**" Peer Review Victim of Murphy's Law "**

Testimony of Gil N. Mileikowsky, M.D.

California Senate
Business, Professions and Economic Development Committee

**" Is Physician Peer Review a Broken System ? "**

State Capitol Room # 4203 - Sacramento, CA

March 9, 2009 - Public Hearing

Senator Gloria Negrete McLeod and members of the Committee,

Thank you very much for inviting me today to testify as part of your hearing on peer review in California.

I also wish to thank all of the members of the committee who voted for AB 632, extending whistleblower protection to all physicians in the state of California, because without such dedicated physicians, we would never know what is really happening behind closed doors.

I was asked to provide you my medical background, my involvement in peer review committee at Encino Tarzana Regional Medical Center, ETRMC, the kind of complaints, sentinel events, and issues that were brought to the committee for my review; the events that led me to testify against ETRMC, and how my practice changed as a result of my decision to testify against the hospital.

In the last 10 years, I have been in litigation against HCA and Tenet. Due to the fact that this matter is presently pending before the CA Supreme Court, I shall not be able to discuss it, nor will I be able to answer any question regarding these litigations.

For your convenience, I provided you a copy of my testimony along with a handout with documents that provide more specifics.

My name is Gil Mileikowsky. I am an OBGYN specialized in infertility, in vitro fertilization, reproductive endocrinology, and laser surgery.

I was born in New York and raised in Israel and Belgium.

On July 4, 1979, I graduated from the medical school of the Catholic University of Louvain, in Belgium.

On July 1, 1979, I became an intern at Cook County Hospital in Chicago, completed my residency in obstetrics and gynecology at Baylor College in Houston, TX and received my degree in reproductive endocrinology from USC in Los Angeles, in 1986.

From 1984 to 1987, I was a Clinical Instructor on faculty at USC.

From 1994 to 2000, I was Assistant Clinical Professor in the Department of Obstetrics and Gynecology at UCLA.

Let me share with you some of my personal experience with medical peer review, since I began my private practice in Los Angeles, **in 1986**:

**1.** Upon my appointment to Northridge hospital, I noticed that there were no criteria regarding the use of laser in gynecological surgery and brought it up to the attention of the medical staff office.

A few months later, two gynecologists at that hospital with little experience in laser surgery did not realize the laser beam was on and burned the drape of the patient in the operating room. Fortunately, a nurse noticed it and used a syringe with water to immediately extinguish it. The patient was under general anesthesia and did not suffer any damage.

Following that incident, the medical staff office asked me to prepare criteria for the use of laser in the department of obstetrics and gynecology.

**In 1987**, the OB/Gyn department approved my proposed criteria and the Chief of Staff appointed me as Chairman of the laser and safety committee in order to implement similar safety measures in all departments of Northridge Hospital. The same criteria where then adopted by my department at ETRMC.

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**2. In the early '90s** both Northridge Hospital and ETRMC were found to have the highest C-Section rates in the State of California as reported in the LA Times. The situation was so embarrassing that both departments of obstetrics and gynecology implemented an automatic review of every single C-section by our peer and chart review committees where we would verify that the C-section was medically indicated. If it was not, the obstetrician would be invited to explain the circumstances.

Accordingly, we succeeded to dramatically reduce the C-section rate in both hospitals.

Hence, at the time physicians applied the principles of medical peer review in a most effective way allowing us to improve the quality of the delivery of care that we provided to our patients.

At one point, I was on staff at as many as 10 hospitals all the way from Anaheim, in Orange County, up to West Hills Hospital in the northern part of Los Angeles.

Whenever I was an "active" member of the staff, I had the duty to serve at least three months every year in the OB/GYN peer and chart review committee to monitor the quality control of delivery of care of my department. Peer review was performed in a collegial fashion with the intention of learning from each others mistakes, errors and complications, so that overall our department would better serve our patients.

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**3. From September 1986 to September 1998**, I was an employee of two very well established gynecologists in the community. I was supposed to become a partner with my employers. Unfortunately, that did not happen. Hence, my former employers entered into a concerted effort with their "old boys network" to prevent me from establishing my own private practice in the same area. They instigated peer review procedures to get rid of me through an obscure rule of the OB/GYN department. They failed because I was able to amend that rule with the assistance of over 50% of the active members of the department.

