Poliner v. Texas Health Systems: Exposing the Consequences of Federal and State Immunities in the Context of Medical Peer Review

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Many in the medical and legal communities were astounded after learning the jury in Poliner v. Texas Health Systems\(^1\) awarded a cardiologist over $366 million dollars in damages arising from the abeyance/summary suspension of his cardiac catheterization lab (“cardiac cath lab”) privileges following his medical peer review.\(^2\) Also remarkable was the doctor’s success in defeating the claims of immunity of the hospital and some physician defendants.\(^3\) This decision and the resulting damage award left many health care lawyers rethinking how best to advise their hospital clients to avoid the errors committed in the Poliner case.\(^4\) In addition, this case prompted the Texas Senate to form a committee to study medical peer review in Texas.\(^5\)

During the 1980s, the health profession increased its efforts to regulate itself through the promotion of peer review.\(^6\) However, following peer reviews, which resulted in adverse actions, physicians would file lawsuits, alleging claims such as antitrust.\(^7\) Concerned that the fear of suit among peer review participants would impede the peer review process, Congress passed the Health Care Quality Improvement Act (HCQIA) of 1986, which in part, grants peer review participants qualified immunity from damage liability, provided that they demonstrate compliance with certain standards.\(^8\) HCQIA allows the individual states to enact even greater protection for medical peer review activities.\(^9\) For example, Texas enacted the Texas Medical Practice Act (TMPA), which provides that a member of a medical committee is not liable for damages for an action taken within the scope of committee functions if taken without malice and “in the reasonable belief that the action or recommendation is warranted by the facts known to the committee member.”\(^10\)

2. See Poliner, 2006 WL 770425, at *2; see also Barbara Blackmond & Phil Zarone, Court Upholds Jury’s Findings in Poliner!, Apr. 12, 2006, available at http://www.hortyspringer.com/AC/Poliner_04122006.htm (“This case may have a chilling effect on physician willingness to participate in peer review matters, and, we can expect attorneys for physicians who challenge professional review actions to couch what was done in terms of what went wrong in Poliner.”); see also University of Texas Law School Annual Health Law Conference, Apr. 6, 2005, http://conferences.utcle.org/law/cle/conferences/archive/HL05/002.1_Regier_HL05_ppt.pdf (“Thus most appellate lawyers believe if judgment is entered on the verdict, it is highly likely to be reversed on appeal. But this is definitely cold comfort.”). The damages have since been reduced to $22.54 million dollars. See generally also Association of American Physicians and Surgeons, Inc., Poliner v. Presbyterian Hospital of Dallas, available at http://www.aapsonline.org/judicial/poliner.php (last viewed Nov. 16, 2006).
4. See Blackmond & Zarone, supra note 2; see also University of Texas, supra note 2.
7. Id.
8. 42 U.S.C.A. §§ 11101-11152 (2006); see also Manion, 986 F.2d at 1037.
From 1996 to 1998, Dr. Lawrence Poliner held privileges at Texas Health Systems d/b/a/ Presbyterian Hospital of Dallas ("Presbyterian Hospital" or "hospital"), including privileges for the cardiac cath lab, echocardiography, admission and consultation. During September through December 1997, nurses at the hospital filed three Committee Event Report Forms concerning Dr. Poliner’s treatment of three patients. While the review of these cases by the hospital’s Internal Medicine Advisory Committee (IMAC) was still pending, Dr. Charles Levin, director of the cardiac cath lab, reviewed the film of an emergency angioplasty procedure in another case performed by Dr. Poliner. He concluded that “Dr. Poliner performed the angioplasty on the wrong artery and missed a totally occluded left anterior descending coronary artery.” He thought this to be “potentially life threatening to the patient.” Dr. Levin discussed the emergency angioplasty case with Dr. John Harper, then Chief of Cardiology. Dr. James Knochel, Chairman of the Department of Internal Medicine at Presbyterian Hospital had also been made aware of the emergency angioplasty case.

In view of the issue regarding the emergency angioplasty patient and the other three reports, which were still pending review by the IMAC, Drs. Knochel, Levin, and Harper met with Dr. Poliner to ask him “to accept abeyance of all procedures in the cath lab” until an ad hoc committee could review Dr. Poliner’s cases. According to Dr. Poliner, he received the abeyance letter at 2:00 p.m. and was told to return the signed abeyance letter by 5:00 p.m. or else his privileges would be summarily suspended. Dr. Knochel specifically told him that he could not consult an attorney before signing the letter. No one informed him about the emergency angioplasty case, nor did anyone provide him with the opportunity to offer any explanation of the situation. Neither did anyone inform Dr. Poliner which patient cases would be discussed by the ad hoc committee. Under what the jury ultimately found to be duress, Dr. Poliner signed and returned the letter, agreeing to the abeyance of cath lab procedures.

