

COMES NOW, SEMMELWEIS SOCIETY INTERNATIONAL, INC. by and through counsel and files this RESPONSE to Defendant-Appellees' OPPOSITION TO SEMMELWEIS' Motion to File *Amicus Curiae* Brief, the Brief *Amicus Curiae* by SEMMELWEIS SOCIETY INTERNATIONAL, INC. in support of Appellant Linda Freilich, M.D., with the consent of the Appellant in this matter, and a motion to file *Amicus* less than 10 days before the argument, scheduled for February 4th 2010.

A. STATEMENT PURSUANT TO MARYLAND RULES OF PROCEDURE 8-511 (b) CONCERNING MONETORY OR OTHER CONTRIBUTIONS TO PREPARE THIS RESPONSE TO DEFENDANT-APPELLEES' OPPOSITION TO MOTION FOR LEAVE TO FILE AMICUS, CONTRIBUTIONS TO THE AMICUS CURIAE BRIEF PRESENTLY SUBMITTED BY SEMMELWEIS SOCIETY INTERNATIONAL, INC. , AND THE MOTION TO FILE AMICUS CURIAE BRIEF LATE, ALL INCLUDED WITH THIS RESPONSE TO OPPOSITION.

Apart from *Amicus Curiae* Semmelweis Society International, Inc., its officers, members and counsel, Texas Attorney Jeffrey C. Grass,¹ Counsel of Record for this RESPONSE TO DEFENDANT-APPELLEES' OPPOSITION to Motion for Leave to

¹ Dallas Texas Attorney Jeffrey C. Grass's clients are mostly physicians, nurses, and other medical personnel disciplined or terminated for reasons not related to improving the quality, safety, or costs of patient care. His typical client faces contrived charges brought in retaliation for being a competitor, viewed as a competitor, or thought to be another kind of a threat or problem for a supervisor, manager or others in control. Physicians and medical staff often are singled out for termination because they deliver, or facilitate the delivery of high quality and safe, yet cost-effective medical services with good patient outcomes. Their "lean" diagnostic and treatment protocols, however, are on average far cheaper for the patient and healthcare insurers including Medicare and Medicaid. In the short term, lean physicians like Dr. Freilich tend to bring in far less money for the hospitals, physicians' groups and clinics where they practice. They make minimal use of expensive diagnostic equipment and facilities, yet achieve good outcomes. Healthcare professionals who seek out Attorney Grass typically have made a report, critique, observation, speech or been proactive in raising the quality and lowering the excessive costs of patient care, speech or actions that put them in disfavor with the managers or ruling forces of the healthcare entity where they serve as credentialed physicians or employed staff.

File *Amicus*, for the accompanying *Amicus Curiae* Brief, and Counsel of Record for Semmelweis Society's Motion to file *Amicus* late (Argument is February 4, 2010), has prepared this RESPONSE TO OPPOSITION, the included Semmelweis Society's *Amicus Curiae* Brief, and Semmelweis's Motion to File *Amicus* Late. Attorney Jeffrey C. Grass is serving Pro Bono in preparing this OPPOSITION, the Brief *Amicus Curiae*, and the Motion to File *Amicus* Late. Michael J. Myers,² Associate Professor of Law, The University of South Dakota School of Law, is assisting Counsel of Record, Jeffrey C. Grass. Professor Myers is serving Pro Bono as Of Counsel for Semmelweis Society International, Inc. in this entire *Amicus Curiae* matter in support of Linda Freilich, M.D.



Respectfully submitted,

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JEFFREY C. GRASS
Counsel of Record

² Professor Myers, who teaches and practices healthcare law and elder law, also teaches the business of healthcare including how to manage hospitals and other medical services organizations. He took a mid-career sabbatical that lasted 17 years, serving as hospital counsel, administrator or CEO of several hospitals in the upper Midwest. His hands-on experience includes five years as CEO of Mayo Clinic flagship hospital, Mayo-St. Mary's in Rochester, Minnesota. Professor Myers' special interests include the problems for healthcare's quality and excessive costs created by non-profit hospital systems that are regional monopolies for medical services within a defined geographic area or "patient services demographic." Upper Chesapeake Health, owning the only two general care hospitals in Harford County, Maryland, and with tie-ins to local physician practice groups, is to Professor Myers a typical regional nonprofit with a monopoly on hospital care services.

Table of Contents

A. STATEMENT PURSUANT TO MARYLAND RULES OF PROCEDURE 8-511 (b)	i
TABLE OF AUTHORITIES.....	iv
B. INTEREST OF AMICUS CURIAE.....	1
C. BACKGROUND OF AMICUS BRIEF	2
D. PUBLIC POLICY ISSUES	13
1. ACCREDITATION AND HOSPITAL LAW:	13
2. MARYLAND LAW AGAINST RETALIATION:	14
3. PHYSICIAN ETHICS AS PUBLIC POLICY:	14
E. ARE PHYSICIANS WHO HAVE "PRIVILEGES" TO TREAT THEIR PATIENTS IN A HOSPITAL, WORKING THERE AS INDEPENDENT CONTRACTORS, EMPLOYEES, OR ARE THEY IN BETWEEN?	15
F. FIDUCIARY ISSUES.....	15
G. CONCLUSION	16
CERTIFICATE OF SERVICE.....	37

