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AUGUST 7, 1995

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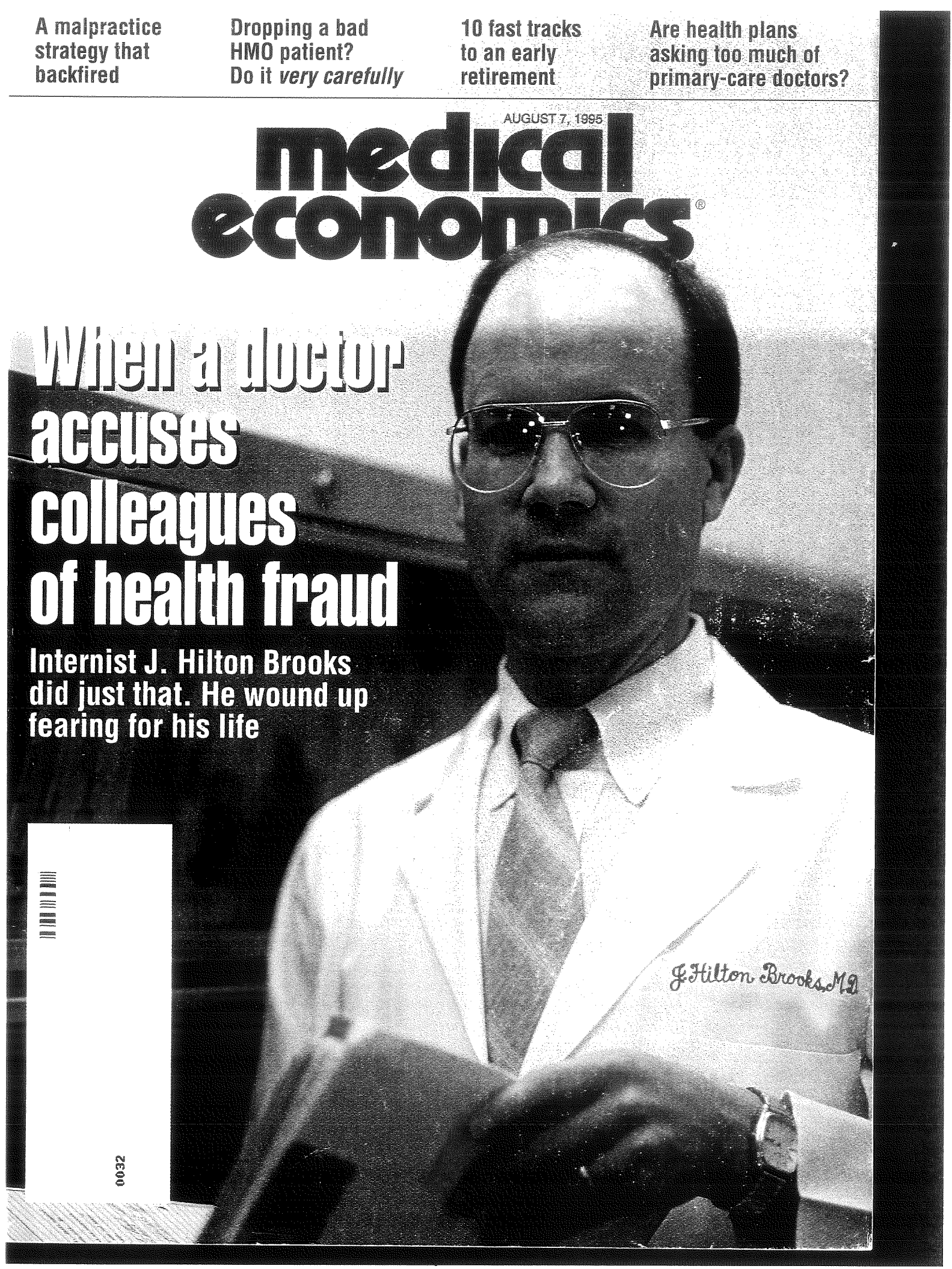
When a doctor accuses colleagues of health fraud

