Case No. 06-11235

IN THE UNITED STATES COURT OF APPEALS
FOR THE FIFTH CIRCUIT

LAWRENCE R. POLINER, MD; LAWRENCE R. POLINER, MD, PA
Plaintiffs – Appellees – Cross-Appellants

v.

TEXAS HEALTH SYSTEMS, A Texas Non-Profit Corporation, doing business as Presbyterian Hospital of Dallas; JAMES KNOCHEL, MD
Defendants – Appellants – Cross-Appellees

On Appeal from the United States District Court
for the Northern District of Texas

BRIEF OF AMICI CURIAE

HEALTH CARE INDEMNITY CORPORATION, AMERICAN HOSPITAL ASSOCIATION, TEXAS HOSPITAL ASSOCIATION, CHILDREN'S MEDICAL CENTER OF DALLAS, THE METHODIST HOSPITAL, MISSISSIPPI HOSPITAL ASSOCIATION, NORTH MISSISSIPPI HEALTH SERVICES, INC., OUR LADY OF THE LAKE HOSPITAL, INC., RUSH HEALTH SERVICES, SUMMA HEALTH SYSTEM, TENET HEALTHCARE CORPORATION, AND TEXAS CHILDREN'S HOSPITAL

IN FAVOR OF APPELLANTS AND IN SUPPORT OF REVERSAL

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SUPPLEMENTAL CERTIFICATE OF INTERESTED PERSONS

The undersigned counsel of record certifies that the following additional listed persons have an interest in the outcome of this case. These representations are made in order that the judges of this Court may evaluate possible disqualification or recusal.

1. Health Care Indemnity Corporation
2. American Hospital Association
3. Texas Hospital Association
4. Children's Medical Center of Dallas
5. The Methodist Hospital
6. Mississippi Hospital Association
7. North Mississippi Health Services, Inc.
8. Our Lady of the Lake Hospital, Inc.

9. Rush Health Services

10. Summa Health System

11. Tenet Healthcare Corporation

12. Texas Children's Hospital

13. Luther T. Munford, Justin L. Matheny, Phelps Dunbar LLP, counsel for amici curiae.

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Counsel of Record

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INTEREST OF AMICI CURIAE

Amici Curiae are hospitals and hospital associations whose peer review activities the Health Care Quality Improvement Act of 1986 enables, enhances, and protects. They appear here to urge this Court to interpret that Act in a manner consistent with both Congressional intent and the uniform rulings of other Circuits.

Hospitals care for patients. Peer review protects patients. For confidentiality purposes, peer reviewers know patients only as a number, such as "9" or "36." But those numbers stand for the most important people in this case.

Congress has put the health of patients first. It has placed their desire for quality care ahead of the concerns of the physician whose care of them is called into question. It has said the reviewed physician cannot sue the peer reviewers so long as they could reasonably have believed their actions were "in the furtherance of quality health care," *i.e.*, might help a future patient in some way. 42 U.S.C. § 11112(a)(1) (2005), App. 1.

Hospitals should be allowed the full freedom afforded by the HCQIA to protect patients and to improve the quality of their care. That freedom includes the right to restrict a physician's privileges temporarily during an investigation of the physician's conduct. This Court should preserve that freedom. It should reverse the district court, whose outlier judgment has cast a pall over peer review not only at defendant Presbyterian Hospital, but at hospitals throughout the Fifth Circuit.

INTRODUCTION

In this case, the critical point is that compliance with the immunity provisions of the HCQIA bars damages actions based on either tort or contract. For that reason, it bars damage actions based on alleged violations of hospital bylaws. Correspondingly, a breach of bylaw provisions is irrelevant when the facts support HCQIA immunity. *Meyers v. Columbia/HCA Healthcare Corporation*, 341 F.3d 461, 469-70 (6th Cir. 2003) (only statute is relevant, not bylaws).[1]

This Circuit's HCQIA decisions have not yet reached the issue. *See Patel v. Midland Memorial Hosp. and Med. Ctr.*, 298 F.3d 333, 347 (5th Cir. 2002) (no contract liability, so HCQIA immunity not considered).[2]

