DR. VERNER S. WAITE - A FABRICATED PEER REVIEW

I intend to detail a totally DECEITFUL medical peer review, to bring out how far hospital administrators will go to protect the bottom line. It is a major problem. Hospitals have been placed above the law by our state courts, refusing to allow these cases before a jury. The immunity that organized medicine dislikes in the hands of PROs, is the same immunity that they insist on in ' hospital peer review. This seeming inconsistency is quite consistent when viewed with a wish to maintain the status quo, in a medical system that is truly a "good old boys" club.

Immunity has released a monster.

This ability to use immunity to hide the destruction of a competitor, to defame another MD's work, or character, and even to commit illegal acts, must be curtailed.

It is not helpful in the public's perception of medical practice to have established physicians inhibit better trained, young doctors. It allows for the destruction of whistleblowers. It favors the maintenance of monopolies. How is the cost of medicine to come down?

Currently, state courts are looking the other way. The Joint Commission looks the other way, as do the California State Hospital Survey teams. In these two letters (projected) to the Joint Commission of Accreditation and to the California State Survey team, we detailed grossly immoral acts. You get no response. We've talked to the JCAHO in person. We have sent detailed copies of everything to the lawyer for the JCAHO, Mr. Harold Bressler. He told me in a face-to-face meeting that he takes this brief home every night and doesn't know what to do with it. So, if you're going to turn to the organized medicine areas to help you, or state licensing agencies, forget it. They're not interested.

The AMA, and your professional societies, look the other way. The California Medical Association, under Catherine Hanson and Howard Lang, has made some notable efforts to obtain a level playing field. With the National Data Bank, honest medical peer review became intensely important. The Semmelweis Society data, collected over the past four years, shows that this problem is pervasive. It involves religious hospitals, veterans and military hospitals, corporation hospitals, all comers. The data reflects over 500 good doctors injured maliciously. The motives involve all of man's baser instincts. The protective cloak is a claim of better patient care and the removal of bad doctors.

To put the motives into perspective, one could look at the highest average salaries paid in the U.S., for twenty industries, as published by Forbes magazine. CEO's of hospitals, at $1,420,000.00 a year, were the highest (projected). This can be a very tempting carrot. The frightful stick could be the prediction that forty

percent of our hospitals will go bankrupt.

This is the backdrop of medical peer review that I see after four years of study. Now, to turn to my specific, yet very typical, case. It actually occurred, and I was the recipient.

What was the motive to subject me to a peer review? First, the hospital was facing me in court on a prior medical peer review lawsuit, which was ruled a malicious action by two judges and a jury, later in 1984. To destroy my credibility before this trial, a second corrective action was ideal. This was then initiated, with a claim that the California Hospital State Survey team had concerns about my practice. These concerns were said to have been expressed in April 1983, during a Joint Commission survey.

There are some interesting aspects to this claim. First, the lack of any activity on this, until some eight months later, from April to December. Strange ... just 25 days before my lawsuit was scheduled to begin trial, on 15 January 1984. Secondly, it was repeatedly stated that a random review of hospital charts had occurred, and only my charts were found wanting. No other physician's charts dropped out. About 10 of mine did. This statement was found to be totally false when a lower level administrator gave me a letter detailing what actually happened. His. signed statement is that, when the Joint Commission began the survey, they presented a list of only my charts for their review, as their initial act. This type of list can be submitted by anyone. The Commission is bound to evaluate the complaint.

The requested charts were all reviewed, and all found okay, and some received complimentary comments. Throughout, a random review never occurred. My administrator, who informed me of this, was present during the entire review. He was totally disgusted with what his superiors were doing, but he, of course, was in fear of losing his job.