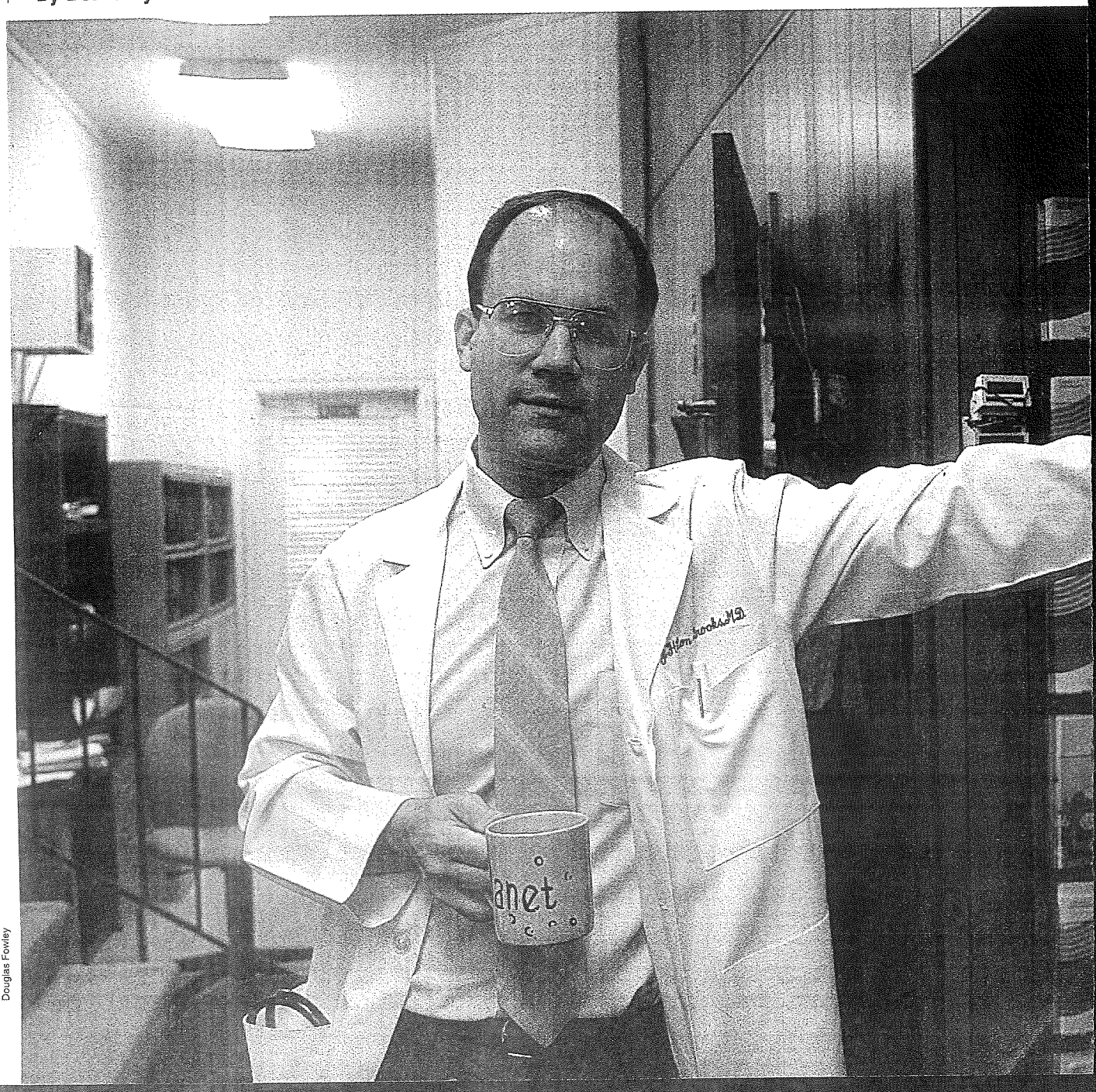
Internist J. Hilton Brooks did just that. He wound up fearing for his life



When a doctor accuses colleagues of health fraud

This internist reported conduct that may have cost taxpayers millions. His life has been in turmoil ever since.

By Berkeley Rice SENIOR EDITOR



Douglas Fowley

Internist J. Hilton Brooks wasn't looking for trouble when he arrived in Pineville, Ky., in the fall of 1986. Fresh out of residency and board-certified, he could have set up shop in much larger Middlesboro, his nearby hometown. But he saw a greater need for his services in rural Pineville (population less than 3,000) where he took over the practice of a retiring physician.

The 100-bed Pineville Community Hospital, whose assistant administrator was his cousin, provided Brooks with free office space for the first year. By 1988, the internist was serving on several hospital committees, including quality assurance and medical death review. He was also elected to the hospital's board of directors, an honor for a newcomer—and one most board members came to regret when he later sued the hospital and his colleagues for Medicare and Medicaid fraud. (The following account of what took place is based on depositions, affidavits, other court documents, and interviews with some of the individuals involved.)

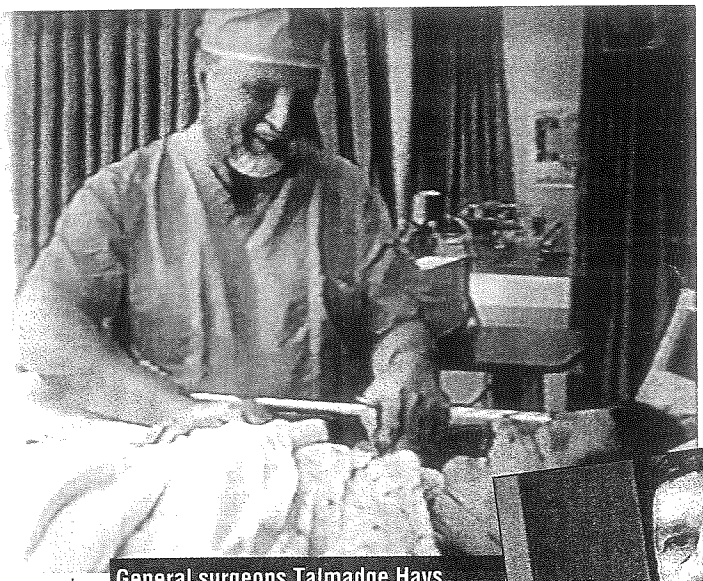
Through his committee assignments at Pineville, which involved reviewing patient charts, Brooks discovered that several of his colleagues weren't actually performing some of the physicals and other services listed in those records.