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[1] *See also Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 834 (3rd Cir. 1999) (same); *Gabaldoni v. Washington County Hosp. Ass'n.*, 250 F.3d 255, 263 (4th Cir. 2001) (same); *Braswell v. Haywood Regional Medical Center*, 2007 WL 1227464 at *7-8 (4th Cir.) (same); *Wayne v. Genesis Medical Center*, 140 F.3d 1145, 1147 (8th Cir. 1998) (bylaw violation irrelevant); *Smith v. Ricks*, 31 F.3d 1478, 1486-87 & n.8 (9th Cir. 1994) (explaining inapplicability of "state law" and "fair procedure guidelines"); *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1331 & n.22 (11th Cir. 1994) (contract judgment reversed). For similar holdings in state courts, *see Cowett v. TCH Pediatrics, Inc.*, 2006 WL 2846282 (Ohio App. 2006), *review denied*, 862 N.E.2d 118 (Ohio 2007), *petition for certiorari filed* (No. 06-1593, May 25, 2007); *North Colorado Medical Center, Inc. v. Nicholas*, 27 P.3d 828, 833 n.2, 840 (Colo. 2001); *Manasra v. St. Francis Medical Center, Inc.*, 764 So.2d 295, 302 (La. App. 2d Cir. 2000).

[2] *See also Van v. Anderson*, 66 Fed.Appx. 524 (5th Cir. 2003) (immunity from defamation claim); *Payne v. Harris Methodist HEB*, 44 Fed.Appx. 652 (5th Cir. 2002) (upholding temporary suspension); *Rose v. University of Texas Southwestern Medical School at Dallas*, 32 Fed.Appx. 131 (5th Cir. 2002) (affirming summary judgment for defendants); 5th Cir. R. 47.5.4.

The issue disposes of this case. The HCQIA immunizes temporary restrictions of staff privileges pending an investigation even though the restricted physician does not consent and has no opportunity to be heard. The district court erroneously imposed other requirements found only in hospital bylaws. That was reversible error.

PRELIMINARY STATEMENT

This brief relies on and will not repeat the Jurisdictional Statement, the Statement of Issues, and the Statement of the Case in the Brief of Appellants. It will also not repeat the Statement of Facts in that brief except that, for illustration, it will sketch out the undisputed facts concerning one of the four patients initially in issue, patient number 36.

Dr. Knochel's decision

Dr. Knochel, a kidney specialist, chaired the hospital's Internal Medicine Department. 2:331-32.[3] After Dr. Larry Poliner completed his work on patient 36, three physicians complained to Dr. Knochel about Dr. Poliner's treatment of the patient. As Dr. Poliner admits, Dr. Poliner did the wrong operation on patient 36.

[3] References to the record are as follows: trial court exhibits are cited as either PX-[exhibit number] or DX-[exhibit number]; trial transcript is cited as [volume]:[page number(s)]; Record Excerpts of Appellants are cited as R.E. [number].

5:1160-65; 7:1581; DX-176; DX-177. *See* Brief of Appellants ("THS Brief") at 14-16.

The head of the cardiac catheterization department reviewed film, talked to Dr. Poliner, and told Dr. Knochel that Dr. Poliner had caused the patient to have a heart attack. 4:812; 4:828; 4:835-46; 9:2149-50. The head of cardiology reviewed the records and concluded Dr. Poliner had operated on the wrong artery. 9:2167-69. An internist criticized other aspects of the treatment. 9:2067-72.

As Dr. Knochel described it, "everybody came and told me what he did wrong. I assumed they are interventional cardiologists and they know what they are talking about." 2:429. After further discussions with at least five hospital physicians or administrators, he concluded that Dr. Poliner should not exercise his lab privileges for a short period while an investigation took place. PX-80. The term used, "abeyance," is found in the hospital bylaws.

Dr. Knochel said he did not at that time have enough information to determine whether Dr. Poliner was a "present danger" to his patients. He wanted to use the investigation to find out. 2:361-62; 2:365; 2:449-50; R.E. 8 p. 8.

Subsequent review.

After two consecutive investigatory periods, a hospital committee held a hearing on June 11, in which Dr. Poliner participated, and found that 29 of the 44 patients studied received substandard care. R.E. 5 pp. 8-9. After this hearing, Dr.

Poliner's cardiac catheterization and echocardiography privileges were suspended pending appeal. *Id.* at pp. 9-10. A later review criticized Dr. Poliner and found the suspension justified on the information available at the time but restored his privileges subject to supervision. *Id.* at p. 10.

