

Vote NO to secrecy, vote NO on HB 416

1. We have no objection to quality assurance, peer review - it is a good idea, it should be continued, and there should be guidelines/requirements for peer review.

2. MTLA opposed the 2001 amendments to the peer review statute, because we feared that the statute would go beyond the purpose of quality assurance and be used to 'hide the ball' - bring **facts** of the incident being reviewed under the protective umbrella of 'peer review.'

3. That fear has been realized since 2001 - and HB 310 would extend that protection to all medical care, except the sole practitioner.

4. We are not talking about discovering the findings, recommendations, analysis, etc of the peer review committee. We do not want just go on a fishing expedition for all the committee's records

5. We are talking about discovering **facts** that the peer review committee may review and or include in their report.

6. These are **facts** that are not contained in the medical records or incident reports.

7. We know there are such **facts** because when we depose health care providers about an incident the **facts** they remember are different than the facts in the record, and differ between the providers involved.

It is almost impossible to provide clear, cogent examples of facts hidden by the peer review process because we almost never get to see them. The objection is made to disclosing the information, we file a motion, it goes into the black hole, the case moves on and is usually resolved before there is a show down on the motion.

Recent case is an example of this. There are at least 4 different stories about what happened to the plaintiff's wife when she died in the Stevensville Clinic. One in the medical records, and three others from the deposition testimony of doctors and nurses. All differ substantially. The defendant admits that it conducted a "root cause analysis" investigation. Because 50-16-201 doesn't shield "incident reports or occurrence reports," those things have ceased to exist. They now travel under different identities, such as "root cause analyses." In this case, the defendant admits that facts about this lady's death were documented in the investigation file. Those facts were never revealed.

Facts about what happens to patients should never be secret from them or their survivors:

Opinions about the facts, and steps taken to address problems those facts reveal, are, legitimate subjects for peer review protection.

However, every statute granting peer review protection should expressly state that patients have an absolute right to obtain all facts about their condition, and all care provided to them, regardless of where that information resides. Peer review should never be used to shield this information from patients or their survivors.

If a peer review investigation turns up facts not contained in the medical records, the patient should have access to them. I suggest adding the following to this proposed statute, and all others of its ilk.

Amendment

"Facts about a patient, and all medical care provided to, or withheld from, him or her are healthcare information to which the patient must be granted access, except in the circumstances described in 50-16-542 (1)(a-c) or (e-g)."

In the airline industry, if a pilot so much as accidentally makes a wrong turn moving away from the gate, anywhere in the world, the event is instantly recorded in global databases and scrutinized by government agencies and the industry itself. **The knowledge gained from this continuous process leads to big and little changes in aviation protocol, equipment, and personnel. As a result, there was not a single airline fatality anywhere in the developed world last year.**

The quality assurance reviews done in aviation investigations contain opinions and facts: opinions are not admissible, but the FACTS are admissible.

In health care, by contrast, patient safety experts often remark that the death toll from medical errors in U.S. hospitals is equivalent to three jumbo jets falling out of the sky and killing all the passengers on board every forty-eight hours. But even the most egregious errors go largely unreported, and when they are reported, they are often buried and ignored. For the most part, all the public gets to hear about are industry-wide estimates and statistical averages.

#1

Doctors X, Y & Z are in an orthopaedic group. Dr. X has a substance abuse problem. He performs a surgical procedure on patient while under the influence of a powerful pain killer. He is adept at covering his use, and no one in the OR knows that he is under the influence. There are complications and patient A loses the use of her leg.

Doctors Y & Z know of Dr. X's substance abuse problem, and they have accepted his assurances that he wasn't currently using. After the botched surgery, Dr. X apologizes to doctors Y & Z, tells them he was under the influence when he operated, is so sorry for having botched the surgery and hurting the patient. Doctors Y & Z tell Dr. X that they have had enough, Dr. X will have to find another position, preferably in another city or state.

Current law:

Patient's attorney deposes doctors X, Y & Z, they truthfully testify that Dr. X was under the influence when he performed the surgery.

Under HB 416:

After patient's surgery, doctors X, Y & Z have a quality assurance "incident review". They discuss the botched surgery, Dr. X apologizes to doctors Y & Z, tells them he was under the influence when he operated, is so sorry for having botched the surgery and hurting patient. Doctors Y & Z tell Dr. X that they have had enough, Dr. X will have to find another position, preferably in another city or state.

Patient's attorney deposes doctors X, Y & Z and asks each - "To your knowledge was there anything about Dr. X's condition on the day he operated that may have affected his abilities?"

Each time the question is asked the attorney for Dr. X objects, "Objection, this question seeks information that is confidential and non-discoverable under Section 53-16-205 and Section 4 of HB 416. Do not answer the question doctor."

Patient's attorney asks each doctor - "To your knowledge was Dr. X under the influence of drugs when he operated on patient?"

The attorney for Dr. X objects, "Objection, this question seeks information that is confidential and non-discoverable under Section 53-16-205 and Section 4 of HB 416. Do not answer the question doctor."

Every subsequent question is met with "Objection, this question seeks information that is confidential and non-discoverable under Section 53-16-205 and Section 4 of HB 416. Do not answer the question doctor."

Please join the coalition of Doctors and Citizens for Ethics, Safety and Quality in Medicine



THE HEALTH INTEGRITY PROJECT WEDNESDAY, MAY 18, 3:00- 4:15 PM

Washington, DC

Main Congress Building, Room HC8

UNETHICAL BIG MEDICINE PEER REVIEWS GAG DOCTORS. DUE PROCESS SAVES LIVES AND BILLIONS OF DOLLARS.

"Of all the forms of inequality, injustice in health care is the most shocking and most inhumane." --The Reverend Martin Luther King, Jr. (1966).

AT STAKE: Billions of dollars and thousands of deaths documented

Ethical Medical decisions undermined by Bad Faith Peer Review (BFPR)

All over America today, Doctors' careers are being ended unfairly by colleagues and hospital administrators using Bad Faith Peer Review (BFPR). Under the guise of immunity provided to it by the Health Care Quality Improvement Act of 1986, Big Medicine uses BFPR to stifle competition and silence whistleblower doctors who push for high quality healthcare. This decreases quality and increases cost. HMOs, hospital owners, administrators, and physicians who sold their souls to them are the main culprits and benefitters. Everyone agrees that Doctors should be able to make independent decisions, yet that is not the case since Doctors are constantly threatened by the sword of BFPR. Most Peer Reviews of physicians have nothing to do with actual merit and are performed with bad faith. Thousands of cases have been documented, and this is now a more pressing issue than the malpractice crisis. Is the Hippocratic Oath dead? Does your Doctor work for you? Please attend our Forum; the answers are going to surprise you.