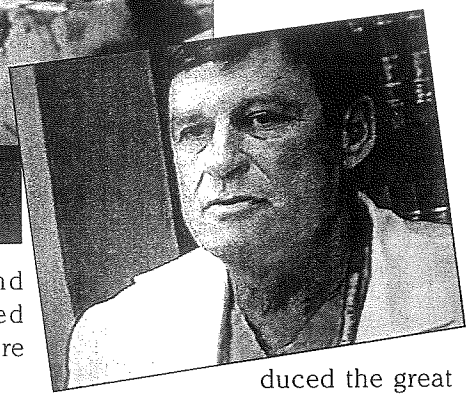
In a typical such case, a Medicare patient would arrive in the ER and receive a physical exam and initial treatment. If she required hospitalization, the ER doctor would call and discuss the case with the attending physician, who would admit her and give orders for her treatment. Later that day, or possibly the next, a medical records clerk would write a history based on the patient's prior admissions and, if necessary, on an interview with the patient.

The clerk would also fill out a physical-exam report, using the vital signs and other findings from the ER physical and stock phrases from the attending's standard form, known as a "normal." The clerk would then stamp the H&P report with the attending's signature over his typed name and that of the ER doctor. That document, created by the records clerk with no direct patient contact by the attending, became the basis for his bill to Medicare for a comprehensive history and physical.

Over the following days, the attending physician might stop by and examine the patient during morning rounds. Or he might not, if he felt there was no pressing need, or if he happened to be busy in surgery. In that case, his office nurse would check on the patient, write progress notes or orders in the chart, and sign the doctor's initials followed by her own. His office would bill Medicare for an intermediate hospital visit by the doctor.

At the end of the patient's stay, the medical records clerk, using information from the chart, would fill out a discharge summary and stamp it with the doctor's signature. The doctor's office would bill Medicare for a discharge exam and treatment plan. After each discharge, the records clerks





General surgeons Talmadge Hays (above) and Jerry Woolum (right), were accused of filing false claims.

would review the chart and "authenticate" any unsigned entries with the doctor's signature stamp.

For some Pineville physicians, these were occasional practices. For others, they were routine. When Brooks protested that they were wrong, the hospital's administrator and chief of staff told him they were simply a service the hospital had always provided to help its busy doctors. To Brooks, such "assistance" was unprofessional, unethical, and unsafe (see page 184).

A zealous reformer runs into stubborn resistance

When Brooks complained about these practices at medical staff meetings, his colleagues' reactions ranged from exasperation to hostility. They advised him to go along with "the way we've always done things here." Hospital-board members responded similarly; one warned him, "Don't try to change the system."

In fact, Brooks had stumbled into a thicket of professional and personal relationships. The four doctors on Pineville's medical staff executive committee, including the chief of staff, all engaged in some of the practices to which Brooks objected. But they also produced the great majority of the hospital's admissions. All of them had served on the hospital's board of directors. Three were partners in—and practiced at—Total Care, the town's big private clinic. The chief of staff's office nurse was the wife of a hospital-board member. Another committee member's nurse served as the hospital's director of quality assurance.

Much of Brooks' committee work led him to criticize his colleagues' conduct or treatment, which did little for his popularity. When he tried to review the chart of one patient who he suspected had received improper medication, the attending doctor took the chart and refused to turn it over. Brooks reported the incident to hospital authorities.

When Brooks persisted in his complaints, his colleagues began to boycott him. Several refused to consult or share call with him or to let him interpret their Holter-monitor tracings. To document what he considered a conspiracy against him, Brooks once brought a minirecorder to a staff meeting and secretly taped the following exchange with GP Emanuel Rader over allowing medical records clerks to fill in patient histories based on their prior admissions:

Brooks: "And why are they doing that when the physician should be doing that already?"

Rader: "They're helping us out, Hilton ... they've done it for 30 years, and I want them to keep on doing it for me."

When Brooks complained about the fabricated charts and other violations to his cousin Milton Brooks—who had become administrator by then—Milton refused to intercede. As Hilton Brooks recalls, his cousin replied, "You just can't change things around here that quickly," and suggested that Hilton "back off."

During a hospital construction project in the summer of 1988, Brooks worried that patients were being exposed to asbestos. Milton assured him the material wasn't asbestos. So Brooks sent a sample to a lab, which found that it was. When he relayed this information to Milton, he recalls, his cousin told him to mind his own business. The doctor felt patient safety *was* his business. He reported the incident to the state environmental agency, which investigated and fined the hospital. After that, Hilton Brooks says, his cousin stopped talking to him.

