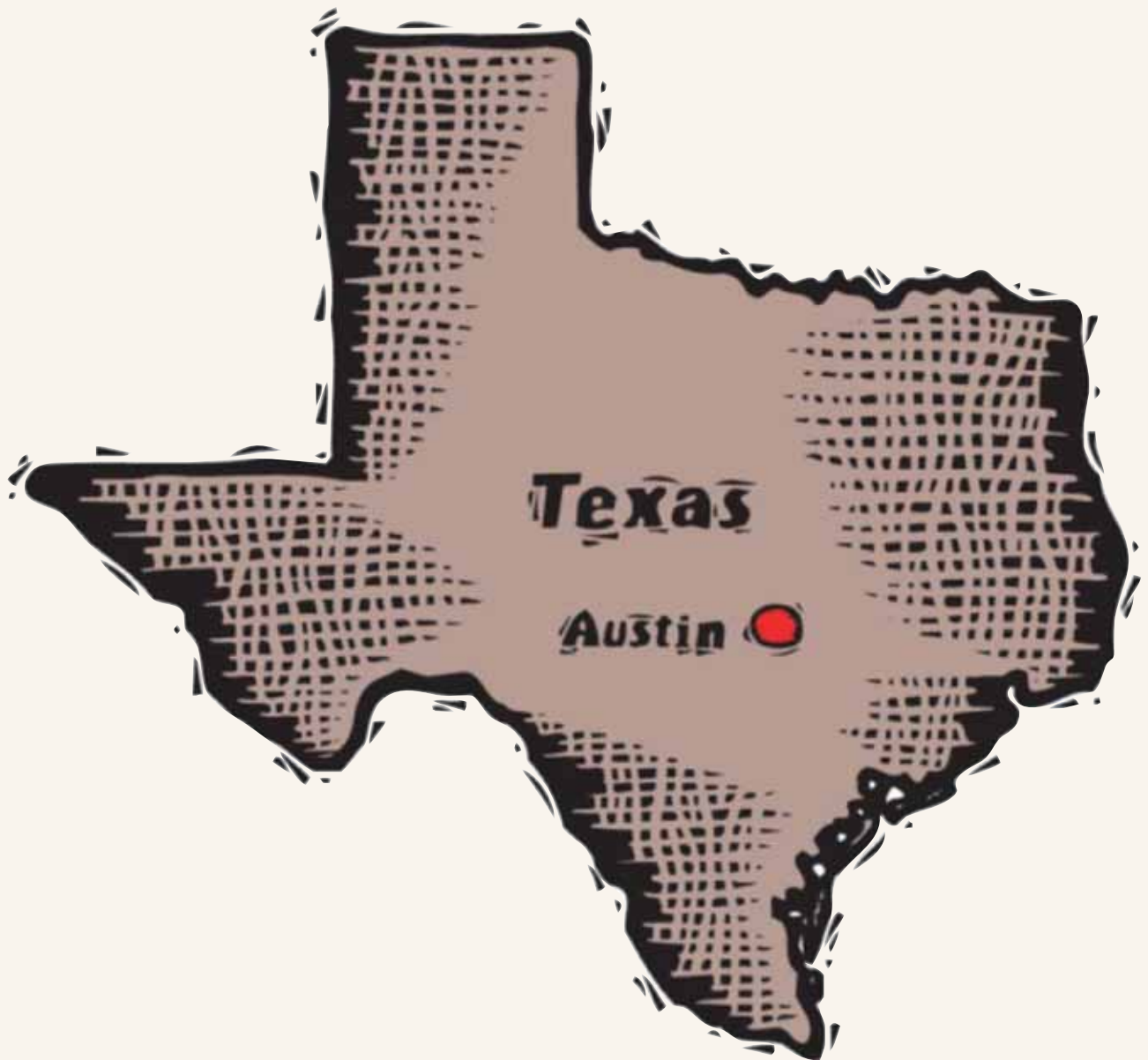


Poliner:

A TEXAS





Credentialing Verdict for Physicians

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I. Introduction

If the \$366 million jury verdict rendered by the U.S. District of the Northern District of Texas in *Poliner v. Texas Health Systems*¹ stands, *Poliner* will be a landmark credentialing case. However, the purpose of this article is to do more than highlight the mega-judgment nature of the *Poliner* case; this article will trace the development of what was an approximate eight-year legal odyssey that has dealt with the typical issues presented in credentialing cases, i.e., confidentiality of peer review records, summary judgment on federal antitrust and state claims, immunity under the Health Care Quality Improvement Act² (HCQIA) and the state peer review immunity statutes, and damages.