THE COALITION FOR HEALTH INTEGRITY

Several Republican and Democratic members of Congress - Government Accountability Project - Semmelweis Society International - Taxpayers Against Fraud - Congressional Black Caucus - Gandhi Institute for Nonviolence - Ethics in Government Group - Health Integrity Project - The American Medical Students Association - The Center for Peer Review Justice - The American Association of Physicians and Surgeons - National Medical Association Council on Clinical Practice - The American Association of University Professors - National Alliance Against Racists and Political Oppression - Concerned Black Clergy of Atlanta - Integrity International - Grady Trustee William Loughrey - Former Congressman Bob Barr - Bioethicist Art Caplan - Patch Adams - Henry Scammell, author of "Giantkillers" - Common Cause - Larry Poliner, MD - recently awarded \$366 million by a Dallas federal jury for BFPR.

PROGRAM AND SPEAKERS

SENATE KEYNOTE SPEAKER (to be announced)

- 1) Dr. Bill Hinnant - President of Semmelweis Society International
- 2) Dr. Don Soeken - President of Integrity International
- 3) Dr. Jeffrey Wigand - "The Insider"
- 4) Tom Devine - Government Accountability Project
- 5) Ron Marshall - The Grady Coalition
- 6) Dr. James Tate - National Medical Association
- 7) Dr. George Holmes - American Association of University Professors

Peer review is part of a system intended to protect patients. If this has been warped, patients are at risk. We ask to improve medicine without spending a dime. That is hard to beat with a stick.

More information can be found at <http://www.semmelweis.org/> and <http://www.semmelweissociety.net>

SEMMELOWEIS SOCIETY MISSION STATEMENT

The mission of the Semmelweis Society is to improve the quality of medical care in the United States through assisting physicians who have been subjected to malicious and improper (sham) peer-review. In many cases, these physicians are not only the most talented but the most concerned with quality patient care. Proper peer review is an essential system intended to protect patients. If peer review is conducted in bad faith, patients and the public at large are defrauded and left defenseless. Many documented cases of bad faith peer review have been shown to greatly harm the public interest. The Semmelweis Society was formed to alert the public, the health care environment, professional societies, academic institutions, government elected officers and Congress, to the enormous threat that bad faith peer review poses. Semmelweis uses the media, professional societies, government, and legal initiatives to end bad-faith peer review and support integrity.

VISION

Semmelweis Society supports cost-effective strategies to support integrity, high standards and credibility in medicine. Semmelweis Society is a concerned group of doctors, lawyers and other professionals that is growing rapidly and partnering with other public interest groups and professional societies that demand integrity and support due process for doctors.

Key Evidence: Peer review initiated for Economic retaliation >70% of time.

In the book "Health care crisis-the search for answers", by John H. Fielder, Ph D, edited by Bruce Jennings, MA, David Orentlicher, MD, JD, and Marvin Dewar, MD, JD., Fielder estimated, in the chapter entitled "Abusive peer review, health care reform", that peer review was initiated for economic reasons as much as 70% of the time. He felt the hospital bylaws are fatally deficient in due process and fail to protect doctors who are falsely accused. Hospitals are not democratic institutions and it is difficult many times to improve quality without frequently confronting entrenched political and financial interests and putting your career in jeopardy.

Other sources place the rate of retaliatory peer review as much higher. Attorney Kevin J. Mirch of Nevada places the rate of bogus peer review at higher than 90%. Evidence compiled by multiple attorneys in the Poliner case agrees that the level of bogus peer review is in that range.

Doctors and lawyers who work in this area are impressed that the rate of wrongful bad faith peer review is very high, regardless of exactly how high it is.

Verner Waite, MD, FACS, founder of the Semmelweis Society, personally reviewed more than 1000 cases of physician peer-review, and determined that at least 80% (and probably 90%) of peer reviews are performed in bad faith, for economic or other reasons.

At present, no standards or definitions exist to guide objective peer review. In the absence of verified standards, it is hard to argue that any peer review can be done objectively under the current circumstances.

Peer review is at present the death sentence for a doctor's career. With the best evidence that unmerited peer review is in the range of 70- 90% by the most knowledgeable sources in the country, it appears that a moratorium is urgently needed while objective measures and procedures with due process can be put in place.

False evidence has been shown to be used at these reviews with alarming frequency. In one case, a peer review was actually forged. No patient can be protected by such mendacity. These reviews are counterproductive and lead to poorer patient outcomes.

It may be that continuous quality improvement will offer a means by which safety, quality and integrity may be guaranteed more effectively.

John B. Payne, DO and James Murtagh, Jr. MD.

**THE CRISIS OF BAD FAITH PEER REVIEW
BAD FAITH PUTS THE PUBLIC AT RISK
PROTECTION LACKING AGAINST BAD FAITH PEER REVIEW
SPECIFIC AIMS, TO CONTROL BAD FAITH PEER REVIEW**

- **Recent surveys show that 80% of current peer review is "bad faith peer review"**
 1. Bad faith peer review occurs when review committees are composed of non-peers, committees destroy or alter evidence, refuse to accept relevant evidence, solicit perjured statements, and come to conclusions opposite to what evidence shows.
 2. Major purposes of bad faith peer review are to decrease competition from better doctors, hide safety violations, hide malpractice (review those reporting malpractice, and remove them), hide fraud (review those reporting possible fraud, and remove them).

- **Bad faith peer review is a major current harm to the public.**
 1. Decreased safety leads to frequent prolonged illnesses and deaths.
 2. 17% of the US GNP is now devoted to healthcare. Big Medicine uses bad faith peer review to hide corruption with major costs. Cases in Dallas, Tennessee, and in Atlanta show that billions of dollars and potentially thousands of lives are at risk.
 3. Some of the most ethical and competent physicians are driven out of the practice of medicine.

- **Failure of current watchdogs**
 1. JCAHO refuses to enforce regulations, when serious, repeated violations are brought to their attention.
 2. HHS does not use effective authority to enforce appropriate regulations on peer review.

- **What can be done**
 1. Remove current ability of hospitals to claim "unlimited immunity," including when mendacity or intent to defraud is demonstrated. Witnesses who testify in good faith should have qualified immunity, as is common in legal and administrative forums.
 2. Empower HHS to decertify JCAHO if that organization refuses to enforce proper peer review rules. Replace JCAHO by a government regulatory body if JCAHO fails to work by a short, reasonable deadline.
 3. Provide for ability of HHS to cut off federal funds to hospitals that engage in bad faith peer review
 4. Define due process for doctors in a manner analogous to that current for other professionals in law, airline pilots and police.
 5. Provide for public scrutiny of the peer review process itself, when requested by the individual being reviewed.
 6. Provide for appeal to a public body, such as a court, to hear cases *de novo*. This will allow establishment of bad faith peer review on which HHS could operate for its enforcement role.
 7. Adopt KEVIN'S LAW: No doctor, medical student or hospital worker should be harmed for standing up for a patient.