Reprimanded by the state board and hospital, Brooks sues

Brooks had a particularly difficult relationship with OBG specialist Lawrence Butcher, whom he'd criticized on several occasions. In July 1988, as Brooks was prepar-

ing for an endoscopy in the OR, Butcher stormed in and began yelling and cursing at him in front of several OR staffers. As Brooks recalled in his deposition, "He said that if I didn't shut my mouth he was going to knock my teeth out." While this altercation took place, Brooks' patient was listening from one OR suite while Butcher's patient was being put under anesthesia in another.

Brooks reported this incident to the Kentucky Board of Medical Licensure. The KBML investigated and wrote to Brooks, Butcher, and the hospital, admonishing the two doctors for their "unprofessional" conduct. Relying on the KBML's letter, and without conducting an investigation or hearing, the hospital's executive committee issued its own reprimands to the two doctors. Outraged, Brooks demanded retractions from the board and the hospital. When they refused, Brooks sued the KBML. (Last summer, after a lengthy legal battle that ended in a state court ruling in his favor, he succeeded in having both letters rescinded.)

By then, Brooks' complaints had become a regular feature of medical staff meetings, often accompanied by his implied threats of legal or regulatory action if things didn't improve. Brooks insisted he was simply trying to assure that Pineville's patients received proper care. But the physicians whose conduct he questioned came to think of him as a meddler who insisted on having things done his way or not at all. In interviews, they described him as a "nitpicker," "a loose cannon," and "a pain in the ass."

Brooks takes his complaints to higher authorities

By 1989, Brooks realized that his complaints had produced nothing but indifference and opposition. He therefore resigned from his committees and the board of directors. If hospital officials took that as a sign of defeat, however, they grossly underestimated him.

Brooks' complaints to state and federal agencies had little effect, and none pursued the possibility of fraud. After reviewing his charges, one official suggested he leave town.

Over the next year or so, Brooks sent or brought his complaints to officials at Medicare, Medicaid, Blue Cross and Blue Shield, the American Medical Association, the Joint Commission on Accreditation of Healthcare Organizations, Kentucky's agency for hospital licensing and regulation, the U.S. Attorney's office in Lexington, and to his congressman.

His appeals had little effect, however. Some of the agencies apparently never investigated his charges. Those that did substantiated some of them, but showed little enthusiasm for enforcement. One official, after reviewing Brooks' charges, suggested that he leave town.

The internist's efforts did prompt an investigation by Medicare, which found numerous examples of "upcoding," "undocumented services," and "possibly fraudulent" billing. The Medicare audit described a particularly high rate of "discrepancies" in the records of general surgeon and Chief of Staff Jerry Woolum. Out of 27 intermediate-level services billed by Woolum, only about half were sufficiently documented to support the level of care or, in several cases, even to verify his presence, the auditors said.

Despite such evidence, none of the agencies pursued the possibility of fraud. Some officials expressed "concern" about the abuses they found at Pineville and recommended procedural changes. Most simply accepted the hospital's assurances that changes had been or would be made. (The medical records staffers did stop using the doctors' signature stamps.)

In a typical response, the medical director of the state's Medicare peer review organization cited "the poor quality" of Pineville's histories and physicals, which he described as "exact duplicates" of the ER physician's exam. He suggested that "this problem could be remedied if there were involvement of the attending physician in these important aspects of patient care." He promised his agency would "continue to monitor" the situation.

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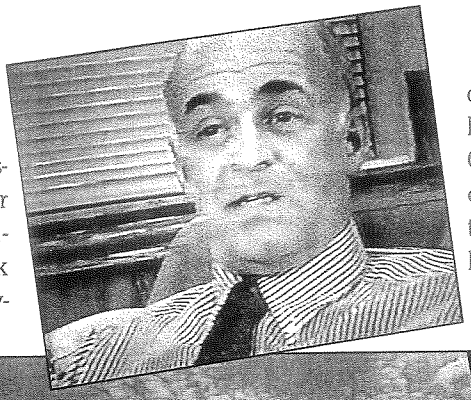
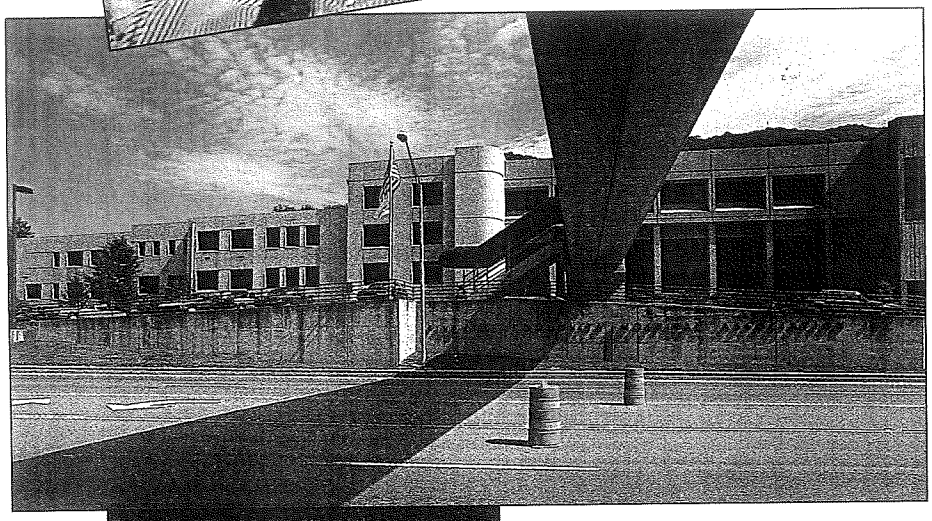




