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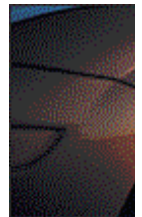
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## U.S. News

### The Cost of Courage: How the tables turn on doctors



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FROM CHAOS TO COURAGE

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First of a series

Sunday, October 26, 2003

By Steve Twedt, Post-Gazette Staff Writer

America's physicians, sworn to protect their patients from harm, increasingly face a surprising obstacle -- their own hospitals.

In medical centers as small as Centre Community Hospital in State College and as prestigious as Yale and Cornell, doctors who step forward to warn of unsafe conditions or a colleague's poor work say they have been targeted by hospital administrators or boards.

Instead of receiving praise or even support for trying to improve care, they're disciplined or dismissed for being "disruptive" or for violating patient confidentiality. Frequently, the hospital turns the tables on the whistleblowers and accuses them of poor care. They also threaten internal investigations that could result in listing the complaining doctors in the National Practitioner Data Bank, which can make finding a similar position at another hospital all but impossible.



**Dr. Tom Kirby, a surgeon, stands in his home that is now in foreclosure after he was suspended from University Hospitals in Cleveland. Kirby has not operated on a patient in nearly 18 months while he fights charges of being "disruptive and abusive." View larger image. (John Beale, Post-Gazette)**

Not even whistleblower laws, designed to give legal protection to those trying to report wrongdoing, safeguard the doctors in many cases. And all too often, state and

**The Series**  
Also in Day One

federal agencies and national accrediting groups do little to protect these physicians or make sure patient care problems are corrected.

During the past 10 months, the Pittsburgh Post-Gazette has examined cases across the United States in which physicians who spoke up about poor care faced reprisals, including peer review hearings, demotions, temporary loss of credentials, involuntary transfers or outright dismissal. In one Missouri case, a physician was cited for violating patient confidentiality after he pushed for further investigation into possible serial murders at the hospital.

While it's unknown exactly how often physicians are targeted for patient advocacy, a 1998 survey of 448 emergency physicians across the United States found that 23 percent had either lost a job, or were threatened with it, after they'd raised quality-of-care concerns. Ed Kabala, a lawyer with the Downtown law firm Fox Rothschild, which represents physicians, said he had noticed a recent increase locally in physicians being accused of disruptive conduct.

"We might have seen two or three in a year, then all of a sudden, we had five in 60 days. Some of them were bona fide and some were not," he said.

"There are cases where physicians have raised legitimate concerns about other physicians, or hospital staffing, and in retaliation they have been subjected to threats that they are disruptive. It's a technique to be used when other disciplinary reasons could not be justified."

### **Isolated incidents?**

Hospital attorneys, not surprisingly, take a different view.

"I don't see it as a large problem," said John Horthy, of Pittsburgh's Horthy Springer and Mattern, one of the leading health care law firms in the United States.

- **Dispute over treatment of heart patients derails career**
- **Doctors who spoke out**
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#### **Day Two**

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-

Horty's firm has represented 400 to 500 hospitals, and is on retainer with about 30, and "we may have one of these [whistleblower physician] cases," he said.

While acknowledging that relationships between physicians and hospitals "are the worst I've ever seen" because of economic and other outside pressures, Horty said that "most disruptive physicians are, in fact, disruptive. If it's nothing but whistleblowing, the hospital almost never acts."

But the Post-Gazette's investigation has shown that while such incidents may not happen at most hospitals, doctors who question quality standards or practices can pay a steep personal and professional price, including:

■ **Loss of patients and their practice.** After he was summarily suspended for complaining about poor care received by his patients, vascular surgeon Dr. Thomas Wieters of Charleston, S.C. had 48 hours to find another physician to tend to his hospitalized patients. Dr. Gil Mileikowsky, an obstetrician-gynecologist in Encino, Calif., had to tell longtime patients that someone else would have to deliver their babies. Similarly, transplant surgeon Dr. Thomas Kirby of Cleveland's University Hospitals has not operated on a patient in nearly 18 months while he fights charges of being "disruptive and abusive."

■ **Prolonged investigations.** Kirby waited more than a year for his hearing, and Mileikowsky has had two hearings abruptly stopped after procedural disagreements arose, such as whether he could question his accusers. Both sought court intervention, only to be told their wrongful termination lawsuits could not be addressed until their administrative appeals within the hospital were completed.

■ **Financial ruin.** Wieters estimates he's lost about 80 percent of his income since his dismissal and is considering filing for personal bankruptcy. Kirby's Cleveland Heights home is now in foreclosure.

■ **Lack of relief from courts.** Almost uniformly, courts have given hospitals a wide berth in handling staff credentialing matters. When kidney specialist Dr. Linda Freilich sued a Maryland hospital that terminated her privileges after she complained about substandard care, the courts declined "to enmesh themselves in hospital governance." Wieters was told by one federal court that the fact that he'd uncovered substandard care was irrelevant.

### Targeting reformers

Those who have witnessed reprisals against physicians or were targets themselves are troubled that advocating for better patient care can be seen as disruptive and lead to

serious professional consequences. Some say it's like arresting a person who yells "A man's been shot!" for violating a noise ordinance.

"We're the only people who can stand up for patients," said Dr. Scott Plantz, an emergency medicine specialist who headed the survey of emergency physicians. "The nurses can't, because they're employees of the hospital. But doctors aren't, or at least they weren't in the past. With managed care, and doctors working for hospitals, it gets worse and worse and worse."

The silencing of whistleblower physicians hasn't received the kind of intense publicity malpractice reform arguments have. But because many of the doctors' complaints involve the basic standards of care being used at hospitals, it could have just as big an impact on the quality of care patients receive.

The targeted whistleblowers include some of the best of the best: chiefs of staff, board-certified specialists, highly regarded transplant surgeons and the president of the Pennsylvania Medical Society.

"There's an attitude that it's better to cover [a problem] up than to let it be known and correct it, because [a hospital] cannot afford the consequences of letting anybody find out that it went wrong," said Dr. Edward Dench, who just completed his year at the reins of the medical society. Dench said he became a target at Centre Community Hospital after questioning procedures there.

"If a nurse or physician speaks up and says, 'This is wrong,' they are the ones most likely to be punished."

And that's only counting the ones who have the courage and conviction to speak up. Many others weigh the professional and financial cost and do not come forward, thus silencing the patient's best and most knowledgeable advocate.



### A Conversation with Steve Twedt

Audio excerpts from a discussion of "The Cost of Courage" with Post-Gazette Staff Writer Steve Twedt

**AUDIO** The project began with a call from a physician. (1MB MP3)

**AUDIO** Across the country patients should be worried about whether doctors are afraid to criticize poor health care practices at hospitals. (1MB MP3)

**AUDIO** Hospitals have been able to threaten doctors with being listed as "disruptive" on a national database originally developed to identify dangerous or incompetent physicians. (500K MP3)

**AUDIO** Powerful and secretive peer review boards can make doctors afraid to speak out. (1.7MB MP3)

**AUDIO** Physicians do not receive the same due process safeguards before a review

"If you want your life to go on without disruption, then that's what you do," said John Blum, a Loyola University of Chicago professor who's written extensively on hospital credentialing. "There is a real public health threat there. There has to be some kind of immunity to those who are presenting allegations of quality problems."

While retaliating against whistleblower physicians does not happen at most hospitals, some say it appears to be on the increase.

"It is clear that we are hearing of more cases of these kind of really difficult conflicts occurring between hospitals, and, in some instances, hospital boards, and the medical staff," said Dr. Paul M. Schyve, senior vice president of the Joint Commission on Accreditation of Healthcare Organizations, which accredits most U.S. hospitals. Schyve said one factor driving these disputes is the economic pressure hospitals face to keep costs down and maintain a good image.

The American Medical Association, while stipulating that there is no clear definition, says physician behavior is disruptive when it interferes with patient care. But the AMA code also notes, "Criticism that is offered in good faith with the aim of improving patient care should not be construed as disruptive behavior."

The whistleblowers at hospitals are not always physicians.


Nurses and other health care workers have come forward, at risk of being fired, having their work hours cut back or being reassigned to an undesirable shift. Occasionally, they've successfully fought back.

Last year, a jury awarded three nurses \$275,000 from a Bradenton, Fla., hospital for retaliating against them after they complained about poor nursing care. In Naperville, Ill., nurse Reem Azhari sued Edward Hospital after she was the only staff member let go because of "budget cuts" in March 2000, not long after she had reported several health and safety violations, including uncertified medical students being allowed to perform surgery.

But whistleblower physicians face a unique vulnerability, one that can

**board that they would expect in court.**  
(1.2MB MP3)

**AUDIO**  **Hospitals are under intense economic pressure to avoid public criticism from doctors who practice there.**  
(884K MP3)

**AUDIO**  **Physicians who want to blow the whistle on practices at a hospital face a real threat from physician review boards and an adverse listing in a national databank.**  
(614K MP3)

**AUDIO**  **There is a high cost for physicians labeled as being "disruptive."**  
(546K MP3)

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make disagreeing with their hospital administrators a career-ending move. Once they've been labeled disruptive, doctors may face sanctions and effective banishment from the profession. That gives hospitals considerable leverage when conflicts occur.

The irony of this growing trend is that hospitals are silencing doctors by using a piece of federal legislation that was meant to protect patients.

Hospital peer review, typically involving a panel of physicians who review patient cases, is an integral part of the Health Care Quality Improvement Act, which Pittsburgh's Horthy co-authored and which Congress passed in 1986. The law sets out a framework for discreetly investigating a physician's performance and ensuring he's meeting accepted standards of care.

The shroud of immunity and confidentiality over internal hospital investigations of physicians is intended to protect both the patient's and the doctor's privacy, and allow for open discussion of the details.

But it also means that physicians who are wrongly or maliciously accused may be pulled into a hearing where they have no legal representation and no opportunity to face their accusers. Or, in some cases, their accusers sit on the panel investigating them.

"The assumption that peer review is always only about quality and not about economic or intra-professional political struggles is less and less realistic as the economics of the health care industry become more competitive," said Sallyanne Payton, a University of Michigan health law professor.

Historically, physicians have supported the confidentiality of peer review proceedings, seeing it as a protection.

But that is changing.

"I'm hearing from more and more doctors that peer review really represents, in too many institutions, physicians who are either employed by the hospital or are linked to the hospital, so they're doing the hospital's bidding," said Dr. John C. Lewin, executive vice president and CEO of the California Medical Association.

Lewin would like to see a "renaissance" of peer review, refashioning it by using outside specialists instead of staff members beholden to the hospital. "We're concerned that some hospital facilities are less interested in objectivity than in using peer review for their own purposes."

In some cases, those purposes include retaliating against whistleblower physicians who jeopardize the daily flow of patients and reimbursements.

The none-too-subtle warning to doctors: If you value your career, report no harm.

