

FILED

MAR 15 2011

COURT OF APPEALS
DIVISION III
STATE OF WASHINGTON
By _____

No. 294153

**IN THE COURT OF APPEALS
OF THE STATE OF WASHINGTON
DIVISION III**

**DIANA P. SMIGAJ, M.D. and CASCADE WOMEN'S
HEALTHCARE ASSOCIATES, P.L.L.C.,**

Appellants,

v.

**YAKIMA VALLEY MEMORIAL HOSPITAL ASSOCIATION;
RICHARD W. LINNEWEH, JR., an individual; RICHARD W.
LINNEWEH, JR. and JANE DOE LINNEWEH JR., a marital
community; ROGER ROWLES, M.D., an individual; CARL
OLDEN, M.D. and JANE DOE OLDEN, a marital community,**

Respondents.

BRIEF OF RESPONDENTS

**MILLER NASH LLP
Greg Montgomery
4400 Two Union Square
601 Union Street
Seattle, Washington 98101-2352
(206) 622-8484**

SEADOCS:430212.4

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I. INTRODUCTION

In 2008, over the course of eight meetings spanning approximately three months, six members of the Memorial Hospital medical staff, with a total of more than sixty-five (65) years of experience as practicing physicians, reviewed three of Dr. Smigaj's 2008 cases for quality concerns. Four of the reviewing physicians were men and two were women. (CP 1878) They practice in the areas of pediatrics, neonatology, gynecology, obstetrics, and family practice. (CP 1877; 1882-1883; 1886-1887; 1892-1893; 2399; 2722)

They reviewed the hospital medical records for each of the cases. (CP 1880; 1887; 1896-97) They met with Dr. Smigaj to discuss questions they had about the cases. (CP 2730-31; 2735-37; 2824; 2861-65; 2941; 2951-55)

The Committee regularly corresponded with Dr. Smigaj about their case reviews. (CP 2730; 2733-36; 2824; 2888-89; 2891; 2893; 2905; 2941) The Committee requested, received, and considered Dr. Smigaj's written responses to their quality concerns. (CP 2735; 2895-97; 2943-44) They received and considered reviews of the cases by Dr. Connor, who was retained by Dr. Smigaj. (CP 1890; 2735-37; 2899-2900; 2946-49) They considered reviews of the same cases by Dr. Tomlinson, who was

retained by Memorial. (CP 1889; 1981; 2067; 2074; 2397; 2436-38; 2723; 2734-36; 2742-43; 2902-03; 2934-38)

Four of the six reviewing physicians had reviewed one or more of Dr. Smigaj's cases for quality concerns before 2008. (CP 1879; 1882-83; 1894; 2723-24) Rather than rely on their memories of these prior reviews for purposes of assessing any patterns or trends in Dr. Smigaj's patient care, they requested and considered summary information on these prior reviews, including minutes of their meetings in which these cases were reviewed. (CP 1888; 1894-97; 2732-33; 2735; 2867-74; 2907-32)

The care that Dr. Smigaj provided in the three 2008 cases of concern violated multiple hospital medical staff rules, regulations, and policies. (CP 2731; 2826-31) (CP 1981, 2067; 2075-76; 2093; 2103; 2111-12) The care did not conform to clinical management guidelines published by the American College of Obstetricians and Gynecologists. (CP 2731; 2833-35; 2844-50) Dr. Tomlinson testified that, in his opinion, the care provided in two of the three cases was below the standard of care. (CP 2029; 2034-36; 2054-55)

The Committee members were also struck by Dr. Smigaj's attitude toward their suggestions that there were deficiencies in her care. Dr. Michael Jach, a family practice physician with obstetrical privileges, who had served on the Committee since 2000, observed that in contrast to

most physicians who were understanding of suggestions for improvement in their quality of care, Dr. Smigaj was defiant and tended to blame others. (CP 1882-83)

Dr. Elizabeth Engelhardt, a neonatologist and Committee member since 1997, commented that part of Dr. Smigaj's problematic practice pattern for years has been her continual insistence that there are no problems with her practice. (CP 1898)

On September 3, 2008, these six physicians concluded that, in their judgment, Dr. Smigaj's ". . . continued practice constitutes unacceptable risk to patients." To address this unacceptable risk to patients, the reviewing physicians voted unanimously to recommend a precautionary suspension of Dr. Smigaj's privileges. (CP 1881; 1883-85; 1887-88; 1890-91; 1897-98; 2738-39; 2742-45)

The President of the Memorial medical staff implemented the recommended precautionary suspension effective midnight September 4, 2008, subject to prompt further review by the Medical Executive Committee ("MEC") to get to the bottom of the quality of care concerns. (CP 1866; 1870-71; 1875-76). Eleven days later, Dr. Smigaj addressed the MEC, requesting that her privileges be reinstated retroactively to the date of the suspension because there was no basis for the suspension. (CP 2395-96; 2398; 2460-63) The MEC voted to reinstate Dr. Smigaj's

privileges, although not retroactively as she requested, subject to an external review of each of her cases for the next three months.

(CP 1916-18; 1977-79)

On November 6, 2008, Dr. Smigaj filed this lawsuit. As the trial court wrote in its Memorandum Decision Regarding Attorneys' Fees:

The entire invective rained down by this litigation on the defendants by the plaintiffs amounted to an allegation that the defendants' actions were a campaign to drive her out of business for anti-competitive reasons and/or a malicious peer review intended to destroy her career for economic reasons based on sham concerns related to her competence. That one claim and all causes of action based on that claim were dependent on a common core of facts and circumstances.

(CP 3967)

Dr. Smigaj continues to "rain invective" upon the Defendants, accusing them of concealing facts, manufacturing evidence, lying, and attempting to cover their tracks by shredding documents, altering minutes, and destroying electronic information.¹ However, neither the material evidentiary facts² nor the applicable Washington law has changed since the

¹ All of this "invective" is directed at establishing that the Defendants acted in bad faith in the course of the peer review of her clinical care. Even if this were true, which it is not, it is irrelevant to Defendants' entitlement to the HCQIA immunity that precludes Dr. Smigaj's claims. *Cowell v. Good Samaritan*, 153 Wn. App. 911, 926 (2009)(Bad faith on the part of the reviewers is irrelevant to HCQIA immunity).

² Dr. Smigaj often presents as fact statement that are nothing more than expressions of opinion or argument unsupported by the citations provided. For example, Dr. Smigaj makes the factual assertion that Mr. Linneweh treated her differently than any other physician who has practiced in Yakima. App. Br. at 4. None of the record citations support this statement. Ms. Hood, who left Yakima in 2000, does offer her opinion that Mr. Linneweh treated Dr. Smigaj differently from other ob/gyns but opinions are not

trial court correctly granted judgment to Defendants and awarded them attorneys' fees and costs. Its decisions should be affirmed in all respects and Defendants should be awarded attorneys' fees on appeal.

II. STATEMENT OF THE CASE

A. Committee Review of the First 2008 Case.

At its May 30, 2008 meeting, the Committee reviewed Dr. Smigaj's care of a 16-year-old who was transferred to Memorial because of her high-risk pregnancy. The patient was 32 weeks pregnant and suffering from pre-eclampsia, involving severe headaches, elevated protein levels, and high blood pressure. (CP 2730; 2818-22)

The patient was admitted to Memorial at approximately 7:00 p.m. in the evening and was not seen by Dr. Smigaj until approximately 6:00 a.m. the following morning.³ During this eleven hour period, Dr. Smigaj gave nursing staff telephone orders to initiate cytotec (misoprostol) induction of delivery. Later, because of reported difficulties monitoring the fetal heart rate, Dr. Smigaj gave nursing staff telephone orders to rupture the patient's membranes to place a fetal heart rate

evidentiary facts. *Grimwood v. Puget Sound*, 110 Wn.2d 355, 359 (1988) ("A fact is an event . . . an act, an incident, a reality as distinguished from supposition or opinion.")

³ The Medical Staff Rules and Regulations provide: "The admitting physician shall be expected to see the admitted patient within 24 hours of the patient's arrival in the hospital unless circumstances demand a more prompt visit by the physician." (emphasis added)(CP 1883-84; 2730-31; 2827)

monitor. Because of fetal heart rate concerns, Dr. Smigaj was called at about 5:00 a.m. and advised to come to the hospital. She arrived about 5:50 a.m. and delivered the infant by cesarean section at about 7:30 a.m. (CP 2436-38; 2730-33; 2861-65; 2876-79)

Memorial Hospital policy requires the admitting physician to obtain both general consent for treatment and specific consent to special procedures, including surgical procedures such as the cesarean section Dr. Smigaj performed the next morning.⁴ (CP 2731; 2782) In treating this 16-year old patient, Dr. Smigaj completely disregarded this informed consent policy, a policy required by state law, federal law, and the hospital accreditation organization.⁵

When Dr. Smigaj gave nursing staff telephone orders to initiate induction of labor, she completely failed to abide by the clinical management guidelines of the American College of Obstetricians and Gynecologists.⁶

When Dr. Smigaj later directed a nurse by telephone to place an electronic monitor to better monitor the fetal heart rate, a procedure that would and did result in the artificial rupture of the mother's membranes,

⁴ In 2005, the Committee had recommended that Dr. Smigaj obtain consent forms on all antepartum patients for possible emergency cesarean section (CP 2726-27; 2782).

⁵ WAC 246-320-245; 42 C.F.R. Ch. IV § 482.13(b)(1) and (3); Joint Commission Standards. (CP 1981; 2118-20)

⁶ (CP 2731; 2833-55)

she ordered exactly what she had been told was outside the nursing scope of practice for hospital insurance and risk reasons.⁷ (CP 2733; 2881-86)

Memorial medical staff rules and regulations require that a history and physical be recorded before any operation unless the attending practitioner states in writing that the delay to record the history and physical would be detrimental to the patient. (CP 2731; 2826-28) Despite ample opportunity to do so, Dr. Smigaj did not record a history and physical until after the operation.⁸ Nonetheless, in Dr. Smigaj's opinion, her medical judgment in this case was without flaw. (CP 2735; 2897)

By letter of June 13, 2008, the Committee advised Dr. Smigaj that it was reviewing this case and invited her to attend its June 20 meeting to discuss the case.⁹ (CP 2824; 2861-65) Dr. Smigaj's approach at the June 20, 2008 meeting was contentious. (CP 2395-97; 2426; 2730-31) She did

⁷ Dr. Johns testified to a similar understanding of the hospital policy as of 2008 (CP 1981; 2103-04) Dr. Tomlinson stated that whether it was appropriate for Dr. Smigaj to direct a nurse to rupture membranes would depend on hospital policy and might be okay in an emergent situation such as existed with this patient, but it would be done with the assumption that Dr. Smigaj was on her way to the hospital. (CP 2438)

⁸ When Dr. Smigaj did record a history and physical for the patient after the cesarean section delivery, she dictated it as if she had seen the patient the day before indicating, among other things, that the plan was to "proceed with induction." (CP 2731-32; 2857-59)

⁹The "AD HOC" appearing on these Committee meeting minutes merely signifies an additional meeting of the Committee beyond its regularly scheduled meetings and is derived from the Medical Staff Peer Review Policy that provide, in part, with respect to situations in which expedited review is appropriate: "It may be necessary to schedule an ad hoc meeting of the appropriate Peer Review Committee to accomplish this." (emphasis added) (CPC 615; 620).

not accept the Committee's suggestion that she should have seen this patient shortly after admission and should have confirmed the fetal position before initiating induction. She told the Committee she would not voluntarily adopt this practice, but that, if they promulgated a policy requiring it, she would comply. (CP 1878-79; 1883-84; 1887-88; 1893-94; 2121-22; 2128; 2730-31; 2861-65)

Following this meeting, the Committee remained concerned about what it viewed as the significantly deficient clinical judgment represented by this case and Dr. Smigaj's apparent complete failure to appreciate the severity of her deficient judgment. (CP 1878-79; 1883-84; 1894; 2732-33) The Committee met again on July 9, 2008 to further consider this case.¹⁰

¹⁰ The Committee also observed certain historical facts about Dr. Smigaj, including extended proctoring, additional conditions to improve her practice, and concern with her ability to deal with a significant hemorrhage. (CP 2724-30) In 1995, three of Dr. Smigaj's cases were reviewed internally and sent for external review. The external reviewer characterized his reviews of all three cases as "critical." (CP 2176-79; 2193-2202). As a result of this review, a committee of medical staff members recommended extended proctoring of Dr. Smigaj's low risk and high risk obstetrical cases. (CP 3343-44; 3424) In 1997, this same external reviewer reviewed another of Dr. Smigaj's cases and yet another external reviewer reviewed the same case and two of the earlier three cases. (CP 2180-81; 2212-13; 2219-20) It was based on the recommendation of one of the reviewers that Dr. Smigaj be monitored, that a monitoring agreement was worked out with Dr. Smigaj in December 1997 (CP 2222-23)

The 2004-2005 practice improvement requirements arose from Dr. Smigaj's repeated use of her mid-wives to care for high risk obstetrical patients in violation of their scope of practice and hospital rules and regulations, delay in seeing the patient, failure to consult with a neonatologist, and the failure to have a neonatologist present for what was expected to be a compromised infant, failures very similar to those repeated in 2008. Dr. Sara Monahan, then chair of the OB/GYN Committee took that Committee's

On July 16, 2008, Dr. Rowles wrote to Dr. Smigaj informing her of the July 9, 2008 meeting, the Committee's concerns, and the decision to engage an external reviewer. The Committee requested that Dr. Smigaj provide a written response to its concerns and voluntarily agree not to accept transfer patients until the Committee completed its review of this case.¹¹ (CP 2733-34; 2888-89) Dr. Smigaj refused to agree not to accept further transfer patients, but did agree to see all such patients within an hour of their admission, to immediately prepare a history and physical, and to consult with Dr. Rowles regarding her management plan for these patients. (CP 1888-89; 2483; 2734; 2891)

The Committee met again on July 21, 2008. Dr. Rowles again wrote to Dr. Smigaj on behalf of the Committee, informing her of this

recommendation to the medical staff credentialing committee which then required compliance with the recommendations. (CP 2724-27; 2747-54; 2756-60; 2762; 2764-65; 2767-69; 2771-72; 2774-78; 2780-83, 3433-36)

The 2007 case was a significant hemorrhage case arising out of a cesarean section. The surgeon who assisted Dr. Smigaj in treating this significant hemorrhage testified that the surgical approach taken by Dr. Smigaj to addressing this life-threatening hemorrhage was not consistent with the approach a trained surgeon would take. (CP 2124-25; 2727-30; 2785-88; 2790-94; 2796; 2798-2800; 2802-05; 2807-08; 2810; 2812-16)

¹¹ It was at the July 9, 2008 meeting that the Committee voted unanimously to recommend to the Medical Executive Committee that Dr. Smigaj not be allowed to accept transfers from outside the community. However this recommendation was never made to the MEC. Dr. Smigaj points to this as some evidence of bad faith on the part of Defendants. App. Br. at 30-31. The recommendation did not go to the MEC because Dr. Smigaj's attorney intervened and persuaded the Committee not to make this recommendation because, if it was imposed, it would be reportable to the National Practitioner Data Bank. The Committee acquiesced in this request and a different agreement was reached with Dr. Smigaj. (CP 3343-46; 3471; 3499-3501)

meeting and its purpose of considering “. . . appropriate interim precautionary steps pending ongoing evaluation of your clinical practice.” (CP 2734; 2893)

The Committee met on July 30, 2008 to review Dr. Smigaj’s written responses to its concerns regarding the case, to consider an external review of the case by Dr. Connor, and to confer by phone with Dr. Tomlinson. (CP 1884; 2734; 2895-97; 2899-2900; 2902-03)

According to Dr. Smigaj’s external reviewer, her failure to see this patient at or near the time of admission was not consistent with best practices. (CP 2899-2900) Dr. Tomlinson told the Committee that Dr. Smigaj’s failure to see the patient before initiating induction was a failure in judgment. Dr. Tomlinson stated that the patient deserved a personal evaluation and that Dr. Smigaj needed to evaluate the status and position of the infant before induction. (CP 2734-35; 2902-03)

Dr. Tomlinson’s subsequent written report confirmed this opinion. (CP 2436-38) In his deposition, Dr. Tomlinson testified that his identification of concerns in this case were synonymous with saying that Dr. Smigaj fell below the standard of care insofar as she failed to evaluate the patient before initiating induction. (CP 1981; 2029; 2033-37)¹² The

¹² Dr. Tomlinson rejected the suggestion that in the absence of a policy requiring prompt evaluation it was appropriate for Dr. Smigaj not to see this patient before the cesarean section the next morning. (CP 2038-39) He also expressed the opinion that physician

Committee wrote to Dr. Smigaj informing her that it had met to consider her responses, the external review provided by Dr. Connor, and the oral report by Dr. Tomlinson. (CP 2735; 2905)¹³

B. Committee Review of the Second and Third 2008 Cases.

The Committee met again on August 15, 2008 to further consider the care provided the 16-year-old high risk pregnancy patient and two more of Dr. Smigaj's cases. (CP 2735-36; 2934-39) One of the two new cases involved a stillborn fetus. The mother was admitted to the Memorial Labor and Delivery Unit with complaints of back pain and vaginal discharge. The patient was 25 weeks and several days pregnant. Initial monitoring indicated contractions. A cervical examination revealed ruptured membranes and feet present in the cervix. An ultrasound confirmed a footling breech presentation of the fetus. Dr. Smigaj arrived to see the patient and arranged for her to be transported to the University of Washington Hospital because of the age of the fetus. (CP 2934-39)

evaluation would have been appropriate when there were problems monitoring the fetal heart rate. (CP 2040-42)

¹³ Dr. Smigaj mischaracterizes the extent of the opinion differences between the Committee and Dr. Tomlinson with respect to this case. (CP 647-650 and 2436-38) Dr. Tomlinson also had a major criticism not mentioned by the Committee. In light of the poor fetal heart rate tracings, in Dr. Tomlinson's opinion Dr. Smigaj took too long after she finally saw the patient at 6:00 a.m. to perform the cesarean section delivery, causing Dr. Tomlinson to categorize this delivery as a "near miss". (CP 2437)

At 10:00 p.m., as transport preparations were being made, the patient began to complain of contractions. A vaginal exam revealed legs in the vagina indicating an imminent breech delivery. (CP 2735-37; 2934-39; 2951-55)

Dr. Smigaj returned to the hospital just minutes before the body of the infant was delivered. The head was trapped but ultimately freed. Efforts to resuscitate the infant were unsuccessful.¹⁴ (CP 2934-39)

Dr. Rowles, Dr. Olden, and Ms. Anyan participated in a conference call with Dr. Tomlinson about this case on August 13, 2008. (CP 2397; 2735-36) Dr. Tomlinson expressed concerns about the accuracy of the determination that the patient was not in labor but felt that, if the facilities and staffing at Memorial were not adequate to care for a 25 week old infant, and Dr. Smigaj's judgment was that the patient was stable for transport, then the transport decision was appropriate. Dr. Tomlinson felt that Dr. Smigaj should have remained with the patient until the transport arrived and should have considered a consultation with a neonatologist prior to transport. Dr. Tomlinson also had concerns about

¹⁴ Dr. Smigaj's external reviewer expressed the opinion that the fetus died about 10:00 p.m. since from that point the fetal heart rate monitor recorded a heart rate that never varied from the maternal heart rate (CP 2949). The autopsy revealed that the fetus died of sepsis/infection. (CP 2952) In his written report in this case, Dr. Tomlinson suggested that the known pus in the vagina indicating the presence of infection would call into question the decision to delay delivery for transport to another hospital. (CP 2398; 2442)

the management of this patient's hypertension prior to delivery and the administration of terbutaline to a hypertensive patient following delivery. (CP 2121-22; 2130; 2938)¹⁵

The second new case reviewed in the August 15, 2008 meeting involved a patient seen by Dr. Smigaj six days before she delivered at which time Dr. Smigaj concluded that the fetal position was vertex (head down). Fetal position was not checked again when, six days later, Dr. Smigaj ordered that cytotec induction be initiated.¹⁶ As it turned out, the fetus was in breech position (feet down) and a difficult delivery followed. The infant was flaccid when delivered and, although a Neonatal Intensive Care Unit ("NICU") nurse was present, others were called to assist with resuscitation. (CP 2938-39)

At this meeting, the Committee also considered a compilation of the minutes of its meetings from 1999 to 2008 at which it had considered

¹⁵ Dr. Rowles did not falsely report Dr. Tomlinson's opinion about the second case. The meeting minutes indicate that Dr. Tomlinson's substandard care opinion had to do with Dr. Smigaj's failure to hospitalize the mother in the second case for blood pressure control. (CP 2938) In his deposition, Dr. Tomlinson testified that he agreed with the Committee that she should have been hospitalized. His report states that Dr. Smigaj should have considered hospitalization for this patient for blood pressure control. (CP 2441) Dr. Tomlinson explained in his deposition that when he pointed out areas of concern in his written report, he was indicating areas in which the care fell below the standard of care. (CP 2033-37)

¹⁶ Dr. Tomlinson testified that the failure to check fetal position before initiating induction was below the standard of care. Dr. Tomlinson testified that this could be done by nursing or the physician but that, if nursing was to be responsible, there needed to be a clear policy or expectation that nursing was responsible to assure that fetal presentation was checked. (CP 2053-57)

Dr. Smigaj's cases. (CP 1895-96; 2735; 2907-32) Following conclusion of the August 15, 2008 meeting, Dr. Rowles wrote to Dr. Smigaj informing her that it had met and reviewed the two new cases and asking her to provide a written response to their concerns about the cases and to attend a meeting with the Committee on August 29, 2008. (CP 2736-37; 2941)

At the August 29, 2008 Committee meeting, Dr. Smigaj provided the Committee with her written responses to its concerns, and with Dr. Connor's opinions that nothing in Dr. Smigaj's management of either case deserved criticism. (CP 2737; 2943-44; 2946-49; 2951-55)

In the stillborn fetus case, Dr. Smigaj stated that, in her judgment, there was a "window of opportunity" to transport the mother and that a successful transport would have been in the best interest of the mother and fetus, although the Memorial NICU had the capability to stabilize and resuscitate a 25-week-old infant. (CP 2737; 2953)

Regarding the second case, Dr. Smigaj responded that it is not standard practice for obstetricians to examine patients for fetal position before a planned induction and, if the Committee believes this should be changed, it needs to be addressed within the Ob/Gyn department and all obstetricians should be held to the same standard. Dr. Smigaj responded that the NICU was informed of a breech delivery and the failure to have a

neonatologist present is something that neonatology services should address.¹⁷ (CP 2737-38; 2943-44; 2954)

The Committee continued to have questions about whether Dr. Smigaj's practice pattern was an immediate concern to patient safety. (CP 1880-81; 1884-85; 1890) The Committee discussed a precautionary suspension while an investigation of Dr. Smigaj's practice moved forward either by forwarding a cumulative quality review summary to the MEC or by forwarding all quality reviewed cases to an external reviewer. (CP 2737-38; 2954)

The Committee met again on September 3, 2008. The Committee felt that each of the three 2008 cases reflected poor clinical judgment. (CP 2738-39; 2936-39; 2952-54) The Committee was of the opinion that these three 2008 cases, combined with the past quality issues reviewed by the Committee, reflected a continuing pattern of quality concerns including poor judgment, deficiencies in knowledge, surgical skills, and communication skills, and an inability to learn from previously identified poor practice patterns.¹⁸ Following discussion and deliberation, the

¹⁷ In fact, the hospital policy in effect at the time of this delivery placed responsibility on the obstetrician to speak personally with the neonatologist about attending the delivery in this case that involved a vaginal breech delivery. (CP 2831) This had been the policy for years. (CP 1981; 2067; 2075-76) Dr. Tomlinson testified that ultimately it was the obstetrician's responsibility to assure the proper people were in attendance, including a neonatologist. (CP 2060-64)

¹⁸ (CP 1881; 1883-85; 1890-91; 1897-98; 2738-39)

Committee unanimously approved a motion that, in its judgment, Dr. Smigaj's continued practice constituted an unacceptable risk to patients and that a recommendation be made to institute a precautionary suspension while proceeding forward with an outside review of all Dr. Smigaj's current and past cases raising quality concerns. The Committee directed Kay Anyan to forward the recommendation to Medical Staff President Dr. Padilla to facilitate the process. (CP 2743-44)¹⁹

C. The September 4, 2008 Precautionary Suspension.

On September 4, 2008, Dr. Brian Padilla notified Dr. Smigaj that her privileges would be suspended effective 12:01 A.M., September 5, 2008. Before making this decision, Dr. Padilla had reviewed some of the external reviews of the 2008 cases and had reviewed some of the Committee meeting minutes.²⁰ In addition, on the morning of September 4, 2008, Dr. Padilla discussed the Committee recommendation, and the reasons for it, with Dr. Rowles. (CP 1866-1870) In his telephone call

¹⁹ Dr. Smigaj points to the fact that the precautionary suspension recommendation went to Dr. Padilla the President of the Medical Staff instead of to the MEC as some indication of bad faith by the Defendants. The record reflects that this is exactly what the Committee anticipated would happen. (CP 3343-44; 3388; 3394-95)

²⁰ In his deposition, Dr. Padilla testified that he reviewed Committee meeting minutes, that he reviewed the written report by Dr. Tomlinson, that he was advised of Dr. Tomlinson's oral reports before he signed the September 4, 2008 letter. (CP 1645-48; 1651-54)

with Dr. Smigaj, Dr. Padilla told her that he would get to the bottom of the concerns about these cases and would initiate further review. (CP 1870)

Dr. Padilla advised Dr. Smigaj that the MEC would meet on September 16, 2008 to review the precautionary suspension and invited her to attend. (CP 1875-76)

D. The September 16, 2008 MEC Meeting.

Dr. Padilla did initiate further review of the quality of care issues. He directed that all materials regarding this matter be collected at the Medical Staff Services office where they could be reviewed by MEC members before the September 16, 2008 meeting. (CP 1871-72)²¹

Dr. Padilla called each voting member of the MEC and urged him or her to review the compilation of materials relating to the precautionary suspension. Almost all of the voting members did review the material before attending the meeting. (CP 1871-722398; 2473)

Fifteen of the seventeen MEC members attended the September 16, 2008 meeting. (CP 1977) Without advocating any particular action, Dr. Rowles explained the Committee's recommendation and the basis for

²¹ After September 3, 2008, the following additional information was received: (i) Dr. Smigaj's office notes substantiating her statement to the Committee that she recommended hospitalization to the 2008 stillborn infant patient but the patient refused; (ii) two additional reports from Dr. Connor; (iii) Dr. Tomlinson's written reports on the second and third cases, (iv) the report of Dr. Brisbois, another external reviewer retained by Dr. Smigaj, on the second and third cases; and (v) Dr. Smigaj's written presentation to the MEC. (CP 2398; 2436-38; 2445-67)

the recommendation. (CP 1871-72; 2739-40) Dr. Smigaj requested that the MEC nullify the precautionary suspension and reinstate her privileges retroactive to September 4, 2008. (CP 1871-72; 2460-63)

In the discussion that followed, Dr. Kevin Harrington, Chair of the Ob/Gyn Department, stated he did not believe the suspension was justified.²² However, to avoid what he perceived might be an MEC consensus to continue the suspension, Dr. Harrington proposed a compromise under which the MEC would lift the suspension and reinstate Dr. Smigaj's privileges, not retroactively as she requested but, effective September 16, 2008, subject to an external review of each of her cases for a three month period following reinstatement. (CP 1999-2000) The MEC voted for the compromise with the additional recommendations that Dr. Smigaj see transfer patients in a timely manner, that she remain with her patients whom she was transferring from Memorial until the transport arrived, and that she consult with the neonatologist on high-risk obstetric

²² Dr. Harrington did not review the medical charts of any of these 2008 cases. He did not discuss the cases with Dr. Smigaj. He primarily relied on the reports of Dr. Connor, who had served as a defense expert in a malpractice action against Dr. Harrington's father and with whom Dr. Harrington maintains a friendship (CP 1981; 1984; 1988; 1992-1995; 1999-2001; 2004), and Dr. Brisbois, who served as a defense expert in the one malpractice action filed against Dr. Harrington. (CP 1277; 2464-67) Dr. Harrington testified that in quality of care reviews, outside reviews, such as Dr. Connor's, are important factors, but they should not be given greater weight than the people on the Committee itself. They do not replace the personal deliberations of the group. Dr. Harrington, however, did not speak with any members of the Committee before forming his opinion based on selected external reviews. (CP 2002)

patients. (CP 1977-79)²³ Immediately after the conclusion of the MEC meeting, Dr. Padilla informed Dr. Smigaj that her privileges had been reinstated at Memorial.

