

**FILED**

FEB 14 2011

COURT OF APPEALS  
DIVISION III  
STATE OF WASHINGTON  
By \_\_\_\_\_

NO. 294153

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DIVISION III  
OF THE STATE OF WASHINGTON

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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., an individual, and CARL OLDEN, M.D. and JANE DOE  
OLDEN, a marital community, Respondents.

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BRIEF OF APPELLANTS

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Attorneys for Appellants

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## I. INTRODUCTION

Appellant Diana Smigaj, M.D. is a highly competent Ob/Gyn physician who has practiced obstetrics in Yakima, Washington since 1995. In 2000 she opened Appellant Cascade Women's Healthcare Associates ("Cascade") which by 2008 employed 35 persons and accounted for approximately 30 per cent of all babies delivered in Yakima. Respondents are Yakima Valley Memorial Hospital ("Memorial"), its CEO, Richard Linneweh, and two hospital officials, Dr. Carl Olden and Dr. Roger Rowles whom Memorial pays to control its peer review process and advance other hospital interests.

During the summer of 2008, Respondents manipulated a peer review committee known as the Perinatal Quality Assurance Committee ("PQAC") and the President of the Medical Staff to engineer a summary suspension of all of Dr. Smigaj's medical staff privileges. They manipulated the process by concealing crucial facts and providing false information about Dr. Smigaj's competence to the PQAC and the President of the Medical Staff. When the PQAC made decisions or passed motions that did not comport with the Respondents' intent to remove Dr. Smigaj's privileges, they bypassed due process provisions in the hospital's bylaws and corrective action policies and took the matter into their own hands. After an independent expert they retained to review two of Dr. Smigaj's cases told them she did not render substandard care to either patient, they misrepresented what he said and persuaded the PQAC to recommend suspension

of her privileges. Afterward, they shredded documents, destroyed electronic information and altered meeting minutes in an effort to cover their tracks.

The PQAC and the President of the Medical Staff failed to detect the misrepresentations and manipulations before Respondents prompted them to suspend Dr. Smigaj's privileges on September 4, 2008 and failed to acquire the hospital's expert's written reports which did not fault Dr. Smigaj. When the Medical Executive Committee reviewed the experts' written reports, it immediately and unanimously reversed the summary suspension on September 16, 2008. By then, Memorial had already spread the news of Dr. Smigaj's summary suspension to all hospital employees and others in the medical community. Even after the suspension was lifted, Respondent Linneweh continued to cast doubt on her competence by misinforming third party payors about the suspension Respondents had orchestrated. Thus, Dr. Smigaj filed this action in November 2008 to establish that the summary suspension of her privileges was unwarranted and to recover damages to her reputation and practice.

## II. ASSIGNMENTS OF ERROR

1. The Superior Court erred by entering judgment for respondents, applying RCW 7.71.030, dismissing the lawsuit, and awarding respondents attorneys fees and costs.
2. The Superior Court erred by holding that Dr. Padilla's summary suspension of Dr. Smigaj's privileges was "related to Dr. Smigaj's competence" and also "not related to her professional competence." The court erred by applying both RCW 7.71.020 and RCW 7.71.030, which are mutually exclusive.

3. The Superior Court erred by entering Finding of Fact no. 1. CP 3986.
4. The Superior Court erred by entering judgment after holding that no reasonable juror could conclude that any of the immunity elements enunciated in RCW 7.71.020/ 42 U.S.C. § 11112(a)(1, (2), (3), (4), and/or 11112(c) was not met.
5. The Superior Court erred by dismissing appellants' defamation claim.
6. The Superior Court committed errors of law in Conclusions of Law 1, 2, 5, and 6, and awarding attorneys fees and costs under 42 U.S.C. § 11113.

*Issues Pertaining To Assignments of Error*

1. In 1986, Congress enacted the Health Care Quality Improvement Act (HCQIA), which provides limited immunity for professional review actions. A professional review action is one "based on the competence or conduct of a physician." The Washington State Legislature incorporated HCQIA and also created a remedy for actions "not related to competence of professional conduct." Here, Dr. Padilla summarily suspended Dr. Smigaj's privileges based on allegations of "poor clinical judgment" in three cases. Did the Superior Court err by finding that Dr. Padilla's suspension was not related to Dr. Smigaj's competence and awarding fees to respondents? (Assignments of Error 1, 2, 3, 7).
2. To survive summary judgment, a physician seeking damages for a professional review action must introduce evidence that the action did not satisfy one of four HCQIA immunity elements. Appellants' exhaustive expert testimony, deposition admissions, and documentary evidence established an inadequate investigation, an unfair process, and an unwarranted summary suspension not pursued in furtherance of quality health care. Appellants also established that respondents manipulated the PQAC, manufactured evidence, then destroyed and altered documents. Did the superior court err by granting summary judgment and awarding fees to respondents? (Assignments of Error 4, 6, 7).
3. A summary suspension is the most drastic penalty a hospital can levy, and will certainly harm a physician's reputation. Did the superior court err in holding that announcing an unjustified summary suspension to hospital employees and to third party payors is not defamatory and did not harm Dr. Smigaj as a matter of law? Did the

superior court err in refusing to consider other grounds upon which Dr. Smigaj asserted a defamation cause of action? (Assignments 5, 7).

### III. STATEMENT OF THE CASE

Appellant Dr. Diana Smigaj is a board-certified Ob/Gyn physician who is fellowship trained and board-certified in Maternal-Fetal Medicine (“perinatology”). CP 385-386. During her fifteen year medical career, she has enjoyed a pristine malpractice claims history. CP 387. Dr. Smigaj was employed by Providence Yakima Medical Center (“Providence”) from 1995 to 2000. CP 386. Providence recruited Dr. Smigaj to practice obstetrics and develop a birthing center that competed with Respondent Yakima Valley Memorial Hospital’s obstetrical service. CP 456-457. In 2000, Dr. Smigaj incorporated Appellant Cascade Women’s Healthcare Associates (“Cascade”). CP 386. By 2008, Cascade employed 35 persons, including Dr. Smigaj, another Ob/Gyn, two certified nurse midwives and two physician’s assistants. That year, her practice accounted for almost 30% of all deliveries in Yakima. CP 387.