The district court's decision.

The district court's decisions on the federal immunity issue are found at *Poliner v. Texas Health Systems*, 2003 WL 22255677 at *2 (N.D. Tex.), R.E. 5 p. 8-11 (denying summary judgment) and *Poliner v. Texas Health Systems*, 2006 WL 770425 at *1 (N.D. Tex.), R.E. 8 p. 7-9 (denying post-judgment motions). They are discussed at pp. 19-20, *infra.*

SUMMARY OF THE ARGUMENT

The district court's critical mistake in this case was to confuse hospital bylaw requirements with the standards for HCQIA immunity.

In two separate provisions, the HCQIA immunizes the temporary deprivation of privileges whether or not the physician has had an opportunity to be heard, whether or not the physician agrees to it, and whether or not there is a "present danger." Those provisions encourage hospitals to take the necessary precautions to protect patient safety. The two provisions independently apply here.

Where either of these provisions apply, Congress has barred damages recovery under "any law." 42 U.S.C. § 11111(a)(1), App. 1. Congress excepted

civil rights suits and some Attorney General suits but did not make an exception for state law tort or contract claims. For that reason, HCQIA immunity defeats any claim made under hospital bylaws.

As a result, the HCQIA immunizes the defendants from damage liability. The judgment below should be reversed and judgment should be rendered here for the defendants.

ARGUMENT

Hospital peer review committees consider internal complaints made against physicians by other physicians, nurses, or other staff. After a complaint and investigation, committees who find physician error can suspend a physician's staff privileges, or they can order "corrective action," such as a requirement that a more skilled physician provide supervision in the future. Physicians have the right to various types of hearings and appeals.

Congress has sought to encourage peer review because it can reach any instance of medical error, even those which do not injure the patient.[4] While

[4] H.R. Rep. No. 99-903, *reprinted at* 1986 U.S.C.C.A.N. 6384. Courts have repeatedly relied on this report to conclude, for example, that immunity was designed to protect decisions made in furtherance of the quality of care, whether or not the physician's conduct injured the patient. *See*, *e.g.*, *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469 (6th Cir. 2003) (unprofessional conduct basis for review action); *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 38 (1st Cir. 2002) (peer review of inappropriate care designed to prevent patient harm, not ensure an adequate response after harm has occurred). *See generally* Note, *Maintaining the Balance: Reconciling the Social*

malpractice suits target some medical errors, it is generally believed that only one in 10 incidents of medical negligence results in a medical malpractice suit.[5] In peer review, expert physicians, not lay juries, do the review. Those physician volunteers in turn have an interest in maintaining quality care at the hospitals where they practice.

I. To protect and encourage peer review, Congress has immunized from damages any peer review action which meets certain objective standards of reasonableness.

When Congress passed the HCQIA, it created a National Practitioner Data Bank to which hospitals are required to report certain information concerning physicians, including whether peer review has ever resulted in a hospital committee's revocation of staff privileges for a period of more than 30 days.[6] Congress wanted to end the ability of questionable physicians to move from state to state in order to escape knowledge of their prior practice.

But Congress knew that damage suits threatened the feasibility of the hospital peer review it wanted to encourage. Congress understood that, by creating

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and Judicial Costs of Medical Peer Review Protection, 52 Ala. L. Rev. 723, 724-27 (2001) (describing peer review process and legal basis).

[5] Robert Adler, *Stalking the Rogue Physician: An Analysis of the Health Care Quality Improvement Act*, 28 AM. BUS. L. J. 683, 688-89 (1991). *See also* Edward Dauer, *A Therapeutic Jurisprudence Perspective on Legal Responses to Medical Error*, 24 J. LEGAL MED. 37, 44 (2003) (stress of a malpractice suit can cause additional physician errors).

[6] 42 U.S.C. § 11133(a)(1)(A) (2005).

the national data bank, it could be encouraging even more suits against peer reviewers.[7] *See* Motion for Leave to File Brief of Amici Curiae pp. 5-8.

So Congress struck a balance. It immunized peer reviewers and their hospitals from individual damage suits if their actions satisfy certain standards of objective reasonableness.[8] At the same time, Congress did not restrict the physician's right to seek declaratory or injunctive relief to enforce the physician's procedural or other state law rights that might protect the physician during the peer review process.[9]

The damages immunity has yet another benefit. It enables those who grant and monitor physician privileges "breathing room" to err on the side of patient safety. Without that immunity, a hospital could end up being "sued if it did and sued if it didn't." If it restricted a physician's privileges, the physician could sue.