Administrator Milton Brooks denied fraud charges against Pineville Community Hospital.

Douglas Fowley

His privileges threatened, Brooks sues the hospital

Annoyed by all this attention, hospital officials chastised Brooks for "going outside" with his complaints instead of trying to "work within the system." By then, however, they realized he wasn't going to give up his crusade, and they decided he had to go.

In December 1989, Brooks received an official letter from hospital administrator Milton Brooks informing him that the executive committee had recommended against his reappointment to the medical staff. Among their reasons: his "hostile, and antagonistic, and disruptive" attitude and conduct toward members of the medical staff, and his "continued threats of litigation and investigation," which had "created an atmosphere of fear and intimidation."

"None of this had to happen," Milton Brooks recently told *Medical Economics*. "We could have dealt with it without all this trouble if Hilton hadn't gone and filed all those complaints. Now, I'm not saying there weren't some things that needed to be changed here. But he comes in and from the very beginning starts telling us things have got to change, and right away. That's just not the way you do things around here."

Calling the committee's decision "arbitrary and capricious," Hilton Brooks demanded a hearing on his threatened termination. But negotiations over the composition of the hearing panel degenerated into another protracted dispute and, eventually, another suit from Brooks, which was dismissed on jurisdictional grounds.

By then, it was clear to the doctor that his days at the Pineville hospital were numbered. One indication was a black rose delivered to his office, with a card that read: "From the employees of Pineville Hospital." He had already moved to Middlesboro (where he had courtesy privileges at the hospital), and in 1990 he established a part-time practice there.

Brooks turns his complaints into a federal case

While Brooks continued to press state and federal agencies, their lack of action led him to explore other legal options. In 1991, he learned about the federal False Claims Act, which allows private citizens to file suits on behalf of the federal government if they have evidence that the government was defrauded (see page 190). Since the government had paid all those questionable Medicare and Medicaid claims, he felt he had sufficient grounds.

Brooks contacted William Copeland, a health lawyer in Cincinnati. Copeland agreed to take the case and brought in as co-counsels William Markovits, a former Justice Department prosecutor, and Thomas Miller and Judith Jones, both lawyers in Lexington. In December 1992, they filed a false-claims suit against Pineville Community Hospital and general surgeons Jerry Woolum and Talmadge Hays. The U.S. Department of Justice declined to join the case, but reserved the right to intervene later.

Brooks and his lawyers targeted Woolum and Hays because those two surgeons admitted about half of Pineville's patients and filed far

more Medicare and Medicaid claims than their colleagues. Both had served as the hospital's chief of staff, chairman of its medical executive committee, and member of its board of directors.

Representing the two doctors, Lexington attorney Robert Houlihan Jr. admitted that their billing practices might have been "inappropriate." But in a recent interview with *Medical Economics*, he denied that they had done anything illegal or had intended to defraud the government.

"This is not a fraud case at all," Houlihan insisted. "Fraud implies an intent to deceive. They may have been sloppy and unsophisticated with their documentation and billing. But they never sat down and tried to figure out how to gyp the government." Houlihan contended that the two surgeons' billing practices were common at many hospitals. The fact that several government agencies had been aware of those practices without taking action, he argued, showed that they weren't illegal.

In their affidavits and depositions, Woolum and Hays admitted that medical records clerks had prepared "some" of their H&Ps and discharge summaries, and that their office nurses had "occasionally" checked on their patients for them when they were busy in surgery. The doctors insisted that they usually did their own physicals on the day after admission and saw their patients on subsequent days, though they didn't always document those visits in the patients' charts. They admitted having billed for those services, however, whether or not they'd actually seen the patients on those days. They felt entitled to bill for them, they explained, because they were responsible for and were supervising those patients' care. As for the allegedly false claims, they said they had relied on their office staffs to send out correct bills, which they rarely reviewed.

The attorney for the two defendant doctors admitted their billing practices might have been "inappropriate." But he denied that they had intended to defraud the government.

Experts debate the allegations of fraud

The two doctors claimed that these practices had been routine at Pineville since they had arrived in the early 1970s. Woolum described them as "purely an effort on the part of the hospital to assist busy doctors with documentation." Defending the use of medical records clerks to create their H&Ps, Hays explained that most of their admissions were "patients whom we've come to know over the course of the past 20 years, ... and [to] sit down and create a voluminous history and physical ... was inappropriate as far as I was concerned, and a waste of time."