On 20 December 1983, eight months later, the outgoing Chief of Staff, Duane Young, a radiologist, and the incoming Chief of Staff, Turner Payne, a fellow surgeon who worked with me often, presented me with a letter stating a corrective action had to be instituted against me. My concerns were natural. Why does this come with no prior warning so close to my impending trial date? A lack of an informal meeting beforehand was in violation of the new by-laws which had been written after my 1979 incident leading to the impending trial. Next, what are the charges? Am I going to be fighting shadows? What charts are involved that dropped out?

The incredible answers were revealing. They did not know the charges. They were willing to proceed only because the administrator, Mr. William Findlayson, said they must. Next, they were not allowed to know the charts involved, even if they had wanted to find out the justification for the action. Contract physicians, a

radiologist in this case, will dance to nearly any tune, if their contract is at risk.

All subsequent communications were by letter, drafted by the hospital lawyers and signed by the Chiefs of Staff, obediently. Privately, they agreed the by-laws were not being followed. They stated that Mr. Findlayson said this was all necessary to satisfy the CALS survey team. They could lose accreditation if they did not do something. Again, because a random review had been done but only my charts dropped out.

Now, what else does my outraged lower level administrator say? The hospital administrator had called the insurance adjusting firm, ACROS, which was working for the insurance company at risk in my pending lawsuit, Farmers Insurance Company. They decided to review my charts. The review, of only MY charts, began about October 1983. A Dr. David Steinhardt, retired chief of surgery at a San Francisco Kaiser hospital, showed up and began a review in a separate room. This occurred over several days, upsetting the staff secretary and record room chief, who were forced to turn over to a stranger, many records for reasons unknown. It was not done with the Medical Executive Committee's knowledge, or approval, and hence it was not, is not, protected by 1157 provisions. This upset the staff secretary.

Some of the charts were on microfilm. Perhaps this is an indication of how wide the search was.

What did they find? The "about ten charts" turned out to be eight in number. One of these was reviewed twice, without the reviewer realizing it., One was the chart of another doctor f or whom I covered, so my name was on the chart. I would hasten to relate that these kinds of errors by insurance doctors, or envious colleagues, are not rare. Doctors are not trained in, nor enthusiastic about chart review. One chart was a carotid endarterectomy about which he had no complaint, so why did he list it?

Another chart listed was never written up. Two were hernia cases. In one, he stated there was no hernia, though a lemon-sized retroperitoneal cord hydrocoel, had to pass through the internal ring, a peritoneal balloon. True there was no open peritoneal sac, just as there is none with a direct hernia that simply makes a bulge on physical exam, and nicely prevents employment. The other hernia had an error on my physical, saying there was no hernia, when that was the chief complaint for which he was operated upon. A hernia sac was removed and the defect repaired, which he agreed with. The clerical error was the molehill, of which a mountain was made.

Two cases involved surgeries for urinary incontinence done along with other procedures. one primary procedure was a hysterectomy done after radiation therapy for endometrial cancer. Using the exposed area of the abdominal hysterectomy, a Marshall-Marchetti procedure was done. My critic referred to this

as an attack on the urethra, rather than calling it a Marshall-Marchetti procedure. He would have had me do a vaginal procedure which would not have been available in the operative field. Contrary to many statements doubting the efficacy of this urinary incontinence surgery, these patients, and this one, did well.

The other complaint was associated with an outrageous lack of comprehension of why the patient was operated upon. An infarcted dead fatty tissue, appendices epiploicae, was causing an intestinal obstruction. It was mandatory that this dead tissue be removed as the threat to her life. A gallbladder with stones was removed, incidentally, and an abdominal urinary suspension procedure was done to stop her embarrassing loss of urine on standing, both en passant surgeries. The lady, as did most, did well.

A Utilization Committee even wrote me a commendation for the expeditious management of her case, saving two additional surgeries.