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[7] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6385.

[8] 42 U.S.C. § 11111(a) (2005), App. 1.

[9] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6391. *See Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 465 (6th Cir. 2003) (temporary restraining order against reporting to data bank granted); *McLeay v. Bergan Mercy Health Sys. Corp.*, 714 N.W.2d 7, 18 (Neb. 2006) (immunity applied but case remanded on equitable issues); Nathaniel Hwang, *Defaming a Physician's Career*, 25 L. LEGAL MED. 95, 107 (2004) (encouraging resort to equitable remedies).

If it did not restrict the physician's privileges, a patient that physician subsequently injured could, in many states, bring a suit for "negligent credentialing."[10]

Immunity from damages means peer reviewers can act in the best interest of patients using reasonable judgment without fear of physician lawsuits. In fact, the HCQIA establishes a presumption that the actions of peer reviewers are reasonable in a suit brought by a physician. 42 U.S.C. §11112(a), App. 1. It specifically does not restrict suits brought by patients. 42 U.S.C. §11115(d). It thus puts patient safety first.

Congress adopted an objective standard of "reasonableness" rather than a subjective standard of "good faith."[11] Although some state laws independently immunize actions taken in good faith, or without "malice," that is not the HCQIA

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[10] Mark Colantonio, *The Health Care Quality Improvement Act of 1986 and its Impact on Hospital Law*, 91 W. VA. L. REV. 91, 104, 109 (1989) (HCQIA eliminates "Catch-22"). *See also* Annot., Benjamin Vernia, *Tort Claim for Negligent Credentialing of Physician*, 98 A.L.R. 5th 533 (2002 & Supp. 2007); Casey Moore, *"In the Wake of the Rose" and "Life After Romero": The Viability of a Cause of Action for Negligent Credentialing in Texas in Light of Recent Texas Supreme Court Decisions*, 58 BAYLOR L. REV. 549, 585-586 (2006) (possible claim for "malicious" credentialing).

[11] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6392-93; *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1335 (11th Cir. 1994).

test.[12] HCQIA protects actions that a reasonable physician or hospital could take in order to protect patients.

Application of the immunity is almost always a question of law for the court, not one of fact for the jury, because the reviewer's subjective state of mind is not in issue.[13] For example, all of the Circuit cases that have considered an immunity defense to bylaw claims have dismissed the bylaw claims as a matter of law. *See* p. 2 & nn. 1, 2, *supra*.

To defeat the hospital's motion, the physician bears the burden of showing by a preponderance of the evidence that "no . . . reasonable belief" supported the hospital's action.[14]

Physicians frequently have legitimate differences about clinical decisions. So the standard of what a reasonable physician could believe includes a range of opinions concerning the proper course of treatment. For that reason, courts have

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[12] *See* LA. REV. STAT. ANN. § 13:3715.3; LA. REV. STAT. ANN. § 40:2205; MISS. CODE ANN. § 41-63-5; TEX. OCC. CODE ANN. § 160.010; TEX. HEALTH AND SAFETY CODE § 161.033.

[13] *Singh v. Blue Cross/Blue Shield of Mass. Inc.*, 308 F.3d 25, 36 (1st Cir. 2002) (question is one of law if no genuine issue of historical fact); *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1332-33 (11th Cir. 1994) (like official qualified immunity). All of the cases on which the district court relied resolved the immunity issue in the hospital's favor as a matter of law. *See* R.E. 5 p. 21.

[14] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6393 ("clear and convincing evidence . . . that no such reasonable belief existed"). Subsequently, Congress dropped the "clear and convincing" language.

generally accepted the defendants' medical views, and have said that courts should not substitute their judgment for that of the hospital.[15] In addition, post-hoc expert medical testimony as to the actual correctness of a plaintiff physician's care will not ordinarily negate the presumption of a reasonable belief under the Act.[16] Nor would the eventual exoneration of a physician at the end of the peer review process.[17]