Respondent Richard W. Linneweh, Jr. has been the CEO of Yakima Valley Memorial Hospital (“Memorial”) in Yakima, Washington since the mid-1970’s. CP 406. Mr. Linneweh is not qualified to perform clinical quality assurance functions. CP 457. Throughout his years as CEO, Mr. Linneweh has treated Dr. Smigaj differently than any other physician who has practiced in Yakima. CP 460, 1291, 396. Over the past six or seven years, Memorial lost

between \$12 and \$16 million dollars on three physician practices it owns in which there are physicians with obstetrical privileges. CP 1419-1420.

Respondent Roger Rowles, M.D. is a board-certified Ob/Gyn who has practiced in Yakima since 1979. CP 1690. In 1999, Mr. Linneweh appointed Dr. Rowles chairman of the Perinatal Quality Assurance Committee ("PQAC"). CP 1691. Memorial pays Dr. Rowles to chair the PQAC. CP 1691, 1698. The other five members of the PQAC serve voluntarily without pay. CP 1157, 1207, 1187,1892. The PQAC is a medical quality improvement peer review committee whose purpose is to improve the quality of perinatal, obstetrical and neonatal services at Memorial. CP 512. The PQAC is not authorized to engage in disciplinary action. CP 512, 1543. Dr. Rowles screens obstetrical cases that are referred to Quality Assurance, performs the initial review, and decides which cases will be discussed by the PQAC. CP 1706. He reviews his own cases but has never submitted any to the PQAC for review even though patients in his practice have experienced bad outcomes, including brain damage and even fetal death. CP 1706, 1709, 1695, 1757. A malpractice claim involving one of his patients in 2005 was settled for over three million dollars. CP 1695.

Respondent Carl Olden, M.D. is a Family Physician who Mr. Linneweh appointed to be Memorial's Medical Director of Quality Assurance beginning in 2005. CP 1533. In 2008, Memorial paid Dr. Olden \$300,000 to function as Medical Director and practice Family Medicine part time. CP 1534, 1536. Dr.

Olden also practices obstetrics. CP 1533. Dr. Olden and Dr. Rowles are the only physicians who select cases for review by the PQAC. CP 1537-1538.

Kay Anyan is Memorial's Director of Medical Staff Services. CP 3200. She is Mr. Linneweh's subordinate who provides administrative services to medical staff committees and physicians. CP 3201. She attends the meetings of the PQAC and Medical Executive Committee ("MEC") as Memorial's representative. CP 625, 631, 643, 645, 647, 651, 655, 662, 666, 669.

On May 30, 2008, the PQAC reviewed the case of patient JA who had been transferred to Dr. Smigaj's care by Dr. Mark Meininger in Sunnyside, Washington on February 26, 2008. CP 678, 3264. Dr. Smigaj worked with Dr. Meininger many times before and relied on clinical information she received from him to initially manage the patient. CP 3265. The primary concern was that Dr. Smigaj should have seen the patient within an hour of arrival, even though the Ob/Gyn department did not require it and Memorial only required that patients be seen within 24 hours of admission. CP 1215, 1644. Dr. Smigaj did not examine the patient for over ten hours because she was exhausted from having to cover her own practice for months without any relief; the entire time she has practiced in Yakima, she has been excluded from an Ob/Gyn call group that has included all other Ob/Gyns except anyone who worked for her. CP 451. At 4 a.m. the next morning, the nurses noted a change in the fetal heart rate but failed to notify Dr. Smigaj for over an hour. CP 580, 583. At 5:23 a.m. they called Dr. Smigaj, who

came to the hospital right away and performed a c-section. CP 580, 678. Both mother and baby had good outcomes. CP 3266.

At the end of the meeting on May 30, the PQAC decided to invite Dr. Smigaj to discuss the case at its next meeting. CP 678. Instead of waiting for the next meeting scheduled for August 15, Respondents called for a special meeting of the PQAC on June 20 to discuss the JA case again. CP 625, 972, 1645. Dr. Olden met with Ms. Anyan on June 12, 2008 and the next day Dr. Rowles sent a letter to Dr. Smigaj and invited her to attend. CP 557, 1600. On June 16, 2008, Dr. Olden conducted a conference call in Mr. Linneweh's office with Memorial's attorneys in Seattle to discuss Dr. Smigaj. CP 1365-1366. Beginning June 20, Respondents designated the PQAC as an "Ad Hoc Committee"<sup>1</sup> to investigate Dr. Smigaj's practice without notifying the MEC, the President of the Medical Staff, the chairman of the Ob/Gyn department, or Dr. Smigaj what they were doing. CP 625. No one ever appointed the PQAC as an investigative body. CP 1118, 1645, 1279. Dr. Smigaj met with the PQAC on June 20 and explained her care of patient JA. CP 626-627. The discussion became somewhat contentious. CP 3264. She

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<sup>1</sup> An "Ad Hoc Committee" is a special committee appointed by the Chief of Staff to investigate a particular physician. CP 526-528; CP 659. Memorial's Corrective Action Policy specifies that requests for investigation must be in writing, shall identify the specific issue for which the investigation is requested, and include a reference to the specific conduct or activities which constitute grounds for the request. CP 526. When a request for investigation is received, the Chair of the Medical Executive Committee ("MEC") must notify the physician of the request, the issue it is based on, and the specific conduct or activities constituting the grounds for the request. CP 526. Within ten days, the Chair of the MEC is required to commence an investigation by the MEC or refer the matter to the Department Chair or appoint an Ad Hoc Investigative Committee to review the matter. CP 526-527. Dr. Smigaj never received any of these procedural protections.

did not deny she should have seen the patient earlier, but objected to being criticized for not seeing the patient within an hour, which no Ob/Gyn had been asked to do before. CP 3264.<sup>2</sup> After she left the meeting the PQAC discussed various disciplinary options, including reduction or removal of her privileges. CP 627. Dr. Smigaj was never informed that the committee continued the June 20 meeting to discuss taking disciplinary action against her privileges. CP 3266.

