treatment or the performance or rendition of medical or hospital services that are performed under public medical programs of either state or federal design.



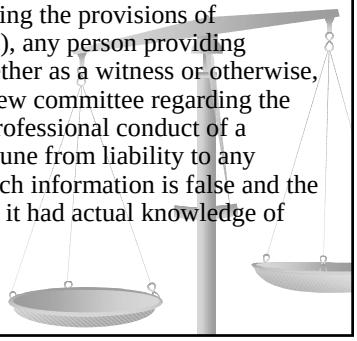
The State Statutes

- (d)(1) All state and local professional associations and societies and other organizations, institutions, foundations, entities and associated committees as identified in subsection (c), physicians, surgeons, registered nurses, hospital administrators and employees, members of boards of directors or trustees of any publicly supported or privately supported hospital or other such provider of health care, any person acting as a staff member of a medical review committee, any person under a contract or other formal agreement with a medical review committee, any person who participates with or assists a medical review committee with respect to its functions, or any other individual appointed to any committee, as such term is described in subsection (c), is immune from liability to any patient, individual or organization for furnishing information, data, reports or records to any such committee or for damages resulting from any decision, opinions, actions and proceedings rendered, entered or acted upon by such committees undertaken or performed within the scope or function of the duties of such committees, if made or taken in good faith and without malice and on the basis of facts reasonably known or reasonably believed to exist. Such immunity also shall extend to any such entity, committee, or individual listed in this subsection (d) when that entity, committee, or individual provides, or attempts to provide, assistance directly related to and including alcohol or drug counseling and intervention through an impaired professional program, or if none, through a requesting professional society, to any title 63 licensee, or applicant for license. Physicians health programs and physicians health peer review committees shall be immune from liability for providing intervention, referral, and other support services to the minor children or spouse or both of physicians.



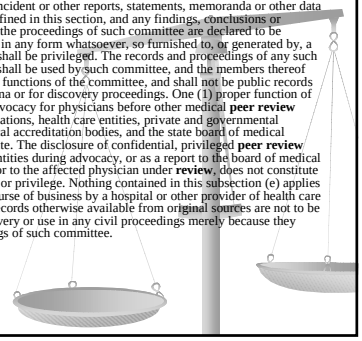
The State Statutes

- (2) Notwithstanding the provisions of subdivision (d)(1), any person providing information, whether as a witness or otherwise, to a medical review committee regarding the competence or professional conduct of a physician is immune from liability to any person, unless such information is false and the person providing it had actual knowledge of such falsity.



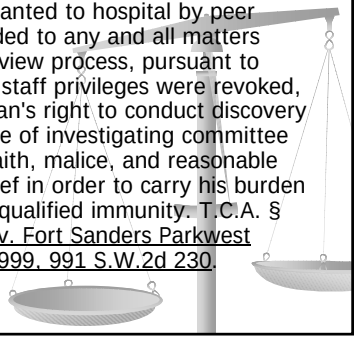
The State Statutes

- (e) All information, interviews, incident or other reports, statements, memoranda or other data furnished to any committee as defined in this section, and any findings, conclusions or recommendations resulting from the proceedings of such committee are declared to be privileged. All such information, in any form whatsoever, so furnished to, or generated by, a medical peer review committee, shall be privileged. The records and proceedings of any such committees are confidential and shall be used by such committee, and the members thereof only in the exercise of the proper functions of the committee, and shall not be public records nor be available for court subpoena or for discovery proceedings. One (1) proper function of such committees shall include advocacy for physicians before other medical **peer review** committees, **peer review** organizations, health care entities, private and governmental insurance carriers, national or local accreditation bodies, and the state board of medical examiners of this or any other state. The disclosure of confidential, privileged **peer review** committee information to such entities during advocacy, or as a report to the board of medical examiners under § 63-6-214(d), or to the affected physician under **review**, does not constitute either a waiver of confidentiality or privilege. Nothing contained in this subsection (e) applies to records made in the regular course of business by a hospital or other provider of health care and information, documents or records otherwise available from original sources are not to be construed as immune from discovery or use in any civil proceedings merely because they were presented during proceedings of such committee.