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[15] *See Lee v. Trinity Lutheran Hospital*, 408 F.3d 1064, 1073 (8th Cir. 2005); *McLeay v. Bergan Mercy Health Systems Corp.*, 714 N.W.2d 7, 16-17 (Neb. 2006) (plaintiffs' expert evidence concerning quality of care was irrelevant) (*McLeay* cites and quotes cases distinguishing *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1996) as a case where defendants submitted false information in the peer review process); *Fox v. Parma Community General Hospital*, 827 N.E.2d 787, 795 (Ohio App. 2005) (genuine differences in opinion; expert affidavit immaterial); *Univ. Health Servs., Inc. v. Long*, 561 S.E.2d 77, 78 (Ga. 2002). *Cf. Sosa v. Board of Mgrs.*, 437 F.2d 173, 177 (5th Cir. 1971) (pre-HCQIA case) (court "cannot surrogate" for hospital board, because "[h]uman lives are at stake, and the governing board must be given discretion in its selection so that it can have confidence in the competence and moral commitment of its staff.").

[16] *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 471 (6th Cir. 2003); *McLeay v. Bergan Mercy Health Sys. Corp.*, 714 N.W.2d 7, 16-17 (Neb. 2006) (collecting cases).

[17] *Lee v. Trinity Lutheran Hospital*, 408 F.3d 1064, 1071 (8th Cir. 2005) (initial decision supported by interim findings, despite eventual restoration of privileges); *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 41 (1st Cir. 2002) (same); *Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992) (same).

II. In two different ways, the HCQIA immunizes the temporary deprivation of staff privileges whether or not the physician has previously been given an opportunity to be heard.

A. HCQIA allows hospitals to revoke privileges for 14 days pending an investigation without affording any notice to the physician and without a finding of imminent danger.

In order for the peer reviewers to enjoy immunity from damages, generally a professional review action must meet four requirements. *See* App. 1; THS Brief at 32. The way the four are treated with respect to a 14 day "investigatory" restriction on privileges is as follows.

1. "[R]easonable belief that the action was in the furtherance of quality health care."

All this language requires is that the action be one that some objective physician could reasonably believe was important to patient care and safety, *i.e.*, in "furtherance of quality health care." *See Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1335 (11th Cir. 1994) ("would promote quality health care").[18] It is *not* tied to any particular standard of care, and does not require only those actions on which all physicians could agree.

[18] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6392. *Bryan* and other cases also quote language from the report about restricting "incompetent" behavior or "protect[ing]" patients. *Id* at 6393. But the plain statutory language is not limited to those situations. Promoting quality health care is enough.

The temporary sidelining and investigation of Dr. Poliner, an experienced physician who had made a serious mistake while operating on a heart, was "in furtherance of health care."

Moreover, when the objective standard is met, immunity attaches. Dr. Poliner's argument to the jury that "this [case] is about personal dislike," 11:2536, shows the weakness of Dr. Poliner's position. So long as there is an objective medical basis for the decision, the Act does not inquire into subjective motive. *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999) (bad faith irrelevant to immunity; cites decisions of four other circuits).[19]

2. "[A]fter a reasonable effort to obtain the facts of the matter."

Before acting, Dr. Knochel had discussed the matter with three physicians who had direct knowledge of Dr. Poliner's care of Patient 36. The HCQIA allows the hospital officer who restricts privileges to rely on others. It does not require a personal investigation.[20]

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[19] *See Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1335 (11th Cir. 1994); *Cowett v. TCH Pediatrics, Inc.*, 2006 WL 2846282 (Ohio App. 2006), *review denied*, 862 N.E.2d 118 (Ohio 2007), *petition for certiorari filed* (No. 06-1593, May 25, 2007); *Gateway Cardiology v. Wright*, 204 S.W.3d 676, 686 (Mo. App. 2006) (individual motive irrelevant); *Zisk v. Quincy Hospital*, 834 N.E.2d 287, 295 (Mass. App. 2005) (bad faith, economic competition immaterial).

[20] *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 261 (4th Cir. 2001) (Luttig, J.). *See also Meyer v. Sunrise Hosp.*, 22 P.3d 1142, 1151-52 (Nev.

Moreover, the "facts" known on May 14 are the same as the "facts" known today. The film is the same. The chart is the same. The facts are that Dr. Poliner took a patient into the cardiac catheterization lab and operated on the patient's other coronary artery without realizing that the patient's left artery was totally blocked. There were no more facts for Dr. Knochel to know.

