Peer Review – Physician Perspective

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American College of Legal Medicine

February 28, 2009 - Las Vegas, NV

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In 1847, ***Dr. Ignaz Semmelweis*** pioneered the prevention of transmission of disease by ***washing hands*** (Prophylaxis), reducing the mortality rate due to Puerperal Fever from 12% to ZERO by enforcing the washing of hands with chlorinated lime.

For his contribution to humanity, Dr. Semmelweis was ***committed to mental institution*** where he died from injuries that resulted from a beating by asylum personnel.

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Has anything changed
since Dr. Semmelweis ?

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In 2003, Dr. Hakim reported the negligence of two staff psychiatrists that led to the suicide of 16 patients.

In response, her hospital fired her and the Connecticut State Medical Board and State Medical Society retaliated against her.

article by Kenton Robinson
New London Day – 12/14/2003
http://www.allianceforpatientsafety.org/hakim2.pdf

Dr. Feyz believed that the hospital's standing orders were not adequate and may not be accurate as sometimes the dose of frequency of medications may change, and therefore may be different than that printed prescription bottle.

He was put on probation and referred for psychiatric examination.

Feyz v. Mercy Memorial Hospital

Because Dr. Feyz continued to write specialized orders for his individual patients, he was placed on indefinite probation by the hospital.

In 2006, the Supreme Court of Michigan Rejected the Absolute Immunity of the HCQIA.

Feyz v. Mercy Memorial Hospital

http://www.allianceforpatientsafety.org/feyz.pdf

In 2004, a San Diego hospital asked Dr. Tohidi to take a 6 day in-patient psychiatric examination in Houston, TX at the cost of $6,000, after satisfying a psychiatric examination in California.

Dr. Tohidi was victim of a false reporting regarding a scalpel incident.

Tohidi vs. Tri-City

http://www.allianceforpatientsafety.org/tohidi.pdf

Dr. Basco reported a nurse for giving pitocin to his patient in labor without his orders. Patient attempted a Vaginal Birth After a previous Cesarean Section, VBAC.

Patient had an emergency cesarean section due to a uterine rupture with a death of the infant 30 days later.

Basco v. Baylor Med. Ctr.

www.allianceforpatientsafety.org/basco.php

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The hospital summarily suspended Dr. Basco' s clinical privileges, in order to defend itself in the medical malpractice law suit that followed.

Basco v. Baylor Med. Ctr.

“ Dr. Basco did not violate any section of the hospital by-laws, the Texas Medical Malpractice Act, nor did he practice medicine beneath the standards of care. ”

Professor Gary Cunningham, M.D.
Chairman, Dept. OB/GYN
Univ. of Texas Southwestern
Medical Center at Dallas

http://www.allianceforpatientsafety.org/basco5.pdf

Yale Medical school professors complained to administrators that cost-cutting measures were putting patients at risk.

They alleged that teaching physicians were rubber-stamping diagnostic studies interpreted by residents without checking their accuracy.

Instead of addressing their concerns, the administration cut their pay and removed them from their leadership positions.

A. Rosenfield, MD, M.Burrell, MD, and R. Smith, MD
vs.
Yale New Haven Medical Center, July 24, 2004.

http://www.allianceforpatientsafety.org/yale.pdf

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HCA alleged that Dr. Clark was engaging in:

“ activities or professional conduct
which are **disruptive** to hospital operation ”.

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What did Dr. Clark do to deserve the label of

“ Disruptive Physician ? ”

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Statement of Charges against Dr. Clark:

1. A letter to CHAMPUS (a federal insurance provider) expressing concerns of substandard child psychiatric care.

2. Letters to JCAHO addressing concerns with the hospital's care.

Statement of Charges against Dr. Clark:

3. Report to the Nevada State Board of Medical Examiners about another psychiatrist regarding the care of Dr. Clark's patient.

4. Dr. Clark alleged that the hospital improperly used his superior credentials to qualify an affiliate hospital for accreditation although he did not work there.

Who is disruptive here ?

Dr. Clark ?

or

HCA ?

Both the Medical Executive Committee and the Board of Trustees of HCA agreed and affirmed the revocation of Dr. Clark's privileges.