**Tomorrow:** A South Carolina surgeon is blackballed

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*(Steve Twedt can be reached at [stwedt@post-gazette.com](mailto:stwedt@post-gazette.com) or 412-263-1963.)*

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## U.S. News

### Dispute over treatment of heart patients derails career

Sunday, October 26, 2003

By Steve Twedt, Post-Gazette Staff Writer

CLEVELAND -- When University Hospitals of Cleveland recruited Dr. Thomas Kirby to head up its cardiothoracic surgery and lung transplant divisions in 1998, he saw it as an opportunity to raise a fledgling program to national prominence.

Kirby, 51, had directed lung transplant programs at two highly renowned hospitals -- Columbia Presbyterian Medical Center in New York and the Cleveland Clinic -- when he got the intriguing offer to run his own program at University Hospitals, which is affiliated with Case Western Reserve University.

"I told them, 'I'm not moving over here to run some second-rate program,'" Kirby recalled. Hospital officials assured him they wanted a premier program, too, and they were eager to have him direct it. His starting salary was \$800,000 a year.

In the ensuing years, the number of lung transplants at UH went from zero to 15 per year, solidly establishing the program as a player in the state.

But, even as more patients received life-saving surgeries, the story took a turn neither Kirby nor the hospital expected.



John Beale/Post-Gazette

**Dr. Thomas Kirby stands outside University Hospitals of Cleveland, which suspended him more than a year ago for "disruptive and abusive" behavior. He had been recruited by the hospital in 1998 to head up its cardiothoracic surgery and lung transplant divisions.**



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Today, nearly six years after he was hired, Kirby is out of work. He was suspended more than a year ago by UH for "disruptive and abusive" behavior.

Kirby says the only thing he was trying to disrupt was the high mortality rate among the hospital's heart patients, which was two to three times the national average.

But being right has not prevented the derailment of Kirby's promising surgical career. For the past two months, he has lived among packed boxes and unhung pictures in his expansive Cleveland Heights home, which is now in foreclosure proceedings.

The divorced father of three -- his oldest started college this fall -- is considering filing for personal bankruptcy.

Last month, the hospital upheld Kirby's suspension, putting the final stamp on his removal. He's now looking for work outside of Cleveland, but is likely to end up at a much smaller program.

"I'm in a state of shock," Kirby said. "I can't believe it. I feel like I've been trashed and mauled."

#### Pushing for change

Not long after he joined UH, Kirby started pressing hospital executives about program changes, particularly for open heart procedures. Kirby said he was alarmed by mounting deaths and complications among intensive care patients after heart surgeries, and took his concerns to hospital administrators and board members.

Among the troubling examples of questionable care Kirby cited at UH:

\*After a 60-year-old lung transplant patient died, it was discovered that a monitoring alarm had not been turned on.

\*A man admitted for a routine heart bypass ended up needing a heart transplant because of a surgical mistake.

\*A man scheduled for surgery the following Monday died after surgeons did not respond to warnings from weekend staff that the patient was bleeding internally.

\*A 52-year-old man died 10 days after heart valve replacement surgery which, for undisclosed reasons, took 24 hours to complete and involved transfusion of 120 pints of blood.

\*A woman, 46, admitted for heart bypass, died of a massive heart attack after post-operative bleeding went untreated.

Eric Sandstrom, a spokesman for University Hospitals, would not confirm or deny Kirby's accounts.

"This has been in the courts for a long time and just the fact that it's a legal matter means we cannot comment on it," he said. He did confirm that Kirby's privileges had been suspended.

Thinking back, Kirby believes UH officials began gathering information about him in late 2000, after he had proposed to the hospital administration that they bring in two new surgeons. That move, Kirby believes, made him "a target of the older surgeons in the group" who felt threatened by the proposal.

When he returned from a five-day vacation in January 2001, Kirby learned he'd been demoted and the two colleagues he'd recruited to the program had been told their services were not needed.

During the subsequent months, acrimony within the department boiled up and eventually led to Kirby filing a slander suit against a fellow surgeon, who Kirby says had made disparaging remarks to other staff members about his clinical competence. That suit is still pending.

No one has disputed that the program had troubles -- at one point, UH temporarily suspended its heart transplantation service after four consecutive patients died. Yet even though the hospital never accused him of poor medical care, it was Kirby who lost his job in April 2002.

Caught in crossfire

Kirby believes he got caught in a political crossfire, with staff surgeons who felt threatened by the changes targeting him from one side and, from the other, hospital administrators, who were upset that Kirby had been speaking directly to hospital board members.

The suspension letter from the medical chief of staff accused Kirby of being "abusive, arrogant and aggressive" with other hospital staff, including use of profanity and "foul and/or sexual language." Accusers were not named, dates were not supplied and Kirby was not offered the chance to continue practicing surgery.

"He made people mad because he didn't settle for mediocre," said Lisa Sorenson, 39, a nurse who followed Kirby from Cleveland Clinic to UH and is now back at the clinic.

"He really believed that to make a program good and keep patient safety at its highest, you had to do things, even if it makes people unhappy."

Kirby sued University Hospitals for wrongful termination, but the judge said the suit could not go forward until Kirby's internal UH appeal was resolved.

At one point, when talk of a possible resolution surfaced, Kirby's attorney sent a letter to the hospital's law firm, insisting that "any settlement of this case will require the institution of reforms in the hospital that, in the future, will prevent careless and fatal medical practices."

Adding fuel to the fire was the fact that Kirby gave a sworn affidavit for a family suing the hospital.

Terry Mullin, 58, received a new heart at UH on May 23, 2001, but died the next day after a second surgery failed to stop internal bleeding. The Mullin family sued in November 2002, accusing the hospital of negligence. The family's attorney knew from news articles that Kirby had been suspended and asked him to testify. He agreed because he thought the hospital was stonewalling the family.

In his affidavit, Kirby said he'd warned key administrators since 1999 "of numerous deficiencies relative to medical care complications and surgical outcomes, which existed in the division of cardiothoracic heart surgery at University Hospitals." Despite those warnings, he added, "no remedial and/or curative action was instituted."

Hospital attorneys have tried to quash Kirby's statement, as well as subpoenas issued for top administrators and the board chairman at UH.

In January, eight months after he'd been summarily removed, Kirby faced a panel convened to consider his suspension. But three days into the proceeding, the panel was abruptly disbanded after Kirby's attorney learned that two of the three panelists were on the clinical council that had ordered his suspension. A second panel was convened in July, leaving Kirby's status in limbo for months longer.

His finances are shot

With last month's final ruling, Kirby faces the challenge of looking for a new hospital, but now his name is included in the National Practitioner Data Bank as a physician who lost his credentials because of professional misconduct. He has not decided whether to appeal the data bank report.

Kirby has not collected a paycheck in more than a year and has attorney fees "in the hundreds of thousands of dollars," he said. His savings and his retirement nest egg are both gone. Kirby, a classical pianist, has had to sell his piano to help cover the mounting bills.

University Hospitals and its patients have suffered, too. After Kirby's departure, the lung transplant program had been inactive until recently.

The hospital received high marks for its heart surgery program from U.S. News and World Report this year, but Health Grades Inc., a

Colorado company that rates health care quality at more than 5,000 U.S. hospitals, has described UH's survival rates for valve replacements and in-hospital deaths as "poor." Health Grades spokeswoman Sarah Loughran said 10 percent to 12 percent of the hospitals reviewed get that ranking.

Last year, the Accreditation Council for Graduate Medical Education revoked UH's authority to train cardiothoracic surgery medical residents, saying the program no longer met council standards.

Although the hospital accused Kirby of being abusive, several staff members testified otherwise at his hearing.

The employees, including his transplant coordinator, several nurses and residents and his secretary, described Kirby as professional and respectful. A surgical assistant for Kirby said the surgeon "had great behavior" and had never been abusive in the 100 or so surgeries they'd done together. He also was nominated as surgical teacher of the year at Case Western Reserve's School of Medicine in 2002.

Kirby does not dispute that he has exacting clinical standards, or that he has used profane language. But he believes he was fired and labeled disruptive for insisting on improvements to the UH program that he thought would save lives.

At the time of his suspension, Kirby said, he did not have a single accusation of poor care against him.

His career aspirations may be so much vapor now, but Kirby said he would not turn his back or compromise on patient care.

"How much is one person's life worth?" Kirby asked. "If I were to prevent even one death as a result of this, it will have been worth it."

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### Return to "The Cost of Courage:" Day One

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## U.S. News

### Doctors who spoke out

Sunday, October 26, 2003

All over the nation, physicians who have spoken out about dangerous hospital practices or poor performance by colleagues have been punished. Here are a few examples.

#### Dr. John Paul Schulze, Corpus Christi, Texas

Schulze, a longtime family practice doctor, criticized Humana Health Care in 1996 for its decision to have its own doctors care for all patients once they were admitted to Humana hospitals. He refused to use the so-called hospitalists, and was then dropped from the plan. Humana cited a malpractice case he had settled years before as its reason. After Schulze sued, a jury awarded him \$19.95 million, later reduced to \$14 million, and said Humana had acted with malice and committed fraud. Schulze later reached an undisclosed settlement with the for-profit firm. Humana denies to this day that Schulze was targeted because of his criticisms.

#### Dr. John Flynn, Anadarko, Okla.

After Anadarko Municipal Hospital administrators failed to act on Flynn's report of a colleague abandoning a patient in 1993, he reported them to state and federal authorities, who threatened to remove the hospital's operating license. The hospital then denied admitting privileges for Flynn, and it took him seven years to win reinstatement to the hospital staff. "They put me through hell," Flynn said of hospital officials. "You speak up against the system, you just put yourself up as a target. I'm not sorry I did it. It's just that it took something from me that I'll never get back, emotionally and physically." The hospital is now under new ownership.

#### Dr. Gil Mileikowsky, Encino, Calif.

Mileikowsky, a board-certified obstetrician-gynecologist, questioned his hospital's failure to review certain cases he believed demonstrated substandard care, including one where a colleague removed the wrong



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fallopian tube. He also agreed to testify as an expert witness for a family suing the hospital for malpractice. Within days, the hospital suspended Mileikowsky's privileges without a hearing, saying he had "exhibited a pattern of disruptive, threatening and non-cooperative behavior." Nearly two years later, two hearings have been started, then stopped, in disagreements over whether Mileikowsky would be allowed to question his accusers, among other things. "How did I work in hospitals for 14 years without ever a suggestion of anything like this, then, all of a sudden, this pops up?" Mileikowsky asked. The hospital declined to comment.

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# U.S. News

## The Cost of Courage: When right can be wrong

Second in a series

Monday, October 27, 2003

By Steve Twedt, Post-Gazette Staff Writer

CHARLESTON, S.C. -- After surgeon Dr. Thomas Wieters began openly criticizing the care his patients were receiving at Charleston's storied Roper Hospital, two noteworthy developments followed.

■ Roper officials labeled Wieters disruptive, summarily removed him from the staff and then had him listed in a national data bank of wayward physicians, effectively crippling his career.

■ Federal Medicare officials, based on two unannounced state inspections at Roper, found evidence of exactly the kind of problems Wieters had reported, including a fatal medication error. They concluded that conditions at the hospital "pose an immediate and serious threat to the health and safety of patients."

A Roper spokeswoman said the hospital would not comment on Wieters or his charges of poor care, but two years later, Wieters, 56, is still paying a high price for being right.