The *Poliner* Complaint was filed on May 12, 2000 in the U.S. District Court for the Northern District of Texas following hospital review proceedings that occupied more than a year. There have been three reported decisions to date in the *Poliner* case:

1. The Discovery Decision³—On June 20, 2001, the first *Poliner* decision dealt with the discovery of peer review records;
2. The Summary Judgment and Immunity Decision⁴—On September 30, 2003, the district court granted and denied summary judgment for both parties on a variety of claims and dealt with immunity under the

HCQIA and the Texas Peer Review Immunity Statute; and

3. The Damages Decision⁵—On March 27, 2006, the district court ordered the plaintiffs were entitled to judgment as a matter of law on the defamation claim in the amount of \$366 million, but also directed the parties to participate in mediation for sixty days from the date of the order and indicated that it would consider the defendants' motions for remittitur and for a new trial. There has been no reported decision on those issues yet.

II. Peer Review Facts

Dr. Poliner was granted temporary privileges at Presbyterian Hospital Dallas (PHD) in 1996 and obtained full privileges on October of 1997. However, peer review questions arose even before Dr. Poliner obtained full medical staff membership and clinical privileges.

On September 29, 1997, a Committee Event Report Form (CERF), the hospital's version of an incident report, was filed regarding Dr. Poliner as a result of a patient's death following a procedure in the cath lab. Two additional CERFs followed on October 29, 1997 and December 18, 1997, the next dealing with a patient who suffered a stroke following a cath lab procedure and the last following the alleged use of a contaminated sheath in the cath

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lab. All of these cases were referred to the hospital's Clinical Risk Review Committee (CRRC), a standing quality assurance committee of the hospital. The CRRC reviewed the cases and eventually referred all three cases to the Department of Internal Medicine for further review. On May 12, 1998, while review of these first three cases was still pending, a fourth case arose in which it was alleged that Dr. Poliner performed an angioplasty in the cath lab on the wrong artery of a patient, leaving the blocked artery untouched and remaining as a threat to the patient's safety. This case was identified by Dr. Charles Levin, the Director of the cath lab, who subsequently brought this to the attention of Dr. Harper, the Chief of Cardiology, and Dr. Knochel, the Chairman of the Department of Internal Medicine.

On May 14, 1998, while all of these cases were under review, Dr. Knochel met with Dr. Poliner and demanded that he voluntarily agree not to exercise his cath lab privileges while the review continued. This procedure identified as "abeyance" in the hospital was alleged by Dr. Poliner and ultimately held by the court to have been a summary suspension involuntarily imposed on Dr. Poliner by virtue of the fact that Dr. Poliner was threatened that if he did not agree to the abeyance his privileges would be summarily suspended. This compulsory abeyance was the pivotal issue in the outcome of this case.

On May 20, 1998, an Ad Hoc Committee (AHC) consisting of Drs. Harris, Das, Brockie, Cherif, Meyer, and Reardon was appointed to review forty-four of Dr. Poliner's cases. All members of the AHC, other than Dr.

Reardon, were later named as defendants. The AHC met on May 20, 1998 and concluded and reported that sub-standard care was rendered in twenty-nine of the forty-four cases under review. The Internal Medicine Advisory Committee (IMAC) then met on May 27, 1998 to consider the AHC report. The IMAC was composed of Drs. Musselman, Rinner, Kaliser, Harvey, and Dr. Knochel, who served as chairman. Dr. Kaliser was the only cardiologist on the IMAC and was the only member of the IMAC not named as a defendant by Dr. Poliner in this case. The IMAC recommended additional review of echocardiograms in consultation with an outside reviewer. The IMAC also suggested an extension of the abeyance.

Dr. Poliner was advised and agreed to an extension until June 12, 1998, but no outside reviewer could be found to perform the necessary reviews in time for the hearing. Dr. Knochel advised Dr. Poliner that there would be an IMAC meeting on June 11, 1998, as part of the peer review process, which meeting was scheduled for one hour. Dr. Poliner requested a postponement of the IMAC meeting; it is unclear from the court decision whether this was a meeting or a hearing because it is referred to as both, but Dr. Poliner's request for additional time was rejected by Dr. Knochel on June 10, 1998. The IMAC meeting proceeded as scheduled and, on June 12, 1998, the IMAC voted unanimously to recommend suspension of Dr. Poliner's privileges, identifying the following specifics concerns:

1. Poor clinical judgment;
2. Inadequate skills;
3. Unsatisfactory documentation; and
4. Substandard patient care.

Upon receipt of the IMAC recommendation, Dr. Knochel summarily suspended Dr. Poliner's cath lab and echocardiography privileges, although Dr. Poliner retained his admission and consulting privileges. The court's opinion refers to both the abeyance and this suspension as summary suspension. Dr. Knochel's letter of June 12, 1998 also advised Dr. Poliner of his appeal rights.