In any event, Dr. Poliner has not shown that the facts on which Dr. Knochel relied were "so obviously mistaken or inadequate as to make reliance on them unreasonable." *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 637 (3d Cir. 1996). The HCQIA requires a reasonable inquiry into the "facts." It does not require peer reviewers to canvass the opinions of every cardiologist who might disagree with the hospital cardiologists.[21]

3. Notice and hearing not required for restriction during investigation

When the restriction is for 14 days pending an investigation, the Act's third requirement, i.e., that the physician have notice and be given a hearing, does not come into play. *See* THS Brief at 33-34.

2001) (review of one chart can be enough). Two of the doctors who spoke to Knochel were sued but are no longer defendants.

[21] The law has long distinguished fact, which can be proven true or false, from mere opinion. *See Milkovich v. Lorain Journal Co.*, 497 U.S. 1, 21-22, 110 S.Ct. 2695, 2707 (1990).

Congress gave hospitals this power so that they could focus without delay on what is needed for patient safety and restrict privileges for short investigatory periods without a hearing. As House Report No. 99-903 provides:

> Under this provision, there is no requirement that due process meet a test of "adequacy" . . . during a suspension or restriction of clinical privileges for a period not longer than 14 days during an investigation to determine the need for a professional review action.[22]

For this reason, there was no basis for the district court to conclude that the failure to give Dr. Poliner notice and a hearing before Dr. Knochel imposed the temporary restrictions meant that the HCQIA requirements could not be satisfied. *Poliner*, 2006 WL 770425 at *4-5 & n.4; R.E. 8 p. 8-9.

Reasoning backwards, the court said that, even if notice and hearing were not required, a jury could find that the failure to provide notice and hearing meant that Dr. Knochel did not make a reasonable investigation or did not believe the purpose of the restrictions was to further quality health care. *Id*. It thus read back in the procedural requirements that Congress expressly took out.

But a court does not have the power to re-write a statute in this fashion. Under the district court's interpretation, a hospital that believed urgent action was needed would be at the mercy of a future jury or court that might find, with

[22] H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. at 6394 (emphasis added).

hindsight, that notice and a hearing should have been given. To be safe, it would have to give them, which is not what Congress intended. As quoted above, Congress intended that procedures applicable to a longer restriction were not applicable to investigatory immunity.

4. "[R]easonable belief that the action was warranted."

When unusual things happen, unusual measures may be taken. Dr. Knochel narrowly tailored the restriction in both scope and time. It only applied to catheterization lab privileges, i.e., invasive heart procedures. It only lasted for a few weeks while the investigation continued. Dr. Poliner continued to have privileges at other hospitals and could have done procedures there.

Moreover, the decision to suspend Dr. Poliner pending appeal, reached at the June 12 hearing after Dr. Poliner was given a chance to present his case, reinforces the reasonableness of Dr. Knochel's belief that his earlier actions were warranted. Courts have generally looked at peer review actions as a whole, and subsequent ratification by committee action is evidence that an earlier decision was also based on a reasonable belief.[23]

For these reasons, neither of the 14-day restrictions on privileges should have given give rise to a cause of action for damages. Even with the second 14-day period, the restrictions lasted less than the 30 days which can lead to national

[23] *Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 947 & n.5 (Pa. 2001).

reporting. It is undisputed that the hospital took the additional time in order to review Dr. Poliner's cases more thoroughly. That was in the patients' best interest. It was also not "unfair" to Dr. Poliner "in the circumstances."[24]

B. If reached, the HCQIA also allows an indefinite restriction of privileges pending a hearing if the hospital believes the failure to restrict privileges "may" be an imminent danger to the health of a patient.

In addition to the 14-day suspension, the statute provides for an emergency suspension if the hospital believes that the physician "may" be an imminent danger to his patients. It says the Act is not to be interpreted as:

> 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.

42 U.S.C. § 11112(c)(2), App. 1 (emphasis added). H.R. Rep. No. 99-903 describes this provision as one to be invoked if "someone's health might otherwise suffer." It says:

> [D]ue process can be provided after the fact where clinical privileges are suspended or restricted on an immediate basis where the failure to take such an action *might* result in an imminent danger to the health of an individual.