The Supreme Court of Nevada concluded that the revocation of Dr. Clark's hospital staff privileges was NOT with the reasonable belief that it was in furtherance of quality health care.

Clark v. Columbia / HCA
The Supreme Court of Nevada, 6/21/01

http://www.allianceforpatientsafety.org/clark.php

Dr. John Brannigan was an OB/GYN at Memorial Hospital Los Banos.

Upon arrival at the hospital, he observed that the standard of care provided to the patients was substandard.

There was a lack of trained nurses, with no competency validation. There was a lack of supplies and staffing.

For instance:

Dr. Brannigan had to perform a C-Section without general anesthesia, due to the aforementioned issues.

There was only one anesthesiologist that covered the entire hospital, thus, if she was unavailable, the lives of the mother and child were in jeopardy.

A nurse could not read a fetal heart monitor, and this almost resulted in morbidity.

After complaining internally became futile, Dr. Brannigan went to the California Department of Health.

They conducted 2 unannounced visits and Dr. Brannigan's complaints were corroborated.

The hospital pulled his medical charts and alleged that he was negligent in 15 of 16 cases !

The peer review was a sham.

The report of the hospital to the Medical Board of California lead to the suspension of Dr. Brannigan's license.

He no longer practices medicine.

At the request of the hospital attorneys, The Medical Board Investigator came to trial to assist them.

The Investigator even amended an allegation during trial in a attempt to influence the jury.

Because he had run out of money.
Dr. Brannigan was not able to afford any longer an attorney or expert for the Medical Board hearing.

Jeffrey A. Rager, Esq.
Attorney for Dr. Brannigan, 2/23/2009

On June 20, 2008, a jury ordered the hospital to pay Dr. Brannigan over $2 Million.

Brannigan

v.

Los Banos Memorial Hospital, Merced, CA

http://www.allianceforpatientsafety.org/brannigan.pdf

“We desperately need to turn the raw peanuts on our floor into money.” email dated 1/19/2009

CEO, Peanut Company of America
knowing peanuts were contaminated
http://www.allianceforpatientsafety.org/pca.pdf

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How many of you believe

that the conduct of

the peanut company

CEO is criminal?

Dr. Charles Rosen, Chief of Surgery of Garden Grove Hospital in California, learned from hospital administrators that he'd spent months operating with instruments cleaned by what appeared to be broken sterilizers.

Aware that the operating room sterilizers were defective, the hospitals administrators were now telling the Chief of Surgery how to explain the situation when federal inspectors showed up for a big evaluation the following day, because the hospital had an unusually **high** rate of **post operative infections**.

Charles Rosen, M.D. resigned

and went to federal authorities.

Melissa Davis, TheStreet.com, 7/25/03

http://www.thestreet.com/story/10103544/1/whistleblower-wants-tenet-to-come-clean.html

How many of you believe

that the conduct of the

hospital administrators

is criminal?

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Dr. Rosen was in for a major shock.

JCAHO ignored the chief of surgery and accepted the hospital's explanation instead.

" Here I'm telling them about a major threat to patients - and the blatant destruction of documents - and they just basically blow me off.

They gave the hospital a rating of 93. "

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Is Sham Peer Review an

" Isolated " phenomena ?

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Circulation of FALSE information Regarding Physicians through the NPDB

“ Problems such as under reporting, over-reporting, and inaccurate reporting call into question the reliability of the data bank as a true depiction of a physician’s competence. ”

Summary of GAO and OIG reports
Bruce Wilken, Vicky Trompler, MD, JD & Brad Areheart
Full Report: http://www.allianceforpatientsafety.org/npdb.pdf
Excerpts: http://www.allianceforpatientsafety.org/npdb-excerpts.php

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“ How Peer Review Failed at Redding Medical Center,

Why It Is Failing Across the Country and What Can Be Done About It ”

Report to U.S. Senate Finance Subcommittee

G. Rogan, MD, F. Sebat, MD, and I. Grady, MD, 9/22/2008

http://www.allianceforpatientsafety.org/redding-failure.pdf

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In 1999, JCHAO, CMS, and California Dept. of Licensing Certification discovered that peer review was not performed beginning as early as 1992 at Redding Medical Center, (RMC).