The *Ad Hoc* PQAC met again on July 9, 2008. CP 628. Dr. Smigaj was not notified of the meeting or asked to attend it, nor was she notified that disciplinary action was being considered. CP 1781, 3266. Ms. Anyan furnished the PQAC with two “Timelines” that listed information in Dr. Smigaj’s file from 1995 to 2007 but omitted certain favorable information regarding her work. CP 634-641. Dr. Rowles and Dr. Olden presented four examples they claimed highlighted poor practice patterns; the first concerned “extended proctoring” in 1995, 1997-98 but they did not inform the PQAC that the proctoring had been imposed by Mr. Linneweh in an effort to disparage her competence CP 457-462 or that none of the physicians who proctored her had any criticism of her management of patients CP 461-62, 1036, 1040-42; the second was a case in December 2004 which Dr. Olden and Dr. Rowles used to impose eight conditions she complied with CP 388-389, 548; the third was a case in 2007 involving a

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<sup>2</sup> A subsequent study showed that other Ob/Gyns at Memorial did not see transfer patients for hours after admission. CP 642.

hemorrhage following a c-section that she managed well but they totally misrepresented to the committee CP 631, 552, 1556, 1512-13; and the fourth was “several disruptive physician reports” they never showed or explained to the PQAC, but which were used as basis to suspend her privileges on September 4, 2008. CP 631, 656, 576. Ms. Anyan said that an outside review of the JA case should be obtained if the committee was considering recommending reduction of Dr. Smigaj’s privileges. CP 629. She also pointed out that if Dr. Smigaj lost her privileges, her two midwives would lose their privileges so Dr. Smigaj’s caseload would then be delivered through the rest of the Ob/Gyn or Family Practice community. *Id.* After that, the committee discussed five disciplinary options including “Reduction of privileges to midwifery level” and “Removal of privileges.” *Id.* Ms. Anyan explained the steps necessary to recommend reduction of Dr. Smigaj’s privileges. *Id.* Legal counsel would be contacted about “process and appropriate steps” and the records of the JA case would be forwarded to an outside reviewer “to ensure an impartial review.” *Id.*

Memorial hired Dr. Mark Tomlinson, an Ob/Gyn perinatologist in Portland to perform an independent review JA’s records in late July 2008. CP 1844. Dr. Tomlinson spoke with the PQAC by phone on July 30 and agreed that Dr. Smigaj should have evaluated the patient earlier, but he disagreed with most of their other concerns. CP 586-588; 645-646. He also criticized the nurses for failing to notify Dr. Smigaj about a non-reassuring fetal heart rate tracing. CP

588; 645-646. On August 4, 2008, Ms. Anyan reported to administration that “the committee does not feel they can defend removal of privileges because of this one case.” CP 667. Three days later, Ms. Anyan sent the records of another one of Dr. Smigaj’s patients (“WC”) to Dr. Tomlinson for his review. CP 1018. Dr. Tomlinson had only minor criticism when he discussed the case with Dr. Rowles, Dr. Olden and Ms. Anyan in a conference call on August 13. CP 599-600, 1793. Two days later, Dr. Rowles presented the WC case to the PQAC and completely misrepresented what Dr. Tomlinson said about Dr. Smigaj’s performance, falsely claiming that Dr. Tomlinson said that Dr. Smigaj provided substandard care to WC. CP 649, 1797.<sup>3</sup> He also presented a third case (patient LH) on August 15 and criticized three aspects of Dr. Smigaj’s care of the patient. On August 29, Dr. Smigaj met with the PQAC for only the second time in 2008, explained her care of WC and LH and provided a copies of an independent evaluation of both cases by Dr. Mize Conner, a well-respected Ob/Gyn in Bellevue, Washington who found nothing wrong with her care of either patient. CP 594-597. After Dr. Smigaj left the meeting, Dr. Rowles added two more criticisms of the LH case he never told her about, but which were used as a basis to suspend her privileges on September 4, 2008. CP 653, 1737, 3109, 3266. On September 2, Ms. Anyan sent

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<sup>3</sup> Dr. Rowles later admitted that Dr. Tomlinson’s written report of the case, which Dr. Tomlinson testified was consistent with what he discussed with Rowles, Olden and Anyan on August 13, did not support any of the criticisms of the WC case that Dr. Rowles presented to the PQAC on August 15. CP 1797.

LH's records to Dr. Tomlinson for his review; on September 3, he told her he had no criticism of Dr. Smigaj's work in the case. CP 1135, 601. That evening, the PQAC held its final meeting to discuss Dr. Smigaj. CP 655. Mr. Linneweh attended 'to ensure adherence to the bylaws.' CP 1817. Ms. Anyan reported that Dr. Tomlinson said "substandard care" was provided to patient LH but she did not clarify the fact that Dr. Tomlinson was critical of the nurses, not Dr. Smigaj. CP 655. Respondents then persuaded the PQAC to recommend that the MEC suspend Dr. Smigaj's privileges immediately based on her performance of the JA, WC and LH cases and unspecified "disruptive practitioner reports." CP 656. Respondents did not wait for the MEC to consider the matter at its next meeting; instead, early on September 4, Ms. Anyan contacted Dr. Padilla, President of the Medical Staff and presented him with a letter to sign drafted by Memorial's attorneys, immediately suspending all of Dr. Smigaj's clinical privileges. CP 576-577 Dr. Padilla did not perform any investigation of his own but relied on what Dr. Rowles told him about Dr. Smigaj's alleged deficiencies. CP 1669, 1831. Dr. Padilla summarily suspended Dr. Smigaj's privileges on September 4, 2008 based on three cases since 1999, the three patients she cared for in 2008 and unspecified reports of disruptive conduct. CP 576. The summary suspension interfered with Dr. Smigaj's practice and seriously harmed her professional reputation. CP 1653, 1232, 1294, 1481.