Dr. Poliner requested a medical staff hearing on July 10, 1998 in accordance with the medical staff bylaws. This medical staff hearing was initially scheduled for September 14, 1998, but was later continued until November 3, 1998 upon Dr. Poliner's request. The hearing actually took place on November 3, 4, and 5 of 1998. On November 9, 1998, the Medical Staff Hearing Committee issued a hearing report restoring Dr. Poliner's privileges with conditions, but approving the summary suspension. On November 18, 1998, the hospital Board accepted the Hearing Committee's recommendation, and on November 20, 1998, notified Dr. Poliner accordingly. On January 15, 1999, Dr. Poliner appealed the Board deci-

sion to the Appellate Review Committee of the hospital in accordance with the bylaws with respect to the affirmation of the summary suspension. The Appellate Review Committee upheld the decision of the Hearing Committee and the Board and, on June 7, 1999, the hospital Board upheld the decision of the Appellate Review Committee.

III. Complaint

Dr. Poliner filed his Complaint approximately one year later on May 11, 2000, naming as defendants, the hospital, Dr. Knochel, Dr. Levin, and Dr. Harper, and seven other physicians who either served on the IMAC or the AHC, i.e., Drs. Harris, Das, Musselman, Brockie, Cherif, Meyer, and Berk; these seven physicians were later granted immunity on summary judgment. The Complaint alleged the following causes of action against the defendants:

1. A combination and conspiracy in violation of Section 1 and 2 of the Sherman Act⁶ and Section 4 of the Clayton Act⁷;
2. An unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983⁸;
3. A breach by the hospital of Dr. Poliner's contractual due process rights under the hospital's bylaws;
4. Business disparagement, slander, and libel;
5. Tortious interference with business;
6. Tortious interference with prospective advantage;
7. Violation of the Texas Deceptive Trade Practices Act⁹; and
8. Intentional infliction of mental anguish and emotional stress.

Dr. Poliner also requested a temporary restraining order, temporary injunction and permanent injunction against the hospital to rescind the summary suspension, declaratory relief that the defendants were not immune from the suit pursuant to either the HCQIA or the Texas Medical Practice Act, and additional declaratory relief declaring that the HCQIA and the Texas Medical Practice Act were unconstitutional.

IV. Discovery Case

Dr. Poliner attempted to depose Dr. Knochel and obtain information regarding the records of the peer review committee, i.e., the IMAC and AHC, which decisions were

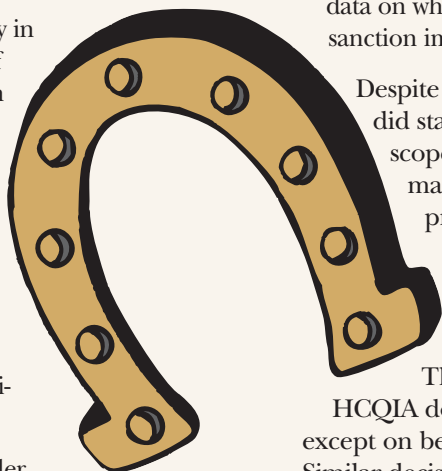
responsible for the ultimate suspension of his privileges. During the deposition, Dr. Knochel attempted to assert privilege on the basis of the confidentiality afforded to peer review materials under the HCQIA and the provisions of the Texas Occupations Code, and relied on prior Texas decisions that the information was privileged and not subject to discovery. The court concluded that HCQIA did not provide protection from discovery stating:

Upon review and consideration of the Health Care Quality Improvement Act (HCQIA), the magistrate judge concludes that this statute does not create an inviolate to discovery of materials relating to peer review committees. Accord, see *Robertson vs. Neuro Medical Center*, 169 FRD 80, 83-84 (MD La. 1996). Further, were such a privilege recognized, it would effectively foreclose a wrongfully disciplined physician from being able to show that a peer review committee acted with malice because he would be precluded from showing that the data on which the committee acted did not support the sanction imposed.¹⁰

Despite finding the absence of a privilege, the court did state that there should be restrictions on the scope of discovery and dissemination of the information because of Congress' obvious intent to protect the confidentiality of this information, thus ordering the production, but redaction, of medical records and other peer review records.

The *Poliner* court is not alone in holding that HCQIA does not create confidentiality or privilege except on behalf of the National Practitioner Data Bank. Similar decisions have been reached in *Rdzanek v. Hospital Service District No. 3*,¹¹ *Teasdale Marin General Hospital*,¹² and *Nilavar v. Mercy Health System*,¹³ with the court opining in the last of the above as follows:

This Court is not persuaded by the *Cohn* court's analysis of the import of the HCQIA. The HCQIA was enacted in the interest of both reducing medical incompetence and protecting physicians who take part in the peer review process, which ultimately exposes such medical incompetence. 42 U.S.C. § 11101. In return for requiring "professional review bodies," defined as groups of health care professionals who review the work of their colleagues, to report to the Secretary of Health and Human Services ("Secretary"), among other things, any action taken which adversely affects a physician's clinical privileges, the statute guarantees that all such information "reported under this subchapter [shall be] considered confidential and shall not be disclosed," except under certain circumstances not relevant herein. (citation omitted) Far from creating a broad privilege, Congress, in enacting the HCQIA, carefully crafted a very specific privilege, applicable to peer review material submitted to the Secretary pursuant to the dictates of the mandatory reporting provisions of that statute. That



is as far as Congress went, and that is as far as this Court should apply the privilege contained therein.