He is shut out of two of Charleston's major hospitals and,



Dr. Thomas Wieters now operates at a small community hospital outside of Charleston, S.C. [View larger image.](#) (John Beale, Post-

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because of the data bank listing, he cannot find work elsewhere. He has since moved to a smaller local hospital, but said his income has dropped 80 percent to 85 percent.

"My life -- both my personal life and my professional life -- is in shambles," Wieters said. "I can't make a living here, and I can't go anywhere in America and get a job."

He sued, but his legal options all but ran out earlier this year when a federal judge dismissed his appeal of an earlier district court ruling favoring the hospital. The court told Wieters that his advocacy for better patient care "was of no consequence" and "irrelevant" because he expressed it in a "disruptive" manner.

Wieters, a decorated Vietnam veteran, remains adamant: He will not compromise on his patients' care -- not today, not tomorrow, not if he could go back five years and restore his career.

"I am disruptive to anything that is harmful to the people I care for," he said. "If I do any less than be an advocate for these people, then I have no business being in this profession."

### How it started

The beginning of the decline of Wieters' surgical career came on the morning of Feb. 11, 1999, after the routine admission of a male patient. The man had come to Roper Hospital so Wieters could repair a life-threatening aortic aneurysm in his abdomen. The operation was scheduled for the next day.

The patient, Wieters later learned, sat in the waiting room more than four hours before being admitted. When Wieters stopped by to see him at 6 p.m., he learned nothing had been prepared: There was no chart, none of his orders had been carried out, no blood typing had been done, no cardiogram was recorded, no vital signs had been taken.

The nursing staff had administered a laxative as Wieters ordered, but mistakenly doubled the dose. The resulting severe diarrhea dangerously lowered the man's potassium level and required intravenous fluids through the night before surgery could safely be done.

Wieters said that was just the latest in a series of problems at Roper that had crept into day-to-day patient care since management of the hospital

Gazette)

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had been taken over by an outside corporation in August 1998. From missed vital signs to unrecorded pain medication administration, there were growing signs that made Wieters believe patient care had slipped.

In one instance, Wieters had ordered immediate antibiotics for a woman admitted with abdominal pain from diverticulitis, an inflammation in the intestinal tract. The antibiotics were not started for 10 hours, and the woman suffered a perforated colon and spent a month in intensive care. Another patient, after colorectal surgery, had to wait six days to get the antacid that had been ordered for her.

It was a disquieting trend for Wieters and others who had invested years at Roper, a hospital with a long, rich tradition of quality care. Situated a few miles from Charleston's antebellum mansions, Roper was founded in 1850, after a former Charleston mayor, Col. Thomas Roper, presented \$30,000 to the physicians of the Medical Society of South Carolina to start the hospital.

The pride that went with a physician-run, physician-owned hospital had created a reputation of excellent care, which Wieters saw dissipating once management of the nonprofit hospital fell into others' hands.

"Our standard of quality, which I had enjoyed from 1985 to the mid-1990s, was no longer. Orders were not being taken, cleanliness went down." And he pointed that out, again and again.

By the hospital's count, according to court records, there were 17 separate incidents of disruptive conduct by Wieters over a period of several months, which the hospital said could damage the hospital's reputation and leave it open to charges of creating a hostile work environment.

### **Demanding reports**

None of these incidents, Wieters said, took place in an operating room or in any patient care area. In most cases, he would write or demand the preparation of a report when he learned of substandard care.

He'd written reports, for example, about how no one took vital signs for one patient after surgery, and how no one documented IV input, urine output or other indications of vital organ function for 32 hours on another patient.

Officials were displeased with Wieters. At one point, the hospital's risk manager sent him a letter, rebuking him for ordering nurses to complete an incident report about a nursing error.

"When you do refer to an incident report in the chart ... it allows 'discoverability' of that report," the manager wrote. In other words, the notation could be subpoenaed by a malpractice lawyer suing the

hospital.

The disastrous care of the man with the abdominal aortic aneurysm, though, marked a new and dangerous low, Wieters thought.

That day, he sought out the hospital administrator and, when he found him, he let his frustration and displeasure be known, at high volume and velocity.

"The only thing I did was ask that my patients receive the standard of care that I ordered. Did I raise my voice? Yes. I raised it loud enough to be heard. But I never threatened anyone, and I've never assaulted anyone."

Two weeks later, Wieters received a certified letter from the hospital, accusing him of disruptive behavior. During the next several months, Wieters came under investigation by two hospital committees. The first committee, from the Department of Surgery, interviewed Wieters and decided the disruptive incidents were explainable, noting that one episode came after a nurse had not recorded vital signs for one of Wieters' patients for 48 hours.

But the second committee, made up of members of the medical executive committee, decided to put Wieters on probation for one year and require him to undergo psychiatric evaluation and anger management counseling. Neither committee raised any issue of negligent patient care by Wieters.

He requested a hearing on those recommendations. He was promised one, but it was never scheduled. During the subsequent two months, Wieters filed three more incident reports.

"He's a whistleblower, but he's an every-day whistleblower. He blew the whistle every time something happened," said Dr. Tom Fitts, a longtime surgeon on Roper's staff who taught Wieters early in his career. "He'd complain and, when nothing happened, he kept escalating the level at which he complained.

"I told him one time, 'Tommy, your family's at stake here. Just do what they say and don't fight it.' And he said, 'I'm right, and they're wrong, and I'm not going to do it.' "

### **A summary suspension**

The hospital then raised the stakes.

In January 2000, Wieters was suspended, without benefit of a hearing, because of "several additional instances of disruptive behavior" -- four incidents in four days in which nurses said he'd made "condescending and unprofessional" comments about patient care at Roper. He had 48

hours to find other physicians to care for his hospitalized patients.

"I think the hospital was offended because of the implication that they weren't running a good ship," said Dr. Richard Fitzgerald, a radiation oncologist at Roper who was part of a three-person ad hoc committee appointed by the hospital that disagreed with the summary suspension.

"There was a line drawn in the sand on the part of the hospital, that 'We have a standard of behavior, of propriety, of decorum, and we feel you're in violation of that.' "

Said Dr. L. William Mulbry, who also was on the committee: "No one, not even his detractors, has ever said he did not provide his patients with top care. That's what I have a hard time with." He added that, since Wieters' departure, he knows of two other physicians who received queries from the administration about their "disruptive behavior" after they had questioned a nurse about a patient's care.

Fitzgerald said Wieters' colleagues were quietly supportive but "were grateful it was not their fight. The rest of the staff wanted the problem to go away."

Still, 36 colleagues signed a petition calling for Wieters' reinstatement, and more than 100 nurses signed their own petition. One nurse, Dixie Ellenberg, testified before the ad hoc committee that Wieters "is one of the best physicians that we have. ... He treats every patient as if it was a member of his family."

There were nurses who were glad to see Wieters leave, she granted. "He would get upset if dressings weren't done right, or labs weren't done," she said. "But it always seemed like he had a reason to get upset."

Despite the petitions, the hospital did not reinstate him. Instead, hospital officials reported him to the National Practitioner Data Bank, a national listing of physicians who have been disciplined or have lost malpractice judgments.

Wieters said he had only once before had someone complain he was disruptive, in 1994, when a nurse failed to alert him that a surgical patient had spiked a 102-degree temperature and he let the nurse supervisor know he was unhappy

"I can assure you, on every single day in every hospital in America, some surgeon does more on a single basis than I've ever done collectively," Wieters said. "But when you ask the CEO tough questions that he can't answer, that's when you become disruptive."

### **Losing in court**

Because that national data bank report noted that Wieters had been

summarily suspended -- the most serious sanction, usually reserved only for those who present an immediate danger to patients -- the listing amounted to "a death sentence" professionally, Wieters said.

He sued, but a U.S. District Court judge ruled against him in November 2001, saying the federal Health Care Quality Improvement Act of 1986 "gave hospitals a considerable amount of discretion, a great amount of authority in dealing with matters of discipline."

The judge said Wieters had been disruptive, and added:

"The fact that that eruption by the physician takes place in an attempt to correct improper care, or with a sincere belief that he is serving the patient's rights and needs by trying to correct those health problems, is of no consequence."

After Wieters appealed, the 4th U.S. Circuit Court of Appeals ruled in February that Wieters' evidence of substandard care at the hospital, corroborated by the state inspection, was "irrelevant" and affirmed the district court decision.

Irrelevant? Wieters disagrees.

"This is about a physician's obligation to his patient. It's not about anything else," he said. "If you come into the hospital, and I'm responsible for your care, and if I see something wrong, do you want me to look the other way?"

He also believes the court ruling means hospitals "are not accountable. They can hide everything under 'peer review.' "

As his own legal case proceeded, Wieters did not let up in his effort to expose poor care of patients.

In the spring of 2000, he gave a sworn affidavit on behalf of a patient who'd been given an injection in the wrong location, causing permanent paralysis in his left foot due to damage to his sciatic nerve. He also wrote a detailed memo to Roper's new administrator about what he believed were other lapses in care.

When that did not produce results, Wieters sent a packet of letters and memos detailing "continuing negligent patient care practices at Roper Hospital" to the South Carolina Department of Health and Environmental Control. He cited two specific instances where patients' records had been altered to cover up poor care, and another case in which the body of a patient who had been given an overdose of a medication for schizophrenia was sent to the coroner with the notation that he'd "died of natural causes."

### **Surprise inspections**

During the next two months, state inspectors made two unannounced visits to Roper and found problems in both the nursing and pharmacy services that they said "pose an immediate and serious threat to the health and safety of patients."

The findings mirrored what Wieters had been reporting -- failure to administer and document medications, incomplete nursing notes, physician orders that weren't followed. One patient, whose heart stopped after removal of his prostate, had received a morphine overdose, the state inspectors noted.

Eugene Grasser, a regional administrator with the federal Medicare agency, told hospital officials that Roper's Medicare funding would be halted unless the hospital took corrective action. The hospital agreed to implement quality assurance procedures and make other changes, and, based on a follow-up inspection, the Medicare funding continued.

By then, Wieters' practice had slowed to a trickle. In May 2001, CIGNA HealthCare of South Carolina notified Wieters it would terminate its contract with him because of his listing on the National Practitioner Data Bank. The company also sent letters to Wieters' patients, telling them they needed to find a new doctor.

Two months ago, he received notice from the appeals court ordering him to pay \$357,000 in attorney fees to Roper Hospital. "I have no choice but to declare personal bankruptcy," Wieters said.

In the past four years, he has had to sell two houses because of his lost income. He and his wife now live 22 miles outside Charleston as he tries to rebuild his practice. He said he was offered a position in North Carolina but, because of his data bank listing, the North Carolina state medical board attached restrictions, including a one-year period of investigation before it would consider licensing him, that made the offer untenable.

He also has looked farther away for work, but the data bank listing is still a major hurdle.

Wieters talked with physician recruiters in San Francisco, Salt Lake City, Chicago and Atlanta and they agreed the listing would make it hard for him to find a job. One recruiter told him the listing was as damaging as if he had been a convicted felon just released from prison. "Another one asked me, 'Have you ever considered employment outside the U.S.?"