BAD-FAITH PEER-REVIEW

WHY 100,000 PEOPLE DIE EVERY YEAR FROM MEDICAL ERRORS

Peer review is part of a system to protect patients. If this has been warped, patients are at risk. We ask to improve medicine without spending a dime. That is hard to beat with a stick.

Peer review is the process by which physicians evaluate the competence and professionalism of their colleagues to determine whether a physician should be granted hospital privileges and determine the extent of those. To further this mission without fear of litigation, almost all states have enacted laws that grant immunity from liability to members of peer review bodies and to the hospitals they belong to. They also made the proceedings and records of the peer review process privileged and confidential from discovery in civil proceedings. The purpose is to encourage physicians and hospitals to further the quality of health care without fear of retaliation by the reviewed physicians.

In 1986, congress enacted the Health Care Quality Improvement Act (HCQIA), a federal law that provides protection from liability to healthcare institutions and physicians involved in peer review, as long as certain conditions are met during the peer review process. The law also established the National Practitioner Data Bank, a repository of actions taken against physicians, to which healthcare institutions must report those actions. The purpose was to prevent incompetent physicians from moving between states without being detected. An entry against a physician in the Data Bank can be equivalent to a death sentence, since it makes it very difficult for a physician to obtain privileges at any other hospital, because the latter verify applicants' credentials with the Bank prior to granting or renewing privileges. The physicians are often left with no choice but to abandon their profession and obtain unrelated jobs. **Even if exonerated later by a State peer review board, a doctor exposed to bad-faith peer-review is likely to lose his career.**

Since HCQIA went into effect in 1989, thousands of adverse reports have been filed with the Data Bank. Unfortunately, a large number of the actions reported have been taken maliciously by hospitals and their Medical Staff against the physicians subjects of the peer review. The motives are usually anti-competitive in nature, but also include retaliation against whistleblowers, personal spite, and even disputes over a parking space. This process has been dubbed sham peer review, has now become a powerful weapon in the hands of hospitals and those physicians who hold the political power in hospitals, and is being misused nationwide. Many lawsuits against the perpetrators have been filed by the victims, but very few of them survived summary judgment because of the immunity provided by HCQIA and because the conditions that need to be fulfilled for a peer review to be considered adequate, as defined by HCQIA, are very vague and subject to (different) interpretation by the Courts.

The recent award of \$366 million to a physician by a Federal Jury in Texas for a single bad-faith peer-review highlights that this practice is adding tremendous cost to healthcare. <http://www.ama-assn.org/amednews/2004/10/04/prsd1004.htm>

The recent use of bad-faith peer-review as an instrument to further widespread political corruption in Georgia shows the destructive nature of bad-faith peer-review, and the potential terrible consequences on the public.

http://www.geocities.com/ron_marshall21/DFOG.RTF

Georgia Senator Charles Walker has been indicted on 142 felony counts for stealing from Georgia hospitals. His scheme used bad-faith peer review to silence any staff member who spoke out. District Attorney Paul Howard covered up. The effects of this corruption on Georgia are widespread.

No one can seriously believe that bad-faith peer review affects only doctors. All of society is badly harmed when huge hospitals rip off the public, silence their doctors, impair medical care and essentially destroy the system designed to protect patients. Verner Waite, MD, FACS, founder of the Semmelweis Society, personally reviewed more than 1000 cases of physician-peer-review, and determined that at least 80% (and probably 90%) of peer reviews are performed in bad faith, for economic or other reasons.

“Jealousy is the main driving force behind bad-faith peer review” says Waite.

His is the most comprehensive review currently known. Upon review of these cases, the officers of Semmelweis Society International find that due process in peer review is the exception, rather than the rule. It is rare to find any hospital that uniformly applies standards of peer review to the members of their hospital staff. As a result, thousands of physicians have lost their careers without any due process.

Bad-faith peer-review against one physician can silence hundreds of physicians and place physicians' livelihoods at extreme risk. It is estimated that 9 out of 10 physicians exposed to bad-faith peer-review never work again as physicians. It is also estimated that a substantial number of physicians exposed to bad-faith peer review commit suicide. Peer review is part of a system intended to protect patients. If this has been warped, patients are at risk. Thousands of deaths have been documented. Bad-faith peer-review is a greater challenge to the practice of ethical medicine than the malpractice crisis.

One Justice on the Nevada Supreme Court noted that HCQIA can sometimes be used, "not to improve the quality of medical care, but to leave a doctor who was unfairly treated without any viable remedy." That Justice also stated: "basically as long as the hospitals provide procedural due process and state some minimal basis related to quality health care, *whether legitimate or not*, they are immune

from liability, which leaves the hospitals free to abuse the process for their own purposes."

Reviewers set up a double standard of covering up the real mistakes of their friends and exposing their politically vulnerable colleagues for non-substantial, flimsy, clinically insignificant, bogus and fabricated reasons. The basic concept that an elite group of physicians who depend on each other and the system for their bread and butter, will demonstrate enough courage to criticize and discipline other members of their elite group, is plain ludicrous. The main result of HCQIA has been to marginalize some of the most competent and most quality-concerned physicians, driving them out of practice or terminating their lives through suicide. At the same time, the medically incompetent, the advocates of continued poor-quality and the most financially driven are allowed to run our hospitals; all because the provisions of the Health Care Quality Improvement Act allow them to do so. And then we ask: why are 100,000 people dying every year from medical errors?

It's because behind the smoke screen of every one physician targeted by sham peer-review, there is a dozen physicians whose medical errors are quietly shoved under the rug! Therein lies the real source of threat to public health, as well as the injustice to those individual physicians who become sacrificial lambs.

In its landmark 1999 report on patient safety, "To Err is Human: Building a Safer Health System", the Institute of Medicine (IOM) recommended the expanded use of reporting systems to analyze and reduce errors in the health care system. The IOM recognized that reporting systems will not achieve their full potential to foster learning about errors and their prevention without "a more conducive legal environment" in which health care professionals can report errors without increasing the threat of litigation. The IOM failed to add: "and the threat of retaliation".

Effective medical peer review is (or rather can be) the ultimate protector of public health! However, in its current secretive form, it invites abuse. There is much reason, as elucidated above, to believe that peer review is practiced more in its corrupt form rather than for its original established purpose. The situation with medicine today is reminiscent of the days when scientists of cigarette companies did their own research and declared that cigarettes did not cause cancer!

Dr. Charles Silver of Dallas, TX, has said that the "noble Act" (HCQIA of 1986) originally intended to monitor problem physicians, has gone totally in the opposite direction and, in many cases, decimated fine careers. Dr. Gerald Moss wrote in The American Journal of Surgery in 1994: Our better (usually younger) surgeons increasingly are placed in jeopardy by the unchecked ignorance and/or malice of their established colleagues. The state of Pennsylvania recently passed the MCARE law, Medical Care Availability and Reduction of Error Act; where each hospital is to have a public safety committee in which all serious events are to be reported. What is truly alarming, disturbing and a fundamental negation of the tenets of peer review is the "Whistle-Blower" protection which states that if an individual feels the hospital is not addressing

serious quality concerns, then that person should report his concerns directly to the State public safety committee. By establishing this, the state has formally acknowledged that hospitals and physicians have self-protective motives: this implies that too many times the present peer review system is ineffective and incapable of functioning and achieving the ends for which it was developed.