"What we did was not fraud," Hays told *Medical Economics*. "It was a failure to understand and comply with regulations. Sure, we took shortcuts, and I realize those methods are no longer appropriate. But we never tried to devise a scheme to defraud the government and enrich ourselves."

To support their case, the defendants produced an affidavit from Joseph Leiker, former medical director for Blue Cross and Blue Shield of Kansas, that state's Medicare carrier. Leiker stated that he had seen similar billing practices as a Medicare administrator. He called them "errors" or "mistakes," and said they "do not rise to the level that they would or should be treated as fraud by Medicare."

Brooks' lawyers produced several experts who disagreed with that opinion. In his deposition, James Holloway, Kentucky's medical director for Medicare, said he had never before encountered a case in which medical records clerks routinely prepared histories, physicals, and discharge summaries for attending physicians. Asked whether the Pineville doctors might have been unaware of what was going on, Holloway replied, "It's difficult for me to see how it could happen without being deliberate."

Cheryilynn Reagan, then manager of surveillance and utilization review for the state's Medicaid program, stated in her deposition: "In order for the Medicaid program to make payment to a physician for a service provided to the recipient, there must be

actual physician-patient contact. The physician can only bill for services actually performed. If a physician didn't see the person, and didn't prepare the records, then as far as we're concerned, they didn't do the service, and they shouldn't have sent a bill in for it."

Barry Steeley, former Chief of the Health Care Branch at the HHS Office of Inspector General, refused to accept Woolum's and Hays' attempts to blame false billings on their office personnel. The Medicare billing form, he explained in his statement, "makes clear that by sending in the bill the physician is certifying that the services claimed were necessary, and were personally furnished by the physician. ...Given that the above practices were not an isolated mistake, but were apparently a routine practice that took place over a number of years, in my opinion the billings resulting from these practices would be treated as false claims stemming from fraud, or at the very least reckless disregard."

As for the hospital's liability, several medical records clerks said in depositions that they had provided their "documentation" services for the doctors under instructions from or with the knowledge of the hospital's senior staff and administration. Milton Brooks, Pineville's administrator, denied any knowledge of this.

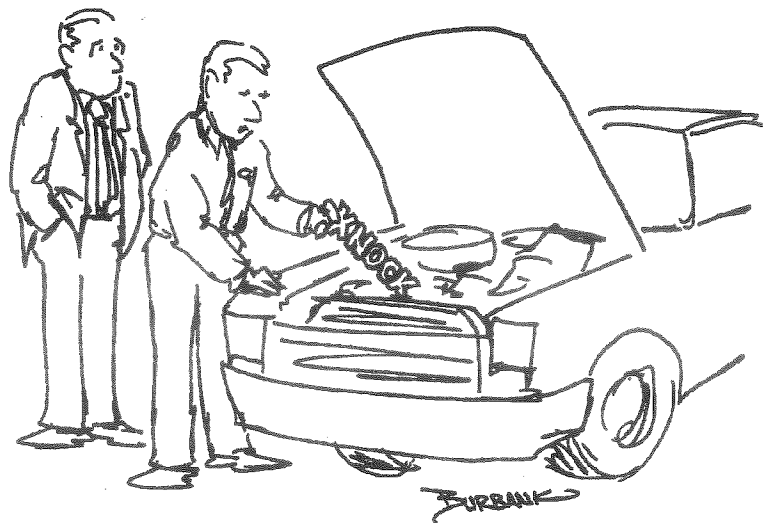
According to a statement by Paul Osborne, former CEO of the Kentucky Peer Review Organization, the practices of the hospital's personnel constituted "a knowing disregard for ethical and legal requirements," as well as "conduct that is dangerous to the patients involved." Discovery of those practices, he said, "should have resulted in denial of the hospital's claims for payment, and such a pattern should have been reported immediately to the U.S. Department of Health and Human Services for a fraud investigation." He called the case "the worst" example of fraud he had ever encountered.

But Milton Brooks defends the billing practices. "Look," he explained recently, "we're a small rural hospital with a small medical staff. All of the doctors here are so busy that we have to help them out with their records. What do you want them to do, take care of paperwork or take care of patients? That's just simple economics. And it's probably common at lots of other small rural hospitals."

The state finally acts, and the community reacts

In October 1994, following news accounts of the allegations of fraud at Pineville, state Medicaid officials launched their own belated investigation. Masten Childers II, the state's new Secretary for Human Resources, said he wasn't surprised that Medicaid officials had taken no action despite having known about the improper billing at Pineville since 1990. "As long as the providers would say they wouldn't do it anymore," Childers told the Lexington Herald-Leader, "they wouldn't pursue it. It's just another example of the way Medicaid coddled doctors and other providers for years."

Soon afterward, Childers notified Woolum and Hays that their Medicaid privileges would be terminated. For Pineville hospital, that meant two of its three sur-



"I think I've found your trouble. ..."