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[24] *See Rogers v. Columbia/HCA of Central Louisiana, Inc.*, 971 F.Supp. 229, 236-37 (W.D. La. 1997) (Little, J.) (denial of a hearing for 10 months after suspension while conduct monitored was "fair to the physician under the circumstances" because Congress did not want "incompetent physicians to practice while the slow wheels of justice grind"), *aff'd*, 140 F.3d 1038 (5th Cir. 1998).

> The Committee felt strongly that it was necessary to establish these exceptions to provide for appropriate protection during investigations and to allow quick action *where it would be reasonable to conclude that someone's health might otherwise suffer*.

Id. at 6394 (emphasis added). If this independent standard is met, then the physician cannot sue for damages. The four-part test does not come into play.

As the committee report says, the statute does not require that no action be taken unless or until imminent danger is determined to exist.[25] It provides immunity where the failure to act "may result in an imminent danger to the health of an individual." "May" means "possibly will." Bryan Garner, A DICTIONARY OF MODERN LEGAL USAGE 553 (1995).

The lab privileges in question were privileges to do cardiac catheterization, a procedure that invades the heart. Every cardiac invasion carries with it some risk of death to the patient. *See Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 947 (Pa. 2001) (upholding immediate restriction on privileges to do "open-heart surgery, an undeniably serious procedure.") (emphasis in opinion); *Curtsinger v.*

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[25] *Lee v. Trinity Lutheran Hospital*, 408 F.3d 1064, 1072 (8th Cir. 2005); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 917 (8th Cir. 1999) ("may"); *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439, 1443 (9th Cir. 1994), *overruled on other grounds*, *Daviton v. Columbia/HCA Healthcare Corp.*, 241 F.3d 1131 (9th Cir. 2001) (en banc) ("may"); *Manzetti v. Mercy Hosp. of Pittsburgh*, 776 A.2d 938, 947 (Pa. 2001). *See also Payne v. Harris Methodist HEB*, 44 Fed.Appx. 652 (5th Cir. 2002) (upholding temporary suspension as a matter of law).

HCA, Inc., 2007 WL 1241294 (Tenn. App. 2007) (upholding immediate restriction when surgeon did not respond to three emergency room calls).

When an experienced physician makes a significant mistake while operating on a heart, allowing him to continue such operations before further investigation can be done "may" be an imminent danger to the health of one of his patients.

For this additional reason, the damages suit against the hospital and Dr. Knochel should not have been allowed to go forward based on the investigatory suspensions alone.

III. HCQIA Precludes Any Cause of Action for Damages, Whether the Damages Are in Contract or in Tort.

A. HCQIA immunity bars Dr. Poliner's contract damage claim for violation of the medical staff bylaws.

1. The district court confused medical staff bylaw standards with HCQIA standards.

The district court's logic is, at best, contorted. *See* THS Brief at 25. But of particular interest to amici is that the district court wrongly uses bylaws language as the standard for complying with the HCQIA. The medical staff bylaws impose requirements not found in the HCQIA.

"Abeyance" under the bylaws can be requested where what the physician has done is "of such concern that in the assessment of the department chairman … further evaluation of the activities or professional conduct [of a physician] is necessary." PX-220 p. 73, App. 3. Abeyance can last for 15 days and then be

extended for 14 days. If it does not result in a suspension, it does not become part of the physician's permanent record. If the physician does not consent to the abeyance, then "the department will proceed with the corrective action or suspension." *Id.*

"Suspension" under the bylaws requires a finding that the act of the physician "constitutes a present danger to the health of his patients." *Id*.

The district court thus failed in several respects in its analysis of the HCQIA. Not only did it confuse HCQIA requirements with bylaw requirements, but it scrambled the requirements of the two different immunities. They have to be examined separately.

Investigatory immunity. What it said with respect to "investigatory" immunity made three errors.

First, as noted above, the district court erroneously faulted the hospital for failing to give Dr. Poliner a notice and hearing that the statute expressly says is unnecessary. *Poliner*, *supra*, 2006 WL 770425 at *4-5.

Second, it said a jury could have found that Dr. Poliner did not voluntarily agree to the restrictions, but under HCQIA whether the physician voluntarily agrees or not is irrelevant.

Third, it implied that a finding of danger was necessary for investigatory immunity, and it is not. *See* pp. 11-16, *supra*.

Emergency immunity. In assessing this immunity, the district court made these errors:

First, it failed to recognize that none of the reasonable belief or hearing requirements apply to emergency immunity.