Memorial did not investigate Dr. Smigaj any further between September 4 and September 16, 2008. CP 1258, 1659. The MEC reviewed the matter on September 16 and voted unanimously to immediately reinstate all of her privileges. CP 664. Meanwhile, Group Health requested information regarding Dr. Smigaj's privileges. CP 3079. On September 24, 2008 Dr. Smigaj's attorney warned Memorial that informing Group Health of the summary suspension would be inappropriate. CP 3093. On September 25, 2008, Mr. Linneweh informed Group Health of the summary suspension and said that Memorial was continuing to investigate Dr. Smigaj. CP 3090.

Appellants' fifty-page complaint seeks damages, declaratory, and injunctive relief. CP 13-63. Respondents moved to dismiss, citing RCW 7.71.030, which provides an exclusive remedy for professional review actions "not related to a physician's competence." CP 4098-4110. Respondents argued that Dr. Padilla's summary suspension was "not related to Dr. Smigaj's competence" because the Complaint alleged misconduct by respondents. CP 192. The court denied respondents' motion and their motion for reconsideration: "the court must focus on the action taken by the professional review body, not Dr. Smigaj's allegations." CP 193.

Thorough discovery followed the court's ruling that "the provisions of RCW 7.71.030 do not apply to this case." CP 193, 1086-1865. Respondents renewed their RCW 7.71.030 argument in a Motion for 12(c) Judgment. CP 219-

227. While that motion was pending, appellants moved for Judgment as a Matter of Law for spoliation and on respondents' assertion of HCQIA immunity; respondents moved for summary judgment asserting immunity under HCQIA. CP 2956-3044, 4262-4321. The Superior Court reversed its earlier rulings and dismissed appellant's complaint under CR 12(c). CP 3611, 3608. It also granted respondents summary judgment under HCQIA. CP 3611, 3605-08. It then awarded respondents attorney fees under RCW 7.71.030 and under HCQIA, entering a \$534,415 judgment against appellants. CP 3985-3995. Appellants timely appealed. CP 3891-3905, 3996-4015, 4023-4046.

#### IV. ARGUMENT

A. Because Dr. Padilla's September 4th Letter Identified Dr. Smigaj's Competence And Professional Conduct As The Reason For The Summary Suspension, RCW 7.71.030 Does Not Apply To This Case.

As this case demonstrates, courts have struggled to interpret the Washington Health Care Peer Review Act, codified at RCW Chapter 7.71, especially the interplay between RCW 7.71.020 and 7.71.030.<sup>4</sup> In two early rulings, Judge Cooper held that "the provisions of RCW 7.71.030 do not apply" and that RCW 7.71.030 does "not apply to preclude the lawsuit." CP 193, 208. But he completely changed course in his final ruling: "RCW 7.71.030 precludes the statutory and common law claims otherwise alleged in Dr. Smigaj's complaint." CP 3968. Review of the superior court's CR 12(c) judgment requires

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<sup>4</sup> See, e.g. *Plaskon v. Public Hosp. Dist. No. 1 of King County*, 2007 WL 4165271 (W.D. Wash. Nov. 16, 2007) ("it is unclear whether [RCW 7.71.030] applies").

this court to examine the pleadings and determine whether any set of facts consistent with the complaint would entitle plaintiffs to relief.<sup>5</sup> Neither the Complaint nor the Answer mentions RCW 7.71.030. CP 13-63, 64-82.

To interpret RCW 7.71, one must first be familiar with the Health Care Quality Improvement Act (HCQIA). Congress enacted HCQIA in 1986 to “encourage good faith professional review activities,” protect “consumers from abuses by bad doctors without insulating improper anticompetitive behavior from redress,” and ensure that “physicians receive fair and unbiased review to protect their reputations and medical practices.”<sup>6</sup> Congress allowed states to adopt HCQIA “for actions commenced before October 14, 1989, if the State by legislation elects such treatment.” 42 U.S.C. § 11111(c)(2). Washington’s legislature accepted Congress’s invitation in 1987 by enacting the Washington Health Care Peer Review Act, codified at RCW Chapter 7.71.

RCW 7.71.010, a Legislative Finding, recognizes the benefits of peer review, and states an intention to “permit only those actions in 7.71.020 and 7.71.030.” (emphasis supplied) RCW 7.71.020 incorporated HCQIA (codified at 42 U.S.C. §§ 11101-11151): “Pursuant to P.L. 99-660 Section 411(c)(2), Title IV of that act shall apply in Washington state as of the effective date of this section.” By its terms, RCW 7.71.020/HCQIA applies only to “a professional review

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<sup>5</sup> *Cary v. Mason County*, 132 Wn.App. 495, 499, 132 P.3d 157 (2006).

<sup>6</sup> H.R. Rep. No. 99-963, 1986 U.S.C.C.A.N. 6384, 6384-85 & 6394.

action.” 42 U.S.C. § 11111(a). “The term ‘professional review action’ means 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 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...of the physician.”<sup>7</sup> Under the plain language of the statute, RCW 7.71.010 applies to actions taken in response to both the competence and professional conduct of the physician.<sup>8</sup>

In RCW 7.71.030, the Washington legislature created a new cause of action for certain peer review decisions based on factors other than competence or conduct: “This section shall provide the exclusive remedy for any action taken by a professional peer review body of health care providers as defined in RCW 7.71.020, that is found to be based on matters not related to the competence or professional conduct of a health care provider.”<sup>9</sup> RCW 7.71.020/HCQIA defines matters “not related to competence or professional conduct” as those issues that concern a physician’s professional association, fees, advertising, or other matters not related to professional conduct or clinical competence:

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<sup>7</sup> 42 U.S.C. §11151 (9).