Diagnosis: "Gastroenteritis" Outcome: Death

On Saturday, Jan. 2, 1988, an elderly widow named Juda Keyes was brought to the ER at Pineville [Ky.] Community Hospital complaining of diarrhea, vomiting, abdominal cramps, and pain. After a physical exam and X-ray, the ER physician called general surgeon Jerry Woolum, who agreed to admit Keyes (whom he'd never seen before) as attending physician.

According to Keyes' hospital chart, and to the $100 claim Woolum later submitted to Medicare, the surgeon conducted a comprehensive history and physical exam later that afternoon. But in fact, he hadn't actually seen her that day. As he explained later in a deposition, "I had made rounds that day, and saw no reason to make rounds again on her, on an elderly patient with gastroenteritis."

The "findings" recorded in Woolum's admission physical on Keyes were remarkably similar to those in the ER doctor's exam. Her temperature, pulse, respiration, blood pressure, and other signs were exactly the same on both records. Each one described an "89-year-old white female [who] has been having many bouts of diarrhea and vomiting 2 days now. She is getting weak and dehydrated. She can't eat. She is complaining of abdominal soreness." Under "heart," each record read: "Regular rhythm, no murmurs." Under abdomen, each reported "no palpable mass." Both concluded with the diagnosis "Gastroenteritis with vomiting and dehydration."

Unfortunately, that wasn't Keyes' problem. As an ER X-ray revealed, the 5'6", 120-pound woman did have an abdominal mass. In fact, the radiologist's report described a "huge aneurysm of the abdominal aorta, size of a grapefruit." But the ER physician had missed it, and so, according to the record, had Woolum. His lapse was more understandable, however, since he hadn't seen the patient yet. By the time he did, he was too late to help.

After repeatedly complaining of abdominal pain, Keyes went into respiratory arrest the next morning. She was intubated and transferred to the ICU, where Woolum was called in to examine her. She died about an hour later. On her death certificate, Woolum listed "acute myocardial infarction" as the cause. But she hadn't complained of chest pain or had an ECG on admission. As Woolum himself later conceded, and as a report on a second X-ray (done just before she died) suggested, the actual cause of death might "possibly" have been a ruptured aortic aneurysm.

geons would no longer be able to treat the area's many poor patients. For Woolum and Hays, the termination represented a considerable financial blow. According to the Herald-Leader, the two doctors had received nearly $540,000 from Medicaid billings in 1993.

Woolum and Hays vehemently denied the charges against them. "I have never knowingly billed for a service that I did not perform," Woolum told reporters for a local television news program. "I hold the practice of medicine very sacred."

The citizens of Pineville rose to the two surgeons' defense. The Pineville Sun ran columns and letters testifying to their competence and character. There were petitions, ads, and a telephone campaign demanding their reinstatement. Hospital staffers wore blue and purple ribbons—the colors of the surgeons' charts—to show their support. The hospital hung banners urging residents to "support your local doctors." As administrator Milton Brooks explained: "We want everybody to know that we are behind them. These aren't criminals. They're good docs."

For many Pineville residents, the bad doc in this case was Hilton Brooks, who became the focus of their anger. His wife received a couple of threatening phone messages about that time. One caller said, "Tell your husband he's a dead man."

Childers and the surgeons eventually worked out a settlement under which he agreed to rescind

their termination in exchange for their agreement to provide three months of free care to Medicaid patients. Their lawyer, Robert Houlihan, claimed the agreement was an acknowledgment that his clients' mistakes were "clerical, and not criminal."

Brooks, Woolum, Hays, and the hospital all settle

Although the false-claims suit asserted that Woolum and Hays had been filing fraudulent bills since at least 1982, it focused on the years 1987 and 1988 because those were the only ones for which Brooks had access to complete records. During those two years, the suit alleged, Woolum and Hays had admitted more than 1,000 Medicare patients through the ER and had billed the government an estimated total of $120,000 for fraudulent H&Ps and discharge summaries. Figuring penalties of $10,000 for each false claim, plus treble damages for the amount of the unsupported charges, the suit asked for total damages and penalties of $31 million.

Last year, as the case was heading for trial, the federal government finally stepped in. The main reasons for the government's entry: the likelihood that Brooks would actually win the case and the fear that a big award in a jury trial might bankrupt the hospital. As the area's major health-care provider and the town's largest employer, its demise—according to the hospital's attorney, Pete Cline—would have been a social and economic disaster.

Last April, under pressure from the state and federal governments, a settlement was reached that left each party at least partially satisfied. Under the terms of the settlement, Pineville Hospital agreed to pay the government $2.3 million, and Woolum and Hays agreed to pay $100,000 each.

Out of that $2.5 million, $675,000 came off the top for Brooks' lawyers' services; the doctor got another $65,000 for his own legal costs outside of attorneys' fees. He'll also keep one-fourth of the remainder, or $440,000, out of which his lawyers will receive one-third as their contingency fee for winning the case. The government will keep about $1.3 million.