My critic complained because I took out an appendix, at that same time. He did not recognize the nature of the dead tissue was not that of an appendix. He wanted an operative permit for an appendectomy, even though there was a note on the chart that an appendectomy had previously been done. A young urologist was unhappy with a general surgeon doing the urinary suspension procedures. This turf battle is what initiated the review. General surgeons at this particular institution introduced, and taught his predecessors in urology, the Marshall-Marchetti procedure. I had done more of these procedures than any other physician. I had no complications. My young urologist "friend" had a death to his credit with this procedure. The procedure makes up about 0.5% of all those done in this hospital, so it isn't a very common procedure.

That leaves only one of the eight ... the one, unknowingly, reviewed twice. This man had seven admissions due to the complications of liver cirrhosis and alcoholism. He died with exsanguination on his last admission, and he bled to death from a gastric varix, a large varicose vein in the stomach.

Dr. Steinhardt said I should have controlled this with an esophageal balloon. Consultants had, endoscopicly, not seen any esophageal varices, and none existed. They did see gastric ulcers. He was also critical that I had, on a prior admission of the same man, inserted a device to drain the massive belly fluid into his venous system, against the advice of a consultant. My critic f ailed to read the acknowledgement by this same consultant that the drainage procedure was very beneficial, and reversed renal failure. And the consultant agreed he had been wrong. Nor did Dr. Steinhardt believe a committee which had reviewed this chart again, at the insistence of my urologist. friend, now the Chief of Surgery, that my management had been correct. This was a rather intensive review. They found my management fine, but Steinhardt ignored that.

These were the "about ten cases" that started the corrective action. What happened with the wheels now in motion? I asked for a hearing, as the by-laws outlined. They suggested two of my detractors serve and two appointed by myself serve also. Next, they said they could not get their appointees to serve, since I had already started a lawsuit. I suggested outside experts be brought in that would be agreeable to myself, my lawyer, and everybody. They aareed, and then refused to allow myself and my lawyer to have a say in the reviewers, or the process they had previously agreed to. Suddenly, there were NOW 77 CASES, instead of the "about 10".

This, I would point out, has become a standard procedure to out-dollar the doctor. This has been referred to by previous speakers. You can bankrupt a doctor if you just increase the numbers. As a hearing date approached, I kept asking for the chart numbers of the "about 10" initial charts. I had still not been given these. I was given these numbers on July 5th, with the hearing to occur on the 10th of July. I was pleased to find them in the 77 cases that now occupied my time. They were not additional

They were all in Dr. Steinhardt's October review

On 10 July, I was allowed 45 minutes to present my rebuttal orally to the entire Medical Executive Committee. The three ACROS physicians, who were not agreed to by me, were put forward as my agreed-upon, objective outside reviewers. This represents a variation of a FORBIDDEN legal principle where one's accusers are not able to sit as the jury. Dr. Steinhardt was allowed to stay, but I was escorted out after 45 minutes of presentation. With its majority of contract physicians, the MEC asked not a single question. This informal hearing had not the usual give and take of a search for the truth. I was not allowed to ask Dr. Steinhardt any questions. I did, but he refused to answer, saying this was an informal hearing. The rigid constraints of the hearing seemed very formal to me.

Let me run down some of the recommendations and criticisms of the hospitals' hired critics on the remaining 69 cases:

First, they indicated I should have chanced cutting across cancer in a lady whose rectal cancer was adherent to the vagina and uterus. I was to leave in the uterus even though I had to take out a part of the vagina. To do so would violate the established principle of en bloc cancer resection (projected). I am sure Dr. Steinhardt was not taught to leave cancer behind. Perhaps he did do this at his Kaiser hospital. This lady had minimal control of her urinary tract before surgery. With the abdominal perineal, we must do to get rid of this cancer, we have to remove the rectum and all the supporting tissues. The bladder, which has already fallen, is going to fall more.

So we did do a Marshall-Marchetti procedure, as referred to previously, and elevated her bladder. If we had not done that, her urinary retention was sure- to

be made worse. we did the anterior bladder suspension immediately available in the operative field. She is now eight years free of cancer and, despite the prediction of no benefit from the urinary procedure, continues to have excellent urinary control.