I mention this because it is very common for physicians who compete with each other to misuse the medical peer review process in order to get rid of a competitor. That does not comply with either the spirit or the letter of the Business and Profession Code of California.

Originally Tarzana Hospital was founded by private physicians who operated it. Then, they sold it to a corporation by the name of American Medical International, AMI. A few years later, AMI sold it to Tenet. Later, it merged with Encino Hospital a property of HCA. So in effect, ETRMC became a joint venture between Tenet (75%) and HCA (25%).

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**4. In 1997**, a patient called my office stating that a colleague of mine failed to remove an ectopic pregnancy in her fallopian tube and mistakenly removed the healthy tube in which there was no pregnancy. As the pathologist reported to the physician that there was no pregnancy in the removed fallopian tube, the patient was readmitted and the physician removed the fallopian tube with the pregnancy. Now the patient could not conceive naturally, as she had no remaining fallopian tubes.

At no time either during my training at various county hospitals or in private practice had I ever heard of any gynecologist missing an ectopic pregnancy and removing a healthy fallopian tube.

So, I did not believe this story because, the physician in question was a friend of mine I knew very well since he trained with me at USC and was an expert in treating ectopic pregnancies medically without any surgery.

Once the patient provided me a copy of her chart, I realized that everything she told me was absolutely true.

Since I happened to be, at that time, serving on the OB/GYN peer review chart committee, I was surprised that this patient's medical record was not submitted to our committee for review. I asked the quality assurance (Q & A) director why that chart was not provided to us ? The Q & A director responded that she was going to look into it, but she never provided the medical record of that patient with this significant complication to our committee.

This was the first time I ever noticed that some medical records, with significant complications, simply escaped completely our internal quality control of medical peer review.

The patient asked me to perform an In-Vitro Fertilization procedure following which she became pregnant and I delivered her twins.

**5. In June 2000**, the director of the Q&A department solicited the input of the physicians in the OB/GYN department to determine which criteria she should use to screen for possible errors and complications. I suggested that every patient that was operated in our department and was readmitted within 30 days should be automatically reviewed. That way we would not miss any similar complication like the one I just described. The physicians of my department objected to my proposal.

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**6.** The next day, an attorney looking for a physician expert witness in a malpractice lawsuit, who found my name in the directory of the Los Angeles County Bar Association, called me and asked me the following question:

"Does it fall below the standard of practice to remove both fallopian tubes of a patient without the patient' s consent ? "

It sounded so barbaric to me, that I asked her in which foreign country this happened. She told me that it was at ETRMC, in Los Angeles, two years prior to our conversation.

Since, I had never heard of that case in my department I asked the attorney if it happened in the department of general surgery. The attorney told me that it was a gynecologist who operated a patient with an ectopic pregnancy.

Not only did he remove both fallopian tubes without the patient' s consent, which constitutes battery, but the hospital also lost three frozen embryos and the gynecologist failed to advise her husband that he had liver disease, hepatitis.

I did not believe a single word that attorney told me until she provided me the medical records of that patient.

I then, had to ask myself a question the attorney could not ask:

" Why was this medical record never submitted to the OB/GYN peer and chart committee at ETRMC ? "

I also wondered: " Why was no one in my department aware of it ? " particularly, that this was a public record, as the patient filed a lawsuit.

**On June 14, 2000**, I reported to the Institute of Medical Quality, IMQ, affiliated with CMA, the LA County DHS and the JCAHO, that ETRMC had a " Double Standard " in Peer Review, as physicians who are significant income providers to the hospital are not reviewed and their complications are covered up. These type of physicians are sometimes referred to as " Rain makers ".

I also reported that the sperms of two husbands were mistakenly placed with the eggs of the wrong wives. As a consequence, the resulting embryos were not suitable for either couple. An emergency meeting occurred, in December 1997, and the attorney of

ETRMC recommended the destruction of these embryos, shutting down ETRMC' s IVF laboratory and reopen in early 1998.