Gilbert Omenn M.D., Ph.D., professor of Medicine, Human Genetics and Public Health at the University of Michigan and chair of the Institute of Medicine's committee on enhancing federal health care quality programs stated:

“the federal government has a responsibility to provide leadership in addressing the serious quality of care and safety concerns confronting our nation.”

Interestingly, he doesn't mention the AMA, the AOA and the hospital peer review systems as vital, productive, and dynamic participants of a new movement aimed at improving quality health care.

Many voices have condemned this abuse of the system and have called for reforms of the HCQIA to no avail. The most prominent of those are the Semmelweis Society International, the American Association of Physicians and Surgeons and the Center for Peer Review Justice. Last October, both the Pennsylvania Medical Society and the Association of American Physicians and Surgeons have separately passed resolutions to investigate bad-faith peer-review. The two physician groups said they plan to independently look into the misuse of hospital peer review proceedings as a way to retaliate against doctors who advocate too loudly or too persistently for better patient care. In both cases, the resolutions were passed by acclamation.

<http://www.aapsonline.org/resolutions/2004-1.htm>

The resolution of the Pennsylvania Medical Society calls on the medical society to "explore all aspects of sham, (bad faith) peer review and explore ways to prevent the misuse of peer review" including looking into "applicable laws and steps that can be taken to protect physicians' rights to advocate for quality patient care." At least two other state medical associations, in Oregon and California, have said they're looking into the issue as well.

WHAT ABOUT OVERSIGHT?

Medical State Boards' Inaction and Bad Faith Actions

State Boards of Medicine have uniformly refused to consider bad-faith peer review a breach of the ethics of Medicine for reasons that are known to everyone. Physicians who participate in bad-faith peer-review are usually friends of the Hospital administrators, who in turn are friends of the State Governor, the Secretary of Health, or the Executive Director of the Board of Medicine. The Boards usually use excuses such as "this is not

within our jurisdiction" or "we do not find clear and convincing evidence that there was a breach of the laws governing the healing arts".

In counterpart, the disciplinary actions taken by the same Boards against the "small" physicians who are not "well connected", are often arbitrary and do not rely on any common sense. A physician who takes out the wrong lung may be penalized half the sum of that imposed on a physician who fails to turn over a medical record in a timely fashion. Few Medical Boards, if any, have any written Standards of Ethics. Board members and the State Attorney (usually acting as the prosecutor at Board hearings) use their own standards, dictated by their own discretion. They may or may not cite AMA's or another organization's standards, although they are not binding to anyone who is not a member of those organizations. In the Boards' sound discretion, bad-faith peer review is not a breach of the ethics of medicine, yet trivial acts can result in a reprimand or a suspension. For instance, a Board may suspend a licensee for failing to honor a check for 10\$, because there is a written law that allows the Board to do so, although the law says: *may* suspend, not *should* suspend. So in the judgment of the Director of the Department of Health, the licensee should be suspended, but the same Director does not consider BFPR unethical.

As an example, we relate the story of a neurosurgeon from Colorado:
"In September 2000, I was summarily suspended from a hospital based on 3 cases, without any peer review. The hospital notified the Colorado Board of the suspension before hearing my appeal of this suspension. The hospital/state-wide panel of their 4 chosen doctors exonerated me in March 2001, and found nothing wrong with my care in any case. Yet In May, 2001, the Colorado Board of Medical Examiners sent me to the Attorney General for "discipline" in two of those cases. I was charged in November 2002 and was offered a "deal" which I would not accept. The other hospital system (where I had worked for 27 years without any bad case) added their suspension. I went through a hearing in October, 2003, with the Administrative Law Judge's results accepted by the Board. Her decision is filled with misunderstandings and ignorance of all of my expert neurosurgeons who affirmed that my care was correct. She even stated that my specialty was "neurology" in her decision. The Board's only neurosurgical witness, from out of state, perjured himself by falsely claiming to be the residency program director, and also gave testimony which would seem absurd to a neurosurgeon. My long list of "exceptions" to the ruling, pointing out errors of fact and medical testimony, was ignored by the Board. My license was revoked in May, 2004; I am in the appeals process. The Board knew (1) that one of my patients was killed by the ICU nurse overdosing my patient with morphine and leaving him unattended off the respirator (I did not know this at the time of hearing, as I was a testifying non-party to the malpractice suit in progress); (2) that their witness committed perjury; (3) that the Board hid many items from me, including my statistics relative to other neurosurgeons, my scheduling of a patient for surgery, hospital regulations, and about 20 of my letters to the hospitals in which I had criticized bad nursing (some with significant injury to my patients), lack of equipment, and the illegal transfer of a 22- month-old girl with a spine fracture which resulted in her paralysis. The hospitals presented fraudulent records, some of which were exposed during the hearing. Their actions have smeared my good reputation and left me without money or lawyer or a job. My 18 years of education to

become a neurosurgeon, nearly 30 years of fine practice with thousands of good operations, and my special personal care for my patients, has been trampled by this bad faith process. There is no neurosurgeon, neurologist, orthopedic or plastic surgeon on the Colorado Board. The Board is either intentionally or inadvertently covering up the bad care in the hospitals which I have been trying to expose.”

The latest example of Board inaction is the case of a physician in Virginia whose appointment to the Medical Staff of a hospital was revoked after a sham review. The physician filed complaints with the Virginia Board of Medicine against three physicians involved in the review alleging that they, along with the President of the Hospital and other individuals, acted with bad faith, malice, ill will and evil intent in suspending his clinical privileges and in revoking his appointment to the Medical Staff, that they denied him due process through intimidation, threats, manipulation, harassment, failure to investigate, concealment of evidence, rigging of reports, fabrication of charges, fabrication of evidence, inhibition of his freedom of speech, holding a kangaroo-court type hearing, carrying a fictitious appeal process and exercising intimidation on another physician to sign a rigged report. He also alleged that the President of the Hospital filed fraudulent reports with the Virginia Board of Medicine and with the National Practitioner Data Bank, that several individuals provided false testimony under oath before a notary public at the hearing on the charges against him, which is a class 5 felony in Virginia, and that the revocation of his appointment involved criminal action under the Virginia Business Conspiracy Act as several individuals combined with each other and with the physician's former employer to terminate his appointment to the Medical Staff maliciously (*sic*). The response of the Virginia Board of Medicine and the Executive Director of the Department of Health Professions, after an investigation that did not go beyond reading the physician's written complaint, was that there was no “clear and convincing” evidence that the above actions constituted a breach of the law or the ethics of Medicine. At the same time, the Department of Health Professions was busy suspending the license of an occupational therapist for failing to honor a check for 10 dollars.