Another lady came into the ER with acute appendicitis and long standing excessive uterine bleeding. Two months earlier a D&C showed only benign tissue. Her 6.4 grams hemoglobin was treated with transfusions, and then a red appendix was removed, and with a stable patient, 51 years old, a hysterectomy was done. The reviewer never mentioned the 6.4 hemoglobin. He never acknowledged the active bleeding. He never acknowledged the patient did very well. His complaint was about the life saving hysterectomy being done with an acute appendicitis.

One of the most revealing cases is that of a lady with a small bowel obstruction due to a 15cm, melon-sized, sarcoma of the ovary invading the small bowel. Here the mass was removed en-bloc with the adherent small bowel (projected) . As per usual, the surgical result was excellent. The reviewer's judgment was that this lady should have had a colostomy only. This is totally ludicrous when the problem is upstream. A colostomy for a small bowel obstruction is useless . Was he really that ignorant? Did his common sense become overwhelmed by some other factor? Again, I would add that such totally ludicrous statements are the rule, not the exception, in medical peer review. You should know that he also referred to the sarcoma as an "incidental" ovarian cyst.

Then there was the case of a five year old Spanish speaking girl with a laceration of the bend in the elbow, exsanguinating from a brachial artery transection. The median nerve was transected and the u1nar nerve was nicked. The nerves were repaired, along with the artery, and pulsation restored (projected). Post-operatively, I mentioned that she had less than the expected median nerve functional impairment. This can occur when the u1nar nerve carries many of the fibers carried in the median nerve. It is a well-reported anomaly. Dr. Steinhardt states I, therefore, did not know what I was doing, and I had not repaired zhe median nerve at all.

He ignores the impossibility of cutting the brachial artery without transecting the median nerve. If you have a cut come down this way, and you get the brachial artery and you nick the u1nar nerve, this nerve is at risk, and there's no way to avoid cutting it. Never let anatomical fact stand in the way of slander.

There are four more cases. There is an end in sight, here.

There was the lady with the huge abdominal mass that he said we were all surprised to find on opening the abdomen. All three doctors, seeing the patient pre- operatively, described the mass. There was even a drawing of it in the chart before surgery. How does one explain the claim it was not known of before

surgery?

Case 16-16-03 involved removal of a 15cm mesenteric mass causing severe pain and shock on standing. My critic objected to its removal, calling it an innocuous mass. A colostomy was all that he thought should have been done. This, of course, would not have removed the mass and would require a second surgery. The colostomy he must be referring to, actually, has to be a cecostomy (projected), so you have loose stool on your abdomen, at all times. Whereas, if you do a primary resection ... a simple right colectomy, connect the small bowel transverse colon, you're over and done with it. It's one of the easiest surgeries possible. How many of you would like to follow his advise and have an unnecessary colostomy?

There was the lady, septic with a vaginal colonic fistula. This developed secondary to an enthusiastic biopsy of necrotic tissue, secondary to radiation therapy. The biopsy was done by another consultant. Such fistulas, with radiation damaged tissues, will not heal spontaneously. He objected to my treating it with a diverting colostomy, so stool would not exude from her vagina and the infection subside, which it did. He wished a direct attack on the fistula, which is against the advice in all the literature and my training at a cancer hospital for two years. In this lady, in addition, he said that I had f ailed to do a pelvic examination. Reviewing the chart, you find the attending physician and other consultants did not do a pelvic exam. I was the only physician that did do a pelvic examination before surgery.

In another colostomy case, we opened an abdomen, with appendicitis as the diagnosis, only to find a perforated sigmoid diverticula with marked peritonitis. He suggested, at this point, I was supposed to stop and get a new operative permit for this desperately ill lady, and could not understand why I resected the fecal laden, perforated bowel using the standard two-stage procedure with a Hartman pouch. His method of choice requires three surgeries and leaves stool behind, to further spill into the belly cavity. The lady had two procedures and did well.