V. The Summary Judgment Case

The hospital and the other defendants moved for summary judgment on all counts. The court's decision in the summary judgment case was handed down on September 30, 2003. The court reviewed the standards for granting a summary judgment (i.e., the moving party must demonstrate the absence of a material issue of fact and the right to prevail as a matter of law while the defending party must provide more than conclusory statements or unsubstantiated assertions regarding the alleged issues and material fact) and divided the plaintiff's claims into eight categories: (1) antitrust, (2) procedural rights under medical bylaws, (3) immunity under the HCQIA and the Texas Peer Review Immunity statute, (4) interference with contractual relations, (5) defamation and business disparagement, (6) intentional infliction of emotional distress, (7) deceptive trade practices act claims, and (8) miscellaneous motions.

A. Antitrust Claims

Dr. Poliner alleged that the defendants, by participating in the suspension of his privileges, entered into a combination and conspiracy in violation of Sections 1 and 2 of the Sherman Act¹⁴ and Section 4 of the Clayton Act¹⁵ and engaged in an unlawful combination and conspiracy in violation of the Texas Free Enterprise and Anti-Trust Act of 1983.¹⁶ The court found that 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."¹⁷

In order to state a cause of action under the Sherman Act, the plaintiff must demonstrate that the defendants (1) engaged in a conspiracy or combination, (2) that the prohibitive action produced an anti-competitive effect, and (3) that such conduct occurred within the relevant market.

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."¹⁸

First, although Dr. Poliner had alleged the AHC consisted of his competitors, with three of the six doctors on the AHC being members of two major competitive cardiology groups at the hospital (i.e., North Texas Heart Center and the Cardiology and Internal Medicine Association), the court found that the other three physicians were independent doctors, as was Dr. Poliner, and that those independent doctors would have no motive or reason to attempt to assist the major groups in eliminating competition. Moreover, Dr. Poliner offered no reason why the major groups "did not turn their anti-competitive designs on these other independent doctors."¹⁹ The court also concluded that the mere fact of combining to conduct peer review was a lawful activity, stating "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."²⁰



Second, the court focused on the impact on competition and reiterated hornbook antitrust law that the antitrust laws are intended to protect competition and not individual competitors. The court concluded that Dr. Poliner could not show any impact on him because, at the time of suspension:

[P]laintiff had full active staff privileges at five other hospitals and courtesy privileges at two other hospitals at the time of his summary suspension. (citation omitted) 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.²¹

Finally, the court concluded that Dr. Poliner's alleged definition of the market was too narrowly drawn. Dr. Poliner had alleged that the market consisted of just the defendant hospital, but the court noted that "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 circumstances, a physician may not limit the relevant geographic market to a single hospital."²² Conversely, the defendants asserted that the relevant market was a seventeen-county area surrounding Dallas and Ft. Worth from which the defendant hospital attracted its cardiology patients. The court did not agree with the defendants that the relevant product market was that large, but did find it to include at least the City of Dallas and some

additional areas, an area much larger than Dr. Poliner's allegations.

B. Procedural Rights Under the Medical Bylaws

The court began its discussion of the breach of contract or procedural due process argument by citing a peculiarity of Texas law, which establishes a distinction between medical staff bylaws, which "are considered incapable of creating an enforceable contract between the hospital and its physicians" and the hospital bylaws, which "may constitute contractual rights between the physicians and the adopting hospital."²³ The court cited a prior federal district court case applying Texas law in this matter, i.e., *Monroe v. AMI Hospitals*.²⁴

However, although there is a distinction between the legal impact of hospital bylaws and medical staff bylaws, Texas courts have previously decided that hospital bylaws that create procedural due process rights can be enforceable.

The court finds that the hospital bylaws in this case are similar to the bylaws in *Gonzalez v. San Jancinto Methodist Hospital*. 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 be provided by the Medical Staffs' bylaws and were to provide for procedural due process for the member. As in *Gonzales*, the bylaws of the PHD medical staff were subject to approval of the Board of Trustees of the PHD and were to provide procedural due process to the staff members. (citation omitted) Thus, the court finds that the hospital bylaws in the present case provided contractual due process rights.²⁵

The court denied the hospital's motion for summary judgment with respect to the breach of contract claims.