**On June 19, 2000**, the attorney representing the couple that sued ETRMC for removing both fallopian tubes without consent, advised ETRMC that I was designated as an expert in that case.

A few days later, **on June 23, 2000**, the CEO of Tarzana Hospital, Mr. Surowitz, sent me a letter advising me that I had to be escorted by security whenever I am on the hospital premises.

I was shocked. After 14 years on staff at ETRMC, I had never heard of any physician being escorted by security for any reason. The CEO of ETRMC did not give any reason for such measures. I could not understand what ETRMC was afraid of. After all, it is obvious to anyone that such conduct falls way below the standard of practice that anyone would expect any gynecologist to perform under.

I was not aware of the "chilling code of silence" that hospital administrators around the country imposed on physicians, nurses, pharmacists, and other health care providers.

For me, to remain silent was not an option, because it would mean that I was an accomplice to such egregious conduct.

Hence, **on June 28, 2000**, my expert opinion in support of this couple was filed in Superior Court of Los Angeles and effectively prevented ETRMC from dismissing this case.

**On July 29, 2000**, I reported my findings to the IMQ, JCAHO and LA County' s DHS.

**On November 13, 2000**, I met with two top FBI agents in the healthcare fraud division in the Westwood Federal Building in a sound-proof room. I provided a very large number of documents and was told not to tell anyone I met with the FBI.

Lo and behold three days later, **on November 16**, Mr. Surowitz, CEO of ETRMC called my office and asked for me to be paged. I immediately called Mr. Surowitz who told me in a trembling voice:

"Dr. Mileikowsky, effective immediately you no longer have clinical privileges at Encino Tarzana Regional Medical Center."

The conduct of Mr. Surowitz triggered such an uproar in several medical associations that it was reported by AM News, the official publication of the American Medical Association, on June 18, 2000.

The editorial is titled: "Due Process - First things first in peer review," and the article "California Physician's Hearing Put on Hold: Some say peer review is jeopardized after a hospital revokes a doctor's privileges and keeps delaying an inquiry on the charges."

I was not provided any reason for such drastic measure. I had no patient at the hospital at that time, nor was there any complaint from any of my patients against me.

**Since 2000**, I am an obstetrician/gynecologist, licensed in the State of California without any hospital to deliver my patients at, as hospitals ganged up on me. I cannot deliver my patients at home or operate on them in my office, as dermatologists or plastic surgeons do. Hence ETRMC, Tenet, and HCA, waged a war of attrition against me, destroying my medical career, and disrupting my relationship with my patients.

I appealed internally Mr. Surowitz's wrongful conduct and my right to a medical peer review hearing was denied three times since then, twice at ETRMC and once at HCA' s West Hills Hospital.

**In the last 10 years**, when anyone asks me: " Gil how are you ? "

I often respond: " Life is Beautiful, like in the movie by Roberto Benigni on the holocaust." Last year, I barely saw any patient in my office.

" How was ETRMC able to prevent this extraordinary deviation of the standard of practice from leaking out ? "

" Why would any hospital in its right mind cover up for such gross negligence, let alone battery ? "

" Why would any hospital subject any physician, such as myself, to this ferocious retaliation ? "

I was so naive, that it took me 9 months to figure out the answer to these questions.

What you and I would refer to as a " Good Physician " is a physician that would treat a patient only when necessary, a physician that would operate on a patient only when it is medically indicated, and would hopefully have the least possible errors and complications.

Unfortunately, in terms of revenue for a hospital this is not a good physician.

For a hospital administrator, an " Ideal Physician " is a physician that admits all of his patients, keeps them in the hospital as long as possible, and operates on all of them. The ideal physician would also have a maximum number of errors and complications.

So in effect, the best interest of hospital administrators run in the opposite direction of our patients' safety.

What has happened over the years, as the control of peer review shifted from physicians to hospital administrators, the original purpose of peer review got lost.

I am ready and willing to answer any question and invite you to visit our website, Alliance for Patient Safety.org, where you will find many articles, medical association

resolutions, the methods and strategies used by hospital administrators and their attorneys to destroy good physicians careers..

Once again, I would like to thank you and your staff, particularly Ms. Pulmano who' s ability to absorb a large volume of documents in seconds is very impressive.