<sup>8</sup> *Morgan v. Peacehealth, Inc.*, 101 Wn.App. 750, 768, 14 P.3d 773 (2000).

<sup>9</sup> RCW 7.71.030. *See also* RCW 7.71.010 (Legislative Finding) (stating the legislature “also recognizes that some peer review decisions may be based on factors other than competence or professional conduct.”).

In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on—

- (A) the physician’s association, or lack of association, with a professional society or association,
- (B) the physician’s fees or the physician’s advertising or engaging in other competitive acts intended to solicit or retain business,
- (C) the physician’s participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,
- (D) a physician’s association with supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class health care practitioner or professional, or
- (E) any other matter that does not relate to the competence or professional conduct of a physician. 42 U.S.C. § 11151 (9).

RCW 7.71.020/HCQIA and RCW 7.71.030 are mutually exclusive because a professional review action cannot be “based on the competence or conduct of an individual physician,” and simultaneously “primarily based on matters not related to the competence or professional conduct of a health care provider.”

Most professional review actions are “based on competence or professional conduct.”<sup>10</sup> *Morgan v. Peacehealth, Inc.* involved a physician’s refusal to obtain an evaluation and counseling even though he was warned that the failure to do would result in a suspension of privileges. The court held the professional review action was “related to Morgan’s professional conduct.” Thus,

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<sup>10</sup> *Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 172 (4th Cir. 2009) (action as a result of sexual abuse of adopted daughter is based on physician’s competence or professional conduct); *Brader v. Allegheny General Hospital*, 167 F.3d 832, 839 fn. 3 (3d Cir. 1999) (action taken to address disruptive behavior is based on competence or professional conduct); *Gordon v. Lewiston Hospital*, 423 F.3d 184, 203 (3d Cir. 2005) (action taken against physician for telephoning patients to disparage another physician is based on professional conduct).

the court applied RCW 7.71.020/HCQIA, and refused to consider a claim under RCW 7.71.030.<sup>11</sup> In *Plaskon v. Public Hospital District No. 1 of King County*, the defendant argued that RCW 7.71.030 was the plaintiff's exclusive remedy; the court disagreed because the privileging "decisions appear to have been based on plaintiff's competence."<sup>12</sup> Because RCW 7.71.030 did not apply, the court then evaluated the immunity enunciated in RCW 7.71.020/HCQIA. *Id.*

The physician in *Cowell v. Good Samaritan Community Health Care* appealed a summary judgment dismissing her claim for damages and an attorney fee award.<sup>13</sup> The appellate court analyzed dismissal of the damages claim under RCW 7.71.020/HCQIA, concluding that Dr. Cowell failed to introduce evidence that the peer review action did not satisfy any of the four HCQIA immunity elements.<sup>14</sup> Because Dr. Cowell also pleaded a cause of action for injunctive relief under RCW 7.71.030(1) and did not prevail, the superior court awarded the defendants attorney fees under RCW 7.71.030(3). Dr. Cowell did not appeal the dismissal of her RCW 7.71.030 cause of action for injunctive relief, but did appeal the attorney fee award. The Cowell decision does not address the interplay between RCW 7.71.020/HCQIA and RCW 7.71.030. It affirmed summary

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<sup>11</sup> 101 Wn. App 750, 766-774 (applying HCQIA) and 776 (refusing to apply RCW 7.71.030).

<sup>12</sup> 2007 WL 4165271 \*3 (W.D. Wash. 2007).

<sup>13</sup> 153 Wn.App. 911, 918, 225 P.3d 294 (2009), *rev. denied*, 169 Wn.2d 1002 (2010), *cert. denied*, 131 S. Ct. 666 (2010).

<sup>14</sup> *Cowell*, 153 Wn.App. at 926.

judgment under RCW 7.71.020/HCQIA, and the attorney fee award was justified because Dr. Cowell invoked RCW 7.71.030 but did not prevail.

*Perry v. Rado* also involved a physician who invoked RCW 7.71.030.<sup>15</sup> Dr. Perry conceded “the action was based on matters not related to the competence or professional conduct of a health care provider.”<sup>16</sup> Because RCW 7.71.030 provides an exclusive remedy for “any action . . . that is found to be based on matters not related to the competence or professional conduct of a health care provider,” the appellate court affirmed dismissal of Dr. Perry’s claims for denial of due process, breach of fiduciary duty, and declaratory relief under CR 12(b)(6).<sup>17</sup> Dr. Perry’s claim for relief under RCW 7.71.030 was dismissed on summary judgment: “as to the peer review claims, the court found KMC was immune from liability under HCQIA.”<sup>18</sup> Still, if the action taken against Dr. Perry was “not related to competence or conduct,” the *Perry v. Rado* opinion does not explain why RCW 7.71.020/HCQIA would apply. RCW 7.71.020/HCQIA applies only when the action is based on the physician’s competence or conduct. Put differently, accepting Dr. Perry’s concession that the matter was not related to his

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<sup>15</sup> 155 Wn.App. 626, 636, 230 P.3d 203 (2010).

<sup>16</sup> *Perry*, 155 Wn.App. at 636. For other authority elucidating when an action is not based on a physician’s competence or conduct, see *Read v. McKennan Hospital*, 610 N.W.2d 782, 786 (S.D. 2000) (hospital’s action in not renewing doctor’s radiology privileges was based upon its erroneous interpretation of a contract, not upon doctor’s professional competence or conduct); *Fullerton v. Florida Medical Association, Inc.*, 938 So.2d 587, 594 (Fla.App. 1 Dist., 2006) (doctor’s testimony in medical malpractice proceeding is not “professional conduct” for purposes of HCQIA); and CP 4060 (contrasting actions related and not related to conduct or competence).