My critics nearly always failed to mention that the patients did well. If they acknowledged this, they attributed it to luck, not skill.

There were 18 cases where they acknowledged they had no criticism. It cost me time and effort to re-educate myself and document the facts, plus the expense of my legal counsel evaluating these charts. This cost seems to be the motive for listing the cases. Another recurring complaint was about a short history and physical form, which was ludicrous, when you compared my history and physical form to those of the other 77 doctors, my form is universally longer. But, if you keep repeating a lie often enough, it becomes accepted as the truth. Slander does work. Malicious lies do their damage, especially when the courts will not let cases come before a jury.

We won our malice lawsuit of 1979 in the trial, 5 years later. The usual court delays made the starting date of the trial November 1984, rather than the 15th of January. The recommendations of the Medical Executive Committee of July 10th were never allowed to be presented to the jury, so this enormous effort of Mr. Findlayson's was entirely wasted. It did, however, prompt a second lawsuit. The MEC recommendations were quite interesting. They would result in a three month suspension, loss of my position as chief of general surgery, loss of Urological and Gynecological privileges, and loss of access to the ER panel. Pretty stif f . As an adverse ruling it triggered the right to a peer review hearing. This hearing was never allowed. The limitations which indicate that I am a defective doctor were never enforced. For an entire year afterward, I continued to take the difficult cases from the ER, manage my colleagues foul-ups, accept referrals from members of the same MEC committee who were chastising me, and have 20% of my practice made up of hospital employees, as before.

If I should have been restricted so severely, how could the hospital, in good conscience, not. carry out the recommendation of the contract physician-dominated MEC, that took them until 1:00am to arrive at? I doubt that it had anything to do with the fact I had had not one single death or complication in GU or Gynecology, or that no one else wanted to get up at 2:00am for ER call. Or, perhaps, it did. I believe the recommendation was obtained for the sole purpose of convincing a Jury that I was a bad doctor. The MEC did not seem to believe it , either.

They dared not give me a peer review. This would have cost them an enormous amount of money. One of the MEC members indicated this was why my request for a hearing was denied. They were hung on their own petard of 77 cases.

In December of 84, the hospital lost a malice law suit and faced another one for the same behavior, only worse. They stated that they would pay me the judgment and not appeal, if I would drop the second lawsuit and go to courtesy staff and, later, resign. If not, they would appeal the first lawsuit. With hospitals protected by the courts, stating that "shabby, unprincipled, and unprofessional peer review is immune by state action", it was a rather chancey decision to proceed with the second lawsuit and have the hospital appeal the verdict in the first one, and lose everything. We did agree to those terms. I did negotiate additional money for the second corrective action. I did refuse to be silent about the proceedings.

Hence, the Semmelweis; Society was formed and we have gathered overwhelming evidence of a corrupt medical peer review system. Three other groups - The Union of American Physicians and Dentists, The Association of American Physicians and Surgeons, and The Independent Doctors of America - have, also, so concluded. From what I've heard today, there's no argument from this group. Someday, this conclusion may be agreed upon and the courts take action. With the court proceedings, I had naively thought my reputation had been cleared. Unfortunately, I know this can never really be done. Hence, one of my

favorite recommendations, when an unjust peer review has been exposed, is for the perpetrator to write a public letter of apology. This might cost five dollars. It seems they would rather spend hundreds of thousands rather than do this. An outside group of reviewers, paid by both sides equally, needs to be part of the system. We need training to do peer review. One in f ive doctors will have to serve on such an onerous committee.

One in f if teen of my classmates has been a target f or removal from a staff. it has become a popular process whereby hospitals gain control of medical staffs. Hence, the rules by which peer reviews are done need to ensure fair play if the public is to benefit, as Congress intended in 1972. As it is, those in power maintain control.

Is it any wonder that a monopolistic tendency is emerging, and hospitals rule over medical staffs? How will the price of medicine ever come down? How will the quality improve?

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