Second, it failed to apply the statutory standard for emergency immunity, i.e., a belief that allowing Dr. Poliner's continued privileges "may result in imminent danger." The district court five times in two paragraphs faulted Dr. Knochel's testimony that on May 13 he did not yet know whether Dr. Poliner "posed a present danger." But whether he "constitutes a present danger" is a bylaw standard, not a federal statutory standard for immunity. *See* pp. 16-18, *supra*.

2. HCQIA immunity bars bylaw contract damage claims.

When HCQIA immunity exists, it applies to both contract claims and tort claims. The statute bars suits for "damages under any law of the United States or of any State" with exceptions not relevant here. 42 U.S.C. § 11111(a)(1), App. 1. Every other circuit that has reached the question has determined that, when the grounds for statutory immunity are satisfied, that forecloses all state law causes of action based on contract, i.e., claims based on hospital bylaws.[26]

[26] *See* p. 2 n.1, *supra*. *See also Imperial v. Suburban Hosp. Ass'n., Inc.*, 37 F.3d 1026, 1027, 1030 (4th Cir. 1994) (no bylaw claim).

For example, once immunity requirements were satisfied, the Ninth Circuit rejected a claim that a physician was not afforded his additional hearing rights under state law.[27] Similarly, the Sixth Circuit has rejected a claim that a hearing violated bylaws by not including enough medical staff members,[28] and the Fourth Circuit has refused a claim that a hospital board had disseminated information about the physician in violation of its bylaws.[29]

These rulings do not, of course, prevent an action for declaratory or injunctive relief. If he chose to do so, Dr. Poliner could have refused the abeyance and, if suspended, could have sued the hospital and timely demanded his rights before the proceedings against him went any further. But he did not.

B. HCQIA immunity also bars the recovery of damages on Dr. Poliner's defamation and tortious interference claims.

The district court's post-judgment opinion makes it clear that the "defamation" in this case, if any, arose out of the peer review proceedings themselves. It said others learned of the restrictions improperly placed on Dr. Poliner's practice. R.E. 8 p. 22-23. The description of the tortious interference

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[27] *Smith v. Ricks*, 31 F.3d 1478, 1487 n.8 (9th Cir. 1994) (whether hospital violated state law professional guidelines is "irrelevant").

[28] *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469-471 (6th Cir. 2003).

[29] *Gabaldoni v. Washington County Hosp. Ass'n*, 250 F.3d 255, 263 (4th Cir. 2001).

claim is similar. R.E. 8 p. 30-32 ("tortious" conduct was defamation and breach of contract).

HCQIA immunity prevents the recovery of damages for actions taken during the peer review process, beginning with statements witnesses give and ending with reports to the National Data Bank, if necessary. 42 U.S.C. § 11111(a), App. 1. After all, defamation damage suits based on such reports are what Congress hoped to stop when it passed the HCQIA. *See McLeay v. Bergan Mercy Health Systems Corp.*, 714 N.W.2d 7, 18 (Neb. 2006).

CONCLUSION

This Court, like Congress, should put patients first. Dr. Poliner has at all times admitted his mistake. His mistake was serious enough to merit an investigation. The temporary restrictions of his invasive cardiology privileges pending investigation were in the furtherance of health care.

That is what the HCQIA requires. That is why this Court should reverse the damages award against the hospital and defendant Dr. Knochel and render judgment here in their favor. This Court should vigorously reject the district court's unprecedented outlier misinterpretation of the HCQIA in this case, which has cast a pall over peer review not only at the defendant hospital, but throughout the Fifth Circuit.

Respectfully submitted,

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Pursuant to 5TH CIR. R. 32.2.7(c), the undersigned certifies this brief complies with the type volume limitations of 5TH CIR. R. 32.2.7(b), for the following reasons:

1. This brief complies with the type-volume limitation of Fed.R.App.P. 32(a)(7)(B) because this brief, together with the lists in Appendix 2, contains 6,766 words, excluding the parts of the brief exempted by Fed.R.App.P. 32(a)(7)(B)(iii).

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Counsel for amici

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I, Luther T. Munford, attorney for the amici curiae, certify that I have this day caused to be delivered by Federal Express a true and correct copy of this Brief of Amici Curiae Health Care Indemnity Corporation, et al. to:

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