The external review imposed as a condition of reinstatement involved thirty-five (35) cases. The reviewers judged four cases to involve significant deviations from the standard of care and two more to involve minor deviations. (CP 3343-44; 3381-82)

III. STATEMENT OF ISSUES

1. Is the exclusive remedy of RCW 7.71.030 applicable only if the physician plaintiff chooses to invoke it and defendants admit that their peer review actions were based on matters not related to competence or professional conduct?
2. Has Dr. Smigaj identified sufficient material evidentiary facts on which a reasonable juror could conclude by a preponderance of the evidence that Defendants' review actions did not meet all four elements of 42 U.S.C. § 11112(a)?
3. Did the trial court properly grant judgment for Defendants on Dr. Smigaj's defamation claims?
4. Did the trial court abuse its discretion in awarding attorneys' fees and costs to Defendants?
5. Are Defendants entitled to fees on appeal?

²³ Dr. Robert Cooper, then Vice President of the Medical Staff, attended the September 16, 2008 MEC meeting. According to Dr. Cooper, the MEC felt the precautionary suspension was warranted. He testified that in the meeting it was pretty universally agreed that there were judgment issues but with a broader approach to these issues, they felt Dr. Smigaj needed to be reinstated with enhanced review. (CP 1981; 2082; 2085-2089) Hospital board member, Mr. Schaake also attended the meeting and testified that no physician spoke against the suspension decision and that several spoke in support of it. (CP 3343-44; 3489; 3492-94)

IV. ARGUMENT

A. **The Trial Court Properly Applied RCW 7.71.030.**

Referring to its early decision to deny Defendants' CR 12(b)(6) motion, the trial court stated that it made those decisions based on Dr. Smigaj's representations that her action revolved around her competence:

. . . . Only after reviewing the arguments on the defendants' summary judgment motion and motion for judgment on the pleadings did it become readily apparent, especially with the invective used by plaintiffs, that the thrust of the lawsuit was not centered around the competence of Dr. Smigaj but, rather on her belief that the peer review action was in fact a campaign to drive Dr. Smigaj out of business for anti-competitive reasons and/or a malicious peer review intended to destroy her career for economic reasons based on sham concerns related to her competence. The plaintiffs' argument crystallized an action founded on matters not related to competence or professional conduct and clearly stands as an action brought under RCW 7.71.030(1).

(CP 4044)

Dr. Smigaj continues to contend that RCW 7.71.030 does not apply to this lawsuit because: (1) Defendants claim immunity under the Health Care Quality Improvement Act of 1986, 42 U.S.C. § 11101 *et seq.* ("HCQIA"); and (2) Dr. Smigaj never invoked this exclusive remedy. Neither law nor logic supports this argument.

In *Morgan v. Peacehealth, Inc.*, 101 Wn. App. 750, 14 P.3d 773 (2000), the plaintiff alleged violations of both RCW 7.71.030 and the HCQIA. The trial court ruled that plaintiff had failed to produce evidence

sufficient to overcome the defendants' presumption of HCQIA immunity, entitling defendants to immunity from damages. However, the *Morgan* court still had to consider plaintiff's RCW 7.71.030 claim for injunctive relief. The court observed that relief under RCW 7.71.030 requires a finding that the review action was not related to plaintiff's professional conduct. In *Morgan*, the court found, based on the evidence presented at summary judgment, that the review action was related to professional conduct. Thus, the court denied plaintiff's RCW 7.71.030 action for injunctive relief.

In *Cowell v. Good Samaritan Community Health Care*, 153 Wn. App. 911, 225 P.3d 294 (2009) *rev. denied*, 169 Wn.2d 1002 (2010), *cert. denied* 131 S. Ct. 666 (2010), as in this case, the plaintiff alleged a variety of common law and statutory claims for damages. The *Cowell* plaintiff also alleged a claim for injunctive relief under RCW 7.71.030. Defendants alleged affirmative defenses including the HCQIA immunity.

On summary judgment, the trial court found that plaintiff had failed to rebut defendants' presumed HCQIA immunity. Following *Morgan*, the trial court also granted judgment to defendants on plaintiff's claim for injunctive relief under RCW 7.71.030. The court then went on to apply the prevailing party attorney fee provision of RCW 7.71.030 to

award defendants attorney fees and costs, finding, as the trial court in this case found, that all of the plaintiff's claims were based on a common core of facts. The trial court rulings on the substantive claims and the attorney fee award were affirmed on appeal.

This Court reached the same result in *Perry v. Rado*, 155 Wn. App. 626, 230 P. 3d 203 (2010), *rev. denied* 169 Wn.2d 1024 (2010), in which it: (1) affirmed the trial court's application of RCW 7.71.030 to dismiss plaintiff's common law damage claims; (2) affirmed the trial court's application of the HCQIA immunity to enter judgment for defendants on plaintiffs' peer review claim under RCW 7.71.030; and, (3) affirmed the trial court's award of substantial legal fees and costs to defendants under the prevailing party attorney fee provision in RCW 7.71.030, and awarded fees on appeal. The *Perry* decision once again reflects that the statutory schemes of the HCQIA and Ch. 7.71 RCW are not mutually exclusive.

Dr. Smigaj also contends that RCW 7.71.030 provides an optional, not exclusive, remedy. She contends that physicians who would prefer to avoid the exclusive remedy under RCW 7.71.030 are free to do so as long as they do not mention RCW 7.71.030 in their pleadings. This also is contrary to Washington law.²⁴

²⁴ When the legislature provides an exclusive statutory remedy for an alleged wrong, courts do not allow litigants to render the legislation a nullity by pleading around the exclusive remedy. *Hatch v. City of Algona*, 140 Wn. App. 752 (2007) (Defendant not allowed to third party in employer of plaintiff since to allow such a claim would defeat

As a practical matter, no physician-plaintiff in a peer review based lawsuit is going to accept the damage limitation, the shortened statute of limitations, and the exposure to an adverse attorney fee award if the exclusive remedy of RCW 7.71.030 is optional as Dr. Smigaj contends. No hospital or physician defendants in such a peer review based lawsuit are going to concede that their actions were based on matters not related to competence or professional conduct so that, according to Dr. Smigaj, RCW 7.71.030 applies, because, in doing so, they would admit liability under RCW 7.71.030, and abandon the HCQIA immunity affirmative defense. As a practical matter, Dr. Smigaj's reasoning renders RCW 7.71.030 a nullity, again contrary to Washington law. *Fifteen-O-One Fourth Ave. Ltd., Partnership v. State Department of Revenue*, 49 Wn. App. 300, 303 (1987) (Courts presume legislature does not engage in vain and purposeless acts.)

The trial court correctly concluded that RCW 7.71.030 was the exclusive, not optional, remedy for Dr. Smigaj's claim. The trial court correctly applied this exclusive remedy to dismiss Dr. Smigaj's common

exclusive remedy under Industrial Insurance Act) Moreover, courts are not bound by how plaintiffs characterize their causes of action. *Dual D Healthcare Operations v. Kenyon*, 291 S.W.3d 486, 488-89 (Tex. App. 5th Dist. 2009) (Plaintiff can not avoid the essence of a suit through artful pleading as underlying nature of the claim will be determinative.)

law tort claims and other damage claims and to award fees and costs to the prevailing Defendants. Its decision should be affirmed.

B. The Trial Court Correctly Concluded That Dr. Smigaj Failed to Show That A Reasonable Jury Could Conclude by a Preponderance of the Evidence That Defendants Did Not Meet All Four Elements of the HCQIA Immunity.

When a defendant moves for summary judgment under the HCQIA, “. . . this court must view the evidence in the light most favorable to [the physician] and determine whether she has shown that a reasonable jury could conclude, by a preponderance of the evidence, that respondents’ review actions did not meet all four elements of § 11112(a).” *Cowell*, 153 Wn. App. at 926.

. . . the Court must be mindful that the immunity provisions of the HCQIA are quite clearly designed to avoid excessive scrutiny of professional review actions in civil litigation. . . . these provisions have the salutary effect of ensuring that the Court need not weight the conflicting views of medical professionals or second-guess a hospital review committee’s decision whether to grant or suspend clinical privileges – tasks this Court lacks the expertise to perform. Instead, the Court is called upon only to determine whether a particular decision, viewed objectively, meets the four criteria set forth at § 11112(a) – and to begin this inquiry with the presumption that it does.

Ritten v. Lapeer Regional Medical Center, 611 F. Supp. 2d 696, 728 (E.D. Mich. 2009), cited repeatedly by Dr. Smigaj.

1. The Professional Review Action Was Taken in the Reasonable Belief That It Was in Furtherance of Quality Health Care.

The real issue under this element of the HCQIA is the sufficiency of the basis for hospital action. *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1335 (11th Cir. 1994). The reasonable belief standard is satisfied if an objective view of the record discloses a sufficient basis for the Committee's decision. *Ritten v. Lapper Regional Medical Center*, 611 F. Supp. 2d 696, 728 (E.D. Mich. 2009).

The factual basis for a professional review action is sufficient unless “. . . the information relied . . . [on] . . . was so obviously mistaken or inadequate such as to make reliance on it unreasonable.” *Fox v. Parma Community General Hospital*, 160 Ohio App. 3d 409, 418 (2005); *Cowell*, 153 Wn. App. at 933 n. 37.

Courts have recognized that such factual challenges may be difficult but that this difficulty was intentional to provide protection for those engaged in peer review *Cowett v. TCH Pediatrics, Inc.*, No. 05MA138, 2006 WL2846282*5 (Ohio Ct. App. Sept. 27, 2006)(Ohio Supreme Court Rules for the Reporting of Opinions; Rule 4 permits citation)(see Appendix 1).²⁵

²⁵ The facts referred to in these decisions are the clinical facts in the medical charts for the patients at issue. These medical records inform the reviewer what clinical care was provided, how it was provided, who provided it, and when it was provided. Dr. Smigaj does not challenge these facts. Instead she directs her attention to the content of committee meeting minutes, several sets of handwritten notes, and the content of reports

Arguments that a physician did not cause harm to any patient or that the actions taken by defendants did not actually improve health care are irrelevant. *Cowell*, 153 Wn. App. at 928 The presumption of immunity is not rebutted by proof that the standard of care was met or that the reviewers reached an incorrect conclusion. *McLeay v. Bergan Mercy Health System*, 714 N.W. 7, 271 Neb. 602, 612 (2006).

At the time the Committee recommended a precautionary suspension, the totality of the information before the Committee included:

a. In 1995, based on concerns raised about her clinical care, Dr. Smigaj received additional proctoring in low risk obstetrical cases from members of the Memorial medical staff and in high-risk obstetrical cases from perinatologists at the University of Washington. (CP 2395-96; 2417; 2419; 2724; 2743)

b. In the last two months of 2004, three of Dr. Smigaj's high-risk patients were cared for by nurse midwives working under Dr. Smigaj's supervision in violation of their scope of practice under hospital policy.²⁶ (CP 1895; 2724-27; 2749-52) These cases resulted in a

HCQIA immunity. *Ritten*, 611 F. Supp. 2d at 727. (Even if defendant acted with questionable motives in suspending plaintiff's privileges and continued to push this agenda through the hearing process, these facts are not relevant to objective standard.)

²⁶ Dr. Johns testified that these high-risk patients who were not initially seen by Dr. Smigaj were, in his opinion, part of a larger pattern of Dr. Smigaj's failure to see high-risk obstetrical patients in a timely fashion as occurred with the case of the 16-year-old high-risk obstetrical patient the Committee reviewed in 2008. (CP 2105-06)

series of practice improvement recommendations that were monitored until their satisfactory completion in Feb. 2006. CP 1916-17; 1920-23; 1952-58; 1960-66; 2121-22; 2124-25; 2142; 2145-51; CP 2727)²⁷

c. In January 2007, Dr. Smigaj experienced a large hemorrhage in the course of performing a cesarean and, according to those present or assisting in this life-threatening complication, Dr. Smigaj's approach was not consistent with the approach typically employed by surgeons. (CP 1880) Practice improvement recommendations were made for additional training and education on management of hemorrhages. (CP 1883; 1895; 1981; 2006; 2017; 2020; 2023-25; 2121-22; 2126-28; 2727-29; 2812-14)

d. In February 2008, Dr. Smigaj: (1) failed to obtain any informed consent of a high-risk 26 week pregnant 16-year-old suffering from pre-eclampsia for her plan of care in violation of hospital rules and regulations; (2) gave telephone orders over the course of the night to initiate cytotec induction without evaluating or counseling the

²⁷ Markedly similar to the first 2008 case considered by the Committee, one of these three patients was transferred from Sunnyside Hospital to Memorial and admitted on December 13, 2004. She was admitted 26 weeks pregnant with ruptured membranes and the fetus in breech position. She was seen by one of Dr. Smigaj's nurse midwives but not by Dr. Smigaj until December 20, 2004. Dr. Smigaj was called multiple times after this assessment regarding changes in the status of the patient. Dr. Smigaj conceded that she may have "missed the boat" on this change in status. In response to the calls, Dr. Smigaj gave phone orders but did not come to the hospital to personally evaluate the patient. (CP 2726-27; 2767-68; 2780-81)

patient contrary to ACOG clinical guidelines; (3) gave telephone orders to a nurse to rupture the patient's membranes to place a fetal heart rate monitor without personally evaluating the patient or status of the fetus in violation of hospital policy and scope of nursing practice; and, (4) performed surgery on the patient without first recording a history and physical in violation of hospital rules and regulations. (CP 1883-84; 1887; 1893-94; 2730-35; 2820; 2827-29; 2835; 2847; 2857-58; 2881-86; 2936)

Dr. Tomlinson advised the Committee that the patient was entitled to a personal assessment and evaluation before induction was initiated. (CP 2428-29; 2436-38) Dr. Tomlinson testified that Dr. Smigaj's care in this case was below the standard of care. (CP 2035-36)

e. In June 2008 Dr. Smigaj failed to confirm fetal position before initiating cytotec induction contrary to ACOG practice guidelines and, after discovering that the fetus was in breech position, did not assure that the neonatologist would be present to assist in the resuscitation of the compromised infant contrary to hospital policy.²⁸ (CP 1896-97; 2737-38; 2831; 2835; 2847) Dr. Tomlinson advised that

²⁸ (CP 2063-65) In *Perry v. Rado*, 155 Wn. App. at 639, the court concluded that this element of HCQIA was satisfied by the fact that the physician had been involved in a single procedure not permitted under a performance agreement with the hospital. In this case, Dr. Smigaj engaged in, directed, and supervised multiple procedures that violated hospital policies with which she agreed to abide as a condition of her membership on the medical staff. (CP 486)

fetal position should have been confirmed prior to placement of Cytotec to induce delivery.²⁹

f. In August 2008, Dr. Smigaj arranged for a 25 plus week pregnant patient to undergo a two plus hour transport from Memorial Hospital to the University of Washington Hospital in Seattle during a perceived “window of opportunity” of unknown duration, when the patient had been experiencing contractions, was 2-3 cm dilated, had ruptured membranes with an infection, and the fetus was in breech position with a foot in the cervix, and did not consult with a neonatologist on this decision despite his presence and the capability of the Hospital NICU to resuscitate and sustain a 25-week-old baby. In the view of the Committee, based on information in her patient’s medical chart, the patient was not stable for transport (CP 1880-81; 1884; 1890; 1896-97; 2735-37)

g. Dr. Smigaj felt she was “not at fault in treatment of” the 2007 hemorrhage patient despite the appearance to those who assisted her that she had neither the skills nor the knowledge to address bleeding of this nature and despite her inability to explain the cause of the bleeding. (CP 1981; 2006; 2017; 2020; 2023-25; 2727-30; 2807; 2810)

²⁹ Dr. Tomlinson confirmed this opinion in his written review received on September 9, 2009. (CP 2443)

h. Dr. Smigaj was contentious when she first met with the Committee about her care of the 16-year-old high-risk obstetrical case, telling the Committee it could not make her see a transfer patient within a specific period unless it adopted a policy requiring this of everyone. Dr. Smigaj continued to believe her judgment not to see this patient on or shortly after admission, her judgment to initiate induction without seeing the patient, and her judgment to direct a nurse to rupture the patient's membranes was not flawed, despite the fact that her judgment violated multiple hospital rules, regulations and policies. (CP 1883-84; 1894; 2121-22; 2128; 2730-35; 2897)

Dr. Smigaj has failed to show that a reasonable jury could conclude by a preponderance of the evidence that the facts were insufficient to support a reasonable belief that the temporary suspension of her privileges was in furtherance of quality health care. The decision was based on immediate as well as long-standing concerns about Dr. Smigaj's clinical judgment and in particular, her repeated failure to attend promptly to high-risk patients. *See, e.g., Cowell*, 153 Wn. App. at 930 (Board decision based on long-standing concerns about practitioner); *Morgan*, 101 Wn. App. at 774 ("It was not unreasonable to conclude that a

physician's failure to undergo evaluation and counseling might impact patient care").³⁰

2. The Decision to Recommend Precautionary Suspension Was Made After a Reasonable Effort to Obtain Facts.

"The relevant inquiry under the second requirement is whether the totality of the process leading up to the professional review action evidenced a reasonable effort to obtain the facts of the matter." *Morgan*, 101 Wn. App. at 770; *Cowell*, 153 Wn. App. at 931. Plaintiffs are entitled to a reasonable effort to obtain the facts, not a perfect effort. *Cowell*, 153 Wn. App. at 932.

On this element of immunity, this Court has stated:

Dr. Perry's interlocutory suspension was in October 2005, with privileges finally revoked in September 2006. The record shows over this 11-month period, physicians and staff were interviewed and Dr. Perry was permitted to make

³⁰ See also *North Colorado Medical Center, Inc., v. Nicholas*, 27 P.3d 828, 839 (2001) (As an objective matter, Board of Directors could have reasonably believed that physician's poor documentation and communication skills caused dissention and confusion among the laboratory staff sufficient to adversely affect patient care thereby satisfying reasonable belief standard of the HCQIA immunity provision for suspension of privileges); *Reyes v. Wilson Memorial Hospital*, 102 F. Supp. 2d 798 (S.D. Ohio 1998) (Suspension following deficient care for one patient and refusal to sign agreement requiring temporary co-admission for all patients satisfied objectively reasonable belief standard). *Imperial v. Suburban Hospital Association*, 37 F.3d 1026, 1029 (4th Cir. 1994) (Failure to learn or show improvement in patient care is a legitimate health care quality concern). *Moore v. Williamsburg Regional Hosp.*, 560 F.3d 166 (4th Cir. 2009) (Suspension of all privileges of surgeon who treated adults and children based on knowledge of charges that surgeon had sexually abused adopted daughter satisfied the HCQIA requirement of reasonable belief that action was in furtherance of quality health care since evidence was that action was taken to protect potential juvenile patients from the possibility of sexual abuse).

statements. Thus, reasonable fact finding occurred;
Dr. Perry merely disagrees with the facts found.

Perry v. Rado, 155 Wn. App. at 639-40.³¹

In the course of its eight meetings between May 30, 2008 and September 3, 2008, the Committee's efforts to obtain the facts of the matter included the following:

a. The Committee thoroughly reviewed the medical records of the 2008 cases that were referred to it for review and sought additional records from outside the hospital when appropriate. (CP 1880; 1884; 1887-88; 1890; 1897; 2730-32; 2735-38; 2902-03; 2905; 2934-39)

b. The Committee wrote to Dr. Smigaj to inform her of its review of each of the cases, to identify the quality concerns it had about each case, to solicit her written response to these quality concerns, and to invite her to meet with the Committee to personally discuss each case of concern. (CP 2824; 2888-89; 2891; 2893; 2905; 2941)

c. Dr. Smigaj provided the Committee a written response to its identified concerns for the 2008 cases and the Committee

³¹ See also *Egan v. Athol Memorial Hospital*, 917 F. Supp. 37 (D. Mass. 1997) (Multiple committee meetings to consider cases, to consider Practitioner's written response to concerns, and to consider external reviews evidenced a reasonable effort to obtain facts); *Fobbs v. Holy Cross Health Systems Corp.*, 789 F. Supp. 1054 (E.D. Cal. 1992), affirmed 29 F.3d 1439 (9th Cir. 1994) (Supervisory Committee made reasonable effort to obtain facts when it reviewed eight of plaintiff's cases, obtained independent review of three, and gave plaintiff the opportunity to discuss the cases).

considered these written responses. (CP 2734-35; 2737; 2895-97; 2943-44)

d. Dr. Smigaj attended two of the Committee meetings to personally discuss with the Committee its quality concerns regarding the 2008 cases. (CP 2730; 2737)

e. The Committee obtained external reviews of the three 2008 cases that raised quality of care issues. The Committee provided Dr. Smigaj with the written report it did receive. (CP 2397-98; 2436-38; 2734; 2736)

f. The Committee received and considered reports from an external reviewer retained by Dr. Smigaj on each of the three 2008 cases that raised quality of care issues. (CP 1884; 1889-90; 1896-97; 2734; 2737; 2899-2900; 2946-49)

g. The Committee considered summary information on past quality reviews of Dr. Smigaj's cases, including a compilation of its meeting minutes reflecting these reviews from 1999 to the present. *See Cowell*, 153 Wn. App. at 933. (Approving committee review of past case reviews prepared by other committees as appropriate.) (CP 1879; 1888; 1897; 2732; 2735; 2867-74; 2907-32)

Dr. Smigaj has failed to produce evidence on which a reasonable jury could find by a preponderance of the evidence that defendants failed to make a reasonable effort to obtain the facts of the matter.³²

3. Defendants Satisfied the Fair Process Requirement for the HCQIA Immunity.

42 U.S.C. § 11112(a)(3) requires that a professional review action only be taken after the physician is afforded adequate notice and hearing procedures or such other procedures as are fair under the circumstances.³³ However, in a situation in which a suspension of privileges is imposed for a period of not longer than fourteen (14) days, during which time an investigation is being conducted to determine the need for professional

³² Dr. Smigaj appears to argue that Dr. Padilla was required to conduct his own independent investigation before implementing the recommendation of the Committee. Dr. Smigaj cites no authority for this argument other than Dr. Connor's declaration. Actual authority does not support this argument. *Cowell*, 153 Wn. App. 938 n.44 (Decision maker may leave facts finding to lower level committee); *Gabaltoni v. Washington County Hospital Ass'n*, 250 F.3d 255, 261 (4th Cir. 2001) (HCQIA does not require decision maker to independently investigate.) Similarly, Dr. Smigaj's argument that the presence of other obstetricians on the Committee defeats the HCQIA immunity is also unfounded. Her citations relate to a hearing panel not a quality assurance committee. (App. Br. At 40) Finally, failure to adhere to medical staff bylaws does not defeat immunity. *Poliner v. Texas Health Systems*, 537 F.3d 368 (5th Cir. 2008)

³³ Dr. Smigaj contends she was not afforded a fair process because she was not informed of all the issues raised by the Committee and was not advised by the Committee that it was considering recommending restriction of her privileges. No authority under the HCQIA supports these assertions. The notice required under 42 U.S.C. § 11112(a)(3), if it applies, is ". . . notice stating that a professional review action has been proposed to be taken against the physician. 42 U.S.C. § 11112(b)(1). (Emphasis Added) Further, nothing in the HCQIA entitles the physician to participate in the review of cases. *Egan v. Athol Memorial Hosp.*, 971 F. Supp. 37, 43 (D. Mass. 1997); *Pfenninger v. Exempla, Inc.*, 116 F. Supp. 2d 1184 (D. Colo. 2000).

review action, compliance with 42 U.S.C. Sec. 11111(a)(3) is not required. 42 U.S.C. § 11112(c)(1)(B) Furthermore, immediate suspension, subject to a subsequent fair process, may be imposed where a failure to act may result in imminent danger to the health of any individual. 42 U.S.C. § 11111(a)(3).

Under applicable medical staff policies, a precautionary suspension is an interim precautionary measure. Within ten (10) days from imposition of a precautionary suspension, the MEC is to commence an investigation and meet to review the precautionary suspension to determine the need for professional review action. (CP 2571-72; 2568)

On September 4, 2008, Dr. Padilla told Dr. Smigaj he would initiate further review by the MEC of the 2008 cases. Dr. Padilla did just this. (CP 1870-1872; 2398) The MEC met on September 16, 2008 to decide whether action should be taken to limit or restrict Dr. Smigaj's privileges. In addition to the review of materials compiled for them, they heard from Dr. Smigaj and Dr. Rowles.³⁴ They decided that professional review action was not needed. Dr. Smigaj's privileges were reinstated

³⁴ Dr. Smigaj provided the MEC with two additional reports from the external reviewer who submitted reports to the Committee, a second external review on two of the three cases of concern, and office records that were not available to the Committee. In addition, Dr. Smigaj prepared her own written report to the MEC in which she requested that the MEC void the Committee recommendation by reinstating her privileges retroactive to the date of the precautionary suspension on September 4, 2008. (CP 2398; 2446-67)

prospectively, subject to external review of her cases over the ensuing ninety (90) days.³⁵ Under these circumstances, immunity under the HCQIA does not require compliance with the procedures of 42 U.S.C. § 11111(a)(3).