<http://www.dhp.virginia.gov/Notices/Medicine/0119002161/0119002161Order11222004.pdf>

The physician even went on to accuse the Board of Medicine of covering up for those individuals because they are well connected to certain members of the Department of Health. The Board of Medicine did not deny it in its response, and the Virginia Secretary of Health declined to answer his letter.

Reading material regarding board actions:

<http://www.courts.state.va.us/opinions/opncavtx/0016022.txt>

<http://www.saccourt.com/courtrooms/trulings/d25archives/2004/Dec10D25-04CS00969.doc>

In summary, the problem with peer review is that:

- 1) It is performed in secrecy.
- 2) It is performed by one "person": the hospital, which acts as the prosecutor, the witness, the jury, the judge and the executioner.
- 3) The participants are granted substantial immunity.
- 4) The process can never be scrutinized in that anyone attempting to do so is shielded from the records by various state peer review protection acts.

Physician Peer Review is the only instance in jurisprudence of any kind wherein those who have the most to gain actually decide the fate of the accused and a conflict of interest is excused. The process, in its present form, is dysfunctional, and tantamount to counterproductive tampering.

SINCE THERE IS NO EVIDENCE TO SUGGEST THAT PEER REVIEW IMPROVES THE QUALITY OF MEDICAL CARE, AND SINCE, IN FACT, THERE IS STRONG EVIDENCE THAT MOST PEER REVIEWS ARE DONE IN BAD FAITH TO ELIMINATE COMPETITION, SILENCE WHISTLE BLOWERS, AND DISCRIMINATE AGAINST PHYSICIANS ON THE BASIS OF RELIGION, SEX, RACE, COLOR OR ORIGIN, DECREASING OPTIONS FOR PATIENTS, DIMINISHING THE QUALITY OF CARE, DECREASING DIVERSITY IN MEDICINE, INCREASING PROFIT AND INCREASING COST, THUS LEADING TO THE LOSS OF MANY LIVES AND BILLIONS OF DOLLARS, THE COALITION FOR HEALTH INTEGRITY ASKS THE U.S. CONGRESS TO TAKE ACTION TO END BAD-FAITH PEER REVIEW AND ENSURE THAT PEER REVIEW IS PERFORMED IN WAYS THAT FURTHER THE NOBLE GOAL FOR WHICH IT WAS CREATED.

HEALTH PREPARADNESS IS VITAL TO NATIONAL SECURITY, AND THIS IS A CLEAR AND PRESENT DANGER TO THE COUNTRY. GOOD FAITH IN MEDICINE SAVES LIVES; GOOD FAITH IN MEDICINE SAVES BILLIONS.

The Coalition for Health Integrity suggests the following remedies to Congress.

- 1) Issue a resolution denouncing the practice of Bad-Faith Peer-Review and declaring it a primordial issue that seriously jeopardizes the quality of health care in the United States.
- 2) Take measures to enforce existing regulations, including JCAHO rules requiring due process in peer review. We are not asking for anything special for doctors, we are just asking for what all professions provide in their review process. JCAHO has been documented not to enforce their regulations and Congressman Stark points out that JCAHO is not doing its job. We also suggest that HHS cut off funds to any hospital not following existing regulations.
- 3) Clearly declare immunity in peer review as qualified, as the Supreme Court of Connecticut recently did, preempting any existing State law that states otherwise.

- 4) Clearly bar any secrecy behind peer review proceedings to deter wrongdoers, allow the accused to face their accuser, be informed of the charges, and defend themselves.
- 5) Enact Kevin's law (principle): "No doctor or student or healthcare worker should be harmed for standing up for patients." Kevin is a Medical Student who was recently dismissed from Medical School in retaliation for a letter he wrote about the poor quality of health care at Grady Hospital in Atlanta.

The best way to improve medical care is "Continuous Quality Improvement" CQI. Most doctors want to improve their practice. Hospitals that continuously monitor the quality of care and practice have been shown to improve care. This is the real solution. We ask for your help in protecting the public by restoring good faith peer review.

Peer review is part of a system to protect patients. If this has been warped, patients are at risk. We ask to improve medicine without spending a dime. That is hard to beat with a stick.

EXHIBIT
DATE
SB

Testimony of Attorney Norman Newhall in Opposition to SB368 3-26-2007

I am an attorney actively engaged in trial practice for more than 35 years in Great Falls, Montana. I submit the following testimony in opposition to Senate Bill 368 which seeks to expand the provisions of Sections 50-16-201 MCA et seq. Sections 50-16-201 et seq. provide that information gathered by healthcare facilities under the auspices of quality control is confidential and privileged. Superficially, these laws appear to permit healthcare facilities to gather information with respect to medical practitioners without fear that the information will be used against the healthcare facility at a later date. As a practical matter, the laws protect careless healthcare facilities by permitting them to hide the fact that they have conducted little or no investigation at all.

At §37-3-101 MCA, the Montana legislature has previously recognized that in licensing physicians, it is the public policy of the state to protect the public from "unprofessional, improper, unauthorized, and unqualified practice of medicine . . ." In conformance with this public policy, the Montana Supreme Court has likewise recognized the common law duty of hospitals and other healthcare entities involved in credentialing and/or granting privileges to physicians to "use reasonable care to employ only competent physicians and nurses". *Maki v. Murray Hospital* (1932) 91 Mont. 251, 7 P.2d 228. Persons who place themselves in the hands of such physicians "have a right to rely upon the performance of such duty . . ." *Id.* at 233. Similarly, one who employs a physician has the duty to "use reasonable care in selecting a reasonably skilled physician". *Vesel v. Jardine Mining Company* (1939) 110 Mont. 82, 100 P.2d 75, 80.

I speak from experience in noting that the practical effect of Sections 50-16-201 et seq., and of any expansion of such sections as is proposed under SB368, is to hide from the public the fact that a healthcare facility involved in credentialing, hiring or granting privileges to a physician has conducted little or no investigation into the physician's background before turning the physician loose on unsuspecting patients.

Dr. Thomas Stephenson graduated from medical school in 1962. Until he came to Montana in 1995, he was engaged in a highly specialized practice of cosmetic surgery in Southern California. In 1991, Stephenson was profiled by the Los Angeles Times as a celebrity plastic surgeon "whose breast implant ads featuring bosomy women in negligees run frequently in the Times." During his practice in California, Stephenson was the subject of an investigation by the Federal Drug Enforcement Administration which reported that Stephenson was "a Demerol addict and was known to steal Demerol to satisfy his habit" and also reported that Stephenson had been convicted of drunk driving. Further, during the 1980s, Stephenson was the subject of an accusation by a patient to the California Medical Board alleging malpractice and that Stephenson had rendered treatment while under the influence of Demerol and alcohol. The accusation was withdrawn only after Stephenson agreed to complete the medical board's Diversion Program.