The majority view is that hospital bylaws, when approved and adopted by the governing board, are a binding and enforceable contract between the hospital and its physicians. Some decisions distinguish between hospital bylaws and medical staff bylaws, the latter of which are typically adopted by the medical staff. The following is a sampling of these holdings from court decisions:

"The majority view, however, appears to be that a hospital's medical staff bylaws constitute a contract between the hospital and medical staff . . . The court finds that the majority view is in accord with Iowa law. Iowa courts have recognized on a number of occasions that organizational bylaws create a contractual relationship between the parties."²⁶

"Because the hospital bylaws constitute a contract between the hospital and the physician, the hospital must comply with those bylaws when taking actions which effect its staff."²⁷

"The procedural rights created in a hospital's bylaws may constitute contractual rights . . . We find in the present case that the procedural rights under the hospital bylaws are contractual."²⁸

"Although there is a split of authority between several states, we agree with the Court of Appeals that the better reasoned view is that a hospital's bylaws are an integral part of its contractual relationship with the members of its medical staff."²⁹

"Breach of a Hospital's By-Laws in terminating a doctor's staff privileges is a sufficient basis upon which to grant compensatory as well as injunctive relief. The majority view is that a Hospital's By-Laws, when approved and adopted by the governing board, become a binding and enforceable contract between the hospital and the physicians comprising the medical staff."³⁰

"It is well settled that hospital bylaws have the force and effect of an enforceable contract."³¹

"The staff bylaws of a hospital constitute the terms of a legally binding agreement between the hospital and the doctors on its staff."³²

The minority view concludes that medical staff bylaws are not enforceable contracts. This outcome is typically based upon standard consideration contract theory, i.e., that contracts are not enforceable without additional consideration and, absent actual additional consideration, the mere performance of a pre-existing duty, which is the typical case when medical staff bylaws incorporate due process procedures required by state law, does not constitute consideration for the establishment of a contract. See *O'Byrne v. Santa Monica Hospital Medical Center*,³³ *Janda v. Madera Community Hospital*,³⁴ and *Virmani v. Presbyterian Health Services*.³⁵ However, both the *Janda* and *Virmani* decisions went on to find other actions constituted additional consideration so that the medical staff bylaws were enforceable as contracts. In *Virmani*, the court concluded that consideration existed because of the application and grant of medical staff privileges, which it characterized as actions over and above the mere adoption of bylaws in

accordance with state law.³⁶ In *Janda*, the court concluded that the hospital's adoption of bylaws that provided rights more specific than those required by law constituted additional action and, therefore, additional consideration.³⁷

C. Immunity for State Law Claims Pursuant to the HCQIA and the Texas Peer Review Immunity Statutes

The defendants asserted that they were entitled to summary judgment on all of Dr. Poliner's claims under state law based upon immunity provided either by HCQIA or the Texas Peer Review Immunity Statutes (TPR).

1. *Health Care Quality Improvement Act.* The court acknowledged that HCQIA was enacted to provide effective peer review coupled with qualified immunity for peer review participants. The court cited the provisions of HCQIA that provide immunity if the peer review action meets certain standards,³⁸ defines the standards required in order to qualify for immunity,³⁹ and establishes that HCQIA includes the presumption that a professional review action satisfies the standards unless the plaintiff can rebut the presumption by a preponderance of the evidence.⁴⁰ In order to qualify for immunity pursuant to HCQIA, a professional review action must be taken: (1) in the reasonable belief that the action was in the furtherance of quality healthcare, (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). The court focused on the first three requirements.

First, Dr. Poliner argued that he raised an issue of material fact as to whether the defendants had acted in the reasonable belief that the action was in furtherance of quality healthcare, because Dr. Poliner asserted that that action was taken based on anti-competitive motives and personal animosity, i.e., alleging a conspiracy to restrain trade. The court concluded that, with respect to the hospital and Drs. Levin, Harper, and Knochel, there was at least a question of fact with respect to whether the abeyance action was taken in furtherance of quality healthcare.

The court concluded that there was an issue of fact as to whether the abeyance was actually a summary suspension, because Dr. Poliner was given no alternative other than the abeyance and the hospital's bylaws require consent for any abeyance. The court reasoned that, if the abeyance was actually a suspension, then the suspension, in order to have been taken in compliance with HCQIA,

could have been taken only if Dr. Poliner presented a danger to the health of patients and after a reasonable effort to obtain the facts. Since the abeyance was allegedly imposed by Dr. Knochel prior to the completion of the IMAC review of the first four cases, the court found that there could be an issue with respect to compliance with the HCQIA standards and, therefore, denied summary judgment for the above-mentioned defendants.