<sup>17</sup> *Perry*, 155 Wn.App. at 636.

<sup>18</sup> *Perry*, 155 Wn.App. at 635.

competence rendered HCQIA inapplicable. In any event, this case is entirely distinguishable from *Perry v. Rado* because Dr. Smigaj never conceded that Dr. Padilla's action was unrelated to her competence or conduct.

In this case, Dr. Padilla's September 4th letter labels the suspension a "professional review action" and attributes the summary suspension to "poor clinical judgment" in three cases, a misleading dictation in a patient chart, and three "disruptive practitioner's reports."<sup>19</sup> Interpreted objectively, the "action" was based on Dr. Smigaj's competence or conduct.<sup>20</sup> Hence, RCW 7.71.030 does not apply and the superior court erred by granting judgment under CR 12(c) and entering Finding of Fact no. 1. CP 3986.

B. A Reasonable Juror Could Conclude That No HCQIA Immunity Factor Was Satisfied Because Defendants Initiated Their Effort With A Preordained Conclusion, Gave The PQAC False Evidence, Ignored And Manipulated Bylaws And Policies, Misled Dr. Padilla, And Then Altered And Destroyed Documents And Electronic Information.

In HCQIA, Congress enunciated four requirements for immunity:

For purposes of the protection set forth in section 11111(a) of this title, 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,

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<sup>19</sup> CP 11. Action taken against a "disruptive physician" is based on competence or conduct. *See Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1324 (11th Cir. 1994) (physician cited for disruptive and abusive behavior in over fifty incident reports); *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461 (6th Cir. 2003) (twenty-two incident reports detailed physician's disruptive behavior).

<sup>20</sup> RCW 7.71.020/HCQIA standards are generally interpreted objectively. *See, e.g., Morgan*, 101 Wn.App. at 768.

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).<sup>21</sup>

HCQIA created a presumption that a professional review action meets the four elements required for immunity, “unless the presumption is rebutted by a preponderance of the evidence”.<sup>22</sup> “The proper inquiry for the court is whether [Dr. Smigaj] has provided sufficient evidence to permit a jury to find she has overcome, by a preponderance of the evidence, any of the four statutory elements required for immunity.”<sup>23</sup> To satisfy a burden of proof by a preponderance, a party must persuade the jury, considering all of the evidence, that the proposition is “more probably true than not true.”<sup>24</sup> Thus, on summary judgment, the issue is, “[m]ight a reasonable jury, viewing the facts in the best light for [the plaintiff], conclude that [she] has shown, by a preponderance of the evidence, that the defendants’ actions are outside the scope of § 11112(a)?”<sup>25</sup> “While immunity may be determined at the summary judgment stage, it also may be left for trial...”<sup>26</sup>

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<sup>21</sup> 42 U.S.C. § 11112 (a).

<sup>22</sup> 42 U.S.C. § 11112(a).

<sup>23</sup> *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324, 1334 n. 9 (10<sup>th</sup> Cir. 1996).

<sup>24</sup> WPI 21.01; *Dependency of H.W.*, 92 Wn.App. 420, 425, 961 P.2d 963 (1998); *In re Sego*, 82 Wn.2d 736, 739 n. 2, 513 P.2d 831, 833 n. 2 (1973).

<sup>25</sup> *Islami v. Covenant Medical Center, Inc.*, 822 F.Supp. 1361, 1376 (N.D. Iowa 1992).

<sup>26</sup> *Id.* See also *Stratienko v. Chattanooga-Hamilton County Hospital Authority, et al.*, 2008 WL 4191275 \*11 (E.D. Tenn. Sept. 8, 2008) (denying summary judgment to defendants), and *Peper v. St. Mary’s Hospital and Medical Center*, 207 P.3d 881, 889 (Colo.App. 2008) (reversing summary judgment granted to hospital), *cert. denied*, 2009 WL 1383832 (2009).

Review of the superior court's order granting summary judgment is reviewed de novo.<sup>27</sup> If an issue of material fact exists as to any of the four immunity factors, summary judgment is inappropriate.<sup>28</sup>

Respondents Misrepresented, Manufactured, and Suppressed Evidence. A cornerstone of fair process requires the decision-maker to rely on reliable evidence.<sup>29</sup> At the PQAC meeting on July 9, Ms. Anyan explained that the JA case would be forwarded to an outside reviewer "in order to ensure an impartial review." CP 633. On July 22, Dr. Tomlinson, a perinatologist in Portland, Oregon, reviewed patient JA's records and spoke to the PQAC on July 30 for 15 minutes. CP 645, 614, 1844. They criticized ten aspects of Dr. Smigaj's care, but Dr. Tomlinson agreed with only one of them; he said that if Dr. Smigaj had seen the patient earlier a number of the issues raised by the committee would not have existed. CP 645. He disagreed with their other criticisms and further criticized Memorial because the nurses failed to contact Dr. Smigaj in a timely fashion about poor fetal monitor readings. CP 646.

After this discussion the PQAC backed away from considering removal of Dr. Smigaj's privileges; on August 4, Ms. Anyan reported to Memorial

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<sup>27</sup> *Estate of Haselwood v. Bremerton Ice Arena, Inc.*, 166 Wn.2d 489,497, 210 P.3d 308 (2009).

<sup>28</sup> *Ryskin v. Banner Health, Inc.*, 2010 WL 4642871 \*8 (D. Colo. Nov. 9, 2010).