Nonetheless all three entities repeatedly certified or accredited RMC.

Patient safety at Redding Medical Center was compromised until the FBI raid in 2002.

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" There is no incentive for CEOs to achieve higher quality of care as it would reduce revenues for hospitals. "

JCAHO President, Dennis O'Leary, MD
on 11/24/2002

http://allianceforpatientsafety.org/oleary.pdf

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"There are some who believe that **this whole system has to be blown up and started over again**, I happen to be one of those advocates."

JCAHO President, Dennis O'Leary, MD
on 11/24/2002

http://allianceforpatientsafety.org/oleary.pdf

“ It’s the System, Stupid ! ”

Internal Bleeding:

The Truth Behind America's Terrifying Epidemic of ***Medical Mistakes***

Robert Wachter, M.D. and
Kaveh G. Shojania, M.D., 2004

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Where there is smoke there is fire.

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Unless you are dealing with a smoke machine.

Special Clinic for Hospital Counsel
Legal Strategy & Tactics
for
Hospital-Physician Disputes

Barbara Blackmond, Esq.
Dan Mulholland, Esq.

HORTYSPRINGER
SEMINARS AND PUBLICATIONS

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Horty & Springer's hostility toward independent private physicians is demonstrated throughout their seminars, courses, and audiotapes that can be purchased on their website:

www.hortyspringer.com

MONDAY, JANUARY 6

8:00 AM TO NOON

- How to spot problems and (hopefully) nip them in the bud
- Types of problem physicians
  - **Clinical competence**: technique, judgment, practice pattern
  - **Professional conduct**: disruptive behavior, sexual harassment, unethical/illegal activities
  - **Impairment**: substance abuse, physical and mental health issues, aging practitioners, effect of the ADA
- Economic competitors

http://www.allianceforpatientsafety.org/hs2.pdf

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Whistleblower or Disruptive Physician:

How Do You Know the Difference ?

How to protect hospitals from whistleblowers ?

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They also teach in those classes:

- " How to regain Control of the hearing process"
- " Composition of the hearing panel:
  who should be excluded ? "
- " Can hearing rights be waived ? "

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What is “ Disruptive ” Behavior ?

- Physical Abuse
- Verbal Abuse
- Threats
- Vulgarity
- Political Disruption
- Sexual Harassment

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How to Detect an Impaired Physician ?

- Odd Behavior
- Personality Change

Accordingly, all MD, JD, ACLM members are impaired physicians.

A surgeon's clinical privileges were summarily suspended for imminent danger because of an assault on a nurse in the O.R.

What happened ?

1. Did the surgeon throw an instrument at the nurse ?
2. Did he strike the nurse ?
3. Did he point a gun at her ?
4. Did he raise his voice?

Chilling CODE of SILENCE

FEAR permeates trough the health care system

“ Not even whistleblower laws, designed to give legal protection to those trying to report wrongdoing, safeguard the doctors in many cases. ”

Steve Twedt, *Post-Gazette*, 10/26/2003

http://www.post-gazette.com/pg/03299/234499.stm

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Chilling CODE of SILENCE

“ **Physicians who spoke up** about poor care **faced reprisals**, including peer review hearings, demotions, temporary loss of credentials, involuntary transfers or outright dismissal. ”

Steve Twedt, Post-Gazette, 10/26/2003
The cost of Courage: How the tables turn on doctors
http://www.post-gazette.com/pg/03299/234499.stm

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Many physicians keep quiet on reporting errors and incompetence:

“ **45%** weren’t always reporting impaired or incompetent colleagues ”

“ **46%** of physicians who knew of a serious medical error were **not** reporting the error, at least once, to authorities ”

Institute of Medicine 12/3/2007

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“ Life is Beautiful ”

Oscar for best foreign language film, 1998

directed by Roberto Benigni

What is the percentage of Medicare patients that die every year from preventable errors in U. S. hospitals ?