Table of Authorities

Cases

<u>Austin v. Mathews</u> , 979 F.2d 728, 741 (1992)	7
<u>American Nurses Association v. Leavitt</u> , 593 F.Supp.2d 126, 133 (2009)	9
<u>Freilich v. Upper Chesapeake Health, Inc.</u> , 142 F.Supp.2d 679, 697-702 (2001)	3
<u>Freilich v. Upper Chesapeake Health, Inc.</u> , 313 F.3 rd 205, 214-217 (2002).....	3
<u>Gerson v. Gerson</u> (179 Md. 171, 177, 20 A.2d 567, 570 (1941)	16
<u>Mathews v. Eldridge</u> , 424 U.S. 319 (1976).....	5
<u>Ritten v. LaPeer Regional Medical Center</u> , 611 F.Supp.2d 696, 711, 718, 720-721, 723 (2009)	11
<u>Sadler v. Dimensions Healthcare Corp.</u> , 378 Md. 509, 836 A.2d 655 (2003).....	5

Articles & Law Reviews

122 PUBLIC HEALTH REPORTS 163.....	12
BNA's Daily Health Care Report, June 4, 2001, and Employment Litigation Reporter, June 26, 2001	2
Charles R. Koepke, M.D., J.D., <u>Physician Peer Review Immunity Policy: Time to Euthanize a Fatally Fawed Policy</u> , 22 J. of Law and Health 1, 1-2, 10-11 (2009)	7
Eleanor D. Kinney, J.D. M.P.H, <u>Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?</u> 13 MSU J. of Med. & Law 57, 58-76, 81(2009)	5
Erica Lai, <u>Appended Post-Passage Senate Judiciary Committee Report: Unlikely "Legislative History" For Interpreting Section 5 Of The Reauthorized Voting Rights Act</u> , 156 U.Penn.L.Rev. 453 (2007)	9
Gail Garfinkel Weis, "Is Peer Review Worth Saving? February 18, (2005)	11
Geneviève M. Clavreul, RN, PhD, <u>The White Coat of Silence Working Nurse</u> , Feb. 25, (2005) pp 11-15.....	10
Institute of Medicine, published as To Err is Human (1999).....	2
<u>Johnson v. Sullivan, M.D.</u> , 758 F.Supp. 1496 (1991).....	9
June Gibbs Brown, Inspector General, The External Review of Hospital Quality—A Call for Greater Accountability, p. 30 (July 1999, OEI-01-97-00050	18
Lu Ann Trevino, <u>The Health Care Quality Improvement Act: Sword or Shield?</u> 22 T. Mar. L. Rev. 315 (1997)	11

Lucian Leape M.D. and Donald Berwick, M.D., wrote, "Five years after 'To Err is Human:' What have we learned?" (Journal of the American Medical Association, May 18, 2005, 2384-90..... 12

Patricia Panchak, "Lean Health Care: It Works!" Nov. 1, 2003, IndustryWeek.com..... 13

R. Monina Klevens, DDS, MPH, PUBLIC HEALTH REPORTS, March-April 2007, 160-167, "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002." 12

Shannon Brownlee, The tale of MEDICARE Fraud reporter Patrick Campbell, M.D., OVERTREATED---Why Too Much Medicine Is Making Us Sicker and Poorer 75-66, 84, 88-89, 92-94 (2007) 8

Steve Twedt, "The Cost of Courage: How the tables turn on doctors." (Six initial articles were published October 26-29, 2003 4

Yann van Geertruyden, in The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community 18 J. Contemp. Health Law 239 (2001) 10

Laws and Regulations

42 U.S.C. § 1395bb..... 9

Code of Maryland Regulations (COMAR) § 10.07.09.16 A.(3) 15

Code of Maryland Regulations, § 10.07.01.24 (E) (3) (b) (vii)3

Health Care Quality Improvement Act (HCQIA) (42 U.S.C. § 11101-11152) 3

B. INTEREST OF AMICUS CURIAE

Amicus SEMMELWEIS SOCIETY INTERNATIONAL, INC. (SSI) is a non-profit organization that supports physicians, nurses, and healthcare staff as they try to provide better, safer, more efficient and cost-effective---optimum---patient care. SSI promotes medical services that spring from the medical ethics canon to provide optimum---not too little or too much---diagnostics and care. A result is that less, not more, of our Nation's healthcare dollars are spent on healthcare. Providers' good faith efforts are opposed by many managers or other physicians who diagnose and treat patients for maximum revenue not wellness. Hospitals frequently retaliate against physicians like Dr. Freilich who work for better and safer care at lower costs because in the short term providing optimum patient care tends to generate less revenue and profit.

SSI's MISSION: to ensure healthcare professionals' rights to advocate for and provide quality and cost-effective medical services. SSI promotes high quality, optimum medical diagnoses and treatment for every patient; care that is continuously improving and safer; more and more efficient and effective as knowledge and techniques improve; yet less costly overall. SSI promotes free speech rights of all healthcare professionals to advocate for and provide optimal yet safer patient care without suffering retaliation from administrators or colleagues. Many doctors are threatened by physicians like Dr. Freilich because they provide medical services that are better, safer, and routinely less costly than average physicians. Hospital managers tend to dislike physicians like Dr. Freilich because they "Do it right the first time," with minimal use of expensive testing machines and fewer medical errors and infections that hospitals usually get paid to treat. Efficient and cost-effective medical care services also put "*quantity care*" physicians at competitive disadvantage in getting and keeping patients.