In Pineville today, there's still plenty of support for Woolum and Hays, and plenty of animosity toward Brooks. Many folks there figure he "did it for the money."

In a separate settlement, the hospital agreed to pay Brooks an additional $300,000 to settle any potential claims for the hospital's alleged retaliation against him. It also granted him courtesy privileges, which he insisted on "as a matter of principle," even though he had stopped practicing there after filing the suit.

Although Woolum and Hays admitted in the settlement that they'd violated regulations governing Medicare payments, they didn't concede having done so knowingly. That would have constituted fraud—and grounds for exclusion from Medicare and Medicaid.

Pete Cline, the hospital's attorney, explained that the hospital had paid most of the settlement because otherwise the surgeons' practices might have been destroyed. When the hospital paid another $300,000 to settle the state's Medicaid claim, the state agreed to drop its demand that Woolum and Hays provide free care to their Medicaid patients. The hospital board, of which both doctors were current or past members, also agreed to pay the doctors' legal fees.

One final condition of the settlement: The hospital agreed to conduct—and pay for—a training program in Medicare and Medicaid billing procedures and regulations, to be attended by all administrators, directors, medical records staff, physicians, and their billing clerks.

Brooks is still paying the wages of obsession

In Pineville today, there's still plenty of support for Woolum and Hays, and plenty of animosity toward Brooks. Many folks there see the settlement as a miscarriage of justice and figure Brooks "did it for the money." As one Pineville doctor told the Herald-Leader, "All that money he's going to get for this, he better take it someplace else, because I really think somebody here will kill him."

If Brooks really "did it for the

The False Claims Act

The federal False Claims Act, under which internist Hilton Brooks sued Pineville [Ky.] Community Hospital and two of its prominent physicians, enables the government to sue suppliers of goods and services.

The law was originally passed during the Civil War to combat ripoffs by companies providing military supplies to the Union Army, such as cannon shells filled with sawdust instead of gunpowder. To encourage private citizens to blow the whistle on such practices by bringing suit on behalf of the government, the law offered them a portion of whatever sums were recovered.

In 1986, Congress amended the False Claims Act to help expose fraud by federal contractors. As amended, the law rewards whistle-blowers with up to 30 percent of any funds recovered, depending on the extent of the government's involvement in their suits. Those sums can be sizable, since the law calls for penalties of $5,000 to $10,000 for each false claim, plus damages of three times the total amount of the overpayment.

The law specifically protects plaintiffs from retaliation by their employers. But if a suit isn't successful, a plaintiff can be sued by the defendant for bringing a frivolous or malicious claim and be held liable for damages, a stiff fine, and the defendants' legal costs.

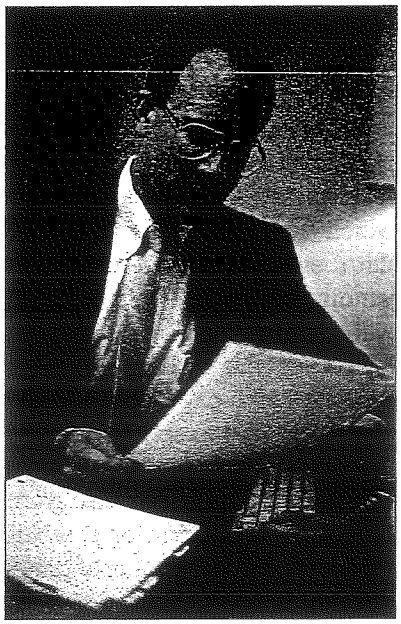
Since the law was amended, the number of private false-claims suits has grown sharply. About 220 cases were filed last year alone, of which nearly one-fourth involved health fraud. Recoveries amounted to $378 million, more than twice the total for 1993.

money," his suit was a failure. After his lawyers' contingency fee is deducted, his share of the recovery comes to less than $300,000, plus the $300,000 he received from the hospital. But he figures the case cost him nearly that much in lost practice revenue over six years. He also spent $30,000 on legal costs in his other suits against the hospital and the state medical board.

"I'm fortunate that I come from a fairly well-off family," Brooks says. "I had no medical-school debt, and no mortgage, and I did have some savings. Otherwise, I couldn't have sustained myself through this case."

The suit also represented a considerable financial risk for Brooks. If he had lost, the defendants could have countersued for defamation and for their legal expenses.

In addition to money, the case took up a great deal of Brooks'



Douglas Fowley

time and energy. For several years, he devoted nearly every evening and weekend to it, and lots of his days. He did much of his own legal research, sending a steady stream of letters and faxes to state and federal officials and his lawyers. The resulting documents and correspondence now fill a dozen file drawers in his office.

Brooks readily admits to being obsessed by his Pineville battles. "I have deep-seated convictions about what's right and wrong," he explains, "and what they were doing was definitely wrong. I was sure that once I brought these things to their attention, they'd stop doing them. And I would have been satisfied if they had. But they didn't. I wouldn't have filed the suit if I had thought those were innocent mistakes." ■