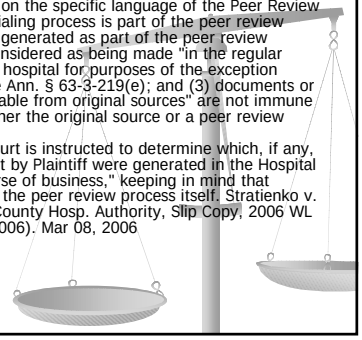
The Courts Interpret

- Broad privilege granted to hospital by peer review law extended to any and all matters related to peer review process, pursuant to which physician's staff privileges were revoked, subject to physician's right to conduct discovery for limited purpose of investigating committee members' good faith, malice, and reasonable knowledge or belief in order to carry his burden in opposing their qualified immunity. T.C.A. § 63-6-219. Eyring v. Fort Sanders Parkwest Medical Center, 1999, 991 S.W.2d 230.



The Courts Interpret

- we conclude that based on the specific language of the Peer Review Statute: (1) the credentialing process is part of the peer review process; (2) documents generated as part of the peer review process are not to be considered as being made "in the regular course of business" of a hospital for purposes of the exception contained in Tenn. Code Ann. § 63-3-219(e); and (3) documents or records "otherwise available from original sources" are not immune from disclosure from either the original source or a peer review committee.
  On remand, the Trial Court is instructed to determine which, if any, of the documents sought by Plaintiff were generated in the Hospital Authority's "regular course of business," keeping in mind that phrase does *not* include the peer review process itself. Stratienko v. Chattanooga-Hamilton County Hosp. Authority, Slip Copy, 2006 WL 550460 (Tenn.Ct.App.,2006). Mar 08, 2006



Competing Interests

- The peer review process is intended to encourage physicians to identify and discipline incompetent and unprofessional behavior for the protection of he patients who my be affected by such behavior. *Wayne v. Genesis Medical Center*, 140 F3d 1145, 1148 (8th Cir., 1998)
- However the goal of protecting patients ad the general public from less than competent physicians must be balanced against the rights of the private physician. *Cooper v. Delaware Valley Medical Center*, 654 A.2d 547, 551 (Pa. 1994)
- It is necessary to be "wary of vigilante capitalism disguised as peer review." *Rogers v. Columbia HCA of Central Louisiana, Inc.*, 971 F.Supp. 229, 234 (W.D.La. 1997)

Lawsuits and the HCQIA

- The case that was the "straw that broke the camel's back" was **Patrick v. Burget** 486 U.S. 94, 108 S.Ct. 1658, U.S.,1988. May 16, 1988
- Amicus briefs against Dr. Patrick were filed by the AMA, the AHA, and the JCAHO.

Lawsuits and the HCQIA

- In the wake of lawsuits re bad faith peer review primarily *Patrick v Burget* the HCQIA created limited immunity for hospitals and members of peer review committees if the conditions of HCQIA are met. 42 U.S.C.A.§§ 11111(a)(1), (2), (b).
- Congress enacted HCQIA to set minimum national stadards for the professional peer review of physicians' competence and professional conduct. *Walls Regional Hospital v. Altaras*, 903 S.W. 2d 36, 38 (Tex.App.—Waco 1994, *no writ) citing* 42 U.S.C.A. §§ 11101-11152.
- The 11th Circuit explained how peer review is supposed to work and when the immunity applies and why.
  - Peer review …. Has become an integral component of the health care system in the United States. Congress enacted the Health Care Quality Improvement Act to encourage such peer review activities "to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior." H.R.Rep. No. 903, 99th Cong., 2d Sess. 2, reprinted