SSI UNDERSTANDS why hospitals and those physicians and medical practices closely affiliated with hospitals try to control medical services within their geographic patient service areas. Besides setting a "bad example," providers of optimum diagnostics and patient care like Dr. Freilich are unwanted competitors because their charges and

results tend to lower reimbursement rates and revenues for similar medical services within the patient demographic where they practice. By protecting healthcare professionals who provide optimum patient care, SSI reduces medical costs for patients, insurers, and all government-paid programs including MEDICARE and MEDICAID.

SSI's VISION: physicians and medical staff fully protected by the law and by well-established "cultures of safety;" professionally empowered so they feel, and in fact are, free to advocate for and provide optimum patient care. The more patients who receive optimum medical care, the lower the percentage of U.S. Gross National Product (GNP) consumed by spending on healthcare.

C. BACKGROUND AND PURPOSE OF AMICUS BRIEF

From its on-the-ground experience and continuous legal and related medical research, SSI is trying to put into context for this Court the timely public policy and emerging health law issues involved in Dr. Linda Freilich's appeal. Based on the cumulative experience of physicians and other healthcare professionals SSI has assisted and works with, SSI believes the disposition of Dr. Freilich's appeal will substantially affect---for better or worse---the quality, safety and medical expenses for the care of every patient in the United States. The legal issues in Dr. Freilich's appeal have especially significant relationships to the excessive costs of healthcare as a dangerously escalating percentage of U.S. GNP: higher and higher healthcare spending that threatens the world-wide competitive position and fiscal soundness of this Nation.

Appellant's litigation against Upper Chesapeake Health for the rights of physicians to advocate for and provide better, safer and less costly patient care is on the watchlists of hospitals, healthcare industries and their attorneys. In the decade since 2000, when Dr. Freilich first filed her patient advocacy and professional free speech rights' claims in the Federal District Court in Baltimore, her claims and how courts ruled on them have been closely watched. (See, e.g., BNA's Daily Health Care Report, June 4, 2001, and Employment Litigation Reporter, June 26, 2001 [both summarizing the Federal District Court opinion granting Defendants' motion for summary judgment]). The healthcare

industry scored big victories for lower quality, less safe, and bloated cost models when the District Court (Freilich v. Upper Chesapeake Health, Inc., 142 F.Supp.2d 679, 697-702 (2001) and the Fourth Circuit (Freilich v. Upper Chesapeake Health, Inc., 313 F.3rd 205, 214-217 (2002) wrongly ruled against her Americans With Disabilities Act and other professional free speech and patient advocacy claims.

The Fourth Circuit held the Health Care Quality Improvement Act (HCQIA) (42 U.S.C. § 11101-11152) provides a near impermeable federal immunity shield: the result is peer reviewers can act unfairly but with impunity. They can act in bad faith, so long as the Court can cherry-pick from the record some "objectively reasonable" evidence to support the peer reviewers' decision, even if admittedly biased, economically motivated, or in bad faith. (see p. 212). If there is any evidence in the record---credible or not---that the physician's "[a]ttitudes, cooperation, and ability to work with others" (Code of Maryland Regulations, § 10.07.01.24 (E) (3) (b) (vii)) are disfavored by the hospital, the efficient, quality care and cost-effective physicians like Dr. Freilich³ can be freely barred.

The federal courts ruled against Dr. Freilich's advocacy for higher quality care, improved patient safety and stronger cost controls over healthcare spending, even though Upper Chesapeake Health owned and managed the only two general purpose hospitals in Harford County.⁴ Denying Dr. Freilich access to Upper Chesapeake's hospitals also

³ From the Record it appears to SSI that all of Defendants' allegations that Dr. Freilich provided substandard patient care were administratively litigated in Dr. Freilich's favor by Defendant Hospital's Ad Hoc Hearing Committee. That committee of physicians also recommended Appellant's reappointment to the medical staff. SSI investigates as best it can whether those who seek SSI support or membership are in fact quality-care healthcare professionals who are neither "Impaired" nor "Disruptive," and consequently merit SSI's support and assistance. Dr. Freilich was vetted by SSI, and in May 2008 she was given SSI's "Clean Hands Award." SSI's award was for Dr. Freilich's courage and determination to establish for every healthcare professional the right to advocate for and to provide better, safer and less costly patient care without fear of reprisals as she has suffered.

⁴ In 2009, the Upper Chesapeake Health System and the University of Maryland Hospital system entered into a partnership that gives Maryland substantial ownership and control

denied Dr. Freilich's many loyal patients their right to be treated in a local hospital by their physician of choice. SSI is especially supportive of physicians who are denied rights to practice in hospitals or systems with geographic monopolies like Upper Chesapeake's monopoly of institutional health services throughout Harford County. Allowing Defendant-Appellees to cut off Dr. Freilich's rights⁵ to treat her patients as they need hospital care, when the parties agree she is a quality-care physician neither impaired nor disruptive, is precedent to deny to every Maryland resident the right to have the physician of their choice continue to treat them when they require hospitalization.