However, the court found that defendants, Drs. Harris, Das, Musselman, Brockie, Cherif, Meyer, and Berk, were sued by Dr. Poliner only because of their roles on the two peer review committees, i.e., AHC and IMAC. The court held that these defendants were entitled to summary judgment on the basis of both HCQIA immunity and TPR immunity, since the committee proceedings did not present the same potential deficiencies as the abeyance action. "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."⁴¹

The court also examined whether a reasonable investigation had been performed. The court concluded that the actions of defendants, Drs. Knochel, Harper, Levin, and the hospital, in summarily suspending Dr. Poliner on May 14, 1998 (which was the date of the abeyance letter) were not made after reasonable effort to obtain the facts in the case and that these defendants therefore were not entitled to summary judgment. The court found that the actions of the other seven individual defendants were sufficient to constitute a reasonable investigation because there was no evidence of any animosity by those defendants against plaintiff and those defendants were conducting typical peer review processes. Furthermore, the court noted the individuals who were members of the hearing committee actually recommended the restoration of Dr. Poliner's privileges, although the committee also determined that there was adequate evidence to support the actual summary suspension.

Finally, the court concluded that there was a fact issue with respect to adequate notice and hearing regarding the abeyance/summary suspension on May 14, 1998, which constitutes another reason for denial of the motion for summary judgment on behalf of the hospital and Drs. Knochel, Harper, and Levin.

Again, the court found that the actions of the AHC and the IMAC were taken after adequate notice to plaintiff and after a hearing. The court addressed the fact that Dr. Poliner was denied additional time for preparation prior to the IMAC meeting, but noted that the denial was the

decision of Dr. Knochel and that there was no evidence that Dr. Poliner had asked the IMAC for additional time.

2. *TPR Immunity Statutes.* The court noted HCQIA allows individual states to provide even greater protection for medical peer review activities than provided by HCQIA. Specifically, the statute 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

The court then cited Section 5.06 of the Texas Medical Practice Act, enacted in 1987, Section 161.031-161.033 of the Health and Safety Code, enacted in 1989, and the Texas Occupation Code, all of which provide greater immunity to peer review participants but require as a condition to such immunity that the peer review participants act without malice and in the reasonable belief that the action is necessary.

The court examined the definition of malice and concluded that, “in the context of the Texas Peer Review Immunity Statutes, actual malice is the standard by which the defendants’ conduct is measured.”⁴³ “Actual malice means the making of statements with knowledge that it is false or with reckless disregard of whether it is true. Reckless disregard means that a statement is made with a high degree of awareness as probable falsity.”⁴⁴

With respect to the hospital and Drs. Knochel, Harper, and Levin, the court concluded that:

[T]here 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 the 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.⁴⁵

As with the other immunity claims, the court granted summary judgment on the state law claims on behalf of Drs. Harris, Das, Musselman, Brockie, Cherif, Meyer, and Berk.

VI. State Tort Claims: Interference with Contractual Relations, Defamation and Business Disparagement, and Intentional Infliction of Emotional Distress

The *Poliner* court treated the three state tort claims similarly. After writing that recovery for tortious interference required proof of four elements, including a willful or intentional act, the court denied summary judgment for defendants, Drs.

Knochel, Levin, Harper, and the hospital, but granted summary judgment in favor of the seven individual physicians, i.e., Drs Harris, Das, Musselman, Brockie, Cherif,

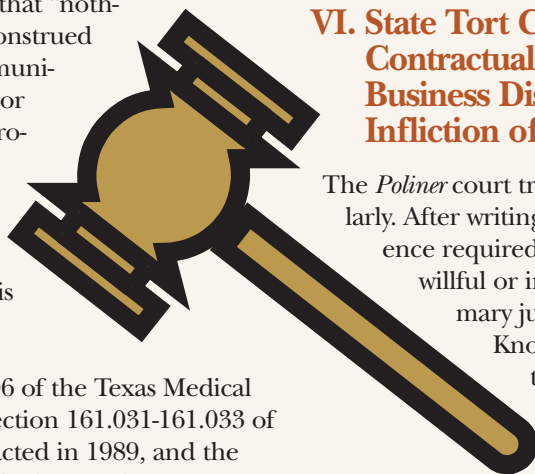
Meyer, and Berk, all on the basis that issues of actual malice had been properly pleaded with respect to the first group of defendants but not established as a fact issue with respect to the second group of defendants.