"I've paid a hell of a price to do what I believe in ... putting patients number one on the list," Wieters said. "But I practice medicine one way -- with the patient at the top of the pyramid."

Fitzgerald thinks the rest of the medical staff has paid a price, too, and, by extension, so will their patients.

"I do see a lowering of expectations on the part of physicians," he said. "There is an acquiescence, or resignation, that things are different. "

**Tomorrow:** Doctors face reprisals in State College

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(Steve Twedt can be reached at [stwedt@post-gazette.com](mailto:stwedt@post-gazette.com) or 412-263-1963.)

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## U.S. News

### A negative data bank listing isn't easy to erase

Monday, October 27, 2003

By Steve Twedt, Post-Gazette Staff Writer

When the San Francisco Department of Health decided in 1998 to cut two staff positions at county-owned Laguna Honda Hospital, Dr. John Ulrich Jr. stood up at a staff meeting and called the layoffs "an injustice to patients." The next week, he and other physicians sent a letter of protest to the health department.

Less than two weeks after that, hospital officials notified Ulrich that he was being investigated for incompetence, "spanning the full range of hospital care" from incomplete diagnoses to inappropriate diagnostic orders to overall poor management of his patients' hospitalizations.

Eventually, a California Medical Board review of Ulrich's performance would determine that the doctor had provided acceptable care. But at the time, Ulrich, believing he was being targeted for speaking out, quit in protest. He posted a resignation letter near a nurse's station that criticized the hospital's budget priorities.

By resigning while under investigation, though, Ulrich learned the next week that he would be reported to the National Practitioner Data Bank, a listing of doctors who have faced disciplinary sanctions, lost hospital privileges or lost malpractice judgments.

Ulrich immediately tried to take back his resignation. When the hospital refused, he sued.

The data bank which strikes such fear in physicians was established as part of the Health Care Quality Improvement Act of 1986, though it was not in operation until 1990. It was prompted by evidence that incompetent or unprofessional doctors, once they had been detected, were simply moving to other states and resuming their practices.

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The listings are not public, but all state medical boards and hospitals check for data bank information on any doctor who applies for a license to practice in their states or for staff privileges at their hospitals.

The Rockville, Md.-based data bank has collected reports on more than 125,000 physicians, most of them for malpractice payments. Reports on doctors who lost their clinical privileges or their licenses represent fewer than 20 percent of the total, with about 1,000 such reports filed each year.

About 1,500 reports overall have been filed for unprofessional conduct, which could include whistleblower physicians if they're deemed disruptive, but also includes doctors who have raped patients or committed fraud.

Once a physician is listed in the data bank, only the reporting hospital can withdraw the report. A doctor can appeal to the Health and Human Services secretary if he believes the report is inaccurate or on technical grounds, but fewer than 5 percent of those appeals succeed.

A data bank report "can essentially make you unemployable, and it can be the difference between getting insurance and not getting insurance," said Dr. Edward Dench Jr., recent president of the Pennsylvania Medical Society. "With malpractice being what it is, insurers are clearly cherry picking, and if there's anything that makes you look unusual, they're not going to take you."

After Ulrich sued, the presidents of two California medical associations told the court that "it will be virtually impossible" for Ulrich to find work at any U.S. hospital with that report in the data bank.

Ulrich, 54, lost in U.S. District Court. Once the resignation was accepted, the hospital did not have to rescind it, the court said. But on appeal, the 9th U.S. Circuit Court of Appeals ruled he could pursue his argument that he had been retaliated against for exercising his free speech rights.

Ulrich, reached by phone, declined to talk about what happened, saying he still hopes to reach some resolution with the hospital. A hospital spokeswoman also declined comment, citing the pending legal action.

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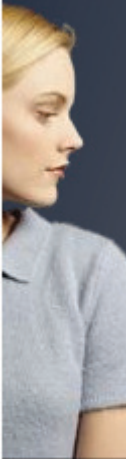
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## Rules of fair play don't always apply

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In going up against hospitals, physicians find the deck is stacked against them

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Monday, October 27, 2003

By Steve Twedt, Post-Gazette Staff Writer

**FLIGHT 93**  
FROM CHAOS TO COURAGE

Dr. Gil Mileikowsky, an obstetrician-gynecologist and fertility specialist, was abruptly suspended from an Encino, Calif., hospital nearly three years ago after he agreed to testify on behalf of a woman whose fallopian tubes had been removed without her consent.

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Today, Mileikowsky, 52, still is waiting to get a full administrative hearing on possible restoration of his credentials. Two earlier hearings ended in disputes over procedural matters. He hasn't delivered a baby since December 2000.

Dr. David Gearhart was fired in 1998 for breach of contract, one month after he appeared on a St. Louis television program and criticized his hospital's decision to eliminate eight nurse surgical assistants.

Gearhart, 58, was dismissed even though his department chairman had approved his TV appearance. Hospital officials then damaged his practice further by not giving patients his new phone number, delaying payments owed to him and turning over unpaid patient bills to a collection agency.

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stories of these two physicians and dozens of others in recent years. When these doctors have run afoul of hospital administrators, they've found that the traditional guarantees of due process or even fair play do not necessarily apply.

During the past 10 months, the Pittsburgh Post-Gazette has interviewed many physicians who say they've faced vague or fabricated allegations, sometimes from unnamed staff members, of incompetence or "disruptive behavior." The doctors say their real offense was speaking up too often, or perhaps too loudly, on behalf of patients.

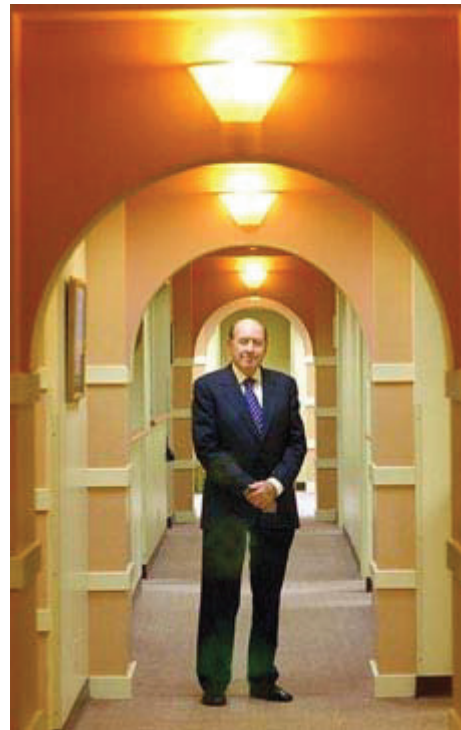
But instead of a timely opportunity to defend themselves, these doctors found themselves out on the street, like Gearhart, or, like Mileikowsky, waiting months to get a hearing before a hospital-appointed panel or officer.

The hearings were held behind closed doors, and often, the doctors did not have an opportunity to confront their accusers or have their attorneys present. And if the doctors felt they were wronged, the hospital representatives had broad protections under federal law that made it difficult for the doctors to win any lawsuits.

When it comes to hospital peer review panels, "there's no state agency that supervises them. It's a free-for-all fight. You have a judge who's favorable to the hospital. You have a jury who's favorable to the hospital. You can guess what the verdict will be," said Dr. Verner Waite, of Cypress, Calif.

### Doctors lose power

Waite, now retired, used the \$550,000 he won in a lawsuit in 1984 for being wrongly punished by a hospital review panel to found the Semmelweis Society, named for a 19th century Viennese physician who faced severe reprisals after suggesting that doctors' handwashing could reduce fatal infections among new mothers. The society has one aim -- to stop unfair peer review of doctors. It has more than 2,000 members, and Waite estimated that he receives about 25 new calls a year from physicians facing peer review.



John Beale/Post-Gazette

**From his office in Pittsburgh's Oakland section, attorney John Horthy represents hospitals around the United States in cases involving physicians. "The courts tend to defer to the hospital because most courts just don't want to take the responsibility of what might happen in the institution," he said.**

Another group, The Center for Peer Review Justice, based in Louisiana, offers consulting and other services to physicians who believe they've been subjected to unfair reviews.

The existence of these groups says a lot about the changes that have taken place in American medicine.

It used to be that doctors were the major force in hospitals, said John Blum, of Loyola University of Chicago, who has done extensive research on the hospital-physician relationship.

At one time, Blum said, hospitals operated almost as hotels, providing a place for doctors to treat patients and making sure there were enough medications, equipment, linens, food and other supplies.

"The whole notion, when you look at the origin of American hospitals, has been one of the ... self-governance of the medical staff and the feeling that it was responsible for the quality of medical care," he said.

But once courts began holding hospitals legally responsible for the care provided inside their walls, the shift of power began.

"That expanded the inroad of administration into medical practice. Compounded with market changes, it has really eroded the power of the medical staff and reduced the professional independence of physicians," Blum said. "Now they're like engineers working for large companies."

As their influence and standing have diminished, so has their ability to advocate for patients, many doctors say.

"What people don't understand is that now no one will ever be able to publicly say there's a problem," said Dr. Scott Plantz, an emergency medicine specialist who once surveyed more than 400 colleagues and found that 23 percent had either lost a job, or had their job threatened, after they raised patient care concerns.

"There are not a lot of venues for physicians to come out and speak," added Dr. Mark Murfin who, with a colleague, faced accusations of being disruptive after they went public about their Illinois hospital's uneven quality of care.

Physicians "have fewer rights than almost anyone in a judicial proceeding. Physicians can lose their license based on very little proof, and with inadequate due process," said Andy Schlafly, legal counsel for the American Association of Physicians and Surgeons.

Schlafly's organization has called for changes to ensure doctors can fairly defend themselves, including the right to a public hearing, the right to question their accusers and requiring that hospitals meet a "clear and convincing" burden of proof rather than the more common

"preponderance of evidence."

### **Hospital protections**

The practice of having doctors review the actions of their colleagues has been around for a long time.

But the Health Care Quality Improvement Act of 1986 made a subtle but important change in that process by giving broad legal immunity to hospitals and panels reviewing physicians' performance.

Ironically, that protection was added partly because of a doctor who believed he had been mistreated by a hospital.

Pittsburgh lawyer John Harty, who is nationally known for his work on hospital legal issues, said the immunity provision in the health care act came out of discussions he'd had with former U.S. Rep. Ron Wyden, D-Ore., and later Rep. Henry Waxman, D-Calif., because of lawsuits such as the one brought by Oregon physician Dr. Timothy Patrick to overturn an unfavorable peer review ruling.

Not long after Patrick moved to Astoria, Ore., he declined an offer to join a private clinic and set up his own practice. A short time later, the clinic doctors reported Patrick to the state medical board for an alleged act of poor care. Then, in their roles with the hospital's peer review committee, they tried to revoke his admitting privileges to the only local hospital.

Patrick sued, citing antitrust violations, and a jury awarded him \$2.2 million in damages. The U.S. Court of Appeals reversed that, saying peer review had civil immunity from lawsuits because it was a "state action." But the Supreme Court unanimously backed Patrick, noting the state did not supervise hospital peer review.