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1.6 %

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In 2004, HealthGrades reviewed 37 million Medicare medical records over 3 years and concluded that about 600,000 patients died from **preventable** medical errors.

http://www.healthgrades.com/media/english/pdf/HG_Patient_Safety_Study_Final.pdf

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Independent “ Blind folded study ” :

“ 83% of cardio-vascular surgeries were … unwarranted at Redding medical Center ”

“ 59% of the bypass surgeries at Doctors Medical Center in Modesto were … unnecessary ”

Melissa Davis 11/4/03, TheStreet.com

http://www.thestreet.com/story/10124365/1/tenet-tangles-with-california-blue-cross.html

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“ We’ve upgraded your condition from critical to costly ”

H.L. Schwardon at Barron’s

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“ In most industries, defects cost money and generate warranty claims. ”

“ In health care, perversely... Physicians and hospitals can bill for the additional services that are needed when patients are injured by their mistakes. ”

LL Leape, MD - JAMA 5/18/05

http://www.allianceforpatientsafety.org/leape2.pdf

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Why Pay for Mistakes ?

LL Leape, MD - Boston Globe 8/23/07

http://www.boston.com/news/globe/editorial_opinion/oped/articles/2007/08/23/why_pay_for_mistakes/

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Leading causes of **preventable deaths** in hospitals.

1) **Falls**, occur when patients need to use the bathroom and do not get response when using the call button, an attempt to climb out of bed without waiting for assistance, is the main cause of **broken hips**, and leading cause of accidental deaths.

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Leading causes of **preventable deaths** in hospitals.

2) 1.5 million **medication** errors cause 40,000 – 80,000 deaths / year.

3) 4 – 6% of hospital patients develop hospital acquired **infections**.

Hospital errors cause more deaths than car accidents, breast cancer or AIDS.

National Academy of Sciences

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Preventable Errors	total revenue
Pressure Ulcer Stages III & IV	$ 11,115,050,160
Falls and Trauma	$ 6,560,726,004
Hospital Infections	$ 3,648,818,766
Diabetic ketoacidosis	$ 492,868,806
Nonketotic hyperosmolar coma	$ 114,378,320
Foreign Object Retained After Surgery	$ 47,723,250
hypoglycemic coma	$ 7,755,172
Air Embolism	$ 4,083,252
Blood Incompatibility	$ 1,210,920
TOTALS	$ 21,992,614,650

Preventable Hospital Acquired Conditions, CMS Fiscal Year 2007 Data

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Why did HCQIA **fail**

to improve the quality of

delivery of care to our patients ?

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HCQIA relies on three pillars:

1. **Corporate hospital executives**

   who are compensated based on the revenues of the hospital and profit financially from unnecessary procedures, errors and complications.

Hospital administrators at Redding benefited from $40 million/year in revenues generated by two physicians that subjected patients to unnecessary cardiac procedures.

Coronary - Medicine Gone Awry, Klaidman 2007

HCQIA relies on three pillars:

2. **Physicians**

   who have a conflict of interest

Patrick v. Burget U.S. Supreme Court, 1998

HCQIA relies on three pillars:

3. **Hospital Governing Boards**

   responsible for their own oversight.

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Hospital's Immunity

42 U.S.C. 11112(b)(3):

*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*.

Failure of HCQIA

Diagnosis:

the myth of self-policing
i.e. no oversight

Wall Street Meltdown

is another example of failure of self-regulation without any oversight.

Rand Corporation, 2006
First national Report Card on
Quality of Health Care in America

- **All adults** in the United States are **at risk** for receiving poor health care,
- no matter where they live
- why, where and from whom they seek care
- or what their race, gender or financial status is

http://www.rand.org/pubs/research_briefs/RB9053-2/

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The U.S. has 3 health care systems :

1. Single Payer System:
   Government Facilities, VA, Counties, Cities, ...

2. Socialist System: HMOs, Kaiser, …

3. Capitalist System: private insurance,
   fee for service

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Why do all 3 systems fail similarly ?

Would you fly a plane in the fog without visibility and no radar ?