One interesting aspect about the defamation and business disparagement claim is that the claims are subject to a one-year statute of limitations in Texas, and more than one year had passed since the initial publication of the disparaging statements. However, Dr. Poliner alleged that each publication of the statements, such as self-disclosure on a re-credentialing application, was an additional cause of action and alleged that he was forced to publish his suspension of privileges when he applied or reapplied for privileges, such as to other hospitals, state agencies, and third-party payors. The *Poliner* court relied upon recognition by the Texas courts of “[a] narrow category of cases of self-compelled defamation.”⁴⁶

VII. The Damages Decision

The damages decision in the *Poliner* cases was handed down on March 27, 2006, following a trial on August 12, 2004 and a unanimous verdict on August 27, 2004. The opinion reports the jury’s findings as follows:

The jury first found that Defendants’ actions were not immune from civil liability under the federal or state peer review statutes. The jury also found in favor of Plaintiffs on all their claims, including breach of contract, defamation, business disparagement, tortious interference with a contract, and intentional infliction



tion of emotional distress. The jury further found that the Defendants had acted maliciously and without justification or privilege. The jury awarded compensatory and exemplary damages against Defendants in the total amount of \$366,210,159.30. Dr. Poliner has since settled with Drs. Levin and Harper, both of whom have been dismissed from this lawsuit.⁴⁷

The key to the *Poliner* decision is the abeyance action. Testimony from Dr. Knochel cited in the opinion is described as follows:

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. (citation omitted) He threatened Dr. Poliner with suspension of his privileges if Dr. Poliner refused to sign the abeyance letter, even though “we 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.” (citation omitted) 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. Clearly, 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. 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. (citation omitted) Dr. Knochel did not offer Dr. Poliner any other options that may have been less severe. (citation omitted) There was also evidence Dr. Knochel told Dr. Poliner that he was not permitted to consult an attorney.⁴⁸

Based upon these findings of fact, the jury concluded a number of things:

1. That defendants’ suspension of Dr. Poliner’s cardiac catheterization lab privileges was not undertaken in the reasonable belief that the action furthered quality healthcare;

2. That the decision was not taken after a reasonable effort to obtain the facts of the matter;
3. That the suspension was not undertaken after adequate notice and hearing procedures;
4. That the summary suspension was not made in good faith and without malice; and
5. That the lack of information prior to the abeyance action/suspension was sufficient to allow the jury to conclude that the suspension, which implicitly stated that Dr. Poliner was a dangerous doctor, was false.

The damages decision also addresses the breach of contract claim. The court concluded that the hospital bylaws specifically incorporated the medical staff bylaws and therefore were sufficient under Texas law to permit the court to affirm its earlier decision that a contract existed between Dr. Poliner and the hospital. Apparently, defendants also argued on post-trial motions that the medical staff bylaws were not enforceable as a contract because there was no consideration given, citing the rationale of a minority of breach of contract cases on this issue. However, the court dismissed this argument because it was not contained in defendants’ motion for judgment as a matter of law and therefore was waived.

Defendants raised another argument that is common in medical staff privilege disputes, i.e., that, regardless of statutory immunity, individual physicians provide contractual immunity when they sign medical staff applications granting immunity for peer review actions to the hospital and the individuals and entities that participate in providing peer review information. However, the court stated that “Dr. Poliner’s Application for Appointment releases Defendants from summary suspensions made in good faith and without malice.”⁴⁹ Therefore, the jury findings regarding the presence of malice with respect to the suspension decisions carried over as a defense to the contractual immunity allegation.

VIII. Conclusion

The *Poliner* trilogy presents a panoramic view of a credentialing dispute. The Discovery Decision deals with the first hurdle for plaintiffs and a common goal for hospital defendants, i.e., limiting access to other peer review data. The Summary Judgment and Immunity Decision illus-



trates a clear development in these cases, i.e., the emerging reluctance of courts to dismiss cases on the basis of immunity without some degree of inquiry. Finally, the Damages Decision illustrates the wild card results—already well known in other types of litigation—that can develop if a case gets to a jury.