Dr. Freilich was one of about a dozen quality-care physicians featured in Steve Twedt's Pittsburgh Post-Gazette series, "The Cost of Courage: How the tables turn on doctors." (Six initial articles were published October 26-29, 2003, plus numerous follow-ons.) Twedt's article about Dr. Freilich, "Law gives hospital panels wide powers over doctors," was published October 29, 2003.⁶ The entire series with video and six short audio clips is at <http://www.post-gazette.com/m/03299/234499-84.stm>. Steve Twedt explains in the short audio clips why and how the good doctors can easily be driven out of hospitals and ruined professionally, financially, and personally.

Mr. Twedt, the Post-Gazette's long-time healthcare reporter, focused on how the Health Care Quality Improvement Act, at issue in Appellant's appeal, was being distorted from its original intentions. Even the statutory language was distorted from its commonly understood meaning, giving near-absolute power to hospitals and their self-selected peer reviewers. Physicians like Dr. Freilich who try to ensure optimum and safe medical services have been made defenseless against their economic competitors. If predatory competitors feel their presence is threatening, inconvenient, or simply distasteful, the predators have near-absolute legal immunity for their bad faith actions.

of Upper Chesapeake.

⁵ Customarily called "hospital 'privileges.'" "

⁶ <http://www.post-gazette.com/pg/03302/235117-84.stm>.

Conscientious, quality care physicians like Dr. Freilich are left with legal claims that only recently are understood and sometimes vindicated.⁷

Typically, healthcare officials and physicians who are on the right rung of the ladder of local power can target and oust the conscientious, quality-care physician for self-serving objectives not related to quality of patient care, including personal dislike or bias.⁸ Managers at the hospital where he or she practices, physicians or others close to or

⁷ A 2009 law review article by Professor Eleanor D. Kinney, J.D. M.P.H, Render Professor of Law and Co-Director, William S. & Christine S. Hall Center for Law and Health, Indiana University School of Law, Indianapolis, reviewed peer review laws and decisions and compiled lists and citations to the cases including articles in the popular press and online commentary. She questioned court decisions that interpreted HCQIA and state peer review immunity legislation that consistently have denied to peer reviewed physicians the "specific dictates of due process" as articulated by the U.S. Supreme Court in *Mathews v. Eldridge*, 424 U.S. 319 (1976). ([Hospital Peer Review of Physicians: Does Statutory Immunity Increase Risk of Unwarranted Professional Injury?](#) 13 MSU J. of Med. & Law 57, 58-76, 81(2009). Professor Kinney comprehensively reviewed the legal and medical literature that has critiqued peer review, and she discussed most of the cases. Her tally from the reported cases was 3 wins and 30 losses for those physicians peer reviewed through mid-2008, who elected to litigate the adverse actions taken against them. SSI estimates that because of the 10-1 or worse odds against success plus the high expense of litigation, less than 1 in 5 challenge their peer reviewers in court, even when they are in fact "clean" and the record contains substantial evidence they are quality care doctors. The 4th Circuit's decision in Dr. Freilich's federal litigation is mentioned on p. 68 and in fn. 69. Semmelweis Society International and similar-purpose organizations are accurately characterized as created by targeted physicians to increase public awareness "about these abusive proceedings and provide targeted physicians with legal assistance and other information" (77; and see 74, 76-78, fn. 108, 116, 121-124). Professor Kinney does not list or discuss [Sadler v. Dimensions Healthcare Corp.](#), 378 Md. 509, 836 A.2d 655 (2003), with its orientation to fairness and requirements for due process. Physicians peer reviewed in Maryland have the right to insist that hospitals conform to the medical staff's contract due process rights as spelled out in medical staff bylaws. The article is available at <http://indylaw.indiana.edu/instructors/kinney/articles/Mich J L&M Peer Review 2009.pdf>.

⁸ The standards of the body that accredits Upper Chesapeake's two hospitals as the statutory delegatee of the U.S. Department of Health and Human Service's Centers For Medicare and Medicare Services, the Joint Commission on Accreditation of Healthcare Organizations (JCAHO) (42 U.S.C.§1395bb), require that the grant or denial of hospital privileges to a physician must be directly related to the quality of patient care (Comprehensive Accreditation Manual for Hospitals (CAMH) (2000) MS.5.4.4:

with influence over the hospital, can have the hospital use a peer review action to force the physician out. Peer reviewers with improper motives nonetheless stand comfortably behind HCQIA's immunity shield as their sham peer review actions are carried out for economic motives or other reasons not related to the quality of patient care. For the last two decades most courts have mis-interpreted HCQIA and mistakenly protected the same kind of improper peer review actions HCQIA was carefully written and passed to protect against.⁹

"Decisions on reappointments or on revocation, revision, or renewal of clinical privileges must consider criteria that are directly related to the quality of care.").