In addition, nothing in the HCQIA precludes the immediate suspension or restriction of privileges, subject to subsequent fair procedures, where the failure to take such action may result in an imminent danger to the health of any individual. 42 U.S.C. § 11112(c)(2). A suspension on this basis does not require that imminent danger actually exist. It requires only that the danger may result if the suspension is not imposed. *Fobbs v. Holy Cross Health Systems Corp.*, 29 F.3d 1439, 1443 (9th Cir. 1994); *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 917 (8th Cir. 1999) (Rejecting physician claim that imminent danger could not exist because he had no patient in the hospital when the suspension was imposed).

The Committee members reasonably believed that Dr. Smigaj's pattern of poor medical judgment, including repeated failures to promptly attend to high-risk obstetrical patients, posed a risk to hospital patients if

³⁵ The MEC's requirement of external review of all of Dr. Smigaj's cases for three months is an endorsement of the validity of the Committee's concerns about the quality of Dr. Smigaj's health care services. *Ritten*, 611 F. Supp. 2d at 726

an immediate suspension was not imposed. (CP 1881; 1884-85; 1897-98; 1981; 2067; 2073; 2077-78; 2738-40; 2742-45)

Finally, with respect to immunity on this element:

The controlling question is whether the Plaintiff “has shown by a preponderance of the evidence, that the defendant[] did not provide him with fair and adequate process under the circumstances.”

Singh v. Blue Cross/Blue Shield of Mass., 308 F.3d 25 , 40 (1st Cir. 2002).

Here, if the fair process requirement of the HCQIA immunity applies, the process afforded Dr. Smigaj was fair and reasonable under the circumstances. Informal review procedures are sufficient to satisfy this element of the HCQIA immunity. *Cowell*, 153 Wn. App. at 936. The Committee kept Dr. Smigaj informed of its meetings and the quality of care concerns it was considering. (CP 2824; 2861-65; 2890; 2891; 2893; 2905; 2941; 2951-55) Dr. Smigaj was provided the opportunity to respond to Committee quality concerns in writing, in person, and through the submission of reports from an external reviewer. (CP 2861-65; 2895-97; 2899-2900; 2943-44; 2946-49; 2951-55) Dr. Smigaj was informed of the Committee recommendation the day after it was made and provided the opportunity to participate in the further additional review of her clinical care conducted by the MEC. (CP 1870; 1875-76; 1916-18; 1977-79) Even if the requirement of a fair and reasonable process under the HCQIA applied to this situation, which it does not, the process

provided to Dr. Smigaj was fair and reasonable, with repeated opportunities to address the quality of care issues raised by the review of her cases.

4. Dr. Smigaj Failed to Rebut the Presumption That Defendants Acted With a Reasonable Belief That the Recommendation of a Precautionary Suspension Was Warranted Based on Facts Known.

The analysis of this final element of immunity, 42 U.S.C. § 11112(a)(4), closely tracks the analysis of the first element regarding an objectively reasonable belief that the action would further quality health care. *Morgan*, 101 Wn. App. 750 at p. 773; *Cowell*, 153 Wn. App. at 939. In making the immunity determination with respect to this fourth factor, the court must not reweigh the evidence or substitute its own judgment for that of the peer review committee. *Egan v. Athol Memorial Hospital*, 971 F. Supp. 37, 44 (D. Mass. 1997) If the decision is supported by objective evidence, then the severity of the action is within the discretion of the professional review committee. *Meyer v. Sunrise Hospital*, 22 P.3d 1142, 117 Nev. 313, 324 (2001); *see also Peyton v. Johnson City Medical Center*, 101 S.W. 3d 76, 88 (Tenn. App. 2002) (simply because Dr. Peyton disagrees with the degree of action taken by the Hospital in no ways means the Hospital's motivation was improper).

Despite uniform case law to the contrary, Dr. Smigaj argues that the court should reweigh the evidence, giving more weight to the opinions

of some doctors and less to the opinions of others than did the Committee. Dr. Smigaj argues that the court should substitute its judgment for that of the members of the hospital medical staff as to the appropriate action to be taken in response to the clinical facts reviewed. Through Dr. Conner's legal opinions, Dr. Smigaj offers her own definition of the circumstances that justify a precautionary suspension, a definition with no support in the case law or in the hospital medical staff bylaws.³⁶ The HCQIA regards an immediate suspension of privileges no differently than any other action taken to protect patients. *Gureasko v. Bethesda Hospital*, 116 Ohio App. 3d 724, 732, 669 N.E. 2d 76 (1996) (Because overriding interest is protection of patient care and safety, Committee can immediately suspend privileges without standard of care violation as long as action is taken in reasonable belief that failure to act might endanger patient); *Pfenninger v. Exempla, Inc.*, 116 F. Supp. 2d 1184 (D. Colo. 2000) (Finding that physician exercised poor judgment in three recent cases with history of similar problems sufficient for immediate suspension under 42 U.S.C. § 11112(c)(2).)

³⁶ Dr. Connor's definition of imminent danger has been rejected by the courts as unreasonable and without foundation in light of the abundance of case law to the contrary. *Sternberg v. Nanticoke Memorial Hospital*, No. CIV. A. 07C-10-011 (TGH), 2009 WL 3531791 at*31(Del. Super. Ct. Sept. 18, 2009)(Del. Super. Ct. Rule 107(g) permits citation)(see Appendix 2). The medical staff policies contain an extensive definition of imminent danger. (CP 529)

Based on a series of cases in 2008, as well as previous quality concerns, the Committee reasonably believed that Dr. Smigaj's clinical care evidenced repeated instances of poor clinical judgment including, but not limited to, repeated instances of failing to promptly and properly attend to high-risk obstetrical patients, that Dr. Smigaj was either unwilling or unable to accept that there were real problems with her clinical judgment and care, and that the combination of these factors posed an unacceptable risk to her patients that warranted immediate action. (CP 1883-85; 1889-90; 1897-98; 2738-40)

5. Dr. Smigaj Relies Primarily on Irrelevancies in Challenging the Trial Court HCQIA Immunity Ruling.

Much of Dr. Smigaj's argument challenging the trial court ruling on HCQIA immunity relies on the forty-one page Connor declaration. (App. Br. App. B) This declaration is improper in general because it essentially represents Dr. Connor's legal opinions as to whether the Defendants have satisfied the elements of the HCQIA immunity. *Hiskey v. Seattle*, 44 Wn. App. 110 (1996) (Experts are not to state opinions of law or material fact and law); *Terrelle v. DSHS*, 120 Wn. App. 20, 30 (2004) (Legal opinions on ultimate legal issue are not properly considered under the guise of expert testimony).

On the significance of medical expert testimony in HCQIA immunity litigation, the court in *Meyer v. Sunrise Hospital*, 22 P.3d 1142,

117 Nev. 313, 323 (2001), summarized the majority view as being that such testimony is irrelevant because the focus is:

... solely on the reasonableness of the peer reviewer's belief, not on whether the peer review action ultimately proved to be medically sound or actually furthered quality care. . . . Therefore, Meyer's proffer of expert testimony stating that the peer review action taken was not warranted and did not further quality care does not create a triable issue of material fact because it does not bear on the relevant issue for our consideration – namely, whether the peer review committee acted with a reasonable belief that its action was warranted by the facts known after a reasonable investigation. (Emphasis Added; citations omitted)

In *Sugarbaker v. SSM Health Care*, 190 F.3d 905 (8th Cir. 1999), the plaintiff produced an affidavit of an independent surgeon to the effect that the peer reviewers could not have entertained doubts as to the plaintiff's care. The court rejected this as irrelevant.

As the court observed in *Poliner v Texas Health Systems*, 537 F. 3d 368, 379 (5th Cir. 2008):

If a doctor unhappy with peer review could defeat HCQIA immunity simply by later presenting the testimony of other doctors of a different view from the peer reviewers, or that his treatment decisions proved to be "right" in their view, HCQIA immunity would be a hollow shield.

Dr. Smigaj also argues at length that the Defendants' treatment of certain documents should be a basis for denying the HCQIA immunity. These documents included handwritten notes taken at two committee meetings and a telephone conversation with Dr. Tomlinson, and electronic

drafts of Committee meeting minutes that were revised before being finalized. Dr. Smigaj argues repeatedly that Defendants' handling of these documents is evidence of a continuing bad faith effort to cover their nefarious tracks. (App. Br. pp. 2; 26-30) As with Dr. Connor's expert opinion on every legal issue raised by this litigation, evidence of bad faith on the part of these reviewers is irrelevant to the issue of the HCQIA immunity. *Cowell*, 153 Wn. App. at 126.

With respect to the document spoliation argument that Dr. Smigaj weaves into her irrelevant bad faith argument, the documents at issue were not relevant, there were multiple alternate sources of the same information, and there was an innocent explanation for the treatment of the documents. *Henderson v. Tyrrell*, 80 Wn. App. 592, 607 (1992) (Adverse inference request requires consideration of relevance of the missing evidence and culpability of the adverse party) The handwritten notes and drafts of meeting minutes do not constitute the objective facts which must be sufficient to support a reasonable belief that the challenged action was in furtherance of quality health care.³⁷ Those facts are contained in the medical records. The handwritten notes and any other documents that may have been shredded were destroyed pursuant to the policy and

³⁷ Meeting minutes are not intended to be a verbatim record of the meeting but are merely to capture the substance and that the substance was never changed by any revisions. (CP 1916-18; 2230-32; 2397)

practice of preserving confidentiality. (CP 917; 938; 1086-88; 1315; 3339-41)

In addition, there were multiple alternative sources of this information. The handwritten notes were converted into meeting minutes made available to Dr. Smigaj. (CP 2424-26; 2428-34) Dr. Smigaj also received letters from the Committee regarding the meetings. (CP 2824; 2888-89; 2891; 2893; 2905; 2941) Dr. Smigaj also was provided all of Dr. Tomlinson's reports. (CP 586-88; 598-601) With respect to the allegedly altered meeting minutes, when asked about them in depositions, the involved physicians characterized them as semantics or as accurately reflecting their comments at the meetings. (CP 1086-88; 1155; 1197; 1640; 1659-60; 3343-44; 3388; 3398-99; 3514-16)

C. The Trial Court Correctly Dismissed Dr. Smigaj's Defamation Claims.

Dr. Smigaj's single core claim has always been that the Defendants' actions were an attempt to misuse the peer review process to drive her out of business for anti-competitive reasons based on sham concerns about her competence. In other words, according to Dr. Smigaj, Defendants lied and made false statements about her competence as part of their overall scheme to misuse the peer review process for anti-competitive reasons. The trial court correctly ruled that RCW 7.71.030 provided the exclusive remedy for Dr. Smigaj's claim.

Dr. Smigaj argues that the trial court should not have dismissed her defamation claims based on four statements: (1) the false implication that she was a risk to patient safety in announcing her suspension to the labor and delivery nurses; (2) the false statements that Dr. Nadig had concerns about the 2007 blood loss case; (3) Dr. Rowles' statements to the Committee about Dr. Tomlinson's opinions of Dr. Smigaj's clinical care; (4) Ms. Anyan's statement about Dr. Tomlinson's opinion of Dr. Smigaj's care. App. Br. at 46-47 These statements are offered by Dr. Smigaj as part of the evidentiary foundation for her claim that the concerns about her clinical care were a sham perpetrated by Defendants in furtherance of their goal to misuse the peer review process to destroy her economically for which RCW 7.71.030 provides the exclusive remedy.

Her argument that she is entitled to assert defamation claims based on the allegations relating to these identified statements is simply an argument that she should be allowed to deconstruct her RCW 7.71.030 claim into its evidentiary components and premise individual common law claims on those components. The trial court applied RCW 7.71.030 correctly. It is the exclusive remedy for Dr. Smigaj's single core claim. It precludes assertion of independent common law claims based on the same facts offered in support of the RCW 7.71.030 claim. *Perry v. Rado*, 155 Wn. App. 626, 636 (2010)

The trial court also correctly concluded that Defendants were entitled to immunity from monetary damage claims under the HCQIA. Therefore, even if Dr. Smigaj were permitted to bring these defamation claims in addition to her exclusive remedy under RCW 7.71.030, which she is not, the trial court correctly ruled that Defendants have immunity from such claims. For this additional reason, the trial court correctly granted judgment for Defendants on all of Dr. Smigaj's defamation claims. *Cowell v. Good Samaritan*, 153 Wn. App. 911, 923 (2009) (Cowell's defamation claim subject to HCQIA immunity).³⁸

D. The Trial Court's Attorneys' Fees and Cost Award Was Proper.

In challenging the trial court fee award, Dr. Smigaj recounts her contention that RCW 7.71.030 does not apply to this litigation. For the reasons stated above, Dr. Smigaj's arguments are without legal or logical

³⁸ Defendants do not concede that the statements Dr. Smigaj identifies were false, either expressly, or by implication. The trial court correctly observed that all the statements in the Group Health letter were factually accurate. (CP 2399; 2585-86) They were not defamatory. *Lee v. Columbian, Inc.*, 64 Wn. App. 534, 538, 826 P.2d 217 (1991) The Group Health letter caused no damage (CP 3561-62) and Dr. Smigaj released Defendants from her claims in any event. (CP 2584) Washington does not recognize defamation by implication, *Yeakey v. Hearse Communications*, 156 Wn. App. 787, 793, 234 P.3d 332 *review denied*, 170 Wn.2d 1014 (2010), and, even if the statements were made as alleged, they are subject to the common-interest privilege. *Moe v. Wise*, 97 Wn. App. 950, 958, 989 P.2d 1148 (1999); *Lipson v. Anesthesia Services*, 790 A.2d 1291 (Del. Super. 2001) (hospital employer's statement regarding physician competency subject to qualified privilege)

foundation. The trial court award of prevailing party attorney fees and costs to Defendants under RCW 7.71.030 should be affirmed.

Dr. Smigaj's statement that Defendants will not be the prevailing party if this court reverses the trial court's CR 12(c) judgment is incorrect. Unless this court also reverses the trial court CR 56 judgment, Defendants still will have prevailed in this action by virtue of the HCQIA immunity. Defendants will still be entitled to prevailing party attorney fees and cost under RCW 7.71.030 unless this court accepts Dr. Smigaj's argument that RCW 7.71.030 is an optional remedy for her single core claim, or, as a matter of law, can not apply to an action in which the court concludes that defendants are entitled to the HCQIA immunity.

Alternatively, Defendants are entitled to an award of prevailing party attorney fees under 42 U.S.C. § 11113. The purpose of this attorney fee provision is to advance the overall objective of the HCQIA to promote vigorous peer review by deterring unreasonable litigation. *Smith v. Ricks*, 31 F.3d 1478, 1487 (9th Cir. 1994). In seeking reversal of the trial court award of attorneys' fees and costs under this provision, Dr. Smigaj contests only the third element, i.e., whether her claims or conduct were frivolous, in bad faith, unreasonable or without foundation.³⁹ Each of

³⁹ The trial court decision that Dr. Smigaj's claims were unreasonable or without foundation is reviewed under the abuse of discretion standard. *Johnson v. Nyack Hosp.*, 964 F.2d 116, 123 (2nd Cir. 1992); *Cowell*, 153 Wn. App. at 943.

these criteria constitute an independent basis for awarding fees and costs under this provision.⁴⁰ Here, Dr. Smigaj's claims throughout this litigation were both unreasonable and without legal foundation.

From the outset, this lawsuit was an attempt to avoid Washington law. Dr. Smigaj filed a lawsuit asserting causes of action not allowed under Washington law in a lawsuit premised on her single core claim. She has argued throughout this lawsuit, and continues to argue on appeal, that the exclusive remedy of RCW 7.71.030 is actually an optional remedy that she can disregard at her choosing. Yet she has failed in the entire course of this litigation to identify a single Washington court decision that supports this "exclusive really means optional" argument.

Despite the absolute illogic of the argument and the fact that *Morgan* applied both the HCQIA and RCW 7.71.030 in resolving that lawsuit, Dr. Smigaj has argued from the outset of this litigation, and continues to argue, despite the intervening decisions in *Cowell* and *Perry*, that RCW 7.71.030 and the HCQIA can not be simultaneously applied in the same lawsuit. As with her "exclusive means optional" argument,

⁴⁰ *Smith v. Selma Community Hospital*, 188 Cal. App. 4th 1, 31-33 (2010), construes identical language in state law. In that decision, without legal foundation was defined to mean without either direct or indirect supporting authority. Unreasonable was defined as "chiefly concerned with the logic, rationale, or reasoning process that connects the underlying foundation with the conclusions advocated by the party."

Dr. Smigaj does not cite a single Washington court decision that supports this argument.

Dr. Smigaj was never able to raise a material factual issue with respect to Defendants' HCQIA immunity affirmative defenses. Her efforts to overcome the presumed HCQIA immunity relied on assertions of bad faith and self-interest uniformly rejected as irrelevant, on the failure to provide process that no court has ever required, on expert opinion that has been overwhelmingly rejected as irrelevant, on failure to follow bylaws also uniformly rejected as irrelevant, and on failure to tailor the eleven day suspension in some fashion which no courts have required.

There was never a basis in Washington law for the causes of action Dr. Smigaj prosecuted in her lawsuit. She avoided dismissal of her claims at the outset only by initially persuading the trial court that her claim was something other than what it actually was. When Dr, Smigaj filed this lawsuit in November 2008 the law was very well developed regarding the arguments she advanced to avoid the HCQIA immunity. Courts had either uniformly or overwhelmingly found the same arguments irrelevant. This lawsuit is an appropriate case for an award of attorneys' fees and costs under 42 U.S.C. § 11113 and the trial court decision in that regard should be affirmed.

E. Defendants Are Entitled to Fees on Appeal.

RCW 7.71.030(3) and 42 U.S.C. § 11113 authorize fee awards on appeal. *Perry v. Rado*, 155 Wn. App. 626, 643 (2010); *Smith v. Ricks*, 31 F.3d 1478, 1488-89 (9th Cir. 1994).

V. CONCLUSION

Dr. Smigaj's argument that RCW 7.71.030 provides an optional, not exclusive, remedy for her and applies only if defendants admit their actions were based on matters not related to competence or professional conduct is without foundation in Washington law and completely unreasonable, rendering the legislation a nullity. Dr. Smigaj primarily relies on irrelevant assertions of bad faith and Dr. Connor's legal opinions to rebut Defendants' presumed HCQIA immunity. Her claims that she was entitled to a perfect investigation and to participation in the review of her cases and the Committee's deliberations have no legal support. The trial court did not abuse its discretion in awarding Defendants legal fees and costs. The trial court rulings should be affirmed and Defendants are entitled to such an award on appeal.

DATED this 14th day of March, 2011.

Respectfully submitted,

MILLER NASH LLP



Greg Montgomery, WSB No. 7985

Attorneys for Respondents

VI. APPENDIX

APPENDIX 1

**SUPREME COURT RULES
FOR THE REPORTING OF OPINIONS**

As Amended Effective May 1, 2002.

Rule

- 1 Opinions and syllabus of the Supreme Court; syllabus of opinions by courts other than the Supreme Court; numbering or lettering of paragraphs of text and of footnotes
- 2 Opinions shall be promptly published and posted
- 3 Opinions of the courts of appeals
- 4 “Controlling” and “persuasive” designations based on form of publication abolished; use of opinions
- 5 Criteria for designation for print-publication
- 6 Form of opinions of the courts of appeals
- 7 Form of citation
- 8 Failure to print-publish an opinion in the Ohio Official Reports; failure to allow a discretionary appeal
- 9 Posting trial and appellate court opinions on the Supreme Court website
- 10 Opinions of the trial courts
- 11 Accuracy
- 12 Effective date

Rule 4. “Controlling” and “Persuasive” Designations Based on Form of Publication Abolished; Use of Opinions.

(A) Notwithstanding the prior versions of these rules, designations of, and distinctions between, “controlling” and “persuasive” opinions of the courts of appeals based merely upon whether they have been published in the Ohio Official Reports are abolished.

(B) All court of appeals opinions issued after the effective date of these rules may be cited as legal authority and weighted as deemed appropriate by the courts.

(C) Unless otherwise ordered by the Supreme Court, court of appeals opinions may always be cited and relied upon for any of the following purposes:

(1) Seeking certification to the Supreme Court of Ohio of a conflict question within the provisions of sections 2(B)(2)(f) and 3(B)(4) of Article IV of the Ohio Constitution;

(2) Demonstrating to an appellate court that the decision, or a later decision addressing the same point of law, is of recurring importance or for other reasons warrants further judicial review;

(3) Establishing *res judicata*, estoppel, double jeopardy, the law of the case, notice, or sanctionable conduct;

(4) Any other proper purpose between the parties, or those otherwise directly affected by a decision.

2006 WL 2846282

Facts

CHECK OHIO SUPREME COURT RULES FOR REPORTING OF OPINIONS AND WEIGHT OF LEGAL AUTHORITY.

Court of Appeals of Ohio,
Seventh District, Mahoning County.

Richard W. COWETT, M.D., Plaintiff-Appellant,

v.

TCH PEDIATRICS, INC., et
al., Defendants-Appellees.

No. 05 MA 138. Decided Sept. 27, 2006.

Civil Appeal from Common Pleas Court, Case No. 02 CV 3259.

Attorneys and Law Firms

Attorney John F. Hill, Attorney Joy Malek Oldfield, Hill Company, LLC, Akron, OH, for Plaintiff-Appellant.

Attorney Paul L. Jackson, Attorney James Kurek, Roetzel & Andress, Akron, OH, for Defendants-Appellees.

Opinion

DeGENARO, J.

*1 ¶ 1 This timely appeal comes for consideration upon the record in the trial court, the parties' briefs, and their oral arguments before this court. Plaintiff-Appellant, Dr. Richard Cowett, appeals the decision of the Mahoning County Court of Common Pleas that granted summary judgment to Defendants-Appellees, TCH Pediatrics, Inc., Forum Health, Western Reserve Care System, and Tod's Children's Hospital (collectively referred to herein as Forum). Dr. Cowett claims the trial court erred by not allowing discovery of a letter, by applying an incorrect standard when granting summary judgment, and by concluding that Forum is immune from suit. Dr. Cowett's arguments all stem from his belief that Forum will not be immune from suit if he can show that it acted in bad faith when terminating his staff privileges. However, both state and federal courts unanimously hold that we must look to the objective reasonableness of the hospital's actions, not whether those actions were taken in good faith. For these reasons, the trial court's decision is affirmed.

¶ 2 Dr. Cowett is a pediatric neonatology specialist who was hired by Forum to be the Director of the Division of Neonatology at Tod's, which placed him in charge of Tod's Special Care Nursery (hereinafter SCN), a neonatal intensive care unit. Dr. Cowett began his duties with Forum on August 1, 2001. When he was hired, Tod's was affiliated with the Rainbow Babies and Children's Hospital in Cleveland, which is operated by the Cleveland-based University Hospitals Health Systems (hereinafter UH). Two of the neonatologists working at Tod's SCN, including Dr. Natalie Yeaney, worked with both UH and Forum. UH did not know of or approve Dr. Cowett's employment until after he was hired by Dr. Robert Felter, the Chairman of Pediatrics & Adolescent Medicine for Western Reserve Care System and Tod's Medical Director and Administrator.

¶ 3 Dr. Cowett was not working at Forum long before staff members began complaining about his abilities. On September 21, 2001, Dr. Yeaney told Dr. Felter about concerns she had in regard to the care Dr. Cowett provided two infants, Baby F and Baby H. Dr. Felter had a staff board certified neonatologist who had not practiced in the area in a few years, Dr. Kurt Wegner, review the charts for these two patients. After a quick review, Dr. Wegner told Dr. Felter that there was cause to investigate Dr. Cowett further. Dr. Felter also spoke with the Chief Resident, Pediatric Residency Director, and SCN Nursing Manager, all of whom reported that the staff under their management had reported issues with Dr. Cowett's clinical skills.

¶ 4 On October 4, 2001, Dr. Felter was informed about further concerns that Dr. Yeaney and the SCN's nurse-practitioner, Beverly Mike-Nard, had regarding the care Dr. Cowett provided to Baby L. After speaking with Dr. Cowett, who denied that the care he provided was substandard, Dr. Felter placed him on administrative leave pending a formal review into the allegations against him.

*2 ¶ 5 Dr. Felter spoke with Dr. Wegner and Forum's Corporate Risk Manager, Michael Keating, who in turn spoke with a variety of people who had knowledge of the situation. However, neither Dr. Wenger nor Keating spoke with Dr. Cowett about the allegations. However, Dr. Wegner later gave Dr. Felter an Executive Summary which criticized the care Dr. Cowett had provided to Babies F, H, and L.

{¶ 6} Dr. Felter and Dr. Wegner met with Dr. Cowett on October 15, 2001, to discuss the allegations. Dr. Cowett was given an opportunity to explain his side of the story. After this meeting, Dr. Wegner told Dr. Felter that the interview did not change the thoughts he expressed in his Executive Summary.

{¶ 7} The information compiled by Dr. Wegner and Keating was later used as part of a Departmental Peer Review Report which was critical of Dr. Cowett's clinical abilities. Based on the information in this report, Dr. Felter requested that the Vice President of Medical Affairs initiate corrective action against Dr. Cowett. The Profession Executive Committee met on October 23, 2001, to discuss Dr. Felter's request and voted to recommend that Dr. Cowett's staff privileges be revoked. Dr. Cowett was provided notice of this recommendation on October 26, 2001.

{¶ 8} Dr. Cowett requested a hearing, which occurred on March 6 and 13, 2002. The hearing was before a three physician panel and twelve witnesses testified. On March 20, 2002, the panel issued an opinion, which concluded that Dr. Cowett had failed to provide appropriate care and recommended that Dr. Cowett's privileges be revoked.

{¶ 9} Dr. Cowett appealed this decision to Forum's board of directors, but on June 19, 2002, the Board voted to revoke his privileges. After Forum received a return receipt on the letter advising Dr. Cowett of the Board's decision, it reported the action to the National Practitioner Data Bank, a federal database which tracks hospital discipline of physicians.

{¶ 10} On August 16, 2002, Dr. Cowett filed a complaint against Forum, asserting numerous claims resulting from these events. On February 26, 2004, Forum moved for summary judgment, claiming immunity pursuant to 42 U.S.C. 11111, et seq., commonly known as the Health Care Quality Improvement Act (hereinafter HCQIA). Dr. Cowett responded to the motion on January 31, 2005.