Faced with the specter of large numbers of peer review rulings being challenged, and physicians refusing to serve on panels for fear of being sued, the Health Care Quality Improvement Act granted peer review panels immunity as long as they acted "in the reasonable belief that the action was in the furtherance of quality health care."

Harty co-authored that section of the law and he remembers taking extra care to include protections for physicians, to improve its chances of being passed. When Oregon's Wyden introduced the bill, he trumpeted it as legal protection "for doctors who 'blow the whistle' to peer review bodies on colleagues they believe are delivering substandard care."

Now, physicians say, the law is sometimes used against whistleblowers whom hospitals want to silence, and the immunity provisions most of the time protect the hospitals in any later legal action.



## A rare victory

A rare exception occurred two years ago, when psychiatrist Kenneth Clark of Reno, Nev., persuaded a court to overturn a peer review finding that had stripped him of privileges because he was disruptive. Clark had offended his hospital by reporting poor patient care to outside agencies. The hospital argued that it had immunity under the federal law, but the Nevada Supreme Court disagreed.

"To punish a physician for reporting potentially dangerous practices ... cannot logically be construed to be an action that one believes [is] in furtherance of quality health care," the court ruled.

But most physicians who challenge the peer review process in court don't win.

"The courts tend to defer to the hospital because most courts just don't want to take the responsibility of what might happen in the institution," Harty said.

And while the law also refers to adequate notice of a hearing, providing an accused doctor with a list of witnesses and giving the doctor a right to question his accusers, those are suggested standards, not requirements.

Encino physician Mileikowsky, for example, asked for a meeting with the medical executive committee after his suspension. He said the committee kept him outside the hearing room for an hour while it discussed charges that he had "exhibited a pattern of disruptive, threatening and noncooperative behavior." Finally allowed in, he had 30 minutes to rebut accusations he was hearing for the first time.

"The deck is stacked against the physician in so many ways," said Paul Gluck, of the University of Miami School of Medicine, who has researched hospital peer review. "The hospital holds most of the cards because, as a doctor, you've got to make a living, whereas the hospital is going to keep doing business."

Some states, including Pennsylvania, have separate laws that give a physician the right to sue if he can show that a negative peer review was motivated by malicious intent. But the burden of proof is on the doctor, and even those physicians who prevail in court can spend years of their professional lives and hundreds of thousands of dollars trying to get their credentials back.

That's why many who have witnessed the fallout say fighting for patients may be the right thing for physicians to do, but not the wise thing.

If hospitals accuse doctors of causing problems, "it's better for them to say, 'fine' and leave. That's what I advise them," said Plantz, the

emergency medicine specialist.

"If the doctor tries to fight, they're fighting a multimillion-dollar operation against their little dinky business. I've seen 20 doctors fight this, and they've all gone bankrupt."

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## U.S. News

### Doctors who spoke out

Monday, October 27, 2003

All over the nation, physicians who have spoken out about dangerous hospital practices or poor performance by colleagues have been punished. Here are a few examples:

#### Dr. Kenneth Clark, Reno, Nev.

Clark, a psychiatrist, lost admitting privileges at a local hospital, Truckee Meadows, after reporting poor care of patients to outside agencies. Among other things, he said the hospital was discharging mentally ill patients when their insurance ran out, whether they were ready for release or not. He was subjected to intensive questioning by the hospital's peer review panel and ordered to undergo psychiatric tests himself, and his name was then put on the National Practitioner Data Bank for having been involuntarily removed from the staff. Clark sued and eventually won when the Nevada Supreme Court said in 2001 that the hospital did not base his removal on "a reasonable belief that it was in the furtherance of quality health care," as required by federal law.

#### Dr. Silvana Riggio, Philadelphia

Neurologist Riggio was forced out of Medical College of Pennsylvania in Philadelphia after complaining that a fellow neurosurgeon was leaving the operating room and allowing resident physicians to place electrodes directly on the brains of epileptic patients, a comparatively new procedure for treating the disorder. According to a 1998 Superior Court ruling, one of the patients died and another lapsed into a coma. Riggio tried to use the state Whistleblower Act to win her job back, but the court ruled she had not proved the hospital violated regulations in allowing the residents to place the electrodes in the neurosurgeon's absence. She later moved her practice to New York City. The hospital has since changed ownership.

#### Dr. John Rabkin, Portland, Ore.

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Surgeon Rabkin won a \$500,000 jury verdict in 2001 after being removed as director of Oregon Health and Science University's liver transplant program following his report of an unexpectedly high death rate among a colleague's patients. Two years later, he's still fighting to get his job back. When Rabkin raised alarms about the fact that in a seven-month period, six of another surgeon's 11 patients died, the hospital rebuked Rabkin for a "lack of collegiality." After yet another patient died, the other surgeon agreed not to perform any more liver transplants, but the hospital also decided to demote Rabkin. He won damages in his lawsuit over his dismissal, but the judge would not reinstate him, saying it would "cause chaos in the department." Rabkin, who hasn't performed surgery at the hospital in a year, is appealing that ruling. A hospital spokeswoman said she could not comment on the case.

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## U.S. News

### The Cost of Courage: Centre County hospital critics soon unwanted

Tuesday, October 28, 2003

By Steve Twedt, Post-Gazette Staff Writer

STATE COLLEGE -- When anesthesiologist Dr. Danae Powers joined the Centre Community Hospital staff in 1992, she remembers hearing a warning about another anesthesiologist there, Dr. Edward Dench Jr.

"They told me he was a troublemaker."

Dench, who this month completed his one-year term as president of the Pennsylvania Medical Society, said his "troublemaker" label started in 1991 after he informed hospital officials that a fellow anesthesiologist was working three and four surgeries simultaneously, leaving nurse anesthetists in charge as he moved from operating room to operating room. Dench told them the doctor was billing Medicare for all the procedures.

"That put them on record, that if they got caught by Medicare, they had knowledge of it," Dench said.

Within a month, he said, he started getting written up for various infractions and was told he was uncooperative.



**Dr. Danae Powers, an anesthesiologist who was once chief of staff at Centre County Hospital, now works at surgical centers and outpatient clinics. View larger image.** (John Beale, Post-Gazette)

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He further alienated his supervisors when he refused to handle simultaneous surgeries on different floors. To Dench, that was unethical and probably illegal, partly because he would have been billing for procedures where he wasn't always present. The administrator told him, "It won't matter. It would help the schedule work better and you won't get caught."

- **Rules of fair play don't always apply**
- **Doctors who spoke out**

### Day One:

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- **Dispute over treatment of heart patients derails career**
- **Doctors who spoke out**
- **About the team**
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It didn't take long before Powers, too, grew concerned about practices at Centre Community, which is the primary hospital not only for the 38,000 permanent residents of State College, but also for Penn State's 40,000 students.

Powers, who had worked at organ transplant programs in Pittsburgh and Atlanta, had gone to State College because her husband was from the area and they thought it would be an ideal place to raise a family.

But she couldn't ignore the problems she saw at Centre Community.

She spoke to her supervisors at the hospital after noticing that patients were being wheeled into surgery without standard preoperative workups that might alert the surgical staff to problems, or with inaccurate information about their conditions. Nurses also told her some anesthesiologists would go to lunch in the middle of a surgery, leaving responsibility for monitoring the patient to a nurse anesthetist.

Powers said her department chair told her not to worry about it.

"Nothing changed," Powers said.

But Powers did worry -- for her patients and for her own potential liability. In late 1993, she consulted a lawyer about how to respond in case the hospital ever asked her to do something she thought was improper. "He said, 'The Nazi Defense will not work. You cannot say they made me do it. I had no choice. It was my job or else.' "

So she wrote a memo in March 1994 to the hospital board and chief of staff, detailing the problems and dangers of what she deemed sloppy medicine.

### **'Life became miserable'**

After that, she said, "My life became miserable at the hospital. The scheduling became absolutely

unbearable. They started trying to slander me. They started making stuff up about me. I got written up for the first time since I had been there."

Later that year, Powers' fears about poor care were realized when Charles Conrad, 69, of Bellwood, Blair County, died after elective knee surgery at Centre Community.



John Beale/Post-Gazette

**Dr. Danae Powers, an anesthesiologist, criticized patient care at Centre County Hospital.**

To avoid unnecessary bleeding during the operation, a tourniquet had been applied above Conrad's knee. Once the operation was done, the tourniquet was removed, but doctors could not restore blood flow to his leg.

Powers, who was not involved in the original operation, was called to help with emergency surgery on Conrad's deteriorating leg. When she checked his chart, she saw that he had a history of systemic atherosclerosis -- hardening and blocking of his arteries -- that should have precluded use of a tourniquet, and probably the surgery.

Realizing the gravity of his condition, Powers said, she begged the surgeon to transfer Conrad to another hospital that might be better equipped to care for him, but was told he was too sick to move. Later that weekend, Conrad's heart stopped and he died in Centre Community's intensive care unit.

"No one ever feels good about a bad outcome, even if there's nothing that can be done to prevent it. Can you imagine how it feels when you know it didn't have to happen?" She went to her department chief and other administrators, upset. She was again told not to worry.

The hospital, in fact, seemed more concerned with Powers than with correcting the problems she was pointing out.

In May 1995, she received a letter from the hospital president, rebuking her for "derogatory, if not slanderous, remarks relative to other physicians." The next month, she received a critical evaluation, calling her "uncooperative at times" and saying she did not always adhere to medical staff bylaws, rules and regulations.

Asked about Powers and Dench, Robert Martin, Centre Community's longtime outside legal counsel, said: "They were uncooperative." He said hospital officials believed the anesthesiology department had divided into two warring camps, bickering over schedules and refusing to cover for each other.

"It reached a point where there was no question but that the hospital had to go to an exclusive contract, where the contract guaranteed that the physicians would in fact work together." The fact that the new group did not include Dench and Powers, Martin said, is the real reason behind their complaints now.

And he dismisses suggestions that Dench and Powers faced reprisals for pointing out patient care problems.

"Nothing could be further from the truth. We expect all physicians to raise concerns about quality of care," Martin said. "There wasn't a quality of care issue. The issue was an anesthesiology staff where there was no cooperation."

### **Another death**

Months after Conrad's death, though, quality of care became an issue again.

On June 25, 1996, William Curley, 73, the retired director of Penn State's food service and father of Penn State Athletic Director Tim Curley, entered Centre Community for a routine hip replacement.

A day later, he was dead.

A subsequent lawsuit brought by Curley's widow, Florence, revealed that a nurse anesthetist had suggested the surgery be postponed while Curley, a diabetic with heart disease, high blood pressure and unstable angina, was evaluated further. The anesthesiologist refused to delay the operation, and apparently did no preoperative evaluation. In depositions for the civil suit, two colleagues said the doctor "had admitted to them that he did not perform preoperative evaluations because he was not paid for them."

Despite his frail condition, Curley received "the same dosage of anesthesia as would have been provided to a healthy, young male," precipitating his death, according to court documents. The jury awarded Florence Curley \$750,000 against the physician, a judgment later upheld by an appeals court.