⁹ Lu Ann Trevino, The Health Care Quality Improvement Act: Sword or Shield?
22 T. Mar. L. Rev. 315, 316 (1997):

Congress was mindful of the enormous power it gave to the members of these peer review committees and the equally enormous potential for abuse by such committees. *What better way to carry out racial or sexual discrimination or eliminate competition than to discredit a fellow physician by questioning her skill in the name of improving the quality of care while wearing the cloak of immunity?* For these reasons, the Act allows physicians who have been disciplined to sue under the Clayton Act, and the Civil Rights Acts. In such suits, the immunities can be revoked and monetary damages assessed if the defendant failed to act in a manner consistent with the improvement of health care. (emphasis added).

The gross legal errors and unfairness interpreting HCQIA can easily be remedied. Courts simply can interpret HCQIA to provide all the due process and fairness guarantees Congress expressly wrote into the Act. SSI supports HCQIA as written including all peer reviewers and peer review actions that carry out the statute's original purpose: Empower and protect the good doctors so they can drive out the bad doctors and improve the quality of patient care. HCQIA is well-drafted and well-intended, but 20 years of aggressive legal distortion of its intended due process and fairness guarantees have put all physicians in terror of sham peer review if they, e.g., try to cut back on unnecessary but expensive tests or "overtreatments" or otherwise get on the wrong side of the power equation. HCQIA has made doctors into quiet, timid sheep when the healthcare system

HCQIA's cloak of immunity also was misused by the Harford County Circuit Court. Granting summary judgment on Dr. Freilich's important claims allows hospitals and the healthcare industry to stop quality care physicians from providing better, safer and cost-effective patient services, forcing them to violate the Hippocratic Oath, "First, Do No Harm." If conscientious physicians advocate, complain, or suggest improvements in patient services as Dr. Freilich did, they risk termination of their hospital privileges and potentially the destruction of their medical careers.(see Charles R. Koepke, M.D.

J.D., Physician Peer Review Immunity: Time to Euthanize A Fatally Flawed Policy, 22 J. of Law and Health 1, 1-2, 10-11 (2009).

SSI's experience is that most physicians are conscientious and want to practice optimal, cost-effective medicine that helps, not hurts the patient. If well-protected from retaliation they can follow their ethical duties and put the patient---not revenues and profits---first. Besides stopping physicians from providing or advocating optimum patient care and safety, the court decisions so far in Dr. Freilich's litigation have silenced those best situated to report healthcare overtreatment and outright MEDICARE fraud. Physicians are on-site with their patients; working with them hands-on and monitoring their condition; able to revise diagnoses or treatment procedures; and to complain or make suggestions in real-time including how the hospital is billing for a patient's care. The rulings against Dr. Freilich have effectively frozen every physician's critical voice, not just in Maryland but throughout the United States because healthcare officials, managers and their attorneys are following this litigation. Doctors rarely talk about it, but they all know what can happen to them if they question whether the patient should be

desperately needs them to bark like the aggressive watchdogs of quality patient care they are intended to be. Judge Pregerson, the dissenter in Austin v. Mathews, 979 F.2d 728, 741 (1992), where the majority held that bad faith peer review was allowable, got it right: "Section 11112 (a) reflects Congress's intent 'to encourage good faith professional review activities of healthcare entities.'"

subjected to multiple tests or procedures; or if they report billings for unnecessary treatment or other MEDICARE fraud. (The harrowing tale of MEDICARE Fraud reporter Patrick Campbell, M.D., is told by Shannon Brownlee, in OVERTREATED---Why Too Much Medicine Is Making Us Sicker and Poorer, 75-77, 84, 88-89, 92-94 (2007). Affirming Upper Chesapeake's bad faith peer-review actions plays right into the hands of the managers of hospitals, profit and nonprofit, increasingly driven by the bottom line.¹⁰

SSI can explain how the bad faith, personally biased peer-review action sustained by the Circuit Court is the opposite of peer review proceedings as required for accreditation by the Joint Commission on Accreditation of Healthcare Organizations. JCAHO demands "objective, evidence-based decisions regarding appointment to the membership on the medical staff. . . ." ¹¹

¹⁰ In an email to a colleague on March 25, 2008, Of Counsel Michael Myers gave an example from a hospital operated by the Mayo Clinic.

[T]he fundamental corporate restructuring the United States Healthcare system has undergone, since the enactment of HCQIA. . . [has] implications for physicians who now overwhelmingly are "employees" of large, integrated, and economically and politically influential healthcare systems. We should dwell upon the influence of such corporate integration upon physician behavior and increased risk for a physician who does not adhere to the clinical and financial forces that drive system profitability. Last semester I had a former Mayo pediatric oncologist confirm how corporatization of Mayo has affected clinical judgment and [physician] autonomy. The employed physician who suggests that certain diagnostic and surgical procedures may be unnecessary and not in the best interests of patient care may be frustrating utilization targets and undermining the "production" incentives found in the contracts of employed physicians. The CEO/CFO and Medical Director will likely be offended with such conduct, as will fellow physicians who stand to profit from increased "clinical production."