Lawsuits and the HCQIA

- in 1986 U.S.C.C.A.N. 6287, 634, 6384…..In furtherance if this goal, HCQIA grants limited immunity, in suits brought by disciplined physicians, from liability for money damages to those who participate in professional peer review activity. *Id* § 11111(a).
- Prior to the passage of HCQIA, the specter of litigation seriously impeded the development and vigorous enforcement of hospital peer review procedures. Congress found that "[t]he threat of private money damage under [state and] Federal laws, including treble damages liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review." *Id* §11101 (4). Accordingly, HCQIA provides that if a "professional review action" (as defined by the statute) meets certain due process and fairness requirements, then those participating in such a review process shall not be liable under any state or federal law for damages for the results. *Id* § 11111(a)(1). Thus, [d]octors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of [HCQIA] are protected from damages sought by a disciplined doctor." H.R.Rep. 903 at 3, reprinted in 1986 U.S.C.C.A.N. at 6385. *Bryan v. James E. Holmes Regional Medical Center*. 33 F.3d 1318, 1321-22.

Lawsuits and the HCQIA

- There is no private cause of action established by the HCQIA
- Nevertheless the House of Representatives clearly anticipated that lawsuits would occur.
  - Initially, the Committee considered establishing a very broad protection from suit for professional review action. In response to concerns that such protection might be abused and serve as a shield for anti-competitive action under the guise of quality controls, however, the Committee restricted the broad protection. As redrafted, the bill now provides protection only from damages in private actions, and only for proper peer review, as defined in the bill……[t]he bill does not restrict the rights of physicians who are disciplined to bring causes of action for injunctive or declaratory relief. If the professional review actions being challenged fail to meet the standards of [the bill], no immunity is provided and the suit can be tried without regard to the provisions of the bill. House Report No. 99-903, 99th Cong., 2nd Sess.1986, 1986 U.S.C.C.A.N. 6384 (1986 WL 31972) (Leg. Hist.)

Lawsuits and the HCQIA

- What the above appears to say is that if the plaintiff physician can show that the standards of 42 U.S.C.A. §§ 11111(a)(1) have not been met, then a private cause of action can be brought and there is no immunity defense.
- Of course, we know better.
  - In *Manzetti v. Mercy Hospital of Pittsburgh*, the Pennsylvania Supreme Court held on July 18, 2001 that the hospital and reviewers were entitled to immunity under HCQIA. The Supreme Court disregarded all evidence relating to the reviewed physician's competitors' involvement in the case and attacks against him. The Court stated that any self-interest, bias or conflicts of interests by the reviewers were ***immaterial.***
  - According to the Court, the only time HCQIA precludes an economic competitor from involvement in the internal peer review process is at the hearing panel phase of the case; however, HCQIA does not preclude economic competitors from perpetrating due process violations and inculcating bias throughout the early phases of the review process.

Lawsuits and the HCQIA

- *Donnell v. HCA Health Services of Kansas, Inc.*, the Kansas Court of Appeals held on July 6, 2001 that physician peer reviewers are immune from liability under HCQIA even if their investigations are *sloppy, negligent, and wrong*. Physicians must prove bad faith and malice to have a peer review decision overturned.
- *Meyer v. Sunrise Hospital*, the Nevada Supreme Court held on May 15, 2001 that a hospital's decision to terminate a physician based upon a *single incident*, regardless of the high quality of care the physician provided throughout the remainder of his career, was sufficient to protect the hospital under HCQIA's immunity provisions. The one dissenting Justice noted that ""basically as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, *whether legitimate or not*, they are immune from liability, which *leaves the hospitals free to abuse the process for their own purposes*."