After the Curleys learned about Powers' previous criticisms, they also sued the hospital board, noting that she had alerted the hospital that charts were not being read before surgery. The suit was settled for undisclosed terms, but hospital attorney Martin cautioned against reading too much into that.

"We settle a lot of cases. There are a lot of factors that go into that," he said.

Because of the family's prominence, publicity from the Curley case



brought new scrutiny of Centre Community, both from its State College neighbors and state officials.

In July 1997, Centre Community, which is changing its name to Mount Nittany Medical Center, was cited by the Pennsylvania Department of Health for several deficiencies in its anesthesia department.

State inspectors found that patients were not evaluated before or after surgeries, there was no record that outpatients had been told of potential risks of anesthesia, and there was a "lack of established criteria for safe administration of anesthesia."

Martin downplayed the report. "They're always going to find deficiencies. And when a deficiency is noted, it is corrected."

Four months later, though, state inspectors slapped the hospital again "for not actively pursuing" quality improvement in the surgical and obstetrics departments. For a second time, they found that there was no record of pre-anesthesia evaluation, this time for expectant mothers. Eight patients had no record of a post-surgical visit from an anesthetist.

### **Investigating the critic**

The hospital, meanwhile, had launched its own investigation -- of Dr. Danae Powers.

In a Dec. 13, 1996, memo, hospital President Lance Rose told the chief of staff to look into Powers' "disruptive conduct and possible breach of patient confidentiality" because Powers "has raised an issue of quality of patient care in the Anesthesia Department."

Six months later, Rose notified Powers and Dench that Centre Community would be contracting out anesthesia services so "all current anesthesia privileges granted to members of the Anesthesia Department will terminate on Jan. 1, 1998." That included both of them, although Powers said she had been told some arrangement would be made so she could continue there.

That same month, the 150 or so members of Centre Community's medical staff elected Powers, then 39, as chief of staff. "Everybody was hoping Danae could do something," to raise quality, said Dr. John Newkirk, a plastic surgeon there at the time.

As one of her first tasks, Powers appointed obstetrician/gynecologist Dr. Michele Manting-Brewer to head an ad hoc committee "to look into quality mechanisms at the hospital." Manting-Brewer got back to Powers within two weeks.

"She came to me and said, 'Danae, there is not a true quality assurance mechanism going on in any department in this hospital. The one that

comes closest is the ER, and [its system is] really poor. But it's happening nowhere. There's no real review, there's no thoroughness.' "

The hospital, meanwhile, was trying to respond to the sudden critical attention from the state.

In an August 1997 memo to Centre Community's board, Rose told them that a state health official "had been called by four physicians on the hospital's medical staff alleging quality issues and lack of reporting of these issues."

He added: "I felt the board should be aware that members of the medical staff are attempting to negatively impact on the hospital's license to operate."

Powers' final, fateful move came Oct. 8, 1997, when she took her concerns directly to the hospital's board chairman who, she recalled, said little during their 30-minute meeting.

Eight days later, Powers fielded an inquiry from a reporter at the local newspaper, the Centre Daily Times. "He asked me for comment because he had been told by Lance Rose that I was going to be gone as of Jan. 1." Less than five months into her tenure as chief of staff, she was about to lose her hospital privileges.

### **Powers sues**

In December 1997, as Powers prepared to leave Centre Community, she filed suit against the hospital, alleging it had negligently allowed preventable patient deaths. The hospital told the Centre Daily Times that the suit was an attempt to derail the contract with the new anesthesia group. It later settled the suit with Powers for an undisclosed sum.

After some patients canceled elective surgeries at the hospital following publicity about Powers' suit, 98 members of the medical staff, presumably including several who'd voted for Powers to be chief, signed their names to a full-page ad supporting the hospital's quality reviews.

But later that year, state inspectors again criticized Centre Community for its "deficient" quality assurance program, citing the hospital's ineffective process for reporting "any unusual incidents," including unexpected deaths.

Martin said that whatever problems the hospital had before, they've been resolved with the exclusive contract held by a group that includes the anesthesiologist sued by the Curley family. He called it "presumptuous" to interpret Powers' and Dench's exclusion as an act of reprisal.

But the problems haven't gone away. In fact, Centre Community is currently facing a lawsuit from obstetrician Dr. Terrence Babb, who says

the hospital retaliated against him for reporting substandard care that included the deaths of two mothers shortly after they gave birth.

Today, Powers still works in the State College area, primarily at local surgical centers and outpatient clinics. In 2002, she became a member of the state's Patient Safety Authority at the recommendation of Centre County Republican Sen. Jake Corman, who cited her uncompromising commitment to patient care. Corman said he received many calls of protest -- he won't say from whom -- when he proposed Powers for the group.

"That tells me it must be a good appointment," he said.

Dench works independently as well, as far away as Ohio and Maryland. As immediate past president of the 20,166-member Pennsylvania Medical Society, he lobbied for statewide peer review panels so physicians who face peer review can appeal to a body of experts outside their hospital if they believe the process is unfair. He hopes to make that a national campaign.



John Beale/Post-Gazette

**Dr. Edward Dench, Jr., immediate past president of the Pennsylvania Medical Society, now must travel from Ohio to Maryland to find work as an anesthesiologist. He is lobbying for statewide peer review panels so physicians can appeal to a body of experts outside their hospital.**

The discouraging part for Powers is that former colleagues have told her that area hospitals have started including contract clauses that make it harder for physicians to challenge their hospitals over patient care issues and limit the hospitals' liability for patient care problems. She fears that by advocating for better care, she's made it harder for other physicians to speak up.

"A bunch of attorneys got rich, the hospital got a road map" for hospital administrators to deter complaints, "and the doctors who are still there have it worse," Powers concluded.

"If I had it to do over again, I wouldn't."

**Tomorrow:** Frustrating efforts to fix the system

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## U.S. News

### Doctors pay for reporting suspicions

Statistics linked deaths to a single nurse, but hospital officials didn't want to hear about it

Tuesday, October 28, 2003

By Steve Twedt, Post-Gazette Staff Writer

COLUMBIA, Mo. -- That September morning in 1992, acting chief of staff Dr. Edward Adelstein passed along what he thought would be a routine request to colleague Dr. Gordon Christensen.



John Beale/Post-Gazette

**A rash of deaths prompted Dr. Gordon Christensen to push for an inquiry into the activities of a nurse at Harry S. Truman Memorial Veterans Hospital in Columbia, Mo.**

Some nurses on Ward 4 East at Harry S. Truman Memorial Veterans Hospital near the University of Missouri campus had asked Adelstein to investigate the high number of recent emergencies and deaths there. The nurses said a certain nurse seemed to be on duty when nearly all the deaths occurred. Adelstein wanted Christensen, the hospital's epidemiologist and the associate chief of staff for research and development, to review the data.

"I really was convinced there wasn't anything there," Adelstein said.

In less than a week, Christensen and researcher Andy Simpson had completed a study that mapped every death on 4 East against the whereabouts of every nurse -- up to 60 in all -- during the previous year, using work records, nursing notes and patients' charts. Christensen assigned a code name for each nurse to avoid bias. He knew that proving anything would be difficult.

"You have to understand, none of these were people who died with a



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knife in their chest. They were just people who died." But the data nearly leaped off Christensen's computer screen. One particular nurse, dubbed Nurse H, was on duty when 45 of the 55 deaths occurred on 4 East between March 8 and Aug. 22.

On average, one patient under Nurse H's care died for every three of his overnight shifts. For three of Nurse H's shifts, more than one patient died, the only nurse who had that occur. A later reanalysis by the VA's Office of Healthcare Inspections confirmed the findings, and that reanalysis was validated by a Penn State biostatistician.

According to Christensen, the statistical probability of that happening by chance was less than 1 in 1,000,000,000,000,000,000,000.

"It doesn't get any more abnormal than that," he said. The two went to the hospital director, Joseph Kurzejeski, and urged him to call the police.

What happened next took them by surprise.

A few days later, Christensen was told he could not present his data to an internal investigating board. During the ensuing months, he was told not to contact law enforcement officers and was warned that his analysis was considered part of the hospital's "quality assurance," which had to be kept private.

When he later reported the nurse to the state licensing board, he was threatened with sanctions for violating hospital confidentiality.

After years of "outstanding" work performance evaluations, Christensen, 55, ultimately found himself before a national VA panel investigating him for poor management of his department. "They were trying to discredit me," Christensen said.

### Lost research grants

Others saw their professional lives take a downward turn, too.

Researcher Simpson, 54, a 15-year VA veteran with a doctorate in microbiology, failed to get renewal of three separate grants in the next three years. In 1995, with no money to support his research, Simpson was let go.

In 1995, Christensen was forced to give up his position as chief of infectious diseases and was excluded from planning and management task forces. His



John Beale/Post-Gazette

**Hospital researcher Andy Simpson, left, helped Dr. Gordon Christensen, right, correlate death rates to nurses at Harry S. Truman Memorial Veterans Hospital.**

appointment to the VA's Disciplinary Appeals Board was blocked at the last minute, without explanation.

"We're simply not players here," said Adelstein, 63, an assistant professor of pathology and chief of laboratories at Truman.

The chief of staff, Dr. Earl Dick, also believed homicides had occurred and, when he pushed the issue, "Mr. Kurzejeski's relationship with me rapidly deteriorated as he became increasingly sarcastic and demeaning," he said later.

The next year, Dick was told he'd been rated "unacceptable" in his job evaluation. Dick was relieved of his duties in 1994.

No one may ever know if the patients at Harry S. Truman Hospital were murdered.

Nearly a year after the deaths, 13 bodies were exhumed, but after so much time, the FBI could not determine with certainty that murders had occurred. Because the deaths were originally listed as being due to natural causes, no autopsies were done.

In 1998, the widow of one patient, Elzie Havrum, won a \$450,000 judgment against the VA in federal court after the judge found, based largely on Christensen's analysis, that the hospital negligently failed to protect patients from the nurse, identified as Richard A. Williams. Two years later, the U.S. 8th Circuit Court of Appeals upheld the decision.

That ruling helped renew interest in the deaths. After more tests, officials found evidence of a paralyzing drug in the exhumed patients' bodies and Williams was arrested.

But two months ago, homicide charges against Williams, 37, were suddenly dropped after Boone County Prosecuting Attorney Kevin Crane said the tissue testing was flawed and could not be used to prosecute him. Crane added that the VA "continues to consider this case under investigation."

After spending a year in jail, Williams is now a free man.

Williams, who has denied any role in the deaths, declined to be interviewed, but his public defender, lawyer Don Catlett, said his client did not hold a current license and was not interested in going back to nursing.

Christensen remains convinced the deaths were the work of a serial murderer, but said "so many things about this have been screwed up, no one may be held accountable for these deaths."

Christensen can't help but wonder if the result would have been different if the VA system had looked into the deaths more rigorously, instead of reacting defensively.

### **Told to stay quiet**

After he made an initial call to the VA inspector general's office, hospital officials told him to have no further contact with the inspector general or the FBI. Later, when Williams went to work for a local nursing home, Christensen was threatened with punishment for contacting the state nursing board.