¹¹ For example, in a July 09, 2008 bulletin, *Applicable Joint Commission*

Applicable hospital law was clarified on July 15, 2008, when Congress passed HR 6331, amending 42 U.S.C. § 1395bb, under the title "Revocation of Unique Deeming Authority of the Joint Commission." Congress finally made MEDICARE law clear by unequivocally declaring that JCAHO accreditation standards always were "the law of the land" for all accredited hospitals like the two operated by Defendant-Appellees. The 2008 federal legislation and follow-up court decisions interpreting the statutes effective since MEDICARE began in 1965 (see, e.g., American Nurses Association v. Leavitt, 593 F.Supp.2d 126, 133 (2009), should have made JCAHO's due process and fairness standards the controlling law in Dr. Freilich's litigation. Action like this by Congress, re-interpreting an existing statute by some type of legislative pronouncement---here, by amending the statute with a pointed title---is referred to in the literature of legislative interpretation as "post-facto legislative history." (see Erica Lai, Appended Post-Passage Senate Judiciary Committee Report: Unlikely "Legislative History" For Interpreting Section 5 Of The Reauthorized Voting Rights Act, 156 U.Penn.L.Rev. 453 (2007). Even though these issues were timely presented to the District Court, this controlling federal legislation was determined inapplicable, a ruling that inadvertently put Defendants' hospitals at risk of losing their accreditation and consequently making them technically ineligible to apply for or receive MEDICARE and MEDICAID payments. (See, generally, Johnson v. Sullivan, M.D., 758 F.Supp. 1496 (1991).

Officers, members, and the experienced professionals who work with SSI attest that *The Freilich Principle* chills and silences the medical community:

[accreditation] Standards, JCAHO describes generally the Medical Staff Credentialing Standard as ". . . [M]aintenance of a credible process to determine competency. . . ." That standard requires a professionally conducted inquiry that is objective, thorough and fair, participation limited to individuals who are not economic competitors, and not personally or otherwise biased. JCAHO always has required its accredittee hospitals to follow medical staff bylaws promulgated according to JCAHO's standards for appointing and reappointing the medical staff.

Any allegations of unprofessional or unethical behavior, or actions such as making valid complaints of dangerous hospital practices or substandard medical services, no matter how contrived or flimsy the allegations against the physician, will support bad faith peer review actions that are so difficult to challenge that as a practical matter there is no accountability.

There is even less chance than before this decision by the Circuit Court, that those few doctors who might have broken their silence to save a patient from death or serious injury¹² will take the ultimate risk to career and medical license to save a patient's life.

SSI fully supports good faith peer review. Being human, physicians can become impaired, disruptive, or lose their medical skills. *Freilich's* facts and holdings, however, create a classic Machiavellian tutorial: "How to Destroy A High-Quality Physician Who Is In Your Way." If the *Freilich Principle* is allowed to stand, any excellent physician can be terminated from hospital practice if labeled "unprofessional" or "unethical," alleged to have a "bad attitude," or in the opinion of hospital managers, not "cooperative" enough.¹³

¹² SilenceKills.com reports the results of a statistically-based survey funded by the American Association of Critical-Care Nurses. The purpose was to find out if the average physician or staff would speak up when they see medical errors happening or about to happen, in real time so the patient will not be harmed. Results were that less than 10 % of physicians will speak out when they see medical errors "in progress," even life-threatening errors that could kill a patient immediately. The *White Coat of Silence* explains nurses' reluctance to call attention to or report what they see, plus some of the reasons for the lockdown in most hospitals of medical professionals' free speech rights. (The *White Coat of Silence* Working Nurse, Feb. 25, (2005) pp 11-15).

¹³ Yann van Geertruyden, in The Fox Guarding the Henhouse: How the Health Care Quality Improvement Act of 1986 and State Peer Review Protection Statutes Have Helped Protect Bad Faith Peer Review in the Medical Community 18 J. Contemp. Health Law 239 (2001), used his physician-father's experience having his medical career derailed right after he refused to accept an "offer" to join a large, local group practice, to examine the wider effects of bad faith peer review. The author characterized the overarching threat of bad faith peer review as creating a constant chilling effect on all doctors, even those not consciously aware of the severe risk from it happening to them. Mr. van Geertruyden described the effect as the "problem in the medical profession which is known by many, but spoken of by few."

While the stated objective of peer review is to protect patients by improving the pool of practicing physicians ("The good doctors weeding out the bad doctors"---the well-intentioned but naïve goal of HCQIA), too many court decisions in the pattern of the *Freilich* rulings immunize illegitimate peer review actions. The bad doctors are both empowered and protected by HCQIA immunity. Because bad doctors tend to bring in more money than good doctors, hospitals are financially pressed to encourage their bad doctors to drive out their good doctors. The Circuit Court's *Freilich* judgment perfectly supports this perverse scenario, which has turned HCQIA upside down and causes healthcare to consume far too much of our Nation's productivity. This corrupted interpretation of HCQIA allows bad doctors to stay in the healthcare system and keep medical spending artificially high, persecuting their competition while wrapped in the cloak of HCQIA's immunity.¹⁴ Some trending legal decisions are favoring physicians.¹⁵ Yet most physician-versus-hospital decisions encourage the destruction of good doctors, so the healthcare system loses the benefits of their higher quality and far less expensive doctoring. The Circuit Court's decision contributes to this national healthcare disaster by immunizing the predominant *quantity-care* forces that control healthcare.