<sup>29</sup> See, e.g. *Bridges v. Wixon*, 326 U.S. 135, 157,65 S.Ct. 1443, 89 L. Ed. 2103 (1945) (where evidence is improperly received, but for the evidence a crucial finding is speculative, deportation hearing is unfair); *Miller v. Pate*, 386 U.S. 1, 7, 87 S.Ct. 785, 17 L.Ed 2d 690 (1967) (state criminal conviction obtained by using false evidence violates 14<sup>th</sup> Amendment).

administration that after hearing Dr. Tomlinson's review of the JA case, 'the committee did not feel they could defend removal of her privileges because of this one case.' CP 667. But respondents continued their initiative. Ms. Anyan said "...we are developing a historical perspective of her cases that have been reviewed...[and]...there will be another meeting on August 11 and a more formal decision will be made." CP 667. After Dr. Tomlinson discussed the JA case with the PQAC on July 30, Respondents made sure he never communicated directly with the PQAC again about his opinions regarding the next two cases he reviewed for them in August and early September 2008. CP 3202, 1863. Instead, only Dr. Rowles, Dr. Olden and Ms. Anyan spoke with Dr. Tomlinson about the WC case during a conference call on August 13, 2008 and only Ms. Anyan spoke with Dr. Tomlinson about the LH case briefly by telephone on September 3. CP 1129, 1858. After he told them he did not think Dr. Smigaj rendered substandard care to either patient, Dr. Rowles then lied to the PQAC about what Dr. Tomlinson said about the WC case at the next meeting of the PQAC on August 15 and Respondents totally misled the PQAC at the final meeting on September 3 when they reported that "in a conversation with Ms. Anyan, Dr. Tomlinson shared that substandard care was provided to the patient [LH]." CP 655. Dr. Rowles criticized seven aspects of Dr. Smigaj's care of patient WC when he presented the case to the PQAC on August 15. CP 648-649. He claimed Dr. Tomlinson agreed with his criticism that the patient should have been admitted to the hospital for

high blood pressure; that she should have considered tocolytics; that she should have consulted neonatology; that she should not have left the hospital before the patient was transferred, when in fact Dr. Tomlinson did not say any of these things. CP 598-600. Dr. Tomlinson testified that his written report of the WC and LH cases was entirely consistent with the comments he made about the WC case on August 13 and the LH case on September 3. CP 1841, 1855, 1858, 1863. Dr. Rowles later admitted that neither Dr. Tomlinson's nor Dr. Conner's written reports supported any of the charges he made against Dr. Smigaj's care of WC at the PQAC meeting on August 15. CP 1797, 404-406, 407. Dr. Tomlinson had a phone call with Ms. Anyan about the LH case on September 3 that was "not lengthy" and Ms. Anyan reported his opinion to the PQAC at the September 3 meeting. CP 1858, 1863, 1132. Ms. Anyan now admits that when she spoke with Dr. Tomlinson about the LH case on September 3, he never said that Dr. Smigaj fell below the standard of care. CP 1135. Dr. Tomlinson criticized the nurses, not Dr. Smigaj, for missing the breech fetal presentation before inducing labor with Cytotec and said nothing about an "unripe cervix" or using a Piper forceps which Dr. Rowles used as reasons to justify suspension of Dr. Smigaj's privileges. CP 655-56. Dr. Rowles' and Ms. Anyan's false and misleading oral hearsay accounts of what Dr. Tomlinson purportedly said led the PQAC to believe that Dr. Smigaj rendered substandard care to WC and LH. CP 656. Incredibly, these three cases, plus unspecified "disruptive practitioner reports" became the basis for the

summary suspension of all of Dr. Smigaj's clinical privileges on September 4, 2008. CP 576.

During the final PQAC meeting on September 3, Dr. Rowles also repeated his criticism of Dr. Smigaj's management of a case in early 2007 involving a patient who experienced a large blood loss after a c-section. CP 655. The case was reviewed in 2007 after Dr. Olden claimed that "the trauma surgeon" had complained about Dr. Smigaj's performance and Dr. Olden had "interviewed the nursing staff and other surgeons involved in the case." CP 3106, 550, 552, 554. Yet Dr. Nadig, the trauma surgeon, testified that he never referred the case for review, Dr. Olden never interviewed him and that Dr. Smigaj's skills were consistent with the standard of care. CP 1512-13, 1510. Dr. Rowles criticized Dr. Smigaj's work despite the fact that authoritative textbooks supported her management of the bleeding in the case. CP 1800-1801. Memorial never submitted the case to an outside reviewer to obtain an impartial review, but Dr. Smigaj did. CP 442-444. He found her management of the case to be reasonable in all respects. CP 444. Notwithstanding, Dr. Rowles brought it up again during the final PQAC meeting on September 3, and convinced other members of the PQAC that Dr. Smigaj had somehow mismanaged the case. CP 1171; 1211-12. If the PQAC had waited to read Dr. Tomlinson's written reports, they would have realized that Dr. Rowles's and Ms. Anyan's reports about his opinions were materially different than what they were told. CP 407, 1189-1190, 2647. One

PQAC member admitted it was “concerning” that Ms. Anyan’s report of Dr. Tomlinson’s evaluation of the LH case could not be reconciled with his written report. CP 1259.

The Respondents suppressed crucial evidence and misled the PQAC when they asserted that Dr. Smigaj had been required to undergo an “extended proctoring period” in 1995. CP 655. The evidence revealed that in 1995 a Conjoined Perinatal Committee reviewed three patient charts and concluded that Dr. Smigaj’s care was “not open to criticism” and that “no further follow up or discussion” was required. CP 779, 783, 459. Respondent Linneweh ignored the physicians’ conclusion and personally sent the three patient charts to an external reviewer, Dr. Barford in Spokane, who had only minor criticisms. CP 459, 3049-55, 1488, 3526. In 1997, Linneweh personally imposed additional proctoring requirements on Dr. Smigaj that were completely unjustified. CP 461. An internal memo expressed a concern that some individuals were carrying out a “vendetta against Dr. Smigaj.” CP 786. In the summer of 2008, Respondents withheld correspondence that the senior obstetricians subsequently sent to Linneweh; none of the senior OBs had any concerns about Dr. Smigaj’s management of high risk patients during the proctoring periods. CP 461-62, 1497, 2643-44.