The medical staff office randomly chose forty-two cases for the ad hoc committee to review. Two additional cases were chosen for review because of concerns that had been raised regarding those patients. Following the ad hoc committee’s conclusion that “substandard care” was

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12 Id. In September 1997, a nurse completed a Committee Event Report Form (CERF) concerning Dr. Poliner’s treatment of a patient who later died after undergoing a procedure performed by Dr. Poliner in the cath lab. In October and December of 1997, there were two other CERFs filed, reporting Dr. Poliner’s treatment of two other patients. One patient suffered a stroke following Dr. Poliner’s cath lab procedure and the other patient’s treatment involved “Dr. Poliner’s alleged use of of a contaminated sheath.” Id.
14 Id.
15 Id.
16 Id.
17 Poliner, 2003 WL 22255677, at *3.
18 Id.
19 Id.
22 Id.
23 Poliner, 2006 WL 770425, at *9, 12.
24 Poliner, 2003 WL 22255677, at *3.
25 Id.
provided in twenty-nine out of forty-four cases, the IMAC, with Dr. Knochel as chairman, met to discuss the ad hoc committee’s findings. The IMAC recommended, among other items, that they involve an outside reviewer. Claiming that no outside reviewer could be found to review Dr. Poliner’s cases on short notice, the IMAC meeting was scheduled and the committee recommended suspension of Dr. Poliner’s privileges by unanimous vote. Dr. Knochel then “summarily suspended Dr. Poliner’s cath lab and echocardiography privileges.”

Dr. Poliner requested a hearing on his suspension, as provided by the medical staff bylaws. Following this three day hearing, the Medical Staff’s hearing committee recommended Dr. Poliner’s privileges be “restored with conditions” but also found that the summary suspension of Dr. Poliner’s privileges was “justified based on the evidence available at the time.”

Dr. Poliner filed suit against Presbyterian Hospital and Doctors Levin, Harper, and Knochel and seven other doctors involved with his medical peer review. Dr. Poliner claimed that the defendants “improperly and maliciously used the peer review process to summarily suspend [his] privileges, thereby causing damage to his interventional cardiology practice.” Following Defendants’ Motion for Summary Judgment, only Doctors Levin, Harper, and Knochel, were each found not to be entitled to immunity and thus remained in the lawsuit.

At trial, the jury found that the professional review did not meet the standards for immunity set forth in the HCQIA or under the Texas Act. The jury found for Dr. Poliner on all submitted claims. In upholding the jury verdict on federal and state immunity, the court highlighted the following evidence that was sufficient to support the jury’s verdict:

1) Dr. Knochel’s testimony 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”;
2) Under the Medical Staff bylaws “the basis for any summary suspension is that the practitioner’s acts ‘constitute a present danger to the health of his patients’”;
3) Dr. Knochel threatened Dr. Poliner with suspension of his privileges if Dr. Poliner refused to sign the abeyance letter, even though at the time no one had determined that he was a “present threat to his patients”;
4) Three of the four cases referenced in the abeyance letter “involved patients Dr. Poliner had treated months prior; thus those cases could not have posed an immediate danger”;
5) Dr. Knochel’s failure to offer Dr. Poliner any less severe options;

26 Id. at *3. Dr. Musselman, the only cardiologist on the committee, and Dr. Knochel were the only named defendants in Poliner’s lawsuit from this committee. See id. at *1-3.
27 Id. at 3.
28 Id.
29 Id.
30 Poliner, 2006 WL 770425, at *2. Plaintiff claimed violations of federal and state antitrust laws, violation of the Deceptive Trade Practices Act, breach of contract (Hospital’s Bylaws), caused business disparagement, slander and libel, tortious interference with business and prospective advantage, and caused intentional infliction of mental anguish and emotional distress. Id.
31 Id. at *1.
32 Poliner, 2003 WL 22255677, at *10-16.
34 Id. at *2
6) Dr. Poliner was told not to consult an attorney in deciding whether to sign the abeyance letter; and
7) Dr. Poliner was not provided with the opportunity to offer any explanation of the emergency angioplasty case.35

Specifically, the court concluded that the foregoing evidence supported the jury’s finding that the four HCQIA requirements were not met and that the defendants acted with actual malice, that is, “the making of a statement with knowledge that it is false, or with reckless disregard of whether it is true.”36