Not long after that, a new hospital director asked a national panel to come in and review Christensen's performance and, in June 1997, it recommended Christensen's removal, citing "concerns about [his] leadership and management skills."

While the hospital never followed through on the recommendation to dismiss him, Christensen still felt persecuted. "I am convinced the VA intended not just to eliminate an inconvenient employee, but to destroy the credibility of my accusations by destroying my professional credibility," he said.

A strong sign of that, he felt, was the fact that his job evaluations gave him consistently high marks for competence and leadership until 1993, the year after he had reported information on the patient deaths. Even then, he was downgraded only on administration, not his clinical abilities. As he persisted in pushing for further investigation into the deaths, his job evaluations continued to decline, and in 1996, he received an overall "unsatisfactory" rating.

Kurzejeski, who retired in 1994, did not return phone messages left at his home in recent weeks. In a 1997 affidavit, he said he was not trying to interfere with the investigations but wanted Christensen "to essentially stop pursuing those efforts and to work at his officially assigned duties as a VA researcher."

Christensen believed that stopping a possible serial murderer took precedence over those duties, and he believes he paid a high price for following his beliefs.

Adelstein felt the hospital's wrath, too.

One month after testifying on behalf of Elzie Havrum's family in its civil suit against the VA, Adelstein was accused of improper removal of a drug used to euthanize pets, an incident that had happened two years earlier.

Adelstein, trained as a veterinarian, said he used a small





John Beale/Post-Gazette

**Dr. Edward Adelstein, former acting chief of staff at Harry S. Truman Memorial Veterans Hospital, asked epidemiologist Dr. Gordon Christensen to conduct what was thought to be a routine investigation correlating death rates and nurses.**

done our job,' " Adelstein said.

Even when hospital administrators began questioning their findings, "we just thought they didn't understand, [and] that when they did understand, of course they would do the right thing."

Instead, their careers were thwarted. "The stress of 11 years of this -- the wear and tear, the whole attack to your character -- it's just beyond imagination," Christensen said.

At the end of July, Christensen decided to retire from the VA after 21 years, "in large part because of this," he said. He'd stayed as long as he did "because I wanted to leave with dignity." For personal reasons, neither Christensen nor Adelstein left Columbia, where both have appointments at the University of Missouri's medical school and where Adelstein is deputy medical examiner for Boone County. Nor did they pursue legal redress, believing it would be too lengthy and costly.

But the ordeal apparently has not hurt Christensen's standing with his colleagues; he has been elected president of the University of Missouri's faculty senate.

Said Christensen with a smile: "People thought I would stand up and say some things."

### **The Cost of Courage: Day Three**

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(Steve Twedt can be reached at [stwedt@post-gazette.com](mailto:stwedt@post-gazette.com) or 412-263-1963.)

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## U.S. News

### Doctors who spoke out

Tuesday, October 28, 2003

*All over the nation, physicians who have spoken out about dangerous hospital practices or poor performance by colleagues have been punished. Here are a few examples.*

#### Dr. Gregory Flynn, Sarasota, Fla.

Flynn, a board-certified anesthesiologist and specialist in treating pain, had worked at Sarasota Memorial public hospital for six years in 1994 when his admitting privileges were suspended and later revoked, despite a medical executive committee vote to reinstate him. The actions came after Flynn criticized the hospital for poor training of staff, unsafe conditions, lack of supplies and other problems. When Flynn sued the hospital, a jury awarded him \$8.6 million in May 1999, an amount later reduced to \$6.5 million in a settlement agreement. A hospital attorney says it disagrees with the verdict.

#### Drs. Morton Burrell, Arthur Rosenfield and Robert C. Smith, New Haven, Conn.

The three radiologists at Yale-New Haven Medical Center protested a new department chief's policies which they said had "the potential to cause serious harm to patients." Their accusations included understaffing, having untrained staff read X-rays, and rushing diagnostic reports at the expense of accuracy. Over the next two years, Smith's and Burrell's salaries were cut, and Smith was cited for his "reluctance to cooperate in the evolutionary process of change." The three now have a lawsuit pending against the university, which "disagrees completely with their characterization of events," a Yale spokeswoman said.

#### Dr. Kyle Bressler, Naples, Fla.

Bressler, an ear, nose and throat specialist, reached a settlement in July with Naples Medical Center in his \$3 million whistleblower lawsuit for what he said was retaliation against him. Bressler had complained about

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errors in the hospital laboratory and he reported that nasal scopes were not being properly sterilized before reuse, even though they were sometimes used with AIDS patients. When patients were not notified, Bressler told state authorities. In response, the center, which is owned and operated by a group of about 20 physicians, doubled Bressler's overhead expenses and he stopped getting referrals. Naples Medical fired Bressler in the spring of 2002, prompting his lawsuit. "It's all lies. That's my only comment," hospital administrator Richard Estes said.

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## U.S. News

### The Cost of Courage: Doctor says whistleblowers need more protection

Wednesday, October 29, 2003

By Steve Twedt, Post-Gazette Staff Writer

HARRISBURG -- One year ago this month, Dr. Edward H. Dench Jr. addressed fellow members of the Pennsylvania Medical Society as their new president, the first ever from Centre County.

Invoking a theme of advocating for patients, Dench's top recommendation may have surprised his audience: Adopt a statewide peer review system for evaluating physicians involved in disputes with their hospitals.

Fixing peer review, the process in which groups of doctors evaluate their colleagues to improve care, has been a five-year battle for Dench, 58, a battle the anesthesiologist now concedes he may lose.

Like other critics, Dench thinks that hospital-based peer review panels too often are biased in favor of hospital administrators or certain powerful physicians who use their authority to punish doctors who speak up about patient care concerns. Creating a statewide group not attached to a particular hospital would go a long way toward making that system



(John Beale, Post-Gazette)

**After fighting five years for a statewide panel to review physician-hospital disputes, Dr. Edward Dench Jr. fears his proposal may "never see the light of day."**

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fairer, he believes.

The fruit of Dench's labors, House Bill 1270, introduced by Centre County State Rep. Kerry Benninghoff, calls for a nine-member statewide panel, including at least one consumer member, and its decisions would be binding on both the physician and the hospital.

But the bill has remained mired in committee for months with little sign that it will ever move out. The bill has faced opposition from the Hospital and Healthsystem Association of Pennsylvania and, Dench suspects, some in his own medical association who fear outsiders evaluating their work.

Promised legislative hearings this summer never materialized.

By the time Dench appeared before the state Senate Judiciary Committee last month, his hopes for statewide peer review had been reduced to one small paragraph of testimony in a hearing otherwise devoted to Pennsylvania's malpractice insurance crisis.

"I'm concerned," he said, "that peer review will never see the light of day."

In Dench's view, hospital peer review in its current form manifests the worst of two worlds: "It is being used to protect people who are bad, and it's being used against people who are good. It protects the doctor who has a good economic income for the hospital and it targets the whistleblower."

### **Disruptive doctors targeted**

Dench's conclusion is supported by a 2001 University of Baltimore study ordered by the Maryland General Assembly on credentialing, the process of granting hospital admitting privileges to a doctor.

The report found that whistleblower physicians who alienate hospital officials are vulnerable to having their admitting privileges taken away, with devastating effects on their practices.

Because the federal Health Care Quality Improvement Act protects peer review panels if they are sued, it also can have the effect of protecting a

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malicious peer-review group motivated by spite, prejudice or a desire to cripple a competitor's practice, the authors said.

"There must be a method for distinguishing the truly disruptive physicians from physicians who express themselves in a fashion that does not affect quality of care but may not be to the liking of peer-review participants."

The University of Baltimore researchers recommended creation of a statewide Physician Administrative Review Board for physicians, similar to what Dench proposes for Pennsylvania. Like Dench's plan, though, the idea has gone nowhere.

A handful of states and the District of Columbia allow limited judicial review when physicians lose their credentials, and Colorado has a committee that can review cases in which a doctor believes he's been unfairly targeted by competitors.

In New York, a health council whose members are appointed by the governor reviews hospital decisions and can overrule them.

Dench's plan would establish an independent council which would be composed of four physicians, two hospital representatives, two patient advocates and the consumer representative. A confidential review could be requested by a hospital, a physician or a patient. For questions about quality of care, a peer review committee of physicians with subpoena power would issue binding decisions.

If the committee decided a physician had provided substandard care, that information would be forwarded to the state medical board. If it decided that a hospital had erred in disciplining a doctor, Dench said, the physician should have his credentials restored.

Besides providing a more objective decision on quality of care disputes, Dench believes, statewide review would have another key benefit -- as a vehicle for physicians to learn from each other's mistakes.

"Peer review is how we prevent and correct judgment errors in a profession," Dench told his fellow physicians at the medical society meeting last year. "Unfortunately, due to influences caused by the business of medicine and competition among physicians and between hospitals, local peer review is becoming increasingly ineffective."

He's made a believer of Benninghoff, a Republican and a former Centre County coroner who once worked as a hospital orderly.

Benninghoff, who still hopes hearings will be scheduled later this fall, said it had been difficult to get the public and fellow legislators to understand the implications of what is happening.

"We think there are times when witch hunts occur, where you get physicians to speak up on a medical issue, then all of a sudden, the table gets turned and they're the bad guy," he said.

"This is not isolated to one kind of hospital. I've heard of multiple incidents of this occurring."

Hospital officials have told Benninghoff they oppose his bill in its present form.

Dench "is assuming his colleagues, other physicians, are not capable of making independent decisions. In many respects, isn't it better to have control at a local level than from afar?" asked Jim Redmond, senior vice president for legislative services for the hospital group.

"I would maintain that if a particular physician ... or hospital employee felt they were being categorized as being disruptive, and they feared losing their job or position, that they can contact the state Department of Health, or ask the Joint Commission [on Accreditation of Healthcare Organizations] to come in and investigate.

"The process we've got isn't perfect all the time, but no way does the process [Dench] supports represent a better process," Redmond said.

Although his term as medical society president is over, Dench vows to continue fighting for a statewide panel. "I really do believe one person can make a difference, and that belief has led me to fight battles that seemed to be impossible."

After 13 years at Centre Community Hospital in State College, Dench and others found themselves out of work in 1998 after the hospital, citing a lack of cooperation among its anesthesiologists, contracted out its anesthesia services. That lack of cooperation, Dench says, stemmed from serious patient care concerns he and fellow anesthesiologist Dr. Danae Powers dared to point out and document, resulting in criticism directed at them.

"Their philosophy is, you get rid of the problem if you get rid of the person pointing it out."

Dench's interest in politics goes back to his undergraduate days at Penn State, where he headed an off-campus organization pushing for enforcement of fire codes in apartments. He also chaired the Reagan-Bush Election Committee in Lehigh County in 1980.

He intends to use some of that experience to continue his fight for a statewide panel. "I just can't see how anybody can argue against an unbiased system."

American Medical Association leaders have told Dench they're



interested in his idea but they are "basically waiting for me to prove that it works," he said. "The only chance we have is Pennsylvania and, if Pennsylvania shows it's good, I think it will be taken [up] nationally."

Given his uphill political challenge, however, it's not at all certain that Dench will get the chance to show the system could be effective.