{¶ 11} On February 3, 2005, Dr. Cowett moved to compel the production of a letter written immediately after his suspension from a physician at UH to Forum. The trial court ordered that the letter be produced in camera and, on April 4, 2005, denied Dr. Cowett's motion, concluding that the letter's contents were irrelevant and, therefore, not discoverable. The same day it denied Forum's motion for summary judgment and set the matter for trial.

{¶ 12} On July 1, 2005, Forum asked the trial court to reconsider its prior order denying summary judgment and Dr. Cowett responded on July 8, 2005. On July 13, 2005, the trial court reconsidered its prior order and entered summary judgment to Forum, concluding that Forum was immune from suit pursuant to HCQIA.

Summary Judgment

*3 {¶ 13} On appeal, Dr. Cowett argues three assignments of error, which all address the same issues of law and fact. They are:

{¶ 14} "The trial court erred in granting summary judgment, by misconstruing Dr. Cowett's evidence as mere proof of 'animosity,' rather than proof that movants did not satisfy the four requirements for immunity set forth in 42 U.S.C. 11112(a)."

{¶ 15} "The trial court erred when it applied a summary judgment standard unsupported by HCQIA and Ohio law."

{¶ 16} "The trial court erred in refusing to compel discovery of the UH letter."

{¶ 17} Dr. Cowett argues that the trial court erred when granting summary judgment to Forum because the facts, when viewed in the light most favorable to him, show that they rebut the presumption of qualified immunity for Forum under HCQIA. In particular, he argues that Forum acted in bad faith when initiating and conducting the peer review process. He maintains that the trial court used the wrong standard when ruling on Forum's motion for summary judgment.

{¶ 18} The standard a court uses when ruling on a motion for summary judgment on a claim of immunity under HCQIA is "somewhat unusual." *Austin v. McNamara* (C.A.9, 1992), 979 F.2d 728, 734; *Moore v. Rubin*, 11 th Dist. No.2001-T-0150, 2004-Ohio-5013, at ¶21; *Menon v. Stouder Mem. Hosp.* (Feb. 21, 1997), 2nd Dist. No. 96-CA27. Congress has concluded that there is a "need to improve the quality of medical care" and enacted HCQIA "to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. 11101. In order to achieve this goal, HCQIA provides immunity from damages to the "professional review body, * * * any person acting as a member or staff to the body, * * * any person under a contract or other formal agreement

with the body, and * * * any person who participates with or assists the body with respect to the action,” as long as the professional review meets certain standards. 42 U.S.C. 11111(a)(1).

{¶ 19} HCQIA creates a presumption in favor of immunity which may be rebutted by a preponderance of the evidence. 42 U.S.C. 11112(a)(4). It is this rebuttable presumption in favor of immunity which creates the unusual standard courts must use when deciding motions for summary judgment involving HCQIA immunity. *Austin* at 734. In a sense, this means that the plaintiff bears the burden of proving that the peer review process was not reasonable. *Bryan v. James* (C.A.11, 1994), 33 F.3d 1318, 1333. Thus, courts must use the following standard for summary judgment when determining whether a professional review body is immune from suit under HCQIA: “Might a reasonable jury, viewing the facts in the light best for [the plaintiff], conclude that [the plaintiff] has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of 11112(a)?” *Id.*; *Gureasko v. Bethesda Hosp.* (1996), 116 Ohio App.3d 724, 731; *Moore* at ¶ 21. An appellate court uses this same standard on review and reviews the trial court's decision de novo. *Catipay v. Humility of Mary Health Partners*, 11th Dist. No.2005-T0030, 2006-Ohio-1700.

*4 {¶ 20} Since we review the issues de novo, Dr. Cowett's second assignment of error is meritless. We will apply the proper standard when reviewing the trial court's decision, so it does not matter whether the trial court applied the proper standard. When a trial court states an erroneous basis for its judgment, we must still affirm that judgment if it is legally correct on other grounds, that is, if it achieves the right result for the wrong reason, because such an error was not prejudicial. *Agricultural Ins. Co. v. Constantine* (1944), 144 Ohio St. 275, 284.

{¶ 21} In order to be eligible for immunity under the HCQIA, a professional review action must be taken “1) in the reasonable belief that the action was in the furtherance of quality health care, 2) after a reasonable effort to obtain the facts of the matter, 3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and 4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and [give adequate notice and hearing procedures].” 42 U.S.C. 11112(a).

42 U.S.C. 11112(a)(1)

{¶ 22} 42 U.S.C. 11112(a)(1) states that a professional review action must be taken “in the reasonable belief that the action was in the furtherance of quality health care.” Dr. Cowett contends that any professional review action which is not instigated and carried out in a good faith belief that the action was in the furtherance of quality health care is not entitled to protection under the HCQIA. In support of this argument, he cites both the statutory language and *Ahmed v. University Hospitals Health Care System, Inc.*, 8th Dist. No. 79016, 2002-Ohio-1823. However, these sources do not unambiguously support Dr. Cowett's argument and courts have unanimously disagreed with his argument.

{¶ 23} Dr. Cowett contends that evidence of animosity or hostility toward a health care professional is relevant under this statute because it shows that the action was not taken in the furtherance of quality health care. However, the language of the statute would only support Dr. Cowett's arguments if it allowed a defendant to commence a professional peer review action against someone *only* because it believes such action will further quality health care. This is not the language Congress used when it drafted the statute. Instead, HCQIA requires that the defendant must reasonably believe such action will further quality health care. HCQIA allows a hospital to have more than one reason to rid itself of a physician as long as “the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.” *Bryan* at 1322. If a hospital rids itself of a doctor both because of health care concerns *and* because of financial/political concerns, HCQIA will give the hospital immunity from suit.

*5 {¶ 24} Because a hospital can be immune under HCQIA if it has a reasonable belief that a peer review action was taken in the furtherance of quality health care, even though it had ulterior motives for wanting to be rid of a particular physician, both state and federal courts nationwide have unanimously concluded that evidence of a hospital's bad faith is irrelevant and that courts should use an objective, rather than a subjective, test to determine whether a hospital's belief was reasonable. See *Reyes v. Wilson Mem. Hosp.* (S.D. Ohio, 1998), 102 F.Supp.2d 798, 812 (“Within the universe of published decisions addressing this issue, the courts are unanimous in holding that evidence of ‘bad faith’ does not

suffice to overcome the presumption that a defendant acted 'reasonably.' "). Ohio state courts have been part of the judicial unanimity on this issue. See *Fox v. Parma Community Gen Hosp.*, 160 Ohio App.3d 409, 2005-Ohio-1665, at ¶ 58; *Moore v. Rubin*, 11 th Dist. No.2001-T-0150, 2004-Ohio-5013, at ¶ 25; *Menon* at 2.

{¶ 25} The sole case Dr. Cowett relies on, *Ahmed*, did not reach an opposite conclusion. Instead, it held that the evidence supported a jury's verdict that the defendants were not immune and noted, among other evidence, that the hospital had a financial motive for engaging in the peer review proceeding. But while the court's decision certainly indicates the possibility that it would approve using a subjective test, that defendant's motive was not the only evidence supporting the jury's conclusion. Furthermore, the same court later specifically held that a defendant's motive is irrelevant to these issues. See *Fox* at ¶ 58.

{¶ 26} At oral argument, Dr. Cowett stated that there is no way to challenge whether a hospital's belief that the action was taken in the furtherance of quality health care is reasonable if not by showing evidence of bad faith. This is simply not the case. For instance, a physician can challenge the facts forming the basis of a hospital's reasonable belief that the action was not taken in the furtherance of quality health care. In many cases this, of course, will be difficult. But Congress made challenges to HCQIA immunity a difficult prospect so physicians would have "incentive and protection for* * * engaging in effective professional peer review." 42 U.S.C. 11101.

{¶ 27} Since any issue of bad faith is irrelevant, Dr. Cowett's arguments concerning the discoverability of a letter from UH to Forum is meritless. The sole reason Dr. Cowett wishes to discover that letter is to further his "bad faith" argument. The trial court did not abuse its discretion when denying Dr. Cowett the ability to discover that letter.

{¶ 28} When this law is applied to the facts of this case, we conclude the trial court properly granted summary judgment to Forum on the issue of whether the professional review action was taken in the reasonable belief that it was in furtherance of quality health care. The review of Dr. Cowett began after Dr. Yeane voiced concerns about Dr. Cowett's professional competence to Dr. Felter on September 21, 2001, based on the cases of Baby F and Baby H. On October 4, 2001, Dr. Felter was also informed about concerns in the case of Baby L. These cases raised serious concerns regarding

the care Dr. Cowett gave to three babies within the first two months of his employment.

*6 {¶ 29} The only evidence Dr. Cowett introduces to rebut the rebuttable presumption that Forum had a reasonable belief that the professional review action was in furtherance of quality health care is his evidence that Forum acted in bad faith. He did not provide any evidence showing that Forum concerns were unreasonable. Accordingly, the trial court did not err when it concluded that it should grant summary judgment to Forum on this issue. Dr. Cowett's arguments in this regard are meritless.

42 U.S.C. 11112(a)(2)

{¶ 30} Dr. Cowett next contends that Forum did not make a reasonable effort to obtain the facts before taking the professional review action. In particular, he criticized Forum's reliance on Dr. Wegner's opinion, since Dr. Wegner was not an actively practicing neonatologist and had not interviewed Dr. Cowett before preparing his executive summary; its reliance on a peer review report, which he claims contained serious flaws; Forum's failure to have a practicing, board certified neonatologist review the cases and testify at the hearing; and, Dr. Felter's failure to interview the surgeon before recommending the professional review action. Dr. Cowett's arguments in this regard are also meritless.

{¶ 31} HCQIA requires that a defendant make a reasonable effort to obtain the facts of the matter before taking a professional peer review action in order to be immune under the statute. In order to determine whether a defendant made a reasonable effort to obtain the facts of the matter, a court must decide "whether the totality of the process" leading to the professional peer review action "evidenced a reasonable effort to obtain the facts of the matter." *Mathews v. Lancaster Gen. Hosp. (C.A.3, 1996)*, 87 F.3d 624, 637. The question of whether a particular professional review action taken against a physician is reasonable is different than whether the action was taken after a reasonable effort to obtain the facts of the matter. *Austin v. McNamara (9th Cir.1992)*, 979 F.2d 728, 735.

{¶ 32} When reviewing whether the effort to investigate was reasonable, courts have not stated that a reviewing body take any particular action. For instance, courts have refused to require "that only physicians in the same field as the physician under review are qualified to determine whether emergency action is necessary." *Penninger v. Exempla*,

Inc. (C. Colo.2000), 116 F.Supp.2d 1184, 1202. Indeed, courts have held that those conducting the review do not even need to be physicians. *Meyers v. Logan Mem. Hosp.* (W.D.Kent.2000), 82 F.Supp.2d 707, 713. Furthermore, the ultimate decisionmaker does not need to ensure that a matter is investigated independently, only that the investigation is reasonable. *Gabaltoni v. Washington Co. Hosp. Assoc.* (4th Cir.2001), 250 F.3d 255, 261.

{¶ 33} When reviewing whether an investigation was reasonable, courts do not require that such an investigation be accurate and thorough. Accordingly, courts have also overlooked factual errors in prepared reports that were used to reach a professional review action. *See Brader v. Allegheny Gen. Hosp.* (3rd Cir.1999), 167 F.3d 832, 841; *Van v. Anderson* (N.D.Tex.2002), 199 F.Supp.2d 550, 572-573. Likewise, an investigation does not need to conclusively resolve why a particular incident which is the subject of the professional review occurred. *Fox* at ¶ 59. Finally, the HCQIA does not require that a physician be notified of or participate in an investigation being conducted against him. *Catipay v. Trumbull Mem. Hosp.*, 11th Dist. No.2003-T-0136, 2004-Ohio5108, at ¶ 44.

*7 {¶ 34} In this case, the incidents which formed the basis of the professional review action were reviewed by a board certified neonatologist who was last recertified in neonatology in 1996 and had last practiced in the field in 1997, four years before he was asked to review Cowett's actions. During the course of the investigation, Dr. Wegner, Dr. Felter, and Forum's corporate risk manager, Michael Keating, spoke to many hospital personnel about Dr. Cowett's practical skills. Finally, the issues were fully heard by a three member panel of the Professional Staff. Dr. Cowett's arguments do not rebut the presumption that this was a reasonable effort to obtain the facts. Instead, Dr. Cowett merely shows that the investigation was not as comprehensive and independent as he would have liked. The HCQIA does not require a comprehensive, independent investigation, only a reasonable effort to obtain the facts. Dr. Cowett's arguments in this regard are meritless.

42 U.S.C. 11112(a)(3)

{¶ 35} Dr. Cowett also argues that Forum did not provide him with adequate notice and hearing procedures. As an example, he cites the fact that the hearing panel issued its decision before the date by which he was told to submit a written

statement. He also contends that he did not have notice of the true reasons behind the peer review action. Dr. Cowett's arguments in this regard are also meritless.

{¶ 36} A professional review action is not immune under HCQIA unless it is taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." 42 U.S.C. 11112(a)(3). 42 U.S.C. 11112(b) "enumerates the minimum, or 'safe harbor' procedures that will, in every case, satisfy the adequate notice and hearing requirements" of 42 U.S.C. 11112(a)(3). *Bryan* at 1323. However, the safe harbor provision also provides that "[a] professional review body's failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3) of this section." 42 U.S.C. 11112(b). Furthermore, there is no requirement that "makes immunity depend on adherence to bylaws." *Wieters v. Roper Hosp., Inc.* (4th Cir.2003), 58 Fed.Appx. 40, 46. "The ultimate inquiry is whether the notice and hearing procedures were adequate." *Smith v. Ricks* (9th Cir.1994), 31 F.3d 1478, 1486. The peer review proceedings need not resemble a regular trial to meet this requirement. *Id.* at 1487.

{¶ 37} In this case, Dr. Cowett's only complaint about the notice given him is that it was not true notice of the reasons for the professional review action. However, he is merely re-raising the issue of whether Forum acted in bad faith when taking the professional review action. Since bad faith is not a proper issue to address when determining immunity under HCQIA, this is not a proper basis to challenge the notice given to him.

*8 {¶ 38} Dr. Cowett also complains that he was not provided adequate hearing procedures since he was not allowed to submit a written post-hearing statement to the hearing panel before it rendered its decision. He contends that 42 U.S.C. 11112(b) "statutorily entitled" him to submit such a statement.

{¶ 39} Although 42 U.S.C. 11112(b)(3)(C)(v) does state that a physician must be given the right to "to submit a written statement at the close of the hearing" in order to meet the "safe harbor" standards set forth in 42 U.S.C. 11112(b), 42 U.S.C. 11112(b) itself states that hearing procedures are not inadequate merely because they do not meet the conditions in that subsection. For example, 42 U.S.C. 11112(b)(1)(B) (ii) states that a physician should be afforded thirty days

within which to request a hearing. However, a hospital can still provide adequate procedures if it only gives a physician fourteen days to request a hearing, depending on the facts of the case. See *Egan v. Athol Mem. Hosp.* (D.Mass.1997), 971 F.Supp. 37, 43-44.

{¶ 40} In this case, Dr. Cowett's sole complaint is that he was not given the opportunity to provide the hearing panel with a written statement before it issued its recommendation. However, the hearing panel was not the ultimate decisionmaker in this case. After it made its recommendation, Dr. Cowett was given the opportunity to provide the Board with a written statement explaining the purported flaws in the hearing panel's opinion and Dr. Cowett submitted such a statement. Thus, Dr. Cowett was given an opportunity to place his arguments in the record before the Board made its decision, which is the purpose behind the requirement in 42 U.S.C. 11112(b)(3)(c)(v).

{¶ 41} Based on these facts, the trial court did not err when it found that no reasonable fact-finder could conclude that the notice and hearing procedures provided to Dr. Cowett were inadequate. Dr. Cowett's arguments to the contrary are meritless.

42 U.S.C. 11112(a)(4)

{¶ 42} HCQIA's final requirement is that the professional review action be taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3)." 42 U.S.C. 11112(a)(4). When making this determination courts are "not to substitute our judgment for that of the hospital's governing board or to reweigh the evidence regarding the renewal or termination of medical staff privileges." *Shahawy v. Harrison* (11th Cir.1989), 875 F.2d 1529, 1533. The relevant inquiry is whether the decision was reasonable in light of the facts known at the time the decision was made, not in light of facts later discovered. *Egan* at 44.

{¶ 43} In this case, the record shows that Cowett failed to demonstrate that the Board's belief that the facts warranted the professional review action taken against Dr. Cowett was unreasonable. Fundamentally, the Board had two sets of facts before it. One set of facts contained the conclusions of two staff neonatologists, a nurse practitioner, experienced nurses, and hearsay evidence from residents who worked with Dr. Cowett, which all questioned Dr. Cowett's clinical abilities and the decisions he made in the cases in question. Another set of facts contained the testimony of Dr. Cowett, his expert witness, and other experienced nurses, which supported both Dr. Cowett's professional competence and the decisions he made in the cases in question. After reviewing these facts and the recommendations given to it, no reasonable factfinder could conclude that the Board's decision was unreasonable. Dr. Cowett's arguments to the contrary are meritless.

Conclusion

*9 {¶ 44} Dr. Cowett believes Forum should not be immune from suit pursuant to HCQIA because it acted in bad faith when determining that his privileges should be revoked. However, the only relevant issues under HCQIA are with regard to the objective reasonableness of the hospital's actions, not whether those actions were taken in good faith. No reasonable fact-finder could conclude that Dr. Cowett could overcome the presumption that Forum's actions were reasonable. Accordingly, the judgment of the trial court is affirmed.

DONOFRIO, P.J., concurs.

VUKOVICH, J., concurs.

Parallel Citations

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APPENDIX 2

RULES OF CIVIL PROCEDURE FOR THE SUPERIOR COURT OF THE STATE OF DELAWARE

I. SCOPE OF RULES -- ONE FORM OF ACTION.

Rule 1. Scope and purpose of Rules.

These Rules shall govern the procedure in the Superior Court of the State of Delaware with the exceptions stated in Rule 81. They shall be construed and administered to secure the just, speedy and inexpensive determination of every proceeding.

Rule 2. One form of action.

There shall be one form of action to be known as "civil action."

II. COMMENCEMENT OF ACTION; SERVICE OF PROCESS, PLEADINGS, MOTIONS AND ORDERS; DEPOSIT AND SECURITY FOR COSTS.

Rule 3. Commencement of action.

(a) Complaint and praecipe. -- Except amicable actions, an action is commenced by filing with the Prothonotary a complaint or, if required by statute, a petition or statement of claim, all hereafter to be referred to as a "complaint" and a praecipe directing the Prothonotary to issue the writ specified therein. Sufficient copies of the complaint shall be filed so that one copy can be served on each defendant as hereafter provided. An amicable action is commenced by filing an agreement specifying the matters agreed upon. Every newly filed complaint shall be accompanied by a Case Information Statement (CIS). The CIS form is used solely for administrative purposes and the information thereon has no legal effect on the action.

(b) Actions pursuant to 10 Del. C. § 3901. -- In all actions upon bills, notes, bonds, or other instruments of writing for the payment of money, or for the recovery of book accounts, on foreign judgments and in all actions of scire facias on recognizances, judgments or mortgages, the plaintiff may make a specific notation upon the face of the complaint requiring the defendant or defendants to answer any or all allegations of the complaint by affidavit.

(c) Appeals de novo. -- When an appeal de novo is permitted by law, an action is commenced in the Superior Court by the appellant filing with the Prothonotary a praecipe within the time prescribed by statute for the filing of an appeal. If no time is prescribed by statute, the praecipe shall be filed within 15 days from the entry of the final judgment, order, or disposition from which an appeal is permitted by law. When the appellant is the party having the duty of filing the complaint or other first pleading on appeal, the appellant shall file such pleading with praecipe. When the appellee is the party having the duty of filing the complaint or other first pleading on appeal, the appellee shall serve a copy of such pleading within 20 days after service of the process on appeal, or if appellee has not been served, within 40 days after the date of the process, and thereafter the pleadings shall proceed as in other actions.

(d) Record; stay. -- The appellant shall file a certified copy of the record of the proceedings below, not including the evidence, within 10 days of the filing of the praecipe. Process shall not issue until the appellant has filed the record. There shall be no stay of execution or other proceedings below unless ordered by this court pursuant to Rule 62(c).

(e) Deposit for costs. -- The Prothonotary shall not file any paper or record or docket any proceeding until the required deposit for costs and fees has been made. Before any civil suit, action or other proceeding is instituted in the Superior Court, the Prothonotary shall demand and receive the sum of \$125, as a deposit of guaranty for the payment of the fees and costs in the Prothonotary's office, and the Prothonotary shall apply the sum of \$125 from time to time in payment of such fees and costs in that office. If the sum of \$125 is expended in the payment of the fees and costs in the Prothonotary's office as the fees and costs accrue from time to time, the Prothonotary shall demand and receive a sufficient amount, which shall be necessary, in the Prothonotary's judgment, to defray the fees and costs for additional service or services

Rule 107. Briefs.

(a) Number. -- The original and a copy of all briefs shall be filed with the Prothonotary in the county in which the case is pending, and the Prothonotary shall deliver the original of each brief to the appropriate Judge; if more than one Judge is sitting at the argument of a case, a sufficient number of copies shall be filed for delivery to each additional Judge. A copy of every letter from counsel to the Court containing argument shall be sent to the Prothonotary for filing in the cause.

(b) Type of print for briefs, motions and other papers. -- All typed matter must be of a size type permitting not more than 11 characters or spaces per linear inch. All printed matter must appear in 11 point type.

(c) Time of filing. -- Brief schedules shall be ordered by the Court, and extensions of time for filing briefs will not be authorized, whether or not consent of other parties is obtained, unless the Court enters an order upon a showing of good cause for such enlargement.

(d) Form. -- The covers of all briefs shall contain the following information:

(1)a. The name of this Court.

b. The title of the case and its number in this Court.

c. The names of counsel for party submitting the brief with the office addresses of such counsel resident outside the State.

(2) All typewritten briefs shall be upon paper approximately 8 1/2 inches by 11 inches in size and shall be bound on the left margin.

(3) The Court may require briefs to be printed and may in its discretion allow the actual cost of printing to be taxed as costs in the case. All printed briefs shall be upon pages approximately 6 1/8 inches by 9 1/4 inches and shall be bound on the left margin.

(4) The following shall be the form of citations:

a. Reported Opinions. -- The style of citation shall be as set forth in THE BLUEBOOK: A UNIFORM SYSTEM OF CITATION, with no reference to State Reporter Systems or other parallel citations. For example:

Melson v. Allman, 244 A.2d 85 (Del. 1968).

Prince v. Bensinger, 244 A.2d 89 (Del. Ch. 1968).

State v. Pennsylvania R.R. Co., 244 A.2d 80 (Del. Super. Ct. 1968).

b. Unreported Opinions. -- The style of citation shall be any of the three alternatives set forth below:

LEXIS Citation Form: Fox v. Fox, 1998 Del. LEXIS 179 (Del. Supr.).

OR

WESTLAW Citation Form: Fox v. Fox, 1998 WL 280361 (Del. Supr.).

OR

Delaware Citation Form: Fox v. Fox, Del. Supr., No. 510, 1997, Berger, J. (May 14, 1998).

c. Other Authority. -- The style of citation to any other type of authority, including but not limited to statutes, books, and articles, shall be as set forth in THE BLUEBOOK: A UNIFORM SYSTEM OF CITATION.

(e) Contents. -- All briefs shall contain the following matter arranged in the following order:

(1) A table of contents or index.

(2) A table of citations arranged alphabetically and indicating the pages of the brief on which each cited authority appears.

(3) In the first brief of each party, a statement of the case, including a statement of the nature of the proceedings and a concise chronological statement, in narrative form, of all relevant facts with page references to the transcript of testimony, if any, and to any pleadings and exhibits.

(4) A statement of the questions involved.

(5) Argument, divided into sections under appropriate headings, one section to be devoted to each of the questions involved.

(f) Failure or neglect to file briefs or discovery material. -- If any brief, memorandum, deposition, affidavit, or any other paper which is or should be a part of a case pending in this Court, is not served and filed within the time and in the manner required by these Rules or in accordance with any order of the Court or stipulation of counsel, the Court may, in its discretion, dismiss the proceeding if the plaintiff is in default, consider the motion as abandoned, or summarily deny or grant the motion, such as the situation may present itself, or take such other action as it deems necessary to expedite the disposition of the case. Upon the showing of good cause in writing, the Court may permit late filing of any of the aforesaid papers and pursuant to a written rule or order. This Rule shall not be deemed to affect any other Rule or Rules of the Court specifically providing for the time in which to file motions to which there may be attached briefs, affidavits and/or memoranda. (Cf. Civil Rule 59)

If motions to compel compliance with existing orders or stipulations are granted or if upon application by the Case Scheduling Office an order compelling compliance issues, after an opportunity for hearing in either situation, the Court shall require the party, person or attorney advising the same whose conduct necessitated the motion, to pay to the other party the reasonable expenses in obtaining and/or attending the motion to compel including attorney's fees, unless the Court finds the delay was justified or other circumstances make the award of expenses unjust.

(g) If an unreported or memorandum opinion is cited, a copy thereof shall be attached to the brief, and the case number in which it was filed shall be stated. If the opinion does not contain a sufficient statement of the facts to demonstrate its pertinency to the pending argument, a statement of the facts shall also be attached to the brief. If the citation is first made in a reply brief, the opposing party may discuss the opinion at oral argument or, upon application made at oral argument, may be given the opportunity to do so in writing.

(h) Length of briefs. -- Without leave of Court, an opening or answering brief shall not exceed a total of 35 pages and a reply brief shall not exceed 20 pages, exclusive of appendix. In the calculation of pages, the material required by paragraphs (e)(1) and (2) of this rule is excluded and the material required by paragraphs (e)(3) through (5) of this rule is included.

(i) Unless otherwise ordered by the Court, any party may serve and file identical copies of any brief and exhibits on CD-ROM. The conditions applicable to the use of such CD-ROM briefs are set forth in the following paragraphs:

(1) The cover page of the brief shall include the following legend in bold type immediately beneath the Civil Action number in the caption: " CD-ROM Version To Be Filed "

(2) Multiple parties which are filing a brief jointly may file such a brief on CD-ROM. Joinders to a brief may also be filed on the same CD ROM.

(3) Four (4) copies of the CD-ROM shall be filed with the Court within fourteen (14) calendar days of the filing and service of the brief, two of which shall be sent directly to the Judge as courtesy copies.

(4) Any party filing a CD-ROM in accordance with this Order shall take all steps that are reasonable and necessary to make it free of any computer virus.

(5) The CD-ROM shall contain a label that includes the following information:

- (a) the name of the case;
- (b) the Civil Action number;
- (c) the docket number;
- (d) the title of the brief; and
- (e) the name of filing counsel and their law firm(s).