Stephenson's notoriety increased even more when he began to be regularly sued for malpractice. Stephenson was the defendant in 11 separate claims from 1986 to 1993. The California Board of Medical Examiners examined only four of the claims and found Stephenson to have committed gross negligence, repeated acts of negligence and incompetence in the practice of medicine, and to have engaged in acts involving dishonesty and corruption. Following further proceedings, the California Board added an additional finding that Stephenson had knowingly filed fraudulent insurance billings. Stephenson's California license was revoked, the revocation was stayed and his license was placed "on probation for a period of ten years" under numerous terms and conditions, all of which was effective on April 11, 1994.

Stephenson also had a Florida license. In 1995, Stephenson was charged by the Florida Board with failing to timely report the action of the California Board. The Florida Board found the allegations to be true and Stephenson's Florida license was suspended and placed on probation.

In 1995, Stephenson, without an active medical license, applied to practice medicine in Montana. The Montana Board granted a temporary license while it investigated Stephenson's application for a permanent license. While Stephenson was practicing under the temporary license, Stephenson was hired as a family practitioner by Triangle Healthcare, a Montana medical clinic, and was granted hospital privileges by Liberty County Hospital.

In November 1999, Stephenson, while practicing with Triangle Healthcare, saw my client, Jack Nelson. Stephenson diagnosed a possible aortic aneurysm, a potentially emergent and life threatening condition. The most basic standard of care required that threat of rupture of the aneurysm be immediately measured by an ultrasound exam costing approximately \$40 and which can be conducted in less than five minutes. The ultrasound machine is portable and was immediately available in the same building on the day of the physical exam. Had the procedure been performed, Stephenson would have discovered an urgent condition which was readily repairable, but which required immediate surgical repair prior to rupture.

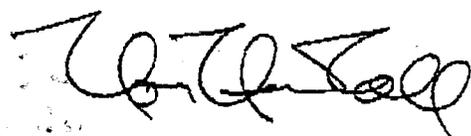
Unfortunately, Stephenson was not even aware of the appropriate diagnostic procedure and dismissed Jack Nelson with a vague instruction to come back the following week for an x-ray. That Stephenson even suggested an x-ray is an indication of just how out of touch Stephenson was with modern practice. Several days later, Jack Nelson died an agonizing, prolonged death when his aneurysm ruptured at home.

Two months after Jack Nelson's death, Stephenson "retired" and, unknown to Jack Nelson's widow, cancelled his claims made malpractice insurance before the widow had discovered Stephenson's negligence.

Through this office, the widow brought a claim against Triangle Healthcare and Liberty County Hospital for negligence in investigating and credentialing Stephenson before hiring him and granting hospital privileges. Since Triangle Healthcare and Liberty County Hospital had the duty under Montana law to exercise ordinary care in the hiring, credentialing and privileging of physicians, Jack Nelson's widow logically sought to discover precisely what Triangle Healthcare and Liberty County Hospital had done to investigate Stephenson prior to hiring and privileging him. A copy of discovery submitted to Triangle Healthcare and Liberty County Hospital is attached to this testimony. Under the provisions of Sections 50-16-201 et seq., both Triangle Healthcare and Liberty County Hospital "stonewalled" Mrs. Nelson's legitimate inquiry thereby posturing as if they had done something to investigate Stephenson, when in fact they had done little or nothing. Subsequent discovery, by means of deposition, disclosed that the person acting as the medical director for Triangle Healthcare and Liberty County Hospital met Dr. Stephenson for lunch on one occasion and the next meeting was at a cocktail reception after Stephenson had already been hired and privileged.

The practical effect of Sections 50-16-201 et seq. is to permit irresponsible healthcare facilities to hide their failure to conduct proper investigation and review. Responsible healthcare providers who properly investigate and credential physicians before permitting them to practice medicine do not need the protections of Sections 50-16-201 et seq. Instead the secrecy encouraged by Sections 50-16-201 et seq. permits the few irresponsible medical providers (the "bad apples") to hide the fact that they have failed to fulfill their legal duty and subverts the public policy previously enunciated by the legislature in §37-3-101 to protect the public from "unprofessional, improper, unauthorized, and unqualified practice of medicine . . ."

SB368 seeks to expand the provisions of Sections 50-16-201 et seq. Under the guise of creating "quality control guidelines" SB 368 actually permits even more medical providers to do nothing to investigate incompetence and then hide such fact from persons who have been injured by incompetent physicians whom they failed to investigate before hiring. The unfortunate, albeit unintended, consequences of Sections 50-16-201 et seq. should not be expanded. I therefore respectfully urge this committee to oppose SB368.



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NESI-01

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Attorneys for Defendants Liberty County and
Liberty County Hospital and Nursing Home, Inc.

MONTANA TWELFTH JUDICIAL DISTRICT COURT, LIBERTY COUNTY

DORIS NELSON, Individually, and as
Personal Representative of the Estate of Emil
J. (Jack) Nelson,

Plaintiff,

-vs-

STATE OF MONTANA; LIBERTY COUNTY, a
Political Subdivision of the State of Montana;
LIBERTY COUNTY HOSPITAL AND
NURSING HOME, INC., a Montana
corporation; THOMAS R. STEPHENSON,
M.D.; RICHARD S. BUKER, JR., M.D.;
TRIANGLE HEALTH CARE; TRIANGLE
HEALTHCARE PLLP; JOHN DOES I-IV.

Defendants.

CAUSE NO. DV-03-3237

DEFENDANTS LIBERTY COUNTY
AND LIBERTY COUNTY
HOSPITAL AND NURSING HOME,
INC.'S RESPONSES TO
PLAINTIFF'S FIRST DISCOVERY
REQUESTS (INCLUDING
REQUESTS FOR ADMISSIONS)

Defendants Liberty County and Liberty County Hospital and Nursing Home, Inc.
provide the following responses to Plaintiff's First Discovery Requests to Liberty County
and Liberty County Hospital and Nursing Home, Inc.:

GENERAL OBJECTION

These Defendants object to the instructions and definitions to the extent that the
preliminary statements in the Plaintiff's First Discovery Requests exceeds the obligation to

respond to discovery as set forth by the Montana Rules of Civil Procedure.

DISCOVERY REQUEST NO. 2001: Produce your complete file and all documents relating to the application of Thomas R. Stephenson for hospital privileges or to be a member of your medical staff at Chester, Montana.

RESPONSE: Objection on the grounds and for the reasons that this discovery request seeks information and documents that are privileged and non-discoverable pursuant to MCA § 50-16-203, MCA § 50-16-205 and MCA § 37-2-201.

Objection is also entered on the grounds and for the reasons that Dr. Thomas R. Stephenson has a legitimate privacy interest in and he has not provided a consent to the release of any documents responsive to this request.