Reality, for most of the quality-care doctors whom this country needs during this period of safety and fiscal crises in our Nation's medical care system, is they are forced

¹⁴ Gail Garfinkel Weiss, in an article in *Medical Economics* ("Is Peer Review Worth Saving? February 18, (2005), recounted the experiences of Steven I. Kern, a New Jersey physician-plaintiff's attorney, veteran of peer review actions against physician-clients. Mr. Kern told Ms. Weiss:

In the 30 years that I've been a health law attorney. . . I've never seen anyone who admits a lot of patients and is well-liked have a problem with the hospital disciplinary mechanism. On the other hand, if you're competing with such a doctor, especially if you're new to the hospital or on the wrong side of hospital politics, you're a potential target. (p.2).

¹⁵ *Ritten v. LaPeer Regional Medical Center*, 611 F.Supp.2d 696, 711, 718, 720-721, 723 (2009), is a case where the court recognized the improper influence of a person with unauthorized but de facto control of Dr. Ritten's fate, and consequently has allowed the matter to go to trial.

by prevailing hospital law to act like silent sheep instead of the noisy watchdogs whose eyes and voices are desperately needed as hands-on monitors of quality, safety and cost.

SSI can document how the decisions against Dr. Freilich, so far, contribute to the high rate in the U.S. of mostly preventable patient-deaths from hospital-caused infections and medical errors. Five hundred forty eight (548) patients die every day of infections or from medical errors that can be prevented through conscientious and methodical oversight of patient care.¹⁶ Prevalence of overdiagnosing and overtreating also costs all healthcare payers---including U.S. taxpayers---hundreds of billions more than the cost-efficient medicine practiced by quality-care physicians like Dr. Freilich.¹⁷

¹⁶ The Wall Street Journal Health Blog, June 9, 2009, commented on the American Medical Association's proposed actions to reduce the 100,000 per year deaths from hospital-acquired infections. Studies confirm that about 548 patients die every day because of, not in spite of, hospital and medical treatments (100,000 from hospital-acquired-infections + 100,000 from medical errors = 200,000 divided by 365 = 548). If two moderately full *Boeing 747* passenger jets crashed every day, something would be done. The annual patient death figure from medical errors is from the work of the Institute of Medicine, published as *To Err is Human* (1999). IOM's studies are periodically updated, although the numbers are not getting better. Two authors of the 1999 study, Lucian Leape M.D. and Donald Berwick, M.D., wrote, "Five years after 'To Err is Human:' What have we learned?" (*Journal of the American Medical Association*, May 18, 2005, 2384-90. Drs. Leape and Berwick concluded:

[T]he groundwork for improving safety has been laid in these past five years but progress is frustratingly slow. . . . [W]e will not become safe until we choose to become safe (p. 2384, 2390).

The annual hospital-acquired-infection death rate is from an article in *PUBLIC HEALTH REPORTS*, March-April 2007, 160-167, authored by R. Monina Klevens, DDS, MPH and six colleagues, "Estimating Health Care-Associated Infections and Deaths in U.S. Hospitals, 2002." Klevens and her colleagues explained:

Among the 1.7 million patients with an HAI [Hospital Acquired Infection] in 2002, there were 155,668 deaths, of which 98,987 were caused by or associated with the HAI." (122 *PUBLIC HEALTH REPORTS* 163).

¹⁷ Estimates by researchers and practitioners of optimum patient care---also called Lean Health Care---are that by applying Lean's strategies and techniques (derived mostly from Toyota Production System [TPS] methods of continuous improvement [kaizen]), the Nation's spending for diagnostics and treatments can be cut by at least \$800 billion per

D. PUBLIC POLICY ISSUES

1. ACCREDITATION AND HOSPITAL LAW:

SSI urges this Court to review the legal relationships between the Joint Commission, HHS/CMS, and Maryland State licensing. The standards for accreditation serve as federal regulatory standards, and Maryland State licensing standards, for all hospitals that are surveyed and accredited by the Joint Commission as agent for HHS/CMS and the State of Maryland. A 1999 report by HHS's Inspector General summarized the relationship of the Commission to MEDICARE Conditions of Participation.

Once a hospital is accredited by the Joint Commission, it is deemed to meet the Medicare conditions of participation. This *delegation of authority to the Joint Commission is granted by Congress*, not by HCFA (now CMS). As such, it is a unique authority held by no other accrediting body in the healthcare field. (June

year from the current total of around \$2.5 trillion. Kaizen is made up of "kai"---"change" and "zen"---"good." Patricia Panchak's article, "Lean Health Care: It Works!" Nov. 1, 2003, IndustryWeek.com., conservatively suggests overall healthcare spending can be cut by at least \$800 billion per year. That saves over \$2 billion per day, a high percentage of these savings from U.S. taxpayers' pockets. Panchak quotes a hands-on pioneer of Lean, Cindy Jimmerson, nurse and medical researcher:

The national numbers for waste in health care are between 30 % and 40 %, but the reality of what we've observed doing minute-by-minute observation over the last three years is closer to 60 % . . . [That's] waste of time, waste of money, waste of material resources (p. 2).