(6) The CD-ROM shall include an imaged version of the signed brief and images of all exhibits. Video versions of exhibits (such as video depositions), that are otherwise properly included as exhibits to a brief, may be included on the CD-ROM.

(7) The CD-ROM shall include imaged or text copies of all legal authorities cited, both reported and unreported.

(8) All images and all text copies of authorities shall be in .pdf [portable document format] format and references within the briefs shall be linked as follows:

(a) Each title or subtitle in the Table of Contents shall be linked to the appropriate page of the brief.

(b) Each citation in the Table of Authorities shall be linked so that:

(i) When the user clicks on the case name or citation in the Table of Authorities, the opinion or other authority appears; and

(ii) When the user clicks on the brief page referenced to the right of the citation in the Table of Authorities, the brief page appears.

(c) All references in the brief to exhibits in an appendix or otherwise shall be linked to the first-cited page of the exhibit.

(d) All references in the brief to cases, orders, or bench rulings shall be linked to the first page of such cases, orders, or bench rulings. Cites to specific pages within such cases, orders, or bench rulings in the brief will be linked to the first page cited.

(9) The CD-ROM shall also include a text version of the brief in the format in which it was created and in RTF [Rich Text Format].

Rule 108. Sureties.

(a) Surety companies. -- Each surety company shall, in the month of January in each year, file with the Prothonotary of the Superior Court, in each county in which such surety company is engaged in business, a power of attorney authorizing the execution of bonds by the attorney in fact designated in said power of attorney, before the Courts shall accept or approve such company as surety. Nothing herein contained shall prohibit the execution by a surety company of any bond within this State by its proper officers as required by law.

(b) Attorneys and other officers. -- No attorney, or other officer of this Court, shall be taken, directly or indirectly, as special bail or surety in any case pending in, or appealed to, this Court. This prohibition shall also apply to any agent, employee, member of the immediate family of any such attorney or court officer, or any corporation in which such attorney or court officer owns a controlling interest. This prohibition shall not apply to any bond in which the attorney, court officer, agent, employee or family member, as above defined, may be the principal. The phrase "member of the immediate family" shall include the spouse, father, mother, father-in-law, mother-in-law, son, daughter, brother, sister, brother-in-law or sister-in-law or any such attorney or court officer.

Rule 109. Board of Canvass proceedings.

A complaint asking that the Board of Canvass exercise its powers under 15 Del. C. § 5702 shall be in a writing under oath filed not later than 12:00 noon on the day on which the Board convenes, unless prior thereto the Board shall extend said time, and shall state the following:

(1) The name of the candidate on whose behalf the complaint is filed.

(2) The office sought by such candidate.

(3) The election district or districts involved.

(4) The specific facts upon which the complaint is based, including:

(a) The fraud or mistake stated with particularity.

(b) The number of votes affected by such fraud or mistake.

(c) Whether or not the number of votes affected by such fraud or mistake affects the result of the election. If fraud or mistake in other election districts is likewise relied upon to affect the result of the election, the names of such districts shall be stated.

(5) Whether the facts are averred upon the deponent's personal knowledge or upon information and belief; and if the facts are averred on information and belief, the name, address and official connection, if any, with the election of all persons known to the one signing the affidavit to have personal knowledge of the specific facts constituting the averred fraud or mistake.

A complaint may be withdrawn only with the permission of the Board.

2009 WL 3531791

Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK
COURT RULES BEFORE CITING.

Superior Court of Delaware,
Sussex County.

Richard J. STERNBERG, M.D., Plaintiff,
v.
NANTICOKE MEMORIAL
HOSPITAL, INC., et. al, Defendants.

C.A. No. 07C-10-011(TGH). Submitted:
July 31, 2009. Decided: Sept. 18, 2009.

Defendants' Motion for Summary Judgment. **GRANTED.**
Plaintiff's Motion for Summary Judgment on Attorney's Fees.
DENIED.

Attorneys and Law Firms

Matthew M. Carucci, Esquire, Carucci Butler, LLC,
Wilmington, Delaware; and Christopher A. Iacono, Esquire,
and Kevin E. Raphael, Esquire, Pietragallo Gordon Alfano
Bosick & Raspanti, LLP, Philadelphia, Pennsylvania,
Attorneys for Plaintiff.

David R. Hackett, Esquire, Griffin & Hackett, P.A.,
Georgetown, Delaware, Attorney for Defendants.

Opinion

MEMORANDUM OPINION

GRAVES, J.

PROCEDURAL AND FACTUAL BACKGROUND

*1 Nanticoke Memorial Hospital (hereinafter "Nanticoke") is a non-profit, tax exempt hospital facility in Seaford, Delaware that offers primary acute care services. Nanticoke's Medical Staff consists of all those physicians, dentists, and podiatrists who have been given the right to exercise clinical privileges within the hospital. The Medical Staff is responsible for the quality of health care provided at Nanticoke, and its By-laws govern the organization,

operation, and discipline of those who practice in the facility. All appointees to the Medical Staff exercise their right to practice at the hospital subject to the rules and regulations contained in the By-laws.

Nanticoke's Medical Executive Committee (hereinafter "MEC") is charged with overseeing the Medical Staff. The MEC is comprised of the officers of the Medical Staff, department chairpersons, and the Intensive Care Unit Director. The President of the Medical Staff chairs the MEC, and Nanticoke's CEO is designated as an ex officio member of the group without voting privileges. The MEC is chiefly responsible for administering Nanticoke's Credentials Policy.¹

Dr. Richard Sternberg (hereinafter "Sternberg") is a board certified orthopedic surgeon who was a member of Nanticoke's Medical Staff from 1999 until 2008. By all accounts, Sternberg is a competent physician. While Sternberg's medical competency is not disputed here, his professional behavior is at the center of the litigation before the Court. Nanticoke claims to have documented thirty-one incidents of inappropriate and disruptive behavior exhibited by Sternberg throughout his tenure at the hospital. It appears from the record presented that these episodes range from emotional outbursts of anger to demeaning and offensive reprimands of staff and patients alike. At least one Orthopedic Specialty Nurse, according to Nanticoke, resigned due to the stress and anxiety caused by Sternberg. Taken altogether, Nanticoke portrays Sternberg as a troublesome figure at the hospital, whose behavior made the tense operating room environment even more stressful for his colleagues-and potentially dangerous to his patients.

Sternberg, quite naturally, contends that he was not a disruptive presence at Nanticoke. To the contrary, while admitting his irritability at times, Sternberg fashions himself as a zealous reformer whose attempts to improve the quality of care of Nanticoke drew the ire of hospital administrators. Because of his desire to correct the flaws at Nanticoke, Sternberg argues that his conduct became excessively scrutinized by hospital officials who did not appreciate his concern for patient care.

However he is described, it is clear that Sternberg was a well known figure to hospital officials. Nanticoke claims that it dealt with those concerns about Sternberg during his initial years at the hospital by informally warning him about his conduct. As far back as 2004, though,

Nanticoke's Chief Executive Officer, Daniel J. Werner (hereinafter "Werner"), appears to have contacted Dr. Carol A. Tavini (hereinafter "Tavini"), Chair of the Delaware Physician's Health Committee, to discuss the possibility of Sternberg being an "impaired physician" or, more accurately, a "disruptive physician."

*2 Thereafter, in January of 2006, Sternberg was referred to the State Physician's Health Committee and Tavini for treatment in managing his behavior. Sternberg asserts that the stress and subsequent breakdown from covering consecutive days of orthopedic call led to the Tavini examination. By letter dated March 17, 2006, the State Physician's Health Committee recommended that Sternberg seek an "excuse from on-call" duty and attend a course on "physician communication and dealing with others." Sternberg did not attend a course on his workplace behavior at this time.

However, Sternberg agreed to be relieved from on-call responsibility. Sternberg claims that this psychiatric order relieving him from being on-call was detrimental to Nanticoke as it meant one less surgeon for on-call duty, thereby risking Nanticoke's trauma designation. Sternberg further takes the position that the psychiatric order failed to provide hospital officials with the means by which they could "exert control" over him. Despite being excused from on-call duty, Nanticoke claims that his behavior did not improve. In May of 2006, Werner allegedly contacted legal counsel for advice on how to respond to Sternberg's continued outbursts. Legal counsel responded with a memorandum outlining recommended steps for dealing with Sternberg, which Werner relayed to the MEC. All the while, Sternberg claims that Nanticoke was looking for a scenario that would force him into accepting on-call responsibility.

Sternberg's alleged actions during a surgical procedure on July 13, 2006, serve as a key moment in his time at Nanticoke. During the operation, it was discovered that surgical equipment was missing. In order to correct the error, a new instrument tray was ordered. According to Nanticoke, the decision to order a new surgical tray enraged Sternberg. With surgical drill in hand, and while the patient remained under sedation, Sternberg allegedly angrily expressed his frustration to his colleagues. Nanticoke avers that at least one operating room staff member was privately concerned that Sternberg's actions would shatter the patient's tibia. Nanticoke also maintains that Sternberg's alleged outburst threatened patient safety as a result of an open incision that was left unattended to during the lull in surgery. Sternberg

disputes this characterization of the incident and argues that he followed hospital protocol, was of no risk to the patient, and held the drill in a non-threatening way. Ultimately, Sternberg successfully completed the operation.

Not surprisingly, Sternberg's alleged actions during the surgery made the rounds at the hospital. Two co-defendants in this action, Dr. Thomas Benz, Chair of Nanticoke's Surgery Department, and Dr. John Appiott, President of Nanticoke's Medical Staff, authored a letter to Sternberg on July 17, 2006, informing him that his "continuing pattern of unacceptable behavior" was to be referred to the MEC at an upcoming meeting and that any further incident of inappropriate behavior would be met with an immediate suspension.

*3 At the meeting called to discuss Sternberg on July 25, 2006, MEC members unanimously voted to recommend that Sternberg's Medical Staff membership and privileges be revoked. Simultaneously, the MEC voted to offer Sternberg a leave of absence option in lieu of the revocation of his privileges at the hospital. The leave of absence option was conveyed to Sternberg in a letter authored by Werner on July 26, 2006. The letter states, in part:

This is to inform you that the Executive Committee is prepared to recommend to the Board (subject to the option for you to take a Leave of Absence set forth below) that your medical staff appointment and clinical privileges be revoked, based on the continuing pattern of disruptive behavior that you have exhibited despite numerous attempts to impress upon you the need to improve that behavior pattern. Your behavior has created a work environment that numerous employees consider to be hostile and counterproductive to the provision of good patient care. Some of the incidents of your behavior have placed patients at risk. You have not responded to any of the past efforts to work with you in the hope that you would gain insight into the inappropriateness of your pattern of behavior and take steps necessary to improve it... You were advised, by letter dated July 17, that if there is any further incident of inappropriate behavior on your part, including, but not limited to, displays of anger, loud tone of voice, or disruption of any kind, you will be

immediately suspended. This caution remains in effect.²

Again advising Sternberg that any further inappropriate incident would result in an immediate suspension, Werner's offer for a leave of absence required Sternberg to submit a plan to the Executive Committee to address how he would resolve his anger management issues. In addition, Werner wrote "because it is a hardship on other surgeons to take additional call, your plan must address your ability to take a reasonable share of emergency call."³ Sternberg suggests that Werner's letter was tantamount to an ultimatum requiring him to take emergency call in violation of a psychiatric order.

By way of response, Sternberg wrote Werner on August 18, 2006, to request both a hearing on the recommendation of his revocation and a sixty-day stay so that he could obtain legal counsel. Werner granted both of these requests in a subsequent correspondence with Sternberg, repeated the conditional leave of absence offer, and reiterated that another inappropriate behavioral issue would result in an immediate suspension. Despite these warnings of immediate suspension, Nanticoke claims that it received three complaints regarding Sternberg's behavior in the aftermath of the MEC's decision to recommend that his privileges be revoked. Apparently, Nanticoke did not conclude that these alleged incidents warranted formal action or review.

In October of 2006, Nanticoke had retained a hearing officer, prepared exhibits, and was anticipating holding a hearing on the Sternberg matter in the first week of November. According to Sternberg, the hospital had obtained the services of another orthopedic surgeon-thus making him expendable. By then, Sternberg had also become a candidate for the Thirty-Ninth Representative District in the 2006 election. Concerned, in part, by the hospital's tax-exempt status, Nanticoke advised Sternberg that political campaigning was forbidden within the facility. Sternberg may have disagreed with Nanticoke's policy, but he was fully aware of the prohibition against political activity on hospital grounds.

*4 The background is thus set for what appears to be the pivotal incident in the long history of tension between Nanticoke and Sternberg. On October 13, 2006, Sternberg invited a newspaper reporter to observe an operation scheduled for that morning. Sternberg argues that he followed hospital procedure by filling out the appropriate visitor attendance forms indicating that the observation was for educational purposes. Sternberg contends that the hospital

was given several days notice regarding the observation yet failed to question him regarding the specifics. Sternberg also alleges that the patient was made aware prior to giving consent that the visitor was a newspaper reporter. However, the hospital did not know that the visitor was a reporter covering Sternberg's political campaign before the incident. According to the hospital, it was natural and reasonable to have assumed or inferred that the individual was a nursing or medical student, rather than a newspaper reporter, when Sternberg filled out the forms indicating that the observation was related to educational purposes.

On the morning of October 13, 2006, according to Nanticoke, the hospital's Interim Director for Patient Services, Mary Beth Waide (hereinafter "Waide"), reported to Werner that one of Sternberg's cases was underway when an observer, believed by hospital officials to have been a student, pulled out a note pad and began taking notes. When an operating room nurse questioned the observer, she responded, "I am taking notes for my story." Pressed further, the observer admitted that she was a newspaper reporter covering Sternberg's political campaign. Upon being notified of the reporter's presence in the operating room, Nanticoke suggests that hospital administrator Tom Brown entered the operating room and escorted her out of the facility.

Thereafter, Nanticoke claims that Werner instructed Waide to evaluate the situation with the newspaper reporter and report back to him. Sternberg vigorously asserts that Werner failed to conduct any investigation into the incident with the reporter. In any event, Werner had sufficient information to write a letter to Sternberg later that afternoon.

Werner's letter, dated October 13, 2006, advised Sternberg that Nanticoke was immediately suspending him pursuant to the precautionary suspension provisions contained in Section 6.C.1. of its Credentials Policy. The letter further explained:

Your behavior this morning has disrupted the entire morning of the Operating Room, and the ability of employees to concentrate on providing appropriate patient care. You breached confidentiality, raising serious issues.... The patient apparently consented to having an individual observe for educational purposes, which was also how you described the reporter prior to bringing her into the Operating Room. This was a misrepresentation.... There were

infection risks created at several points in the process. Your behavior has left me no choice but to protect patients from your disruptive conduct by removing you from the hospital immediately. You have exceeded any boundaries of proper behavior.⁴

*5 Suggesting that Sternberg had placed his personal interests above patient care while potentially risking Nanticoke's tax-exempt status, Werner concluded by notifying Sternberg that the MEC would be convened to examine the matter within fourteen days as required under the Credentials Policy.

According to Sternberg, the imposition of a precautionary suspension effectively ends a physician's career since a suspension that lasts more than thirty days must be reported to a federal database pursuant to federal law. Thus, by design, a precautionary suspension for Dr. Sternberg would mean that all future employers would know of his alleged conduct at Nanticoke.

Section 6.C. of Nanticoke's Credentials Policy provides for the precautionary suspension of Medical Staff employees. The relevant portion of the Credentials Policy maintains:

6.C.1. Grounds for Precautionary Suspension or Restriction:

a) The President of the Medical Staff, the chairperson of a clinical department, the CEO or the Board Chairperson will each have the authority to suspend or restrict all or any portion of an individual's clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.

b) Precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself. It will not imply any final finding of responsibility for the situation that caused the suspension or restriction.

c) A precautionary suspension or restriction will become effective immediately upon imposition, will immediately be reported in writing to the CEO and the President of the Medical Staff, and will remain in effect unless it is modified by the CEO or Executive Committee.

6.C.2. Executive Committee Procedure:

a) The Executive Committee will review the matter resulting in a precautionary suspension or restriction within a reasonable time under the circumstances, not to exceed 14 days. Prior to, or as part of, this review, the individual may be given an opportunity to meet with the Executive Committee. The individual may propose ways other than precautionary suspension or restriction to protect patients and/or employees, depending on the circumstances.

b) After considering the matters resulting in the suspension or restriction and the individual's response, if any, the Executive Committee will determine whether there is sufficient information to warrant a final recommendation, or whether it is necessary to commence an investigation. The Executive Committee will also determine whether the precautionary suspension or restriction should be continued, modified, or terminated pending the completion of the investigation (and hearing, if applicable).

c) There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.⁵

*6 In accordance with the Credentials Policy, the MEC met to review the matter resulting in Sternberg's precautionary suspension on October 16, 2006. During the MEC meeting, it was recommended that action on the precautionary suspension be continued until the previously scheduled hearing on Sternberg's recommendation of revocation was held. The MEC's decision was relayed to Sternberg via a letter written by Werner on October 18, 2006. It also mentioned the possibility, once again, of treating the matter as Sternberg's choice to pursue a leave of absence for the purpose of focusing on his election campaign.

The record reveals that the MEC never met in early November of 2006, as scheduled, to review Sternberg's recommendation of revocation. Instead, the hospital and Sternberg's representatives engaged in negotiations to resolve both the precautionary suspension and the recommendation of revocation issues. On December 7, 2006, Nanticoke's Board reappointed Sternberg with clinical privileges until the Board's January of 2007 meeting. Sternberg's monthlong reappointment was subject to his approval and compliance with certain conditions. One of these conditions required Sternberg to complete a video training portion of the Physicians Universal Leadership Skills Program.

Moreover, both parties reached an agreement that called for Sternberg's precautionary suspension to be characterized as a leave of absence. The agreement to consider the precautionary suspension as a leave of absence signified that Sternberg would not be reported-and Nanticoke would not have to report-Sternberg's alleged conduct to federal authorities. The agreement also meant that both parties were to recognize that the precautionary suspension did not occur. Thereafter, Hospital officials informed staff at that time that Sternberg was returning from a nearly two-month leave of absence upon his reinstatement on December 13, 2006.

This agreement or compromise is important to this case. Sternberg had the chance to seek an injunction or restraining order regarding his precautionary suspension. He did not pursue these options. Furthermore, Sternberg had the opportunity for a full due process evidentiary hearing as to whether there was a factual basis for the suspension. Instead, he chose to resolve the issue by an agreement that was of benefit to him.

In January of 2007, the MEC lifted the Recommendation of Revocation in favor of a conditional reappointment. Sternberg remained with Nanticoke until his resignation effective January 31, 2008. The record reveals no evidence of alleged disruptive behavior by Sternberg from December of 2007 until his resignation from Nanticoke. After completing a remedial course, the Defendants contend that Sternberg's improved conduct shows that the precautionary suspension ultimately prolonged his career as it forced him to obtain help to control his behavior.

This litigation is brought by Sternberg against Nanticoke, Werner, and fourteen physicians (hereinafter collectively the "Defendants") who were members of the MEC during Sternberg's precautionary suspension. Sternberg's central contention is that the precautionary suspension imposed by Werner and continued by the MEC was improper under both Nanticoke's Credentials Policy as well as state and federal statutes because the failure to impose the suspension would not have resulted in imminent danger to the health and safety of any individual. As a result, Sternberg has brought a multi-count complaint for damages for tortious interference with business relations, negligence, breach of contract and implied covenant of good faith and fair dealing, intentional infliction of emotional distress, defamation, and vicarious liability. As a result of the precautionary suspension issued on October 13,

2006, until his staff privileges were reinstated on December 13, 2006, Sternberg seeks \$1.9 million in damages.

*7 The Defendants have filed a counterclaim seeking attorney's fees pursuant to the Health Care Quality Improvement Act of 1986, 42 U.S.C. §§ 1101-1152, (hereinafter the "HCQIA") and under 2.C.2.(e) of Nanticoke's Medical Staff Credentials Policy. Sternberg has filed a motion for summary judgment as to the Defendants' counterclaim arguing that they have failed to establish threshold requirements under the HCQIA and the Credentials Policy for the award of attorney's fees. The Defendants have since filed a motion for summary judgment asserting immunity from liability under the HCQIA, the Medical Staff Credentials Policy, and, for all of the Defendants other than the hospital, Delaware's Medical Practices Act, 24 *Del. C.* § 1768(a) (hereinafter "Medical Peer Review Statute").

This decision will examine the Plaintiff's motion for summary judgment regarding attorney's fees pursuant to the HCQIA and Nanticoke's Credentials Policy as well as the Defendants' motion for summary judgment on the assertion of immunity under the HCQIA, the Medical Peer Review Statute, and the Credentials Policy.

STANDARD OF REVIEW

A motion for summary judgment is properly granted if there is no genuine issue of material fact, and the moving party is entitled to judgment as a matter of law.⁶ When a motion for summary judgment is supported by evidence showing no material issue of fact, the burden shifts to the non-moving party to demonstrate that there are material issues of fact requiring trial.⁷ Upon motion for summary judgment, the Court must view the facts in a light most favorable to the non-moving party.⁸ The Court will accept as established all undisputed factual assertions, made by either party, and will accept the non-movant's version of any disputed facts. From those accepted facts, the Court will draw all rational inferences that favor the non-moving party.⁹

However, the Court is faced with a relatively unusual legal standard for summary judgment motions in matters involving professional review action immunity under the HCQIA. The HCQIA alters the summary judgment burden because Sternberg, the non-mover for summary judgment as to HCQIA immunity, has the burden of demonstrating at the outset that a reasonable fact finder could conclude

by a preponderance of the evidence that Nanticoke did not meet HCQIA requirements for a professional review action and had acted unreasonably.¹⁰ As one court has pointed out, "since HCQIA immunity may only be overcome by a preponderance of the evidence, the statutory presumption in favor of the health care entity shifts to the plaintiff 'not only the burden of producing evidence but the burden of persuasion as well.'" ¹¹ In addition, it is well worth noting that HCQIA immunity ultimately is a question of law that the trial court may determine on summary judgment.¹²

DISCUSSION

1. The Factual Basis for Summary Judgment is Supported by the Record

As an initial matter, Sternberg has raised several evidentiary issues in support of his argument that the Defendants fall short of state and federal immunity standards. All of these arguments relating to the evidentiary record have been crafted to create an impression that there is a fact question in the case at bar. The Court is not persuaded by these evidentiary claims, and, accordingly, rejects these arguments

*8 The Defendants have presented sufficient evidence in their filings with the Court to dispose of this matter. The Court reaches its decision based on the following undisputed and material facts:

1. Sternberg's behavior had been a subject of concern to hospital officials for a substantial period of time prior to his precautionary suspension.
2. The MEC voted to recommend that Sternberg's privileges be revoked at Nanticoke prior to the incident with the reporter which led to his precautionary suspension.
3. The MEC's decision to recommend the revocation of Sternberg's privileges was based on reports regarding his behavior.
4. After it was recommended that his privileges be revoked at Nanticoke, Sternberg was put on notice by hospital officials, including Werner, through repeated warnings, that behavior deemed by hospital officials to be inappropriate would result in an immediate suspension.
5. Sternberg invited a newspaper reporter to observe a procedure on October 13, 2006. This was done to further

Sternberg's political campaign for the legislature even though he had been informed that there was to be no politicking in the hospital.

6. The hospital did not know that the individual who would observe the procedure was a newspaper reporter prior to the incident on October 13, 2006.

7. As a result of the reporter's presence in the operating room, hospital officials had to remove the reporter from the operating room on October 13, 2006.

8. Werner outlined his reasons for issuing the precautionary suspension via a letter to Sternberg on October 13, 2006.

9. On October 18, 2006, the MEC voted to continue Sternberg's suspension until the hearing on the revocation of his privileges was held.

10. A hearing examining the recommendation that Sternberg's privileges be revoked never took place. Instead, Sternberg reached an agreement with hospital officials to remove the precautionary suspension from his record and replace it with a leave of absence. As a condition for removing the precautionary suspension, Sternberg was required to participate in a remedial program as to his conduct.

11. Thereafter, Sternberg successfully completed a Physicians Development Program and returned to his clinical practice on December 14, 2006. Sternberg remained at Nanticoke, without incident, until his resignation on January 31, 2008.

The Court finds any attempt by Sternberg to create a fact question by raising the particulars of how Werner received the information regarding the reporter's presence in the operating room to be irrelevant. For reasons set forth, *infra*, the Court specifically holds that Mary Beth Waide's involvement in any "investigation" is immaterial for purposes of summary judgment.

Nor will the Court disregard the evidentiary record surrounding Sternberg's "pattern of disruptive behavior" as inadmissible hearsay. The evidence of Sternberg's behavior at the hospital is not being offered for the truth of the matter asserted—that Sternberg was disruptive. To the contrary, this documentary record is proffered by the Defendants for the non-hearsay purpose of showing what potential evidence was known by Werner and the MEC, and what potential evidence was considered, when the precautionary suspension

was issued to Sternberg.¹³ Other courts have also concluded that documentary evidence is non-hearsay when offered to show what the decision maker considered when engaging in a peer review activity for purposes of the HCQIA.¹⁴

*9 Moreover, the Court will not strike Werner's affidavit under the "sham affidavit" doctrine. Under our sham affidavit jurisprudence, "the core of the doctrine is that where a witness at a deposition has previously responded to *unambiguous questions with clear answers* that negate the existence of a genuine issue of material fact, that witness cannot thereafter create a fact issue by submitting an affidavit which *contradicts* the earlier deposition testimony, without adequate explanation."¹⁵ In order for the sham affidavit doctrine to be applicable, six elements must be met.¹⁶ The Court concludes that at least two of these elements are missing in the present matter.

First, the sham affidavit doctrine requires that the affidavit be submitted for the purpose of defeating an otherwise properly submitted summary judgment motion.¹⁷ Here, the Defendants have submitted Werner's affidavit in support of its own motion for summary judgment on immunity grounds and in opposition to Sternberg's motion for summary judgment on HCQIA attorney's fees. Thus, it cannot be said that Werner's affidavit was submitted by the Defendants to defeat Sternberg's motion when it was proffered to the Court, in the main part, to support their own motion to the Court.

In addition, the sham affidavit doctrine mandates that the affidavit contradict prior sworn deposition testimony.¹⁸ The doctrine is designed to ensure that summary judgment cannot be defeated by a procedural tactic crafted solely to subvert the process.¹⁹ Yet, at its core, the sham affidavit doctrine requires that the affidavit in question negate genuine issues of material fact.²⁰ Despite providing the Court with supposed examples to support this claim, Sternberg has failed to show that Werner's affidavit contradicts his prior deposition testimony. And, for purposes of discussion only, even if Werner's affidavit provided contradictory evidence, Sternberg has offered no explanation as to how this supposed contradictory testimony relates to a *material* issue of fact that would preclude summary judgment. Thus, Sternberg's attempt to strike Werner's affidavit under the sham affidavit doctrine must be rejected.