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End Notes

- ¹ *Poliner v. Texas Health Sys.*, No. 3-00-CV-1007-P, 2006 U.S. Dist. LEXIS 13125 (N.D. Tex. Mar. 27, 2006).
- ² Health Care Quality Improvement Act (HCQIA) of 1986, 42 U.S.C.A. § 11101 (2005).
- ³ *Poliner v. Texas Health Sys.*, 201 F.R.D. 437 (N.D. Tex. June 29, 2001).
- ⁴ *Poliner v. Texas Health Sys.*, No. 3-00-CV-1007-P, 2003 U.S. Dist. LEXIS 17162 (N.D. Tex. Sept. 30, 2003).
- ⁵ *Poliner*, 2006 U.S. Dist. LEXIS 13125.
- ⁶ The Sherman Anti-Trust Act of 1890, 15 U.S.C.A. § 1-2 (1890).
- ⁷ The Clayton Act, 15 U.S.C. § 15 (1914).
- ⁸ Texas Free Enterprise and Anti-Trust Act of 1983, TEX. BUS. & COM. CODE § 15 (2005).
- ⁹ Texas Deceptive Trade Practices Act, TEX BUS. & COM. CODE § 17 (2005).
- ¹⁰ *Poliner*, 2001 U.S. Dist. LEXIS 13029, at **3.
- ¹¹ *Rdzanek v. Hospital Serv. Dist. #3*, No. 03-2585, 2003 U.S. Dist. LEXIS 19336 (E.D. La. 2003).
- ¹² *Teasdale v. Marin Gen. Hosp.*, 138 F.R.D. 691 (N.D. Cal. 1991).
- ¹³ *Nilavar v. Mercy Health Sys.*, 210 F.R.D. 597 (S.D. Ohio 2002).
- ¹⁴ The Sherman Anti-Trust Act of 1890, 15 U.S.C.S. § 1-2 (1890).
- ¹⁵ The Clayton Act, 15 U.S.C. § 15 (1914).
- ¹⁶ Texas Free Enterprise and Anti-Trust Act of 1983, TEX. BUS. & COM. CODE § 15 (2005).
- ¹⁷ *Poliner*, 2003 U.S. Dist. LEXIS 17162, at *21-*24.
- ¹⁸ *Id.* at *22-*23.
- ¹⁹ *Id.* at *24.
- ²⁰ *Id.* citing *Willman, M.D. v. Heartland Hosp. East*, F.3d 605,610 (8th Cir. 1994).
- ²¹ *Id.* at *25-*26.
- ²² *Poliner*, 2003 U.S. Dist. LEXIS 17162, at *27 quoting *Ginsberg v. Memorial Health Care Sys.*, 993 F. Supp. 998, 1013 (S.D. Tex. 1997).
- ²³ *Id.* at *30 citing *Weary v. Baylor Univ. Hosp.*, 360 S.W.2d 895, 897-898 (Tex. Civ. App. 1962); *Gonzalez v. San Jacinto Methodist Hosp.*, 880 S.W.2d 436, 438 (Tex. Civ. App. 1994).
- ²⁴ *Monroe v. AMI Hosps.*, 877 F. Supp. 1022, 1029 n.5 (S.D. Tex. 1994).
- ²⁵ *Poliner*, 2003 U.S. Dist. LEXIS 17162, at *31-*32.
- ²⁶ *Islami v. Covenant Med. Ctr.*, 22 F. Supp. 1361, 1371 (N.D. Iowa 1992).
- ²⁷ *Houston v. International Health Care, Inc.*, 933 P.2d 403 (Utah Ct. App. 1997).
- ²⁸ *Gonzalez*, 880 S.W.2d 436, 439 (Tex. Civ. App. 1994).
- ²⁹ *Lewisburg Community Hosp. Alfredson*, 805 S.W.2d 756, 759 (Tenn. 1991).
- ³⁰ *Lawler v. Eugene Wuesthoff Mem'l Hosp. Assoc.*, 497 So.2d 1261, 1264 (Fla. Dist. Ct. App. 1986).
- ³¹ *Anne Arundel Gen. Hosp., Inc. v. O'Brien*, 432 A.2d 483 (Md. App. 1981).
- ³² *Berberian v. Lancaster Osteopathic Hosp.*, 149 A.2d 456 (Pa. 1959).
- ³³ *O'Byrnes v. Santa Monica Hosp. Med. Ctr.*, 114 Cal. Rptr. 2d 575, 585 (Cal. Ct. App. 2001).
- ³⁴ *Janda v. Madera Community Hosp.*, 16 F. Supp.2d 1181 (E.D. Cal. 1998).
- ³⁵ *Virmani v. Presbyterian Health Servs.*, 488 S.E.2d 284 (N.C. App. 1997).
- ³⁶ *Virmani*, 488 S.E. 284.
- ³⁷ *Janda*, 16 F. Supp.2d 1181.
- ³⁸ 42 U.S.C.A. § 11111 (2005).
- ³⁹ 42 U.S.C.A. § 11112(a) (2005).
- ⁴⁰ 42 U.S.C.A. § 11112(b) (2005).
- ⁴¹ *Poliner*, 2003 U.S. Dist. LEXIS 17162, at *43.
- ⁴² 42 U.S.C.A. § 11115 (2005).
- ⁴³ *Id.* at *53 citing *Johnson v. Hospital Corp. of Am.*, 95 F.3d 383, 395 (5th Cir. 1996).
- ⁴⁴ *Id.* at *53 citing *Duffy v. Leading Edge Products*, 44 F.3d 308, 314 (5th Cir. 1995).
- ⁴⁵ *Id.* at *54-*55.
- ⁴⁶ *Id.* at *58 citing *Purcell v. Sequin State Bank and Trust Co.*, 999 F.2d 950 (5th Cir. 1993).
- ⁴⁷ *Poliner*, 2006 U.S. Dist. LEXIS 13125, at *5.
- ⁴⁸ *Id.* at *33-*35.
- ⁴⁹ *Id.* at *33.