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## U.S. News

### Law gives hospital panels wide powers over doctors

Wednesday, October 29, 2003

By Steve Twedt, Post-Gazette Staff Writer

WASHINGTON, D.C. -- It may take an act of Congress. That's the conclusion of attorneys Alan Ullberg and Paul Blumenthal after their client, Dr. Linda Freilich, unsuccessfully challenged the constitutionality of the Health Care Quality Improvement Act last year.



John Beale/Post-Gazette

**Attorneys Alan Ullberg, left, and Paul S. Blumenthal in Annapolis.**

They had hoped to convince the court that the federal law unfairly allows hospitals to silence whistleblower physicians by giving the hospitals broad protection against lawsuits. They believe their client represents a prime example of just that.

Freilich, a board-certified internist and kidney specialist, lost her privileges at a Maryland hospital after she complained about changes she believed had lowered the quality of care. When the hospital decided not to reappoint her, she sued -- and lost.

The 4th U.S. Circuit Court of Appeals, upholding an earlier trial court ruling, said the law made it clear that it wasn't the judiciary's job to interfere with hospital decisions on how to spend money or on which physicians to employ.

"The medical community is best equipped to conduct the balancing that medical resource allocations inevitably require," the court ruled in December.



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"It is not the job of a federal court ... to referee disagreements between a hospital and staff physician over what constitutes the appropriate funding or manner of such care."

On Freilich's contention that the hospital was retaliating against her by denying her reappointment, the court said: "Hospitals have historically had wide discretion to make decisions regarding their medical staff," including "the consideration of factors beyond technical medical skills."

Now, the two lawyers believe nothing short of congressional intervention will protect physicians such as Freilich who are trying to protect their patients.

"There is no recourse without further legislation" Blumenthal said.

"They don't have to undo [the act]. All they have to do is go back to the original intent," said Ullberg. "I don't think the original intent was to protect bad faith credentialing."

As it stands now, he added, "[The Health Care Quality Improvement Act] prevents doctors from actually trying to improve the medical system in which they work, even though they are the best people to improve the system."

The Freilich case marked the first direct attack on the law in federal court. The problem with the law, from their perspective, is that it presumes that hospital review panels will make good-faith decisions based on a fair and reasonable process.

But too often, Ullberg said, the 1986 law is being used to silence physicians who complain about poor quality care by labeling them "disruptive" and subjecting them to career-crippling sanctions.

The immunity clauses were included in the law because physicians had been reluctant to serve on review panels for fear of being sued if, for instance, they tried to dismiss a doctor who was harming patients. The unintended effect, Ullberg said, is that the hospital-appointed panels now can unfairly target physicians without being held accountable.

That turns the intent of the law on its head, he said. "The whole system is set up and is operating to discourage complaints about quality of care."

Freilich, 52, treated patients at Harford Memorial Hospital in Maryland's Upper Chesapeake area from 1982 until 2000.

After Harford decided to contract out its quality assurance services, Freilich became alarmed at the growing instances of poor care, including the use of uncertified nurse assistants. In one case, a patient's cervical fracture went undetected. Another time, one of Freilich's patients was

given dialysis without her knowledge and the patient nearly died, Freilich said.

She was particularly vocal about uninsured and disabled patients receiving less care than other patients.

But her advocacy did not sit well with Harford administrators.

When Freilich applied for the standard two-year renewal of her credentials in 1998, the hospital balked, agreeing only to a one-year renewal.

In April 2000, the hospital board, even though it did not question her clinical competence, said it would not reappoint her. The denial of privileges "was based upon your failure to demonstrate ethical and cooperative behavior with regard to your position in the hospital and patient care," according to a letter Freilich later received from the Maryland Department of Health and Mental Hygiene.

The state launched its own investigation of Freilich. Four months later, she was cleared.

But by then, the hospital had submitted a report on her to the National Practitioner Data Bank, a list that is kept to identify doctors with malpractice judgments or who have lost their hospital privileges because of misconduct. Freilich's listing flagged her as a problem physician to any future employer. She has not worked in her home county since and has struggled to keep her practice alive.

After Freilich filed suit in December 2000, the hospital's attorneys countered that if she were successful, "all disruptive, yet clinically competent, physicians would have been insulated from peer review in Maryland hospitals."

"What grabbed my attention," said Ullberg, 70, "was that she is a good practitioner and yet the system was beating up on her."

Although Freilich is still pursuing a lawsuit in state court, Ullberg believes the chances of any successful legal challenge to the law "are probably low." That's bad news for Freilich and other physicians like her, Ullberg said, but it's also bad news for patients.

With reimbursements falling short of costs, hospitals will continue to face financial pressure to lower expenses, he believes, and eventually that will mean lowering the acceptable minimum standard of care.

If a doctor notices this, he might not speak up under the present law, Ullberg said, because if he is threatened with the loss of his credentials "he can't afford to care if a patient lives or dies."

## The Cost of Courage: Day Four

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## U.S. News

### Doctors who spoke out

Wednesday, October 29, 2003

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#### Dr. Jerome Finkelstein, New York City

Finkelstein, a burn specialist at New York Hospital-Cornell Medical Center, began noticing in 1994 that a colleague was acting oddly. The other burn specialist blamed the death of three firefighters on nurses who wanted "to make him look bad," accused a secretary of having Mafia connections and confronted Finkelstein for "taking part in a conspiracy to interfere with [his] impending marriage." When Finkelstein reported the behavior, the hospital terminated his and the other doctor's faculty positions "because of the continued personal issues" between the two. Finkelstein also was transferred to a smaller hospital with no burn unit, and his salary was halved. He filed a suit over the actions, but in 2002 withdrew it. He is now director of the Staten Island University Hospital burn center.

#### Drs. Mark Murfin and Bruce Frank, Centralia, Ill.

Murfin and Frank were suspended at St. Mary's Hospital in 1994 for "disruptive behavior" after going public about what they described as the hospital's inadequate quality controls and the fact that Medicare patients were being hospitalized 60 percent longer than national average. Murfin eventually got his position back; Frank had to leave town after his patient referrals dropped 70 percent. Hospital spokeswoman Julie Long declined comment, noting that the hospital now has different leadership.

#### Dr. David Shaller, Wilkes-Barre, Pa.

Shaller, 52, was fired from the Veterans Affairs Medical Center at Wilkes-Barre after trying to expose poor patient care, and his legal attempts to regain his position continue 13 years later. Shaller, chief of rheumatology and chief physician for the hospital's nursing home care unit, complained in 1988 when his hospital began transferring seriously ill patients from the facility's hospital to an adjacent nursing home. A hospital committee, which included the physician who ordered the



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patient transfers, decided Shaller's complaint had no validity. Afterward, he was transferred to lower level jobs, threatened with a sexual misconduct charge and eventually fired after he had complained about patient care to the VA inspector general's office. A congressional subcommittee looking at VA medical care later cited Shaller as one example of how "honest employees have had their jobs eliminated and their lives destroyed because they attempted to expose poor patient care." He has filed several lawsuits trying to get his job back, but has not been able to get a hearing on them.

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## Editorial: The hospital canker

### Lawmakers need to protect physician whistleblowers

Monday, November 03, 2003

For many years, a fundamental principle for physicians has been popularly understood as: "First, do no harm." These words are not in the ancient Hippocratic Oath, but they have been handed down as a rough but sensible synopsis.

As it happens, fealty to the original wording is pointless, because across the nation some hospitals have reworked this noble idea. Too often for physicians who see harm being done, the operating principle is today: "First, make no waves."

A sea of misery engulfs doctors who dare to make waves in the name of medical ethics. What is more, this scandalous situation has barely registered with most Americans, the very ones who stand in jeopardy.

That is why last week's report by Post-Gazette Staff Writer Steve Twedt came with the force of a shocking thunderclap.

His four-part series, "**The Cost of Courage**," was the result of a 10-month investigation. In case after case, he found doctors being punished for warning hospital authorities about unsafe conditions or poor performance by other doctors. Whistleblowers too often find the whistle blown on them.

And what is the cost of their courage? As Mr. Twedt discovered, the cost can be counted in ruined careers. Physicians seen as troublemakers can find themselves listed on the National Practitioner Data Bank, which is supposed to be a resource for hospitals to help ensure that bad doctors don't move from one place to another.

Instead, it has also served as a career-ending blacklist for good doctors whose main offense was to speak out about bad situations. As the series reported, those targeted as troublemakers were not just marginal physicians. The ranks of the persecuted include "the best of the best: chiefs of staff, board-certified specialists, highly regarded transplant





surgeons and the president of the Pennsylvania Medical Society."

The bureaucratic self-defense reflex of hospital authorities is as strong as it is alarming.

In one case, a doctor working for a veterans hospital noticed that one nurse was present when 45 of 55 patients died, a huge statistical incongruity. But the nurse was not the focus of official concern. Instead, the doctor and chief of staff who supported him found themselves in disfavor for having the temerity to warn about a possible serial murderer (the nurse was later arrested but the homicide charges were dropped because proper testing wasn't done at the time).

As the series noted, even when state or federal investigations subsequently prove the whistleblowers right, the damage to their careers has been done. The law is heavily stacked in favor of hospitals, and once a doctor's name appears in the data bank only the hospital can remove it.

How can such injustices occur? Although many fine hospitals are untouched, it seems that in some institutions the corrupt values that have blighted corporate America have leaked into the business of medicine. A narrow self-interest rules. America has come a long way from the days when doctors effectively ran hospitals and HMO was not a term known in the language.

The debate about caps on malpractice damages also looms over what is happening, but not as an opportunity for trial lawyers to make their familiar point that the persistence of medical errors is the real problem. Actually, the moral is the reverse: Many hospitals are clearly terrified of lawsuits and perceive doctors who speak out as giving aid and comfort to litigants.

This is wrong as a matter of morality, wrong as a matter of social policy. Still, as quietly as the issue has festered, state Rep. Kerry Benninghoff, a Republican from Centre County, has introduced a bill that envisages an independent statewide review panel to judge doctors whose competency or behavior has been questioned. Another lawmaker, Rep. Camille "Bud" George, a Democrat from Clearfield County, is proposing to expand the state's whistleblower law to offer more protection to health-care workers. Both efforts deserve support.

But the real remedy must come from Congress. After all, this is a national problem. While only a small minority of hospitals may be affected, the relatively few injustices are gross enough to be subversive of the overall efficiency of the health-care system.

The first order of business should be to revisit the Health Care Quality Improvement Act of 1986. Passed with the best intentions, it gave too much discretion and protection to hospital-based review panels which have too often demonstrated a tendency to shoot the physician-

messenger of bad tidings. Anyone who doubts this should reread the exhaustive documentation of cases cited in the "Cost of Courage."

Ordinary people who enter the hospital certainly expect that their doctors will do them no harm. But, with simple trust, they also expect that their doctors will intervene if they are not getting the best care in the system.

That is the disgrace at the heart of the Post-Gazette series. The trust of patients is being abused. The weight of the law and hospital administration are all against doctors who speak out in good conscience. It's time for Congress to make its own waves to set this right.

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