2. *The Health Care Quality Improvement Act*

Having concluded that evidentiary issues do not preclude summary judgment, it is necessary to examine the HCQIA. Congress passed the legislation in 1986 in response to what has been described as a "crisis" in the monitoring of doctors and other health care professionals.²¹ By the mid-1980's, state licensing boards had a long history of examining the conduct and competency of their health care workers. With the passage of the HCQIA, Congress found that the increasing occurrence of medical malpractice and the need to improve the quality of medical care were truly national issues that required greater attention than could be undertaken by any one state.²² Congress also concluded that it was far too easy for incompetent doctors to move to different locales to continue their practices. Therefore, Congress mandated the establishment of a national database that recorded incidents of misconduct and made this information available to all health care entities for the screening of potential employees.²³

*10 At the same time, Congress also recognized that threats of anti-trust action and other litigation deterred health care entities from engaging in and conducting meaningful peer review. To foster peer review that would truly highlight incompetent health care professionals, the HCQIA was enacted so that health care entities and individual doctors would be shielded from liability for damages stemming from the examination of health care workers.²⁴ By immunizing peer reviewers from damages, the HCQIA provides a mechanism by which doctors are encouraged to "identify and discipline other physicians who are incompetent or who engage in unprofessional behavior."²⁵ Ultimately, however, the goal of the HCQIA is to balance the chilling effect of litigation on peer review with concerns for protecting physicians improperly subjected to disciplinary action.²⁶

2. *Defendants' Actions Were Professional Review Actions under the HCQIA*

The Defendants' main contention in this litigation is that they are immune from damages by virtue of the HCQIA. Among his many arguments against this contention, Sternberg asserts that the Defendants' precautionary suspension was not a "professional review action" for purposes of HCQIA protection. Sternberg asserts that Nanticoke's By-laws control the "professional review action" analysis and suggests that because the Defendants allegedly did not follow their own

By-laws, they did not take a “professional review action” under the HCQIA.

As a threshold matter, the Court must focus its inquiry on whether the Defendants were engaged in a “professional review action” when Sternberg was suspended. Congress clearly wanted to establish peer review immunity through the HCQIA. On the other hand, Congress did not provide immunity for every individual or entity who engages in investigative activity of health care professionals. Instead, immunity is available under the HCQIA for “professional review actions.”²⁷ The HCQIA defines “professional review actions” as:

An action or recommendation of a *professional review body* which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes *professional review activities* relating to a professional review action.²⁸

For purposes of the definition of “professional review action”, a “professional review body” under the statute is a “health care entity and the governing body of a health care entity which conducts professional review activity, and includes any committee of the medical staff of such an entity when assisting the governing body in a professional review activity.”²⁹ A “professional review activity,” in turn, is “an activity of a health care entity with respect to an individual physician-a) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity, b) to determine the scope or conditions of such privileges or membership, or c) to change or modify such privileges or membership.”³⁰

**II* An extensive statutory analysis of the precautionary suspension at issue here under the HCQIA is not required. For purposes of HCQIA immunity, the Court finds that Nanticoke is a health care entity and the MEC a governing body that conducts professional review activity necessary for a “professional review body.” The Court also holds that, because the precautionary suspension undisputedly

changed, modified, and adversely affected Sternberg's privileges and membership at Nanticoke, the precautionary suspension is both a “professional review activity” and ultimately a “professional review action.” Thus, were the examination limited solely to the confines of the HCQIA, the precautionary suspension would most certainly be eligible for HCQIA immunity as a “professional review action.”

However, Sternberg argues that the Defendants' By-laws exclude precautionary suspensions from being considered HCQIA “professional review actions.” First, Sternberg claims that a hearing is an explicit requirement imposed by the HCQIA on professional review actions. Sternberg contends that since the Defendants' By-laws deny aggrieved doctors the right to a hearing for a precautionary suspension, the By-laws thereby violate the HCQIA.³¹ Sternberg further notes that the plain language of Nanticoke's Credentials Policy removes a precautionary suspension from “professional review action” status under the HCQIA.³²

Moreover, Sternberg argues that the Defendants' precautionary suspension was not a “professional review action” as neither Werner nor the MEC made the determination that failure to suspend Sternberg may have resulted in imminent danger to the health and/or safety of any individual as required by the Credentials Policy.³³ Because he reasons that the Credentials Policy controls the analysis of the precautionary suspension, rather than the HCQIA, Sternberg asserts that the Defendants' alleged failure to abide by the Credentials Policy means that the precautionary suspension cannot be considered to be a “professional review action” under the HCQIA.

The Court is unconvinced that any of Sternberg's arguments about the validity of the precautionary suspension here have merit. Sternberg presupposes that the Defendants' Credentials Policy controls the HCQIA analysis when the weight of authority indicates otherwise. The Court concludes that the precautionary suspension was a “professional review action”, the propriety of which will be examined according to HCQIA immunity standards.

An analysis of HCQIA case law shows that the HCQIA's definition of “professional review action” is definitive and any deviation with respect to the By-laws is immaterial at this stage of the analysis.³⁴ “HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards.

Provided that a peer review action ... complies with those [HCQIA] standards, a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages."³⁵ Even though there is an abundance of case law to support the proposition that adherence to the By-laws is irrelevant in the HCQIA analysis, Sternberg argues that the case *Lipson v. Anesthesia Services, P.A.* creates a unique standard in Delaware such that hospitals must follow their own By-laws to receive "professional review action" status under the HCQIA.³⁶

*12 The Court concludes that *Lipson* does not mandate this conclusion. The *Lipson* plaintiff sued his former medical practice group, a private professional association.³⁷ The *Lipson* Court rejected the group's assertion of HCQIA immunity, concluding that the medical association was not a "professional review body" and was not engaged in an HCQIA protected "professional review action" activity.³⁸ In doing so, though, the Court explicitly noted that had the record supported the medical association's contention that it conducted the investigation of the plaintiff doctor on behalf of the hospital, the court would have concluded that the medical practice group was a "professional review body" eligible for HCQIA immunity if engaged in a "professional review action."³⁹

In the present case, unlike in *Lipson*, the Defendants acted as a "professional review body" engaged in a "professional review action."⁴⁰ Consequently, the analysis into the inquiry could easily end here. Yet, as in *Lipson*, the Court will nevertheless address the assertion that *Lipson* requires adherence to the By-laws for HCQIA "professional review action" protection.

Sternberg has given great attention in particular to one section of *Lipson* for his contention that Delaware has a new standard in HCQIA jurisprudence. There, the Court stated:

Even assuming arguendo that [defendant medical practice] was acting as a 'professional review body' or a 'health care entity,' or both, it still can not credibly maintain that its actions with respect to *Lipson* constituted peer review activity. The Court has been presented with compelling evidence that [defendant medical practice] employed no peer review process at all.⁴¹

The *Lipson* Court went on to state:

The Court has concluded that [plaintiff doctor] has satisfied his burden to establish that [defendant medical practice] was not engaged in peer review activity under the HCQIA because it was not acting as a "professional review body." By failing to follow [the hospital's] Corrective Action/Fair Hearing Plan, and in the absence of any internal "formal peer review" process to guide their investigation, [defendant medical practice's] conduct—at least in the eyes of the HCQIA—was nothing more than employee discipline, cloaked with no more protection or immunity from suit than any other personnel decision it may have made.⁴²

Sternberg's reliance on *Lipson* is misguided. The emphasis in *Lipson* on the importance of following internal peer review procedures was made precisely because *Lipson* involved a private group medical practice that employed literally no peer review procedures. For purposes of the HCQIA, as the *Lipson* Court intimated, a medical practice could conceivably be considered a "health care entity" and "professional review body" necessary to receive "professional review action" protection when it "follows a formal peer review process for the purpose of furthering quality health care..."⁴³ Nowhere in *Lipson* did the Court state that a designated "health care entity" and "professional review body"—as the Defendants have been defined by the Court—must follow By-laws and internal procedures to become eligible for "professional review action" immunization under the HCQIA. To the contrary, the *Lipson* holding is limited to the factual circumstances of that case in which a medical practice could not be considered a "health care entity" or a "professional review body" because it employed literally no formal internal peer review processes as recognized by the HCQIA. Any other reading of *Lipson* would eviscerate the HCQIA's establishment of a "uniform set of national standards."⁴⁴

*13 In addition, Sternberg, again, presupposes that *Lipson* is appropriate here because the Defendants have failed to follow their own By-laws. The Court rejects the contention, discussed *infra*, that Sternberg has met his burden to show that the Defendants have violated their internal peer review procedures. For purposes of rebutting Sternberg's arguments, the Court has only assumed that the Defendants failed to adhere to their By-laws. With the facts here so dissimilar to those in *Lipson*, the Court cannot see how *Lipson's* language in dicta about By-law compliance is controlling in circumstances where the HCQIA applies-

especially considering the case law cited herein, *supra* at footnote 35.

Because the HCQIA, rather than the Defendants' By-laws, is authoritative in the present controversy, the Court deems the plain language of the Defendants' Credentials Policy outlining precautionary suspensions to be irrelevant.⁴⁵ Likewise, the Court finds no merit in the suggestion that the absence of a right to a hearing in the Defendants' Credentials Policy violates the HCQIA.⁴⁶ Thus, the Court concludes that Sternberg has presented no issue of material fact to preclude a finding that the precautionary suspension was a "professional review action" eligible for HCQIA immunity.

3. The Four Strands of HCQIA Immunity

As a "professional review action," the precautionary suspension issued and continued by the Defendants potentially offers immunity from damages arising out of the peer review process.⁴⁷ Although the Defendants are eligible to receive statutory immunity, the Court is required to review the precautionary suspension under HCQIA immunity standards.

Consequently, in order qualify for HCQIA immunity, the "professional review action" must have been taken:

- 1) in the reasonable belief that the action was in the furtherance of quality health care;
- 2) after a reasonable effort to obtain the facts of the matter,
- 3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
- 4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).⁴⁸

These four HCQIA standards necessary for immunity will be satisfied if "the reviewers, with the information available to them at the time of the professional review action would reasonably have concluded that their action would restrict incompetent behavior or would protect patients."⁴⁹ Congress adopted an objective, reasonable belief standard to permit a determination of immunity without an extensive inquiry into the state of mind of peer reviewers.⁵⁰ Consequently, the standard is one of objective reasonableness after looking

at the "totality of the circumstances."⁵¹ Courts have overwhelmingly concluded that peer review actions should be examined under objective standards. The Court will thus apply those standards here.⁵²

*14 In addition, the HCQIA provides that "a professional review action shall be presumed to have met the preceding standards necessary for protection set out in [42 U.S.C. § 11111(a)] unless the presumption is rebutted by a preponderance of the evidence."⁵³ As other courts have explained:

[T]he rebuttable presumption of HCQIA section 11112(a) creates an unusual summary judgment standard that can best be expressed as follows: "Might a reasonable jury, viewing the facts in the best light for [the plaintiff] conclude that he has shown, by a preponderance of the evidence, that the defendants' actions are outside the scope of § 11112(a)?" If not, the court should grant the defendants' motion. In a sense, the presumption language in HCQIA means that the *plaintiff* bears the burden of proving that the peer review process was *not reasonable*.⁵⁴

Therefore, the Court here will focus the inquiry on whether Sternberg provided sufficient evidence to permit a jury to find that he had overcome, by a preponderance of the evidence, the presumption that the Defendants would reasonably have believed that they had met HCQIA immunity standards.⁵⁵

4. The Defendants Acted in the Reasonable Belief that the Precautionary Suspension was in the Furtherance of Quality Health Care

In order for HCQIA immunity to attach, the precautionary suspension of Sternberg must have been taken "in the reasonable belief that the action was in the furtherance of quality health care."⁵⁶ Sternberg argues that the precautionary suspension was not based on the concern for patient safety or for health care improvement but was actually motivated by a desire to discipline him for his zealous advocacy of patient care in the hospital. Citing personal animosity towards him, Sternberg also suggests that the precautionary suspension was reflective of a "one-strike policy" designed to provide hospital leadership with the means to discipline Sternberg outside of the confines of the By-laws.

The HCQIA does not require that the precautionary suspension of Sternberg result in an actual improvement of the quality of health care nor does it require that the conclusions reached by the reviewers be correct.⁵⁷ Instead, the analysis is an objective inquiry in which the totality of the circumstances is considered and the good or bad faith of the reviewers is irrelevant.⁵⁸ Moreover, Sternberg must show that the totality of the information available to the Defendants did not provide a basis for a reasonable belief that their actions would further quality health care.⁵⁹

Considering the totality of the information available to the Defendants, the Court concludes that Sternberg has failed to meet his burden. Knowing that Nanticoke had recommended a revocation of his privileges at the hospital, together with multiple subsequent warnings that a disruption of any kind would result in an immediate suspension, Sternberg made the conscious decision to bring a newspaper reporter into the operating room. Sternberg had been informed by his superiors that he was not to be involved in politicking at the hospital. Nevertheless, without informing hospital administrators, Sternberg brought the newspaper reporter into the operating room for the purpose of advancing his political career. It is reasonable to infer that Sternberg did this under the false pretense of “education”-“education” for the reporter as opposed to traditional “education” customarily reserved for nursing or medical students. Hospital officials were entitled to assume that when Sternberg asserted that the observer was present for “education,” the individual's presence was related to the practice of medicine rather than to promote his election to office.

*15 When medical staff learned that the newspaper reporter was in the operating room, an administrator was informed of the situation. Hospital personnel entered the operating room and escorted the reporter out of the facility. The hospital could reasonably believe that this incident was a disruption of the normal, orderly, and regimented protocol absolutely necessary for the effective treatment of patients.

And it is just as reasonable to find that the Defendants acted in the reasonable belief that suspending Sternberg would result in the furtherance of quality healthcare at Nanticoke. The Defendants knew of the history of allegations regarding Sternberg's behavior of the hospital; they certainly knew that his privileges had been recommended to be revoked; they knew that he had repeatedly been warned not to cause a

disruption in the hospital pending the hearing to review his privileges. Nevertheless, they were informed that he caused some sort of disruption by bringing a hospital reporter into an operating room under false pretenses. Faced with possibility that Sternberg would continue to be disruptive at the hospital absent a change in his interpersonal skills, the Defendants' decision to suspend him was reasonable in the furtherance of quality healthcare.

The Court holds that any claim of personal animosity toward Sternberg in this process is irrelevant.⁶⁰ Nor can the Court find that the mere allegation of a “one-strike policy” is sufficient to show that the Defendants did not have a reasonable belief that the action would result in the furtherance of quality health care. Even if the Defendants engaged in a “one-strike policy” against Sternberg, which is speculative and immaterial, Sternberg simply does not show that the precautionary suspension was *not* based on the reasonable belief that it would further quality care at Nanticoke considering the long history of allegations surrounding his disruptive behavior. As a result of all the evidence before the Defendants, the Court concludes that Sternberg has failed to raise an issue of material fact as to whether his suspension was taken in the reasonable belief that it would further quality health care.

5. The Defendants Made a Reasonable Effort to Obtain the Facts Before Issuing the Precautionary Suspension

The second prong of HCQIA immunity mandates that the professional review action must have been taken “after a reasonable effort to obtain the facts of the matter.”⁶¹ Sternberg asserts that the Defendants did not make a reasonable effort to obtain the facts prior to issuing the precautionary suspension. Sternberg also claims that the Defendant members of the MEC failed to undertake a reasonable investigation when his precautionary suspension was continued.

More specifically, Sternberg's argument centers around the contention that Werner failed to make a reasonable effort to obtain the facts before issuing the precautionary suspension indicating that Sternberg was an imminent danger to the health and safety of any individual. Likewise, Sternberg maintains that the MEC did not fulfill its purported “check and balance” function in the By-laws by reaffirming Werner's decision to suspend Sternberg without examination.

*16 To support these assertions, Sternberg refers to the deposition testimony of several hospital employees to show that the Defendants unreasonably failed to obtain the facts surrounding the precautionary suspension. In particular, Sternberg cites to Waide's deposition testimony which suggests that she did not initiate a formal investigation of the reporter's presence in the room. Waide's testimony, according to Sternberg, conflicts with the claim that Werner asked Waide to investigate the matter. As a result, Sternberg claims to have raised an issue of material fact regarding the reasonableness of the Defendants' efforts to obtain the facts surrounding the suspension.

The HCQIA does not require the ultimate decision maker to investigate the matter independently.⁶² Only a reasonable effort to obtain the facts is required to meet HCQIA standards, and the Court must consider the totality of the process leading up to the professional review action.⁶³ To meet his burden here, Sternberg must establish that no reasonable jury could conclude that the Defendants made a reasonable effort to obtain the facts.⁶⁴

Reviewing the totality of the process surrounding Sternberg's precautionary suspension, the Defendants made a reasonable effort to obtain the facts. Before the precautionary suspension, the Defendants were aware that Sternberg's privileges were subject to revocation, pending a hearing, due to allegations of disruptive behavior at the hospital. The Defendants were aware that Sternberg had been repeatedly notified that any further disruptive incident would result in an immediate suspension. Moreover, the Defendants knew that Sternberg had been warned by hospital officials not to engage in activity that could be construed as political in nature.

Given these circumstances, Werner's effort to obtain the facts was reasonable. While Sternberg attempts to create a fact question regarding Werner's investigation of the reporter's presence in the operating room, the nuances of this examination are irrelevant. Werner most assuredly was not in the operating room when the reporter was removed. Later that same day, however, Werner penned a letter outlining the precautionary suspension. Werner had to have attained the information relayed in that letter from some source that had knowledge of the situation. Werner was entitled to rely on the information provided to him by hospital staff, and there is nothing in the record to suggest that the information was

“so obviously deficient so as to render Defendants' reliance ‘unreasonable.’ “⁶⁵

A formal examination may not have been initiated by Werner, but an extensive inquiry was not necessary either. As a decision-maker at the hospital, Werner was readily aware of what has been described as a “shock wave” when it was learned that a reporter was in the operating room. In light of all that had occurred and all that was known leading up to the precautionary suspension, Sternberg was only entitled to a reasonable effort to obtain the facts, not a perfect effort.⁶⁶ The Court is persuaded that this fact-gathering was entirely reasonable under the circumstances.

*17 While the reasonableness of this inquiry is fact sensitive, other courts have reached the same conclusion when hospitals have performed minimal investigations. The court considering *Onel v. Tenet Healthsystems*, for instance, concluded that a hospital administrator made a reasonable effort to obtain the facts even though he did not have first hand information about the incident giving rise to the precautionary suspension of a practicing internist.⁶⁷ There, the doctor was arrested on suspicion of vehicular homicide and driving while intoxicated.⁶⁸ A hospital administrator read in the local newspaper that the doctor had been arrested and charged in what was reported as an alcohol-related accident.⁶⁹ The *Onel* Court noted that the hospital official was aware that the doctor had a history of being verbally abusive. The administrator also was made aware that the doctor was belligerent on the night of the accident. No formal inquiry or extensive investigation was launched by the defendant hospital when the doctor was summarily suspended. Even though it was ultimately determined that alcohol was absent from the doctor's bloodstream, the *Onel* Court nevertheless held that the hospital's fact finding was reasonable under the facts presented.⁷⁰

The Court does not find *Onel* to be persuasive because of any factual similarities. Rather, *Onel* underscores the point that the HCQIA does not require a sweeping inquiry in every case. Just as it was reasonable for the administrator in *Onel* to suspend the doctor, in part, after reading of the accident in a newspaper, Werner's fact finding mission was reasonable given the obvious disruption by a doctor who had been warned time and again not to cause an incident at the hospital.

Similarly, the MEC's examination of the precautionary suspension was reasonable under the circumstances. Having

concluded that the HCQIA controls the analysis, Sternberg's contention regarding the MEC's supposed "checks and balances" role is of no consequence here.⁷¹ Even if the MEC was required to review the decision to suspend Sternberg, as it is suggested, the Court is satisfied that the MEC exercised reasonable diligence when it reaffirmed Werner's order. The MEC, for instance, recommended revocation of his privileges, and it is clear from the record that members of the MEC were well aware that Sternberg was asked not to be disruptive after this decision.⁷² Considering the MEC's close involvement with Sternberg leading up to the precautionary suspension, a minimal review of Werner's decision would be reasonable under the circumstances.

The record further indicates that the MEC's examination of the suspension meets HCQIA standards. During its meeting on October 18, 2006, the MEC specifically debated Sternberg's suspension, including the circumstances behind Werner's decision, and concluded that "given the previous communications with the physician about the need to control future behaviors, this was something that violated patient rights, disrupted the OR and warranted the action."⁷³

*18 The Court thus finds that the MEC engaged in a reasonable fact-finding process when it recommended that Sternberg's precautionary suspension be continued. Weighing the totality of the process leading up to Sternberg's suspension, the Court cannot conclude that Sternberg has met his burden to show that the Defendants failed to make a reasonable effort to obtain the facts under the circumstances presented.

Finally, the Court notes that much of this analysis is necessary to address Sternberg's arguments. Yet, Sternberg does not dispute the core facts known to Werner. Even though he disagreed with it, Sternberg had been informed of the policy prohibiting political activity at the hospital. Sternberg brought a newspaper reporter into the operating room after obtaining permission to have a visitor for educational purposes. It was reasonable for the hospital staff approving the request to conclude that education in this setting was for medical education and training and not for a newspaper reporter's "education" in covering a political campaign. Nor is it disputed that a staff member at Nanticoke had to enter the operating room and remove the newspaper reporter. As a result, Sternberg's arguments here must fail.

6. Adequate Notice and Hearing Procedures were provided to Sternberg

A. The Defendants had Reasonable Grounds to Suspend Sternberg as an Imminent Danger to the Health of any Individual.

The HCQIA mandates that professional review actions be taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances."⁷⁴ The law, however, contains an emergency provision that permits suspensions "subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action *may result in an imminent danger to the health of any individual.*"⁷⁵ The emergency provision does not require that imminent danger actually exist before a summary restraint is imposed. "It only requires that the danger *may result* if the restraint is not imposed."⁷⁶

Ultimately, the central contention in Sternberg's case is that the Defendants did not make the determination that failure to suspend him or continue the suspension would have caused imminent danger to the health of any individual as referenced by the HCQIA emergency provision. Sternberg claims that the "imminent danger" standard is only satisfied when it is shown that a physician was incompetent, has substance abuse issues, or has deliberately harmed patients. Consequently, Sternberg implies that disruptive behavior, outside of these confines, is insufficient to meet imminent danger principles. Further, Sternberg asserts that the Defendants did not make-and could not make-the determination that he was an imminent danger to the health of any individual.

At first glance, Sternberg appears to have sufficient evidence to raise a genuine issue of material fact as to whether he was an imminent danger to any individual. Sternberg notes that Werner did not specifically mention the potential for imminent danger in the letter in which the precautionary suspension was issued. He observes that Werner did not discuss the possibility that Sternberg was an imminent danger when the MEC met to examine the precautionary suspension. In addition, as Sternberg points out, several individual Defendants, comprised of doctors and peer reviewers, testified after the fact that in their estimation he was not an imminent harm to the health or safety of any individual.

*19 While this evidence is interesting, it is not determinative. No magic word or written phrase related to imminent danger by Werner, alone, would have triggered HCQIA immunity, and Werner's failure to communicate the precise imminent danger terminology does not end the inquiry either.⁷⁷ Likewise, those assertions made by Sternberg's colleagues that he was not a direct risk to patient safety have the benefit of hindsight. These opinions lack the expertise, perspective, or knowledge of the HCQIA upon which to render a legal conclusion in the eyes of the law. As a result, the Court must review the HCQIA to determine as a matter of law whether a competent physician with behavioral issues can be considered an imminent danger for the emergency provision.

Essential to Sternberg's argument is the contention that disruptive doctors cannot be an imminent danger to the health and safety of any individual. The Court rejects this narrow approach to HCQIA jurisprudence. To the contrary, behavioral issues were most certainly contemplated by Congressional officials when the HCQIA was enacted. The Court observes, for instance, that the legislative history for the HCQIA highlights unprofessional conduct or behavior as an area of concern on no less than fifteen occasions.⁷⁸

That Congress meant to include disruptive doctors within the purview of the HCQIA is further exemplified through the statutory construction of a "professional review action." As one court explained:

The plain language of the statute indicates the breadth of "conduct" encompassed within the definition of "professional review action" by the inclusion of conduct that "could affect adversely the health or welfare of a patient." 42 U.S.C. § 11151(9). The statute contemplates not only potential harm through use of the term "could," but it also affords protection to actions taken against physician conduct that either impacts or potentially impacts patient "welfare" adversely, meaning patient "well being in any respect; prosperity." Black's Law Dictionary (West Group, 7th Ed.1999). Even if the statutory language was deemed to be ambiguous, the legislative history would support the same construction. *See* Health Care Quality Improvement Act of 1986, H.R. 5540, 99th Cong.2d Session (1986), 132 Cong. Rec. at 30768 (Oct. 14, 1986) ("competence and professional conduct should be interpreted in a way that is sufficiently broad to protect legitimate actions based on matters that raise concerns for patients or patient care.").⁷⁹

It is clear that in applying the HCQIA, immunity for professional review actions is available to combat behavioral matters, such as a revocation of privileges or a denial of credentialing.⁸⁰ In *Frelich v. Upper Chesapeake Health, Inc.*, the court *explained* its rationale for immunizing the denial of a doctor's medical privileges:

Today's health care environment has become increasingly complex. As [plaintiff's] complaint itself demonstrates, the operation of a hospital requires the coordination of numerous employees and departments, each with different responsibilities that build and depend upon each other. Thus, staff cooperation and communication are essential to ensuring a high quality of patient care. Disruptive behavior in the workplace can not only affect the moral and teamwork of the staff itself, but in so doing cause actual harm to patients.⁸¹

*20 However, Sternberg further contends that disruptive doctors who have been *suspended* cannot be considered an imminent danger to any individual without a direct risk to patient safety. A review of the case reveals that such an assertion is misplaced.⁸²

Given the intent to regulate unprofessional conduct, HCQIA case law indicates that the imminent danger standard is much broader in scope than Sternberg represents.⁸³ In *Sugarbaker v. SSM Health Care*, for example, the court rejected a contention offered by a surgeon that the hospital was not entitled to HCQIA protection because the doctor had no patients admitted at the time of his suspension, thus implying that the physician was of no imminent danger to any one individual. The court explained:

We see no reason to limit the HCQIA emergency provisions to situations in which there is a currently identifiable patient whose health may be jeopardized. The HCQIA does not require imminent danger to exist before a summary restraint is imposed. It only requires that the danger may result if the restraint is not imposed.⁸⁴

Other cases highlight the breadth of the imminent danger standard described in *Sugarbaker*. The plaintiff internist in *Onel* argued that he was of no imminent danger to any individual because his medical competency was not at issue.⁸⁵ In rejecting this claim, the *Onel* Court reasoned:

Dr. Onel argues that the emergency provision does not apply because the accident had nothing to do with patient care or his ability to practice medicine. Dr. Onel argues that prior cases have used the summary suspension provision only following evidence of incompetence in patient care. Although the plaintiff correctly observes that the summary suspension provision can and has been invoked in cases of physician incompetence in patient care, § 1 1112(c)(2) is not limited to instances of incompetence in patient care. The emergency provision's language is broad, and permits summary action in any case where the failure to act "may result in imminent danger" to any individual's health, subject only to subsequent notice and hearing.⁸⁶

Sternberg attempts to distinguish the holding of *Onel* by suggesting that the case applies only where a physician has a substance abuse problem. In doing so, Sternberg ignores the permissive nature of the emergency provision underscored by the "may result in imminent danger" language. He also fails to consider that substance abuse fits in squarely with the proposition that disruptive behavior can result in imminent danger.