There are a few healthcare work environments (probably no more than 5 %) where Lean is in full-flower because management has completely bought into continuous improvement. Where continuous improvement is in full effect, there is no retaliation for physicians' speaking up professionally, even with unwelcome complaints or critiques. The result is physicians feel totally protected as in SSI's VISION, supra. Unfortunately the great majority of doctors work in a climate of continuous fear, not continuous improvement. They may not understand how much they are at risk unless they have experience with sham peer review. But most physicians know enough to observe the code of silence (see fn. 12 and 13), and to avoid being "on the wrong side of hospital politics" (fn. 14). Whether they can articulate their situation or not, they are not free to practice or advocate for optimum patient care as most would prefer.

Gibbs Brown, Inspector General, The External Review of Hospital Quality—A Call for Greater Accountability, p. 30 (July 1999, OEI-01-97-00050).(emphasis added).

SSI urges this Court to view the Joint Commission's accreditation standards as policies, principles and procedures that suffuse all the legal relationships within Defendant-Appellee's hospitals, including Upper Chesapeake's relationships with all on-staff physicians such as Dr. Freilich. The Commission insists that all relationships between hospital and staff be conducted within a culture of safety, which means an "open workplace" that totally forbids any form of retaliation or reprisals for good faith observations, suggestions, complaints and critiques. By the Joint Commission's standards, Defendant-Appellee is in serious default on its promised commitments to the Commission that it made when it submitted to accreditation by the Commission.

2. **MARYLAND LAW AGAINST RETALIATION:**

Code of Maryland Regulations (COMAR) § 10.07.09.16 A.(3) prohibits the exact type of retaliation against caregivers that Appellant Dr. Freilich suffered because she tried to protect the patient-residents in Upper Chesapeake's licensed skilled nursing facility. Dr. Freilich is a pioneer in claiming legal relief for herself and other third parties who attempt to protect the elderly, disabled and vulnerable adult residents in Maryland's skilled nursing facilities, commonly called nursing homes. For the sake of those resident-patients she advocated for to the Defendant Hospital, this Court should provide to her the protections expressly set forth in the subject COMAR.

3. **PHYSICIAN ETHICS AS PUBLIC POLICY:** Maryland Courts should not ignore or treat as of no consequence in locating sources for and articulating public policy, Dr. Freilich's and all other physicians' professional ethical duties to "First, Do No Harm, and "Put The Patient First?" SSI believes these physician canons ought to be foundations for Maryland's and all other States' public policy for healthcare; especially for a

healthcare system that presently is overtreating and overspending, dangerously undermining the health of our population, economy and pushing up our National Debt.

E. ARE PHYSICIANS WHO HAVE "PRIVILEGES" TO TREAT THEIR PATIENTS IN A HOSPITAL, WORKING THERE AS INDEPENDENT CONTRACTORS, EMPLOYEES, OR ARE THEY IN BETWEEN?

The reality, as is clear from the way Defendants have been able to terminate Appellant and hold her at bay with legal proceedings for over 10 years, that physicians who have privileges to practice in hospitals are neither independent contractors in the typical sense nor conventional employees. Their legal status is much more like employees than independent contractors. This point deserves review, in the context of considering the rights and remedies that credentialed physicians ought to have while working, literally under the thumb, of hospital management.

F. FIDUCIARY ISSUES

Based on its experience with situations similar to Dr. Freilich's relationship with Upper Chesapeake Health, her reliance on Defendant Hospital's numerous no-retaliation policies that were required by federal and state law including JCAHO accreditation standards and then blatantly violated when Appellant was betrayed by retaliatory termination, SSI urges this Court to review the facts of this case against Maryland's standard as to when, and how, fiduciary duties to Appellant were created under Maryland law. Maryland adopted the "floating fiduciary principle" in Gerson v. Gerson (179 Md. 171, 177, 20 A.2d 567, 570 (1941)), and the facts of her reliance, lack of power, vulnerability and related factors qualify her as a betrayed party in a fact-based fiduciary relationship. This fiduciary relationship was created and agreed to by Defendant-Appellant when it issued all those Culture of Safety and no-retaliation policies in order to qualify for and retain JCAHO accreditation, State licensing, and eligibility for Medicare and Medicaid funding. It was cemented when Appellant acted on those promises that were broken by Defendant Hospital's repeated betrayals of the trust it deliberately engendered in its medical staff.

G. CONCLUSION

Physicians must have enforceable due process rights to sustain the independence and professional free speech protections they need to advocate for patients and provide optimum medical care. With true legal protections physicians can work to make healthcare better, safer, and far less costly. Quality care doctors like Appellant Linda Freilich are key to solving the quality, safety and cost problems with healthcare in the U.S. SSI prays this Court will consider the direct connections between the legal issues in Dr. Freilich's appeal and our Nation's current problems with healthcare's quality, safety, and overspending.

Respectfully submitted,

A handwritten signature in black ink, appearing to read 'Jeffrey C. Grass', written in a cursive style.

/s/ JEFFREY C. GRASS
JEFFREY C. GRASS
Counsel of Record

CERTIFICATE OF SERVICE

I certify that a true and correct copy of the foregoing document was sent by First Class U.S. Mail, Express Mail, Federal Express or similar overnight messenger service, or hand delivered this 2nd day of February, 2010, to each of the following:

**MARYLAND COURT OF
SPECIAL APPEALS**

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On this the 2nd day of February 2009.



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