Lawsuits and the HCQIA

- In *Freilich v. Board of Directors of Upper Chesapeake Health, Inc.*, a federal court in Maryland held on May 14, 2001 that the HCQIA immunity provisions do not violate due process or equal protection under the U.S. Constitution.
- *Brader v. Allegheny General Hospital*, 167 F.3d 832 (3rd Cir. 1999). It was proven that the hospital's outside expert report had several incorrect conclusions. The Court of Appeals, however, ignored these mistakes because it found the report to be "otherwise thorough." Thus, the report must be 100% wrong.
- In *Gordon v. Lewistown Hospital*, 714 A.2d 539 (Pa. Cmwlth. 1998), Commonwealth Court found that there is a presumption of validity of the hospital's disciplinary procedures. Though there were hostile internal physicians who essentially poisoned the facts, since an outside consultant using these facts arrived at a negative conclusion the doctor got due process under the *totality of the process*

Lawsuits and the HCQIA

- There is no legal remedy or recourse to the physician under the "totality of the circumstances" test. Hospitals have figured out that all they need to do is establish an independent “fair” hearing panel, give minimal due process at that final phase of the case, and their immunity will be intact.
- When discussing the broad HCQIA immunity and typical hospital bylaws burden shifting and standard setting procedures that are anything but fair and balanced, JCAHO staff take the position that they "don’t care about detail" even if, as applied, the physician has no chance to overcome the standards.
- In *Lyons v. St. Vincent Health Center*, Commonwealth Court stated: "It is not up to the courts to second-guess hospitals in their decisions as to the best way to deliver services; it is up to the institution itself.

What went wrong for the hospital in the Poliner case?

- A patient case was brought to the attention of the Chiefs of Internal Medicine and Cardiology, and a peer review was commenced.
  - 1. Experts for Dr. Poliner testified that there was no patient harm.
  - 2. Dr. Poliner was forced to accept an abeyance for caths under the threat of termination of all privileges.
  - 3. Dr. Poliner objected and asked to discuss the case, asked for options, requested additional time to consider the abeyance, and asked to talk to an attorney. There was clearly no “imminent danger” to any patient. All requests were denied and Dr. Poliner was forced to accept the abeyance.
  - 4. The actual decision to force the abeyance was made by the Chief of Internal medicine though the Chiefs of Cardiology and Cath lab were present.
  - 5. At the end of the abeyance, in June 1998, the hospital suspended Dr. Poliner’s privileges to perform cardiac cath and echocardiograms

What went wrong for the hospital in the Poliner case?

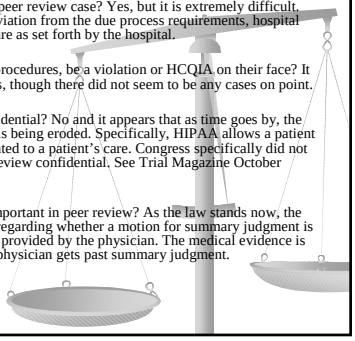
- In November 1998, after an administrative hearing, Dr. Poliner’s privileges were restored.
- Seven physicians performed the investigation that resulted in the post-abeyance suspension.
- Dr. Poliner’s experts stated that the conclusions that these doctors reached was so flawed that they could not have suspended Dr. Poliner in good faith that thus the post-abeyance investigation must have been malicious.
- Substantial errors in conclusions and in the facts were discovered and further conclusions were not based on reasonable accepted standards.
- Defendants filed a motion for summary judgment claiming immunity. All post abeyance actions were dismissed as Dr. Poliner had “adequate due process”

What went wrong for the hospital in the Poliner case?

- The result of the summary judgment was that the entire trial and all awards were based on the actions leading to and the forced abeyance of Dr. Poliner’s cath privileges.
- During the trial and despite the findings of the administrative hearing finding that Dr. Poliner did not perform unsatisfactorily, the Chief of Medicine stated that regardless of the facts he felt that Dr. Poliner was dangerous and not competent. This apparently had a substantial impact on the jury and demonstrated the arrogance that this individual had.
- The Take Home Lesson from *Poliner v. Texas Health Systems* 74174 2003 WL 22255677 (N.D. Tex. 2003)
  - Had the abeyance been not forced or a cardiologist had required the abeyance there may have been no case.
  - If there had been no abeyance and just a summary suspension after a brief investigation, again there would have been no case.
  - Finally, if the hospital had managed to stack the hearing panel in some way (remember only direct competitors are excluded) there would have been no case.