Similarly, in *Jenkins v. Methodist Hospitals of Dallas, Inc.*, although there was some suggestion that the plaintiff doctor was incompetent, the Court focused its analysis on accusations that the cardiologist fostered a "hostile work environment."⁸⁷ The court recognized that the complaints against the physician "allege demeaning comments to staff, berating the staff, threatening the staff with loss of employment, and other disruptive behavior."⁸⁸ In concluding that the summary suspension was reasonable pursuant to HCQIA emergency provision standards, the *Jenkins* Court specifically relied upon evidence that the doctor was "largely responsible for a hostile work environment ... that was potentially injurious to patient care" and an indication that the physician made the staff feel "rushed to perform their duties, causing them to fear mistakes."⁸⁹

*21 While *Jenkins* directly counters Sternberg's contention that disruptive doctors do not represent an imminent danger to the health of any individual, the *Straznicky v. Desert Springs Hospital* case further reinforces the point. There, the plaintiff physician entered an operating room where one of his colleagues was performing a surgical procedure.⁹⁰ In need of a lead shield, the plaintiff asked his colleague about using the

surgical instrument in his own surgery. When the colleague denied this request, the plaintiff became "confrontational" and "visibly upset" and took the lead shield anyway.⁹¹

Thereafter, the plaintiff was summarily suspended for "disruptive conduct that caused a distraction" to his fellow surgeon.⁹² Challenging the propriety of his suspension, the plaintiff argued that he needed the shield for his own protection and did not directly harm any individual. In response, the *Straznicky* Court observed that "by removing this equipment from the operating room where it was needed for a procedure, Straznicky placed someone in that adjacent operating room at harm."⁹³ The *Straznicky* Court thus rejected the supposition that the physician had to cause *direct* harm to any individual to satisfy imminent harm criteria. In addition, the court responded to a contention that the taking of the shield was an isolated incident ill reflective of "on-going imminent harm to patients":

The argument ignores that past disruptive conduct can be indicative of an underlying characteristic that could manifest in future disruptive conduct. When the nature of the disruptive conduct indicates both that an imminent harm to a patient occurred and that the failure to take immediate action may result in imminent danger to the health of individuals, a reviewing body can reasonably believe that an immediate, summary suspension is warranted.⁹⁴

As the *Straznicky* Court further explained, "the court readily concludes that a patient is placed in danger of imminent harm when someone causes the surgeon, who is performing a procedure on a patient, to become visibly disturbed and distracted during the procedure."⁹⁵

The common thread in all of these cases is that summarily suspended doctors have been found to be an imminent danger to the health of any individual as a result of their unprofessional behavior rather than their competency. Because a review of the case law reveals that a disruptive physician can be an imminent danger for purposes of the emergency provision, Sternberg's narrow reading and application of HCQIA jurisprudence misses the mark.

Thus, the question before the Court is not whether Sternberg was an imminent danger when he was suspended. If it were, the Court would be highly persuaded by the testimony of Sternberg's colleagues suggesting otherwise. Instead, the Court holds that the proper inquiry is whether the

Defendants had reasonable grounds for suspending Sternberg if imminent danger *may* have resulted had the restraint not been imposed.⁹⁶

*22 From the record presented, the Court finds that it was reasonable for the Defendants to consider Sternberg an imminent danger to the health of any individual when they issued and continued the precautionary suspension. Both Werner and the members of the MEC had knowledge of those allegations against Sternberg which led to the recommendation that his privileges be revoked. After recommending that his privileges be revoked, and by bringing in a reporter to the operating room under what they reasonably inferred was false pretenses, Sternberg engaged in behavior that most certainly disrupted the normal order at the hospital. Since, from the Defendants' viewpoint, Sternberg had shown an inclination to disregard repeated warnings and a history of disconcerting behavior, the Court finds that it was imminently reasonable for both Werner and the MEC to conclude reasonably that if Sternberg were not removed from the hospital imminent danger to patients *might* result. At the end of the day, it was reasonable for the Defendants to conclude that Sternberg's continued disruptive behavior required action to safeguard against the possibility of imminent danger to their patients.

The Court further notes that Sternberg's occupation as a surgeon plays some role in the imminent danger analysis. At least two incidents of his disruptive behavior allegedly occurred in the operating room close in time to surgical procedures. As *Straznicky* recognized, surgeons are members of a select few occupations where "life and death decisions" are a distinct possibility each time they enter the workplace. In such an extremely stressful environment, surgeons, in the course of their employment, have a responsibility, if not duty, to avoid causing distractions. To take *Straznicky* one step further, this Court readily accepts that a patient is placed in danger of imminent harm when a surgeon, who is in the process of performing a procedure on a patient, becomes visibly disturbed and distracted—regardless of the cause of the disturbance. In light of the foregoing, Sternberg fails to convince the Court that the Defendants did not have reasonable grounds to suspend him as an imminent danger to the health of any individual.

B. The Adequacy of the Notice and Hearing Procedures Provided to Sternberg

Since the Defendants had reasonable grounds to suspend Sternberg as an imminent danger to the health of any individual, the Court is satisfied that the precautionary suspension was appropriate under the HCQIA emergency provision. However, the analysis of this HCQIA prong does not end there. The HCQIA states that nothing in the act precludes an immediate suspension based on imminent danger to the health of any individual "subject to subsequent notice and hearing or other adequate procedures."⁹⁷

Sternberg correctly notes in this respect that the HCQIA requires a hearing or other fair procedures before a professional review action can be taken.⁹⁸ Sternberg also recognizes that the hearing requirement can be delayed under the emergency provision if imminent danger may result from the failure to act. Because Sternberg argues that the Defendants could not find imminent danger here, he contends that a hearing was required before the professional review action was initiated. Thus, according to Sternberg, the failure to provide a hearing before the suspension was issued and continued violates HCQIA notice and hearing requirements. Sternberg supports his argument here by suggesting that Nanticoke's By-laws do not entitle a doctor to a hearing at any time regarding a precautionary suspension.

*23 The Court has little trouble in rejecting these contentions. As has been discussed, the Defendants had reasonable grounds to suspend Sternberg as an imminent danger to the health of any individual. By meeting this standard, the Defendants were not required to provide Sternberg with a hearing before he was suspended. Thus, Sternberg's arguments here are not persuasive.

The Court reiterates that the By-laws do not control the HCQIA analysis. Yet, assuming they did, there is nothing in Nanticoke's Credentials Policy that violates the HCQIA on its face. Nanticoke's By-laws state that "there is no *right* to a hearing based on the imposition or continuation of a precautionary suspension or restriction."⁹⁹ Likewise, the HCQIA's emergency provision indicates that an immediate suspension can be taken subject to subsequent notice "*or other adequate procedures.*"¹⁰⁰ With the inclusion of the "*or other adequate procedures*" language, the HCQIA, itself, does not provide a right to a hearing when a doctor is suspended. Consequently, this Court cannot say that the restriction of a *right* to a hearing in the Credentials Policy violates the HCQIA—even if the inquiry was material.

Moreover, the Court notes that the Defendants did provide Sternberg with the opportunity for a hearing in the wake of his suspension. At the time Sternberg was suspended, a hearing regarding the revocation of his privileges at the hospital had already been both scheduled and delayed to accommodate Sternberg's need for counsel. The MEC voted that action on the precautionary suspension should be continued until the hearing on the revocation of Sternberg's privileges was held.

In light of the recommendation that Sternberg's privileges be revoked, it was entirely adequate under the circumstances for the MEC to continue the suspension until the hearing about his privileges was held. Sternberg and the Defendants mutually agreed not to have this hearing when it was decided that the precautionary suspension would be characterized as a leave of absence. This circumstance further reinforces the point that there were no deficiencies in the due process procedures offered to Sternberg. Outside of his contentions surrounding the failure of the Defendants to find that he was an imminent danger, Sternberg does not allege any other due process inadequacies. Because his imminent danger argument is without merit, the Court finds that Sternberg has failed to show by preponderance of the evidence that the notice, hearing, or other procedures afforded to him were inadequate or not fair under the circumstances.

7. The Precautionary Suspension was made in the Reasonable Belief that the Action was Warranted by the Known Facts

The fourth and final strand of the HCQIA requires that the professional review action must have been taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirements of paragraph (3)."¹⁰¹ This prong "essentially combines the first three elements" of the HCQIA.¹⁰² The Court's analysis here mirrors that regarding the standard for professional review actions taken in the furtherance of quality health care.¹⁰³ Accordingly, the Court will not reweigh matters that have been thoroughly discussed. For the reasons stated above, the Court holds that no reasonable jury could conclude that Sternberg has demonstrated by a preponderance of the evidence that the Defendants did not act in the reasonable belief that the precautionary suspension was warranted by the facts known after a reasonable effort to obtain the facts.

*24 The Court recognizes that, by design, the standards and presumptions for HCQIA immunity are weighted in favor of those hospitals and physicians that engage in the peer review process. Undoubtedly, the HCQIA has the potential to reach unjust results.¹⁰⁴ Yet, the analysis in *Poliner v. Texas Health Systems* on this issue is directly on point:

It bears emphasizing that this does not mean that hospitals and peer review committees that comply with the HCQIA's requirements are free to violate the applicable bylaws and state law. The HCQIA does not gainsay the potential for abuse of the peer review process. To the contrary, Congress limited the reach of immunity to money damages. The doors to the courts remain open to doctors who are subjected to unjustified or malicious peer review, and they may seek appropriate injunctive and declaratory relief in response to such treatment. The immunity from money damages may work harsh outcomes in certain circumstances, but that results from Congress' decision that the system-wide benefit of robust peer review in rooting out incompetent physicians, protecting patients, and preventing malpractice outweighs those occasional harsh results; that giving physicians access to the courts to assure procedural protections while denying a remedy of money damages strikes the balance of remedies essential to Congress' objective of vigorous peer review.¹⁰⁵

Although it is clear that the HCQIA is potentially unforgiving to doctors, such is not the case here. Considering the record presented, the Court is satisfied that this matter is precisely the type of case that Congress intended to be adjudicated under HCQIA immunity standards. Moreover, balancing all of the evidence indicating that Sternberg was a disruptive doctor with the *potential* to cause imminent harm to patients, the Court will not substitute its judgment "for that of health care professionals and of the governing bodies of hospitals in an area within their expertise."¹⁰⁶

In sum, the Court finds that Sternberg has failed to produce any evidence from which a reasonable jury could conclude that he has overcome, by a preponderance of the evidence, the presumption of compliance with the four prongs of the HCQIA. Immunity, pursuant to the statute, therefore applies to this matter.

The HCQIA immunizes "(a) the professional review body (b) any person acting as a member or staff to the body, (c) any person under a contract or other formal agreement with the body, and (d) any person who participates with or

assists the body with respect to the action” from all damages claims which arise out of the peer review process.¹⁰⁷ HCQIA immunity applies not only to individual physicians, but it also is extended to hospitals and corporate entities.¹⁰⁸ As a result, the Court concludes that Nanticoke Hospital, Werner, and the other fourteen named individual Defendants who were members of the MEC receive immunity under the HCQIA in this case.

*25 Moreover, all of Sternberg's claims for damages are precluded by HCQIA immunity.¹⁰⁹ Sternberg's claims include tortious interference with business relations, negligence, breach of contract, breach of implied covenant of good faith and fair dealing, intentional infliction of emotional distress, defamation, and vicarious liability. All arise out of the peer review process on the premise that he was improperly suspended under the HCQIA. The Court has concluded that this premise was unfounded. Since Sternberg claims no other remedy other than monetary damages in this case, the Court grants the Defendants' motion for summary judgment on HCQIA immunity grounds.

8. The Individual Defendants are Immune from Suit under Delaware's Peer Review Statute

A. Delaware's Medical Peer Review Statute

The Defendants have also argued that Delaware's Medical Peer Review Statute provides a separate basis for immunity independent of the HCQIA analysis. Like the HCQIA, Delaware's Medical Peer Review Statute was crafted to foster the peer review process and improve the quality of care in our state by conferring immunity upon the good-faith actions of peer reviewers.¹¹⁰ As a result, the Medical Peer Review Statute maintains that hospital employees or committees:

[W]hose function is the review of medical records, medical care and physicians' work ... are immune from claim, suit liability, damages or any other recourse, civil or criminal, arising from any act, omission, proceeding, decision or determination undertaken or performed, or from recommendation made, so long as the person acted in good faith and without gross or wanton negligence in carrying out the responsibilities, authority, duties, powers, and privileges of the offices conferred by law upon them, with good faith being presumed until proven otherwise, and gross or wanton negligence required to be shown by the complainant.¹¹¹

As the Defendants acknowledge, the Medical Peer Review Statute applies only to Werner and the fourteen individual doctors and MEC members who were named as Defendants in this action. The state statute does not apply to Nanticoke as a hospital entity.¹¹²

The immunity offered by Delaware's Medical Peer Review Statute is broader than that provided by the HCQIA. Thus, unlike its federal counterpart, Delaware's legislation extends beyond claims for damages. It should be reiterated, however, that “good faith” is presumed in the Medical Peer Review Statute.¹¹³ In addition, the complainant in litigation surrounding the Medical Peer Review Statute has the burden of establishing bad faith or gross or wanton negligence.¹¹⁴

B. Sternberg's Reliance upon *Lipson* is Unfounded and does not Bar Immunity under the Medical Peer Review Act

In an attempt to defeat summary judgment under the Medical Peer Review Statute, Sternberg repeats the same arguments he employed with the HCQIA. For example, Sternberg argues that *Lipson* requires peer review committees to follow hospital By-laws in order to receive immunity under Delaware's Medical Peer Review Statute. Sternberg contends that Werner and the members of the MEC violated Nanticoke's By-laws by ignoring the imminent danger provision or even referencing hospital policy on visitors in the operating room before issuing and continuing his suspension. Thus, Sternberg reasons that *Lipson* bars immunity under the Medical Peer Review Statute due to these alleged violations of the By-laws.

*26 The Court once again declines to accept Sternberg's analysis of *Lipson* as being controlling in the present matter. First, Sternberg simply has not raised an issue of material fact indicating that the Defendants have failed to follow Nanticoke's By-laws. Because this point has been addressed above in the context of the HCQIA, it need not be repeated here.¹¹⁵ However, the Court adopts the reasoning employed there for purposes of Delaware's Medical Peer Review Statute.

Moreover, the Court emphasizes that the holding in *Lipson* is not germane for purposes of Delaware's Medical Peer Review Statute in circumstances, like the present case, where a formal peer review process was utilized. It bears repeating that the defendant in *Lipson* was a private medical practice

group.¹¹⁶ In the context of the Medical Peer Review Statute, the *Lipson* Court reasoned that the private medical practice could engage in protected peer review activity even though prior case law was silent on the issue.¹¹⁷ Yet, *Lipson* made it clear that immunity pursuant to the Medical Peer Review Statute was available to that defendant “to the extent it acted in accordance with the Act’s provisions.”¹¹⁸

In holding that the *Lipson* defendant was not entitled to immunity under Delaware’s Medical Peer Review Statute, the *Lipson* Court found that no evidence had been supplied to suggest that the defendant medical practice group “even considered, much less actively enforced, professional standards” by which the plaintiff doctor’s conduct was examined to support the suspension at issue there.¹¹⁹ As a result, the *Lipson* Court observed that the defendant’s conduct was inconsistent with “the Legislature’s goal of creating an environment for the establishment and enforcement of professional standards.”¹²⁰

Furthermore, while troubled that the private medical practice did not employ professional standards, the *Lipson* Court deemed the defendant’s failure to conduct its peer review process in accordance with established procedures to be fatal.¹²¹ There, the defendant considered the doctor’s suspension on an “ad hoc basis at a regularly scheduled meeting of its board of directors. No process attached to the ‘peer review’ aspects of the meeting, e.g. there was no formal notice of the meeting or a meeting agenda provided to [the plaintiff], no explanation of the process to be followed by the board when considering [plaintiff’s] behavior, no explanation of possible corrective action to be taken by the board, and no explanation of [plaintiff’s] rights during the process.”¹²²

The *Lipson* Court reasoned that that the Medical Peer Review Statute’s mandate of good faith and fairness was not preserved since the private medical group extended literally no peer review process.¹²³ The court concluded that the private medical practice was removed from the umbrella of immunity because Delaware’s legislation “provides no protection for members of a medical practice (or other health care entity) who take steps to discipline a rogue care provider outside of a clearly defined peer review process, even if the ultimate goals are the enforcement of professional standards and patient safety.”¹²⁴

*27 As has already been discussed, the peer review processes employed by the private medical practice there in comparison to the Defendants actions are so dissimilar as to make *Lipson* distinguishable. Sternberg does not argue that that the Defendants’ issuance and continuation of the suspension were proffered in the absence of a defined peer review process. If he had, the totality of the peer review process used by the Defendants including Nanticoke’s Bylaws, the peer review committees defined by the By-laws, and the imminent danger standard referenced in the By-laws would quickly end the argument.

Yet, Sternberg argues that the decision-making process of Werner and his fellow Defendants on the MEC was so tainted as to remove them from the umbrella of immunity under Delaware’s Medical Peer Review Statute. Even if the steps taken to discipline Sternberg were flawed, an argument the Court has repeatedly rejected, Delaware’s Medical Peer Review Statute provides immunity to individuals “who act in good faith without gross or wanton negligence in carrying out the responsibilities, authorities, duties, powers, and privileges of the offices conferred by law upon them.”¹²⁵ Nothing in Delaware’s statute requires the process employed by peer reviewers to be perfect or even correct. Instead, the process utilized must be made in good faith and without gross or wanton negligence.

As a result, the Court concludes that *Lipson* is the appropriate authority when the process employed by peer reviewers is so insufficient that it offends the Medical Peer Review Statute’s mandate of good faith and fairness. Since Sternberg has not raised a material issue of fact in this regard, the Court finds that *Lipson*’s holding does not remove the Defendants from consideration under Delaware’s Medical Peer Review Statute.

C. Sternberg has not Rebutted the Presumption that the Defendants Acted in Good Faith and Without Gross or Wanton Negligence Under Delaware’s Medical Peer Review Act.

The Court finds that the examination of the Medical Peer Review Statute focuses on whether the Defendants acted in good faith and without gross or wanton negligence. Under the statute, immunity is available for hospital employees who act acted in “good faith and without gross or wanton negligence in carrying out the responsibilities, authority, duties, powers, and privileges of the offices conferred by law upon them.”¹²⁶

The Defendants are statutorily presumed to have acted in good faith until proven otherwise.¹²⁷

At the outset, the Court finds that the precautionary suspension provision in Nanticoke's Credentials Policy represents "duly adopted rules and regulations" envisioned by the Medical Peer Review Statute in this case.¹²⁸ Moreover, the Court concludes that the issuance of his suspension by Werner and the continuation of the suspension by the MEC relate to the "authority, duties, powers, and privileges" of the Medical Peer Review Statute. Thus, the key question here is whether Werner and the members of the MEC acted in good faith when the suspension was issued and continued, respectively.

*28 The Court concludes that Sternberg cannot rebut the presumption that the Defendants' acted in good faith throughout the process leading up to the MEC's continuation of the suspension. Nor does Sternberg show that Werner and his named Defendant colleagues acted with gross or wanton negligence in this case. Rather, Sternberg contends that the Defendants had a history of animosity towards him, presumably stemming from his advocacy for patient care at the hospital. As a result, according to Sternberg, the Defendants continually sought to terminate his employment at the hospital and did so as soon as he was no longer needed to satisfy the hospital's requirements for orthopedic emergency call.

Beyond these unsubstantiated allegations, Sternberg fails to produce evidence sufficient to negate the presumption that the Defendants acted in good faith under Delaware's Medical Peer Review Statute. While Sternberg offers an affidavit suggesting that some of the Defendants wanted to "get rid" of him, he fails to provide the context in which the statement was uttered. The affidavit is nothing short of conclusory and cannot defeat summary judgment.

The Court also fails to be convinced that the Defendants acted in bad faith or with gross or wanton negligence considering the totality of the circumstances surrounding Sternberg's suspension. The Court observes, for instance, that the Defendants moved the original date for the hearing on the revocation of his suspension to accommodate Sternberg's need for counsel. The Defendants appear to have been fully prepared to present their case for a revocation of his privileges at the hearing until it was postponed due to his precautionary suspension. No evidence suggests that the Defendants even attempted to skirt due process in their dealings with Sternberg

as one might assume had they been motivated by gross or wanton negligence or bad faith.

In addition, the record provides evidence that directly contradicts Sternberg's claim that the Defendants acted in bad faith. On multiple occasions, the Defendants reached out to Sternberg, offering to characterize the precautionary suspension as a leave of absence in an ostensible effort to provide him with an opportunity to receive help related to his behavior at the workplace. The Defendants negotiated with him, and they ultimately agreed to consider the suspension to be a leave of absence—thus salvaging Sternberg's career by not reporting him to the federal database. Thereafter, Sternberg remained a practicing physician at Nanticoke hospital for over one year before he chose to resign.

None of the above suggests that the Defendants were out to "get rid of him" as Sternberg would have the Court believe. Nor can Sternberg rebut the presumption of good faith in the Medical Peer Review Statute. Thus, the individual named Defendants are entitled to summary judgment as a matter of law on the basis of Delaware's Medical Peer Review Statute.

9. Immunity under the Credentials Policy

*29 The Defendants next claim that that they are entitled to absolute immunity pursuant to Nanticoke's Credentials Policy. The Defendants argue that when he applied for reappointment in August of 2006 and agreed to abide by the Medical Staff By-laws, including Nanticoke's Credentials Policy, Sternberg expressly consented to release the Defendants from any and all liability. Accordingly, Nanticoke's Credentials Policy states the following:

2.C.2. Grant of Immunity and Authorization to Obtain/Release Information:

a) Immunity:

To the fullest extent permitted by law, the individual releases from any and all liability, extends absolute immunity to, and agrees not to sue the Hospital, any member of the Medical Staff, their authorized representatives, and appropriate third parties for any matter relating to appointment, reappointment, clinical privileges, or the individual's qualifications for the same. This includes any actions, recommendations, reports, statements, communications, or disclosures involving the individual which are made, taken, or received by the Hospital, its authorized agents, or appropriate third parties.¹²⁹

The Defendants do not argue that the Credentials Policy constitutes an enforceable contract immunizing them from liability. Rather, the Defendants suggest that Sternberg waived all claims when he applied for reappointment to Nanticoke in 2006 and acquiesced to its Credentials Policy.¹³⁰

Sternberg urges the Court to consider the Credentials Policy to be a contract, contending that the Bylaws are contractually unconscionable and void as a matter of law. Sternberg further argues that the Defendants breached this contract as a result of the alleged improper suspension of Sternberg thereby excusing him from performance.

Having reviewed the considerable record in this matter, it is clear that both parties have focused their efforts primarily on immunity under the HCQIA and, to a lesser extent, under Delaware's Medical Peer Review Statute. Consequently, the record was not fully developed on the contractually based claims. Because the Defendants' have been found to be immune from liability under the HCQIA and Delaware's Medical Peer Review Statute, the Court need not rule on the immunity provision in Nanticoke's Credentials Policy.

10. Attorney's Fees

A. The HCQIA

While the HCQIA offers immunity in certain prescribed situations from a suit for damages, the statute offers yet another potential benefit—the payment of reasonable attorney's fees. Sternberg initially filed a motion for summary judgment arguing that the attorney's fee provision was inapplicable here because the Defendants could not establish that they qualified for HCQIA immunity protection. The Defendants, in turn, argue that they meet statutory prerequisites for attorney's fees. More specifically, the Defendants contend that Sternberg's claims are without foundation and were brought in bad faith.

The HCQIA provides that:

**30* In any suit brought against a defendant, to the extent that a defendant has met the standards set forth in 42 U.S.C. § 11112(a) and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending any such claim the cost of the suit attributable to such claim, including a

reasonable attorney's fee, if the claim, or the claimant's conduct during the litigation of the claim, was frivolous, unreasonable, without foundation, or in bad faith.¹³¹

In order to recover reasonable attorney's fees, the Defendants must establish:

- 1) that they are among the persons covered by 42 U.S.C. § 11111;
- 2) that the standards set in 42 U.S.C. § 11112(a) were followed;
- 3) that they substantially prevailed; and
- 4) that the plaintiff's claim, or the plaintiff's conduct during the litigation, was frivolous, unreasonable, and without foundation or in bad faith.¹³²

The determination of whether the party's conduct was frivolous or without foundation is a question committed to the sound discretion of the trial court.¹³³

The Court readily concludes that the Defendants meet the first three elements necessary for attorney's fees under the HCQIA. However, even if the first three elements are met, the Defendants must establish that Sternberg's claims are frivolous, unreasonable, and without foundation or in bad faith. Sternberg disavows any suggestion that his claims are frivolous, unreasonable, without foundation or brought in bad faith as required by the forth prong for HCQIA attorneys fees.

It is clear from a review of the case law that a finding that the Defendants are immune from suit pursuant to the HCQIA does not automatically result in the award of attorney's fees.¹³⁴ In this regard, the Court will “resist the understandable temptation to engage in post hoc reasoning by concluding that, because a plaintiff did not ultimately prevail, his action must have been unreasonable or without foundation.”¹³⁵

While evaluating the attorney's fees matter, the Court again observes that all of Sternberg's claims are grounded on the argument that the precautionary suspension was improper since he was not—and could not have been—as a matter of law—an imminent danger to the health of any individual. In carrying out this responsibility, the Court gives considerable weight to the assertion that Sternberg's claims were brought

in bad faith, particularly considering that the parties' leave of absence agreement kept Sternberg's name out of the federal HCQIA database.