To the extent that this request is not for "data" as defined by MCA § 50-16-201 and is not privileged or confidential as provided by the above-referenced statutes, responsive documents are attached as Exhibit A.

DISCOVERY REQUEST NO. 2002: Produce your complete file and all documents relating, directly or indirectly, to the grant of hospital privileges to Thomas R. Stephenson or the admission of Thomas R. Stephenson as a member of your medical staff.

RESPONSE: Objection on the grounds and for the reasons that this discovery request seeks information and documents that are privileged and non-discoverable pursuant to MCA § 50-16-203, MCA § 50-16-205 and MCA § 37-2-201.

Objection is also entered on the grounds and for the reasons that Dr. Thomas R. Stephenson has a legitimate privacy interest in and he has not provided a consent to the release of any documents responsive to this request.

DISCOVERY REQUEST NO. 2003: Produce your complete file and all documents relating, directly or indirectly, to the efforts of you, or of persons working on your behalf, to credential, investigate or to otherwise determine the qualifications of Thomas R. Stephenson to be granted hospital privileges or to be a member of your medical staff.

RESPONSE: Objection on the grounds and for the reasons that this discovery request seeks information and documents that are privileged and non-discoverable pursuant to MCA § 50-16-203, MCA § 50-16-205 and MCA § 37-2-201.

Objection is also entered on the grounds and for the reasons that Dr. Thomas R. Stephenson has a legitimate privacy interest in and he has not provided a consent to the release of any documents responsive to this request.

DISCOVERY REQUEST NO. 2004: Produce your complete file and all documents relating, directly or indirectly, to the termination of Thomas R. Stephenson's hospital privileges or of his permission to serve as a member of your medical staff.

RESPONSE: Objection on the grounds and for the reasons that this discovery request seeks information and documents that are privileged and non-discoverable pursuant to MCA § 50-16-203, MCA § 50-16-205 and MCA § 37-2-201.

Objection is also entered on the grounds and for the reasons that Dr. Thomas R. Stephenson has a legitimate privacy interest in and he has not provided a consent to the release of any documents responsive to this request.

Without waiving this objection, the termination of Dr. Thomas R. Stephenson's hospital privileges and/or his permission to serve as a member of the medical staff was the result of Dr. Stephenson relocating to another community.

March 26, 2007

Dear Representatives serving on the Human Services Committee,

My name is Barbara Gutschenritter, MD. I am a cancer specialist. I have been practicing medicine for 25 year, for 20 years here in Montana. I have hospital privileges on 5 medical staffs. I am here today to voice my vehement opposition to SB 368. I certainly would have been here to testify before the Senate, had I known about this bill.

I understand that, from the perspective of the public and the Senate, one would assume that this bill serves the purpose of providing hospital oversight of its medical staff or for a medical group to provide oversight of the physicians in their group.

I am here today to let you know how the process of "Peer Review" can be abused and manipulated. It can be used to target and attempt to destroy a physician who has made no error in patient care, but who has, for some reason, fallen out of favor with the hospital or medical group. Such an attack against a physician and the initiation of "sham" peer review may occur for a number of reasons, e.g.: the physician may be seen as an economic competitor; the physician may have raised patient care concerns that make the hospital or physician colleagues uncomfortable; the physician may have raised concern about another physician's lack of credentials in performing a certain procedure; the physician may have declined to participate in another physician's sham peer review process.

This is retaliation disguised to look like peer review. How can this happen? It's easy. Ask the Horty Springer law firm of Pittsburgh, PA. There is a well-formulated template:

-- Hospital administrators typically are able to find a few physicians they can count on. Often the etiology of that loyalty is money. Perhaps the physician is offered \$50K, perhaps \$100K, perhaps \$150K to head one of the hospital departments. Perhaps the administration surreptitiously contributes to a physician's medical group by paying a hefty salary. Perhaps it's a lavish trip. Unfortunately, physician loyalty can be bought and can be manipulated.

-- Once you have a few in the core group, the next step is to start the rumor mill about the targeted physician. Assemble a list of ALLEGED wrongdoings on the part of the physician, no matter how trivial, no matter how invalid. Try to make it a huge list; try to overwhelm the physician.

-- Start a paper trail. Start hauling the doc in to "peer review" meetings, which can be scheduled with a 24 hour notice, to discuss "concerns" with no notice of what the issues are. If, for example, a secretary complains that a physician makes too many corrections on consultation reports, that complaint is not specified to the physician. It may be couched as a vague complaint that the physician is creating a hostile work environment, in order to "protect confidentiality". No one is allowed to accompany the physician to a peer review meeting, no legal representation, no taping of any such meeting. And this is

carried out with the warning that the mention of anything about this meeting to any hospital employee, any colleague, or any board member by the physician is grounds for immediate dismissal.

--Perpetuate a rumor mail. Start telling other physicians, board members, etc ANYTHING about this doctor. Make it up...the individual was raised in an abusive family environment, that he/she, has a long history of mental illness or perhaps a history of some weird sexual addiction. It doesn't matter. This is all under the guise of "peer review", which is shrouded by confidentiality.

--Find some reason to send the doctor off for a psychiatric evaluation (at his or her expense). If it comes back clean, find a different evaluator and try again. Arrange for the evaluator to visit with hand picked witnesses to the physician's behavior. If the evaluation finds the hospital to be dysfunctional, bury the report.

--If doc resigns or is "fired" (privileges revoked), attempt to block him/ her from working elsewhere. Try to ruin him/her financially so that the doctor is unable to fund a legal challenge

I have seen too many physician colleagues who smeared by this sham peer review process. This is a travesty. This is Kafka-esque. The medical profession is the only one in which a physician may be fired and have absolutely no recourse, because of the veil of immunity or "confidentiality". A doctor targeted by this process has no means to clear his or her name. Only with the initiation of a law suit does the physician even get to see, through discovery, the specific allegations. This bill does not allow the physician to EVER learn of the specifics of any complaints. This bill takes away the physician's only recourse which is in the courts of the state.

Moreover, the valid patient care concerns frequently at the heart of this type of retaliation never come to light. This should be frightening to all of us.

I urge you representatives to look behind this bill, to the intent behind it. While PURPORTING to facilitate Peer Review within a hospital or a medical group, what this legislation does is make it easier for a hospital or a medical group to fire physicians who have differing views.

I urge you to all to protect your constituencies from bad doctors. I urge you to vote against this bill.

Sincerely,

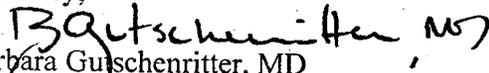

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EXHIBIT 2
DATE 3-20-07
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Dr. Scott Rundle is shown in June 2006 outside the emergency room at Kalispell Regional Medical Center. Rundle has filed a multimillion-dollar lawsuit against Silvertip Emergency Physicians, the company that provides doctors for the emergency room. Karen Nichols file photo/Daily Inter Lake

The Daily Inter Lake

A former emergency-room doctor filed a lawsuit Tuesday that alleges defamation, civil conspiracy, wrongful discharge and other illegal acts by Silvertip Emergency Physicians, the company that provides emergency-room care at Kalispell Regional Medical Center.