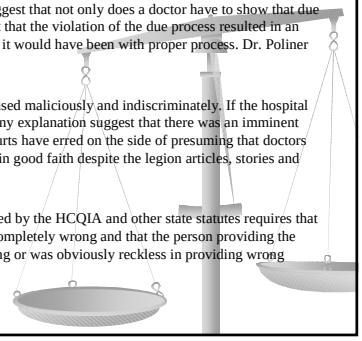
Where are we in 2006? Summary

- Can you get into Court with a peer review case? Yes, but it is extremely difficult. You must show substantial deviation from the due process requirements, hospital bylaws, or the hearing procedure as set forth by the hospital.
- Can hospital bylaws, hearing procedures, be a violation or HCQIA on their face? It would appear the answer is yes, though there did not seem to be any cases on point.
- Is peer review absolutely confidential? No and it appears that as time goes by, the confidentiality of peer review is being eroded. Specifically, HIPAA allows a patient to discover all information related to a patient’s care. Congress specifically did not agree when asked make peer review confidential. See Trial Magazine October 2004.
- Are the actual medical facts important in peer review? As the law stands now, the least important determination regarding whether a motion for summary judgment is sustained is the quality of care provided by the physician. The medical evidence is only important if the Plaintiff physician gets past summary judgment.



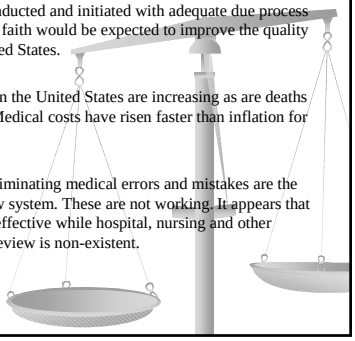
Where are we in 2006? Summary

- Case law would appear to suggest that not only does a doctor have to show that due process was not followed, but that the violation of the due process resulted in an outcome that is different than it would have been with proper process. Dr. Poliner met this burden in his case.
- Summary suspension is still used maliciously and indiscriminately. If the hospital or doctors can under almost any explanation suggest that there was an imminent danger to any patient, the Courts have erred on the side of presuming that doctors are inherently honest and act in good faith despite the legion articles, stories and proof of the opposite.
- The proof of malice as required by the HCQIA and other state statutes requires that the information provided is completely wrong and that the person providing the information knew it was wrong or was obviously reckless in providing wrong information.



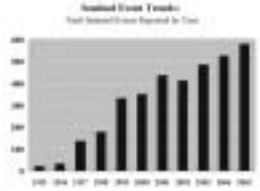
Where are we in 2006?
Summary

- Peer review, if properly conducted and initiated with adequate due process from the beginning in good faith would be expected to improve the quality of medical care in the United States.
- The errors in medical care in the United States are increasing as are deaths due to preventable errors. Medical costs have risen faster than inflation for the last 20 years.
- The primary methods for eliminating medical errors and mistakes are the JCAHO and the peer review system. These are not working. It appears that physician peer review is ineffective while hospital, nursing and other medical professional peer review is non-existent.



JCAHO and Sentinel Events
Telling Statistics

- Sentinel Event Reporting Started in 1995 and reports are listed for 10 years. Sentinel Events include wrong sided surgery, deaths and other events that result in substantial patient injury or death



JCAHO and Sentinel Events
Telling Statistics

- As we have seen, due to complaints about the study that showed 44,000 to 98,000 deaths per year in US hospitals, Healthgrades improved the study breadth and detail. A better estimate is 195,000 preventable deaths per year. Let's err on the side of conservatism. Suppose there are only 44,000 deaths, and other sentinel events are not reported. Let's then assume that ½ are not recognized as a sentinel event. Over 10 years there should have been 220,000 sentinel events reported. There is no liability for reporting and the reports are used according to the JCAHO website for educational purposes only. Further, though reporting is voluntary, JCAHO can sanction a hospital for not reporting sentinel events.
- Since 1995, the total sentinel events reported are slightly over 3,000.