Although a precautionary suspension surely does not advance a physician's career, one wonders why this Court should not consider Sternberg's claims to be rooted in bad faith. After all, Nanticoke made apparently good faith overtures on multiple occasions to remove the precautionary suspension and replace it with a leave of absence. Sternberg and the Defendants negotiated and reached an agreement whereby the precautionary suspension disappeared. Sternberg thereby received the benefit of not being reported to the federal database and having had his career as a practicing physician severely prejudiced as a result. After satisfying the condition that he complete a remedial course on his behavior, he returned to work at Nanticoke for over one year without incident before resigning and initiating the process that led to this action. Sternberg appears to have "had his cake" when he was not reported to the federal database. By pursuing this litigation, the Court assumes that he wants to "eat it, too."

*31 In addition, Sternberg's arguments about the imminent danger standard in the emergency provision of the HCQIA were less than persuasive. Even though some of Sternberg's colleagues indicated that he was not considered to be an imminent danger at the time he was suspended, there nevertheless was substantial authority indicating that the Defendants had reasonable grounds to suspend Sternberg as an imminent danger due his disruptive behavior.¹³⁶ To stress as a matter of law in briefings and at oral argument that the imminent danger standard could only be satisfied when a doctor had substance abuse issues, deliberately harmed patients, or was incompetent is without foundation and is unreasonable in the eyes of this Court in light of the abundance of case law to the contrary.

Furthermore, the Court recognizes that the purpose of providing for attorney's fees in the HCQIA is to "discourage the kind of litigation that is so baseless that the cost of litigating would discourage people from serving on peer review panels."¹³⁷ Using that concept as a guiding factor in this analysis, the Court is struck here by Sternberg's acknowledgement of the core facts that led to his precautionary suspension.¹³⁸ He does not dispute that Nanticoke had informed him that he was not to engage in politicking at the hospital. He does not dispute that a newspaper reporter was brought into the operating room

despite this prohibition. And, the Court notes he does not dispute that hospital personnel removed the newspaper reporter from the operating room. In the alternative, Sternberg attempts to place the blame on Nanticoke for the newspaper reporter's visit to the operating room when it was entirely reasonable for hospital officials to consider an observation for "education" to be related to medical training. Ultimately, the Court fails to be convinced that an award of attorney's fees to the Defendants in light of these facts is contrary to the HCQIA's mission to discourage baseless litigation and to promote meaningful peer review.

As a result, the Court holds that the Defendants have established that they are among the persons covered by the HCQIA, that the standards set forth in the HCQIA were followed, and that the Defendants substantially prevailed in this matter. Moreover, the Court finds that Sternberg's claims were unreasonable and brought in bad faith. In light of the Court's discretionary authority, the Defendants are entitled to reasonable attorney's fees for the costs associated with defending this matter. Sternberg's motion for summary judgment is therefore denied.

Counsel for the Defendants and for Sternberg shall file affidavits and documentation regarding fees earned in this matter within twenty days from the date of entry of this order. As the Court advised counsel earlier in this case, when this Court considers an award of attorney's fees, the Court prefers to know the attorney's expenses of both sides. Plaintiff's counsel shall have the opportunity to respond within fifteen days upon receipt of Defendants' documentation on the amount of attorney's fees incurred. The Court will award a reasonable amount of attorney's fees to the Defendants after the parties have supplemented the record on this issue.

B. The Credentials Policy

*32 Finally, Sternberg seeks summary judgment on the Defendants' claim that they are entitled to attorney's fees under the Credentials Policy. In this regard, Nanticoke's Credentials Policy states:

If, notwithstanding the provision in this section, an individual institutes legal action and does not prevail, her or she will reimburse the hospital and any member of the Medical Staff named in the action for all costs incurred in defending such legal action, including reasonable attorney's fees.¹³⁹

Sternberg contends that the Defendants are not entitled to attorney's fees under the Credentials Policy because the By-laws represent a contract of adhesion. Consequently, he claims that that provision awarding attorney's fees is unconscionable and void as a matter of law. Sternberg further argues that he is excused from performance under the contract of adhesion as a result of the Defendants' material breach related to the improper issuance and continuation of his suspension.

Sternberg is an experienced physician and is not an unsophisticated individual. There is no overreaching or improper leverage shown here for the Court to conclude that the provision is so one-sided as to be unconscionable as a matter of law.¹⁴⁰

The Court thus denies Sternberg's motion for summary judgment regarding attorney's fees under the Credentials

Policy. Since attorney's fees have been awarded pursuant to the HCQIA, however, the Court declines to render an opinion as to the propriety of an award for attorney's fees to the Defendants under the Credentials Policy.

CONCLUSION

For the reasons set forth above, Defendants' motion for summary judgment is **GRANTED** on the basis of HCQIA immunity and, for those Defendants who were individually named, is **GRANTED** as to Delaware's Medical Peer Review Statute. Plaintiff's motion for summary judgment on attorney's fees under the HCQIA and the Credentials Policy is **DENIED**. The Court will establish the amount of attorney's fees owed to the Defendants pursuant to the HCQIA at a later date.

IT IS SO ORDERED.

Footnotes

- 1 For purposes of this decision, the terms "By-laws" and "Credentials Policy" are used interchangeably. The Court thus recognizes that the "Medical Staff By-laws" includes the "Credentials Policy" at issue here.
- 2 Letter from Daniel Werner, CEO, Nanticoke Memorial Hospital, to Richard Sternberg, Physician, Nanticoke Memorial Hospital (July 26, 2006).
- 3 *Id.*
- 4 Letter from Daniel Werner, CEO, Nanticoke Memorial Hospital, to Richard Sternberg, Physician, Nanticoke Memorial Hospital (Oct. 13, 2006).
- 5 Nanticoke Memorial Hospital Staff Credentials Policy §§ 6.C.1, 6.C.2.
- 6 *Celotex Corp. v. Catrett*, 477 U.S. 317 (1986).
- 7 *Urena v. Capano Homes, Inc.*, 901 A.2d 145, 150 (Del.Super.2006).
- 8 *Merrill v. Crothall-American, Inc.*, 606 A.2d 96, 99 (Del.1992).
- 9 *Id.*
- 10 *Pamintuan v. Nanticoke Memorial Hosp.*, 192 F.3d 378, 388 (3d Cir.1999); *Lipson v. Anesthesia Services, P.A.*, 790 A.2d 1261, 1272 (Del.Super.2001) ("Plaintiffs bear the burden of establishing that [defendant] is not entitled to immunity under the statute, and, in this regard, the burden on summary judgment is transferred at the outset of the analysis to the non-moving party."); *See also* 42 U.S.C. § 1112(a)(4) ("A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 1111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.");
- 11 *Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 33 (1st Cir.2002) (citing Jerome A. Hoffman, *Thinking about Presumptions: The Presumption of Agency from Ownership as Study Specimen*, 48 Ala.L.Rev. 885, 896-897 (1997)).
- 12 *Onel v. Tenet Healthsystems*, 2003 WL 22533616, *2 (E.D.La.Oct.31, 2003).
- 13 *See* D.R.E. 801
- 14 *See Johnson v. Christus Spohn*, 2008 WL 375417, at *1 (S.D.Tex. Feb. 8, 2008) (concluding that a timeline that outlined the case for HCQIA immunity was "admissible for the non-hearsay purposes of showing what evidence various peer review committees considered and whether the committee members reasonably believed they were acting to further quality healthcare. These considerations are relevant to whether Defendants are entitled to immunity from damages under both federal and state law....").
- 15 *In re Asbestos Litigation*, 2006 WL 3492370, at *5 (Del.Super.Nov.28, 2006).
- 16 *Id.* (The sham affidavit rule "requires the trial court to find the following elements before striking an affidavit or deposition errata sheet as a sham: (1) prior sworn deposition testimony; (2) given in response to unambiguous questions; (3) yielding clear answers; (4) later contradicted by sworn affidavit statements or sworn errata corrections; (5) without adequate explanation; and (6) submitted to the court in order to defeat an otherwise properly supported motion for summary judgment.").

- 17 *Id.*
18 *Id.*
19 *Id.*, at *4.
20 *Id.*, at *5.
21 *See Singh*, 308 F.3d at 31.
22 *Id.* *See also* 42 U.S.C. § 1101(1).
23 *Singh*, 308 F.3d at 31-32. *See also H.R.Rep. No. 99-903*, at 2, *reprinted* in 1986 U.S.C.C.A.N. 6384, 6385. (The Court notes, as others have, that the language of H.R.Rep. No. 99-903 referred to legislation that was substantially similar to the HCQIA. Consequently, the Court cites to the committee report as have nearly all other courts who have addressed the considerable legislative history of the HCQIA.).
24 *Singh*, 308 F.3d at 31-32.
25 *H.R.Rep. No. 99-903*, at 2, *reprinted* in 1986 U.S.C.C.A.N. 6384.
26 *Bryan v. James E. Holmes Reg 'l Med. Ctr.*, 33 F.3d 1318, 1322 (11th Cir.1994)
27 42 U.S.C. § 11111(a).
28 42 U.S.C. § 11151(9) (emphasis added).
29 42 U.S.C. § 11151(11).
30 42 U.S.C. § 11151(10).
31 Nanticoke Memorial Hospital Staff Credentials Policy § 6.C.2. (c) (“There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.”).
32 Nanticoke Memorial Hospital Staff Credentials Policy § 6.C. 1. (b) (“A precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself.”).
33 Nanticoke Memorial Hospital Staff Credentials Policy § 6.C. 1. (a) (“The President of the Medical Staff, the chairperson of a clinical department, the CEO or the Board Chairperson will each have the authority to suspend or restrict all or any portion of an individuals clinical privileges whenever, in their sole discretion, failure to take such action may result in imminent danger to the health and/or safety of any individual. The individual may be given an opportunity to refrain voluntarily from exercising privileges pending an investigation.”).
34 *See Wahi v. Charleston Area Med. Ctr.*, 563 F.3d 599, 609 (S.D.W.Va.2006).
35 *Id.* (quoting *Poliner v. Texas Health Systems*, 537 F.3d 368, 380-81 (5th Cir.2008)). *See also Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 469-470 (6th Cir.2003) (Failure to comply with hospital bylaws does not defeat immunity since “even assuming [defendant hospital] did violate the bylaws, the notice and procedures complied with the HCQIA’s statutory ‘safe harbor.’.”); *Smith v. Ricks*, 31 F.3d 1478, 1487 (9th Cir.1994) (“Whether or not [defendant hospital] violated state law or professional guidelines is irrelevant because once the immunity provisions of the HCQIA are met, defendants ‘shall not be liable in damages under any law of the United States or of any State based on a professional review action.’.”); *Bakare v. Pinnacle Health Hosps., Inc.*, 469 F.Supp.2d 272, 290 (M.D.Pa.2006)(“The court need not determine whether MEC followed the Bylaws. HCQIA immunity attaches when the reviewing body satisfies the requirements under HCQIA, regardless of its own policies and procedures.”); *Brader v. Allegheny Hosp.* 167 F.3d 832, 842 (3d Cir.1999) (“The HCQIA does not require that a professional review body’s entire course of investigative conduct meet particular standards in order for it to be immune from liability for its ultimate decision.”); *Wieters v. Roper Hosp.*, 2003 WL 550327, at *6 (4th Cir. Feb. 27, 2003) (“Nothing in the HCQIA makes immunity depend on adherence to bylaws ...”); *Reed v. Franklin Parish Hosp. Serv. Dist.*, 2006 WL 3589676, at *6 (W.D.La. Dec. 11, 2006) (“Dr. Reed also contends that the HCQIA does not authorize a health care facility to violate its own bylaws, but he provides no authority for this position. Deviation from the bylaws, if any occurred, is irrelevant to whether Defendants are entitled to immunity, so long as they complied with the procedures set forth in the HCQIA.”); *Christus Spohn*, 2008 WL 375417, at * 13 (“Plaintiffs also at times argue that Defendants violated their own Medical Staff Bylaws. The HCQIA, however, does not explicitly require compliance with such bylaws...”); *Taylor v. Kennestone Hosp., Inc.*, 596 S.E.2d 179, 185 (Ga.Ct.App.2004) (“[T]here is no statutory requirement set forth in the HCQIA that a peer review proceeding must be conducted in accordance with a hospital’s own specific internal bylaws or procedures.”); *Poliner*, 537 F.3d at 378 (“To be clear, the abeyances are temporary restrictions of privileges, and we use that terminology, which comes from the Medical Staff bylaws, in our discussion; but for the purposes of HCQIA immunity from money damages, what matters is that the restriction of privileges falls within the statute’s definition of ‘peer review action,’ and what we consider is whether these ‘peer review actions’ satisfy the HCQIA’s standards, and not whether the ‘abeyances’ satisfy the bylaws.”).
36 790 A.2d at 1274.

- 37 *Id.* at 1265.
- 38 *Id.* at 1274.
- 39 *Id.* at 1273.
- 40 To reiterate, a “professional review body” includes “a health care entity ... or any committee of a health care entity ...” 42 U.S.C. § 11151(11). A health care entity includes “a hospital that is licensed to provide health care services by the State in which it is located.” 42 U.S.C. § 11151(4). A “professional review activity” means an activity of a health care entity which changes or modifies the physicians’ privileges or membership in the entity. 42 U.S.C. § 11151(10)(c). A “professional review action” is an action of a professional review body which is taken or made in the conduct of professional review activity and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. 42 U.S.C. § 11151(9). To be clear, therefore, Nanticoke Hospital is by definition a “health care entity” and the members of the MEC are a “committee of the health care entity” that was acting as a “professional review body” that engaged in a “professional review action” because the precautionary suspension adversely affected Sternberg’s clinical privileges at Nanticoke.
- 41 *Lipson*, 790 A.2d at 1273.
- 42 *Id.* at 1274.
- 43 42 U.S.C. 11151(4)(A)(iii) (emphasis added).
- 44 *Wahi*, 563 F.3d at 609.
- 45 See Nanticoke Memorial Hospital Staff Credentials Policy § 6.C. 1.(b) (“A precautionary suspension or restriction is an interim step in the professional review activity, but it is not a complete professional review action in and of itself.”).
- 46 See Nanticoke Memorial Hospital Staff Credentials Policy § 6.C.2.(c) (“There is no right to a hearing based on the imposition or continuation of a precautionary suspension or restriction.”); see also 42 U.S.C. § 11112(c) (“[N]othing in this section shall be construed as ... (2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice an hearing or other adequate procedures, where the failure to takes such action may result in an imminent danger to the health of any individual.”). Therefore, the HCQIA does not mandate a hearing as suggested by Sternberg in the event of a precautionary suspension. In any event, Sternberg’s argument is rendered moot in light of the fact that his precautionary suspension was to be continued until the hearing on the recommendation of his revocation was held. This hearing was not held because Sternberg and Nanticoke reached a mutual agreement to consider the precautionary suspension as a leave of absence.
- 47 See 42 U.S.C. § 1111(a).
- 48 42 U.S.C. § 11112(a).
- 49 *Singh*, 308 F.3d at 32 (citing *H.R.Rep. No. 99-903* at 10).
- 50 *Singh*, 308 F.3d at 32 (citing *H.R.Rep. No. 99-903* at 12).
- 51 *Frelich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir.2002) (citing *Imperial v. Suburban Hosp. Ass’n, Inc.*, 37 F.3d 1026, 1030 (4th Cir.1994)).
- 52 See, e.g., *Singh*, 308 F.3d at 32; *Imperial*, 37 F.3d at 1030 (“The standard is an objective one which looks to the totality of the circumstances.”); *Smith*, 31 F.3d at 1485 (“[T]he ‘reasonableness’ requirements of § 11112(a) were intended to create an objective standard, rather than a subjective standard.”); *Bryan*, 33 F.3d at 1335 (“The test is an objective one, so bad faith is immaterial. The real issue is the sufficiency of the basis for the [Hospital’s] actions.”).
- 53 42 U.S.C. § 11112(a)(4).
- 54 *Bryan*, 33 F.3d at 1333 (quoting *Austin v. McNamera*, 979 F.2d 728, 734 (9th Cir.1992)).
- 55 *Bryan*, 33 F.3d at 1333.
- 56 42 U.S.C. § 11112(a)(1).
- 57 *Imperial*, 37 F.3d at 1030 (“But more importantly to the issue at hand, even if *Imperial* could show that these doctors reached an incorrect conclusion on a particular issues because of a lack of understanding, that does not meet the burden of contradicting the existence of a *reasonable belief* that they were furthering health care quality in participating in the peer review process.”).
- 58 *Poliner*, 537 F.3d at 378.
- 59 *Pamintuan*, 192 F.3d at 389.
- 60 See *Bryan*, 33 F.3d at 1335 (“[A]ssertions of hostility do not support his position [that the hospital is not entitled to the HCQIA’s protections] because they are irrelevant to the reasonableness standards....”).
- 61 42 U.S.C. § 11112(a)(2).
- 62 *Poliner*, 537 F.3d at 380 (citing *Gabaldoni v. Wash. County Hosp. Ass’n.*, 250 F.3d 255, 261 (4th Cir.2001)).
- 63 *Poliner*, 537 F.3d at 380 (citing *Mathews v. Lancaster General Hosp.*, 87 F.3d 624, 637 (3d Cir.1996)).

- 64 *Poliner*, 537 F.3d at 380.
- 65 *Poliner*, 537 F.3d at 380.
- 66 *Id.*
- 67 *Onel*, 2003 WL 22533616, at *4.
- 68 *Id.* at * 1.
- 69 *Id.*, at *4.
- 70 *Id.*, at * *4-5.
- 71 Because the HCQIA is the focus of the inquiry, Sternberg's suggestion that the MEC violated the By-laws when it continued the precautionary suspension is not relevant to the fact-gathering discussion.
- 72 *See, e.g.*, Letter from Dr. Thomas Benz, Chief of Surgery, Nanticoke Memorial Hospital, to Richard Sternberg, Physician, Nanticoke Memorial Hospital (August 28, 2006).
- 73 Minutes of Medical Executive Committee, Nanticoke Memorial Hospital (October 18, 2006).
- 74 42 U.S.C. § 11112(a)(3).
- 75 42 U.S.C. § 11112(c)(2) (emphasis added).
- 76 *Onel*, 2003 WL 22533616 at *5 (quoting *Fobbs v. Holy Cross Health Sys. Corp.*, 29 F.3d 1439, 1443 (9th Cir.1994)).
- 77 The Court recognizes that even though Werner may not have stated "imminent danger" in his letter issuing the precautionary suspension to Sternberg, he did write that "your behavior has left me no choice but to *protect patients* from your disruptive conduct by removing you from the hospital *immediately*." Werner Letter (Oct. 13, 2006) (emphasis added). Werner's letter implicitly recognizes that Sternberg was an imminent danger to patients.
- 78 *See, e.g.*, *H.R.Rep. No. 99-90* at *2 ("This bill is needed to deal with one important aspect of the medical malpractice problem in this country-incompetent *and* unprofessional physicians."); ("The purpose of this legislation is to improve the quality of medical care by encouraging physicians to identify and discipline other physicians who are incompetent *or* who engage in unprofessional behavior."); ("The bill's focus is on those instances in which physicians injure patients through incompetent *or* unprofessional service, are identified as incompetent *or* unprofessional by their medical colleagues, but are dealt with in a way that allows them to continue to injure patients.");("Unfortunately, groups such as state licensing boards, hospitals and medical societies that should be weeding out incompetent *or* unprofessional doctors often do not do so.") (emphases added).
- 79 *Gordon v. Lewistown Hosp.*, 423 F.3d 184, 203 (3d Cir.2005).
- 80 The Court notes that there is an abundance of HCQIA case of case law invoking immunity for professional review actions based on unprofessional conduct unrelated to medical competence. *See, e.g.*, *Bryan*, 33 F.3d at 1324 (HCQIA immunity for revoking physician's privileges where inappropriate and unprofessional conduct was exhibited stemming from "being a volcanic-tempered perfectionist, a difficult man with whom to work, and a person who regularly viewed it as his obligation to criticize staff members for perceived incompetence or inefficiency."); *Yashon v. Hunt*, 825 F.2d 1016, 1027 (6th Cir.1987) ("a physician's unprofessional conduct, incompatibility and lack of cooperation on a hospital staff are appropriate considerations for denying staff privileges"); *Mahmoodian v. United Hosp. Center, Inc.*, 404 S.E.2d 750, 759 (W .Va.1991) ("A hospital has the right, indeed the duty, to ensure that those persons who are appointed to its medical staff meet certain standards of professional competence *and professional conduct*, so long as there is a reasonable nexus between those standards and the hospital's mission of providing overall quality patient care").
- 81 *Frelich*, 313 F.3d at 219.
- 82 As multiple cases have pointed out, "other courts have gone as far as to conclude a finding that the peer reviewer's actions were taken in a reasonable belief the action furthered quality health care necessitates a finding that a summary suspension was taken to prevent the possibility the physician could harm an individual." *Christus Spohn*, 2008 WL 375417, at * 12 (citing *Peyton v. Johnson City Med.*, 101 S.W.3d 76, 88 (Tenn.Ct.App.2002)). The Court is perplexed as to how Sternberg could imply that disruptive behavior cannot meet the imminent danger standard as a matter of law in light of all the evidence to the contrary, discussed *infra*.
- 83 *See Sugarbaker v. SSM Health Care*, 190 F.3d 905 (8th Cir.1999); *Jenkins v. Methodist Hosps. of Dallas, Inc.*, 2004 WL 3393380 (N.D.Tex. Aug. 14, 2004); *Sraznicky v. Desert Springs Hosp.*, 2009 WL 1905298 (D.Nev. July 1, 2009); *Onel*, 2003 WL 22533616.
- 84 *Sugarbaker*, 190 F.3d at 918.
- 85 *Onel*, 2003 WL 22533616, at *5.
- 86 *Id.*
- 87 *Jenkins*, 2004 WL 339380, at *2.
- 88 *Id.*, at *3.
- 89 *Id.*, at * 19.

- 90 *Straznicky*, 2009 WL 1905298 at *2.
91 *Id.*
92 *Id.*
93 *Id.*, at *11
94 *Id.*, at *9.
95 *Id.*
96 *Christus Spohn*, 2008 WL 375417 at * 12 (citing *Patel v. Midland Mem 'l Hosp. & Med. Ctr.*, 298 F.3d 333, 343-344 (5th Cir.2002) (“[W]hen determining the amount of process constitutionally due [a physician] prior to [a summary suspension] of his privileges, the key question is not whether [the physician] was actually a danger, but whether the [committee implementing the suspension] had reasonable grounds for suspending him as a danger.”)).
97 42 U.S.C. § 11112(c)(2).
98 42 U.S.C. § 11112(a)(3).
99 Nanticoke Memorial Hospital Staff Credentials Policy § 6.C.2. (c) (emphasis added).
100 42 U.S.C. § 11112(c)(2) (emphasis added).
101 42 U.S.C. § 11112(a)(4).
102 *Onel*, 2003 WL 22533616, at *6 (quoting *Rogers v. Columbia/HCA Cent. Louisiana, Inc.*, 971 F. Supp 229, 237 (W.D.La.1997)).
103 *Id.* See also *Sugarbaker*, 190 F.3d at 916; *Brader*, 167 F.3d at 843.
104 See Yann H.H. van Geertruyden, *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. Heath L. & Pol'y 239 (Winter 2001).
105 *Poliner*, 537 F.3d at 381.
106 *Bryan*, 33 F.3d at 1337.
107 42 U.S.C. § 11111(a)(1).
108 See 42 U.S.C. § 11151(4)(A)(i), (11); *Bakare*, 469 F. Supp 2d at 291; *Matthews*, 883 F.Supp at 1025-1026.
109 See *Lipson*, 790 A.2d at 1272 fn. 14 (“In this case, however, immunity provided by the HCQIA would blunt all of plaintiffs' claims. The relief sought is limited to money damages; plaintiffs do not seek reinstatement or other equitable relief in their pleadings.”).
110 See *Quinn v. Kent General Hosp., Inc.*, 617 F.Supp. 1226, 1234 (D.Del.1985).
111 24 Del. C. § 1768(a).
112 *Id.* See also *Dworkin v. St. Francis Hosp.*, 517 A.2d 302, 303 (Del.Super.1986).
113 See 24 Del. C. § 1768(a).
114 *Id.*
115 The Court recognizes that Sternberg endeavors to establish a fact question for the first time here by observing that a number of the individual Defendants testified that they did not review hospital policy on visitors in the operating room. That some of the Defendants did not formally review these guidelines in connection with Sternberg's suspension is immaterial. The simple fact of the matter is that Sternberg brought the reporter into the operating room under what can reasonable be inferred as false pretenses. The Court is satisfied that an examination of hospital policy in this regard was therefore not necessary.
116 *Lipson*, 790 A.2d at 1265.
117 *Id.* at 1275.
118 *Id.*
119 *Id.* at 1276.
120 *Id.* (citing *Danklef v. Wilmington Med. Ctr.*, 429 A.2d 509, 513 (Del.Super.1981)).
121 *Lipson*, 790 A.2d at 1276.
122 *Id.* at 1277.
123 *Id.*
124 *Id.* at 1276.
125 24 Del C. § 1768(a).
126 24 Del. C. § 1768(a).
127 *Id.*
128 Nanticoke Memorial Hospital Staff Credentials Policy § 6.C.1.

- 129 Nanticoke Memorial Hospital Staff Credentials Policy § 2.C.2. (a).
130 See, e.g., *Deming v. Jackson-Madison County Gen. Hosp.*, 553 F.Supp.2d 914, 936 (W.D.Tenn.2008).
131 42 U.S.C. § 11113.
132 *Matthews*, 87 F.3d at 637.
133 *Johnson v. Nyack Hosp.*, 964 F.2d 116, 123 (2d Cir.1992).
134 See, e.g., *Matthews*, 87 F.3d at 642.
135 *Id.*
136 See *Sugarbaker*, 190 F.3d 905; *Jenkins*, 2004 WL 3393380; *Straznicki*, 2009 WL 1905298; *Onel*, 2003 WL 22533616. The Court appreciates that Sternberg was first made aware of *Straznicki* at oral argument. Nevertheless, the point remains the same.
137 *Gordon v. Lewistown Hosp.*, 2006 WL 2816493, at *4 (M.D.Pa. Sept. 28, 2006).
138 See *id.*
139 Nanticoke Memorial Hospital Staff Credentials Policy § 2.C.2(e).
140 See *Tretheway v. Basement Waterproofing Nationwide, Inc.*, 1994 WL 680072, at *3 (Del.Super.Oct.19, 1994) (The Superior Court found unconscionability as a matter of law when, “at the time the contract was made, the questionable provision amounted to one party taking unfair advantage of another.”).

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