Dr. Scott Rundle filed the legal action, which includes allegations that Silvertip's physicians covered up another physician's alcohol abuse, ignored Rundle's concerns over patient-care quality and made referrals more for financial gain than for patient care.

Rundle requests more than \$16 million in compensation.

Silvertip Emergency Physicians, which contracts to provide physicians in the KRMC emergency room, did not answer the Inter Lake's requests for a response. (See related story for comments from Kalispell Regional Medical Center.)

Rundle, 39, was a member of Silvertip until October. He became celebrated

in the Flathead as the emergency-room physician who refused to give up on reviving 3-year-old drowning victim Jacob Felghtner in 2004. The boy recovered after two hours of clinical death.

Rundle also served as medical director of Kalispell Fire and Ambulance Service, Flathead County EMS Service, Marion Ambulance Service and Flathead Valley Community College's paramedical program.

In the lawsuit, Rundle alleges Silvertip physicians defamed his character, reputation and clinical competence. He said he was "coerced into providing Silvertip with his resignation" on Oct. 12, 2006. He maintains their motive was retaliation for the concerns he raised over patient care and his refusal to go along when another physician was targeted and pushed out of the group.

The suit names Dr. Keith Lara, director of the corporation, and eight other unnamed members of Silvertip.

Kalispell Regional Medical Center was not named as a party to the lawsuit.

According to the lawsuit, Silvertip members allegedly falsely accused Rundle of using illegal drugs, writing illegal prescriptions and refusing to answer pages while on duty.

The physician also said in the suit that Silvertip physicians made false allegations that he sexually harassed nurses and other staff and that he had contracted and then transmitted herpes to at least two medical center employees.

He claimed in the court filing that he was the victim of false allegations that he had engaged in inappropriate sexual behavior with another member of the staff while on duty at Kalispell Regional Medical Center.

The suit charges that all the rumors and allegations were false and that the Silvertip defendants knew they were lies.

"These allegations have, as designed, spread not only throughout the KRMC medical community, but to the entire medical community in Western Montana," the suit says.

Rundle was hired by Silvertip in July 2000. According to the lawsuit documents, he and other Silvertip physicians each earned about \$300,000 in 2005, compared to other emergency-room doctors within a 120-mile radius earning from \$90,000 to \$150,000.

According to the suit, Kalispell Regional Medical Center pays Silvertip 70 percent of the gross dollars billed for services rendered by the group's emergency-room doctors.

Since leaving Silvertip, Rundle has worked part time, earning about \$90,000 per year, as an emergency room physician in the Flathead Valley and Polson area.

Attorney Scott Hilderman of Johnson, Berg, McEvoy & Bostock of Kalispell represents Rundle and filed the lawsuit in Flathead County District Court. Hilderman would not comment except to say that he has specific facts and evidence to back up every allegation in the suit.

The lawsuit states that Rundle first noticed substantial changes in his treatment after he voiced numerous concerns about the quality of patient care provided by Silvertip.

These concerns included the removal of an emergency-room physician from Silvertip for "inappropriate and personal reasons" including that his personal appearance, which included a beard, was not up to par.

According to Rundle, the doctor, who isn't named to protect his privacy, was forced out in 2003 after unsubstantiated allegations that he used marijuana and had "an adverse trend" in his clinical care.

The lawsuit claims that the Silvertip physicians were led to believe that Velinda Stevens, the medical center's chief executive officer, wanted the physician removed from the group for "substandard patient care or disruptive behavior."

Rundle said this ER doctor was nearly always the highest-ranked Silvertip physician based on patient surveys. Because he didn't believe the allegations, Rundle asked to make an independent review of the doctor's patient charts.

"Rundle was warned by several group members that this was a bad idea and that he should go along with the vote to terminate Doctor's status with Silvertip to 'protect himself,'" the suit says.

In spite of the warnings, Rundle reviewed the charts of 17 patient cases in question and concluded the allegations of substandard care had no merit.

He then presented his findings to other members of Silvertip, but said all the members of the group refused to review the findings. Some expressed anger at Rundle for investigating the charges.

At that meeting, he was told that Stevens still wanted the physician removed and that he could call her himself. Rundle did call her and allegedly was told that the medical center had no concerns about the physician's work, but the other Silvertip members allegedly refused to believe him.

At a subsequent meeting, Rundle voted to retain the doctor but others voted to remove him, saying that he was "a bad and dangerous doctor." But the group allowed him to work for four more months so other physicians didn't have to work additional shifts.

Rundle also claims he raised concerns that doctors at Kalispell Regional Medical Center were pressured to admit patients into HealthCenter Northwest rather than the nonprofit medical center when it wasn't in the patients' best interests.

Rundle said in the filing that the health center (which is licensed as a private hospital) "does not provide the same level of care for patients as KRMC." However, the Silvertip physicians, as investors in HealthCenter Northwest, receive quarterly payments from net receipts.

In another potentially damaging allegation, Rundle claims in the lawsuit that Silvertip had retained a physician with a drinking problem.

"While on duty for KRMC, this emergency room physician overdosed on alcohol and was admitted into the emergency room as a patient and placed on a mechanical ventilator for two days."

Rundle claims that the incident was ordered "covered up" by Silvertip members. He said he was warned not to speak about the episode.

In the lawsuit, Rundle alleges that Silvertip members misused their peer review process to cover up malpractice by its physician as well as to attack other physicians for personal reasons.

The dispute involving Rundle came to a head at an Oct. 11 meeting of all Silvertip members. According to the lawsuit, Stevens, the medical center CEO, appeared at the beginning of the mediation and requested that Silvertip move beyond the dispute and recommended that Lara resign his position as director of Silvertip. Stevens then left the room.

After that, the lawsuit says, Lara restated the accusations about drug use, illegal prescriptions, refusal to answer pages and inappropriate sexual conduct.

"Defendants also falsely accused Rundle of an inappropriate relationship with a female firefighter while serving as (medical) director of Kalispell Fire and

Ambulance Service," the suit said.

The suit reports that Lara then said that Rundle had put the group's contract with the medical center in jeopardy and that Rundle had put the group at risk for a sexual harassment claim.

Rundle claims he was then given a choice of getting fired, resigning or going into rehab. When he asked rehab for what, he said none of the members would give him a specific problem.

The lawsuit's specific charges against the Silvertip group include defamation, intentional infliction of emotional stress, civil conspiracy, wrongful discharge and breach of contract.

Rundle requests direct damages of \$5.4 million, \$800,000 for wrongful discharge, consequential damages "in an amount to be proven at trial," and punitive damages of \$10 million.

Reporter Candace Chase may be reached at 758-4436 or by e-mail at cchase@dailyinterlake.com

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