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Airline Passenger Safety is achieved through

Three fundamental pillars:

1) The Black Box
2) The FAA
3) NASA

The Healthcare industry has NONE of these.

http://www.allianceforpatientsafety.org/blackbox.pdf

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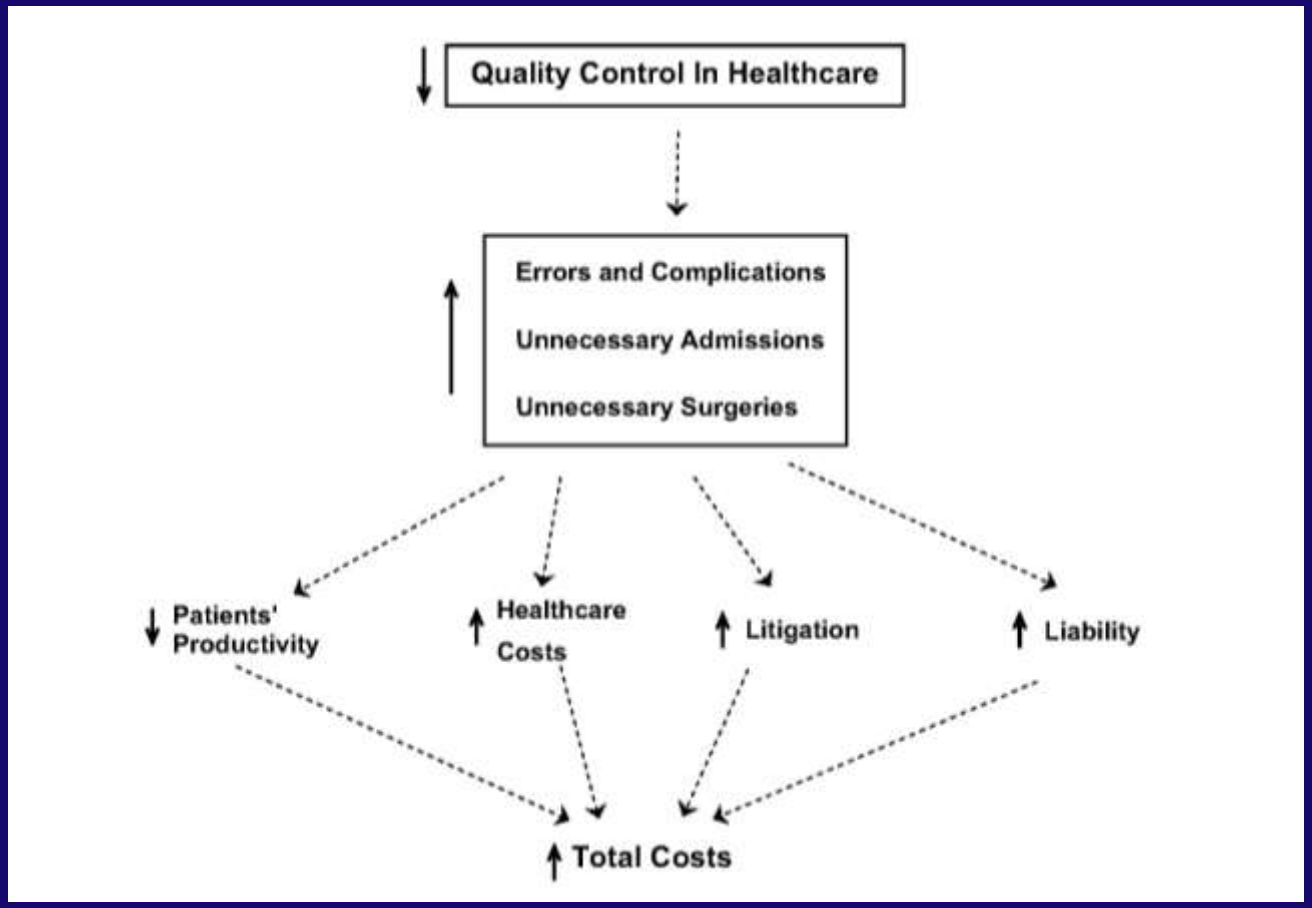
Winston Churchill observed:

“ Americans can always be counted on to do the right thing... after they have exhausted all other possibilities. ”

NO Peer Review or Sham Peer Review



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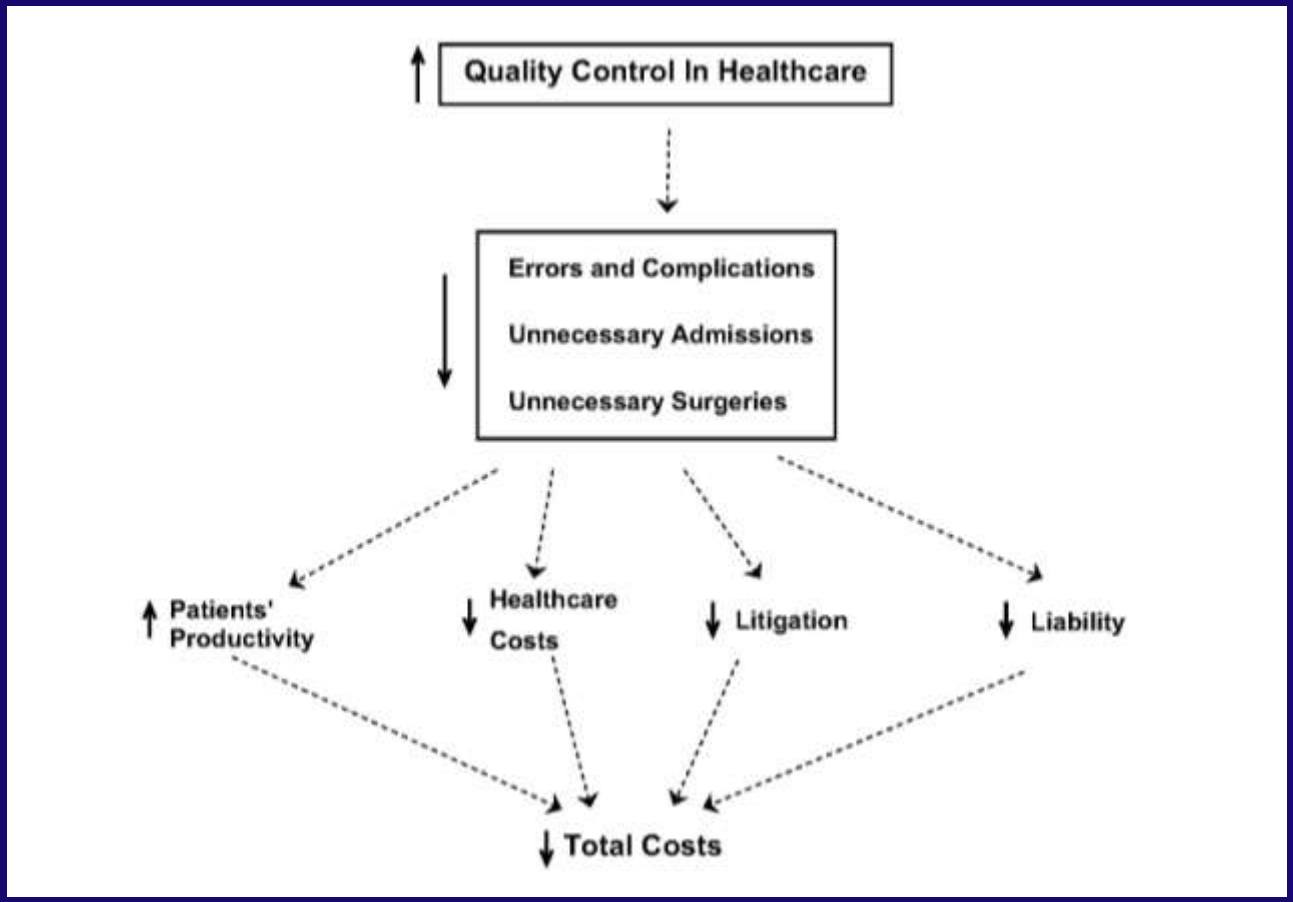
Legitimate Peer Review



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Economic Impact of the Lack of Patient Safety

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