The intent behind medical peer review is ultimately to protect patients from incompetent physicians.37 However, some commentators believe that the peer review that took place in the Poliner case was an example of a sham peer review.38 A sham peer review is one that takes place for “for reasons other than patient care” or the use of the peer review process in an “anticompetitive or malicious manner.”39 His lawyers agree, arguing that peer review is routinely not being used to address patient care but to rid a hospital of competitors.40 They opine that although the incidents of medical errors are increasing, doctors committing such errors are not often scrutinized.41 Instead, successful solo practitioners, such as Dr. Poliner, “who are upsetting the local pecking order” are often targets of the peer review process while doctors in large and powerful practices are rarely subjected to the process.42 The jury must have agreed as well. In a footnote, the court provides its observation of why the jury award was so significant:

There is no doubt the jury awarded Dr. Poliner a tremendous amount of money in damages. The jury’s attitude and award was influenced by Defendants’ unwillingness to acknowledge their own wrongdoing and their callous attitude toward Dr. Poliner at the time of the abeyance/suspension and at trial. Defendants’ insistence on taking the position that Dr. Poliner voluntarily agreed to the abeyance caused Defendants to lose credibility with the jury. Likewise, Defendants’ cavalier attitude toward Dr. Poliner’s situation and their

35 Id. at *4-12.
36 Id. at *5. “However, the evidence supporting the jury’s finding of malice under the Texas peer review statute is the same evidence used to defeat contractual and HCQIA immunities.” Id.; see also Poliner, 2003 WL 22255677, at *15. “At the summary judgment stage, “inadequate investigation coupled with the presence of ulterior motives may be sufficient to raise a fact issue as to actual malice.” Id.
37 See Manion, 986 F.2d at 1039.
41 Id.
42 See Logan & Zaner, supra note 40; see also Chalifoux, supra note 39; Verner S. Waite, M.D., Sham Peer Review: Napoleonic Law in Medicine, 8 J. AM. PHYSICIANS & SURGEONS 84, 85 (2003), available at http://www.jpands.org/vol8no3/waite.pdf.
unwillingness to acknowledge any mismanagement of his case demonstrated a callousness that influenced the jury’s decision.43

Whether the medical peer review that took place was a sham or not, Poliner helps demonstrate that physicians challenging peer review win only in the most egregious cases. This is due in part to a presumption under the HCQIA that peer review actions meet all of its requirements, as well as a presumption under the Texas statute that the defendants acted without malice, and the burden is on the physician under each statute to show otherwise.44 In light of these presumptions, a hospital can be factually wrong, and still be immune.45 Dr. Poliner arguably would not have won his case without “smoking gun” evidence that the HCQIA requirements were not followed.46

The Poliner case prompted the Texas legislature to form a Joint Interim Committee to Study the Medical Peer Review Process.47 Specifically, some of the areas the committee plans to examine include “the appropriate level of immunity protections” for hospitals and medical peer review participants and “the adequacy of the Texas Medical Board’s oversight and investigation of physician claims that the medical peer review process is misused.”48

These issues and others are a good place for the reformation of the peer review process to begin. A movement toward a stricter standard for immunity may make it impossible for plaintiffs to win even the most egregious of cases. The definition of malice under the Texas statute, now defined as a “specific intent” to cause substantial injury or harm, may actually make it more difficult for plaintiffs to overcome the presumption that medical committee actions were taken without malice.49 Providing less immunity or overturning HCQIA entirely to make peer reviewers completely accountable, as one commentator suggests, however, may result in fewer doctors being willing to take part in the peer review process – an outcome which may effectively “chill” peer review.50 And even Dr. Poliner believes that medical peer review is necessary to protect patients, “but only if it is carried out with honesty and integrity.”51

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43 See Poliner, 2006 WL 770425, at *11, n.7.
44 42 U.S.C. § 11112(a) (2006) provides that “[i]n order for immunity to apply under the HCQIA, the professional review action must be (1) in the reasonable belief that the action was in furtherance of quality health care; (2) after a reasonable effort to obtain the facts of the matter; (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances; and (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3).” See also Poliner, 2003 WL 22255677, at *9; Wheeler v. The Methodist Hosp., 95 S.W.3d 628, 641 (Tex.App. –Houston [1st Dist.] 2002).
45 See Chalifoux, supra note 39.
46 See id.
47 See S.B. 419, 2005 Leg., 79th Sess. (Tex. 2005); see also Tex. State Senate, supra note 5.
48 Id.
50 See Waite, supra note 42, at 86; see also Bryan v. James E. Holmes Regional Medical Center, 33 F.3d 1318, 1322 (11th Cir. 1994) “The statute attempts to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action….” Id.
51 See Logan & Zaner, supra note 40.