Respondents Destroyed and Altered Material Evidence. The duty to preserve documents arises as soon as a party “reasonably anticipates litigation.”<sup>30</sup> The duty to preserve “extends to that period before the litigation when a party reasonably should know that the evidence may be relevant to anticipated litigation.”<sup>31</sup> In this case, Memorial’s duty to avoid spoliation attached on May 14, 2008, the date on which it asserted the work product doctrine to avoid producing documents. CP 3133. The duty to preserve certainly attached by July 17, 2008, when Memorial retained counsel to edit Ad Hoc PQAC meeting minutes related to Dr. Smigaj “for content.”<sup>32</sup>

PQAC members took notes at various meetings during summer 2008. CP 1104. Kay Anyan took handwritten notes at the July 21st, July 30th, and September 3rd PQAC meetings. Ms. Anyan took notes during the August 13th and September 3rd phone calls with Dr. Tomlinson. On September 4th, Ms. Anyan read to Dr. Padilla from her notes. CP 1661, 3204. Ms. Anyan “reported based on my notes of the conversation” at the September 3rd PQAC meeting. CP 1104, 3204. Sometime after September 4th Anyan subsequently destroyed all these documents:

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<sup>30</sup> *Pension Committee of the Univ. of Montreal Pension Plan v. Bank of America Securities, LLC*, 685 F.Supp.2d 456, 465 (S.D.N.Y. 2010).

<sup>31</sup> *Silvestri v. General Motors Corp.*, 271 F.3d 583, 591 (4<sup>th</sup> Cir. 2001)(citing *Kronisch v. United States*, 150 F.3d 112, 126 (2d Cir.1998); see also *Innis Arden Golf Club v. Pitney Bowes, Inc.*, 257 F.R.D. 334, 340 (D.Conn. 2009) (duty to preserve attached when counsel was actively involved).

<sup>32</sup> CP 973. Mr. Linneweh acknowledged that Miller Nash was retained to edit the minutes because it anticipated a “Fair Hearing.” CP 1473.

Q. Now, what happened to your handwritten notes from the July 21st, 2008 Perinatal QA meeting?

A. **Shredded.**

Q. What happened to the notes from the July 30th, 2008 Perinatal QA Committee meeting?

A. **Shredded.**

Q. What happened to your notes from the September 3rd, 2008 Perinatal QA meeting?

A. **Shredded.**

Q. What happened to your notes of your conversation with Dr. Tomlinson?

A. **Shredded.** [CP 1104; *see also* 687 (litigation hold letter)]

Despite his involvement in lawsuits and administrative actions, respondent Linneweh took no steps to prevent spoliation. CP 1473, 1407.

In addition to shredding documents, Memorial spoliated electronic evidence. Ms. Johnston took notes at PQAC meetings on her computer. CP 2231.

Her notes from November 21st attribute specific statements to specific speakers:

Dr. D[avenport]: . . . letters from our reviewer were not very strong.

Dr. O[Iden]: advise from legal counsel plus our expert wouldn't commit to 'substandard care'. Fair hearing not enough substance to back up possible issues. [CP 670]

The computer notes would then be "cleaned up." CP 2231, 1351. The "clean up" of the November 21st notes eliminated twenty-six lines of damaging admissions and other statements by committee members. Cf. CP 670 with CP 658. Beginning in 2007, Ms. Anyan instructed Ms. Johnston to delete her notes after the committee approved the meeting minutes. CP 1333. Although the PQAC did not

review 2008 meeting minutes until November 21st, Ms. Johnston deleted her electronic notes. CP 1333, 1345-46, 669, 658.

In mid-July, with Mr. Linneweh's knowledge, Ms. Johnston began sending the meeting minutes for review by Memorial's attorneys: "I understand that, for the immediate future, that all Perinatal QA Committee minutes (drafts) are to be forwarded to you for content." CP 973, 1472. With input from Ms. Anyan, the hospital's attorneys shaped the story by editing meeting minutes "for content" continuously from July 17th through September 17th; respondent Olden also "reviewed and approved" meeting minutes before a final version was presented (without comment) to the PQAC.<sup>33</sup> Neither the PQAC nor Dr. Padilla knew that the hospital's lawyers, Ms. Anyan, and respondent Olden were altering meeting minutes. CP 1815, 1642, 1815.

Ms. Johnston's "cleaned up" version of the August 29th meeting minutes quotes a question posed: "Is the practitioner's current practice pattern an immediate concern to patient safety?" CP 1081. A day after Dr. Padilla signed the summary suspension letter, Memorial's attorney changed the question to a declaration: "Concerns were raised that the practitioner's current practice pattern may be an immediate concern to patient safety." CP 1081, 1387-88. Memorial's

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<sup>33</sup> Memorial had a substantial relationship with its attorneys, paying them \$333,194 in 2002. CP 3235. Attorney editing is evidenced at CP 973 (7/17/08), 3113 (7/21/08), 3116 (8/4/08), 3116 (8/5/08), 3117 (8/25/08), 1074/3118 (9/5/08), 990-991 (9/10/08), 3102 (9/15/08), and 1394 (9/17/08). Respondent Olden's participation is evidenced at CP 983, 990, and 692.

lawyers inserted language into the September 3rd meeting minutes asserting that Dr. Smigaj's judgment, practice patterns and behavior "may place patients at risk . . ." CP 3110, 1391. The attorneys also inserted immunity language taken directly from HCQIA into the September 16th MEC meeting minutes. CP 661, 1116.

"[W]here relevant evidence which would properly be a part of a case is within the control of a party whose interests it would naturally be to produce it and he fails to do so, without satisfactory explanation, the only inference which the finder of fact may draw is that such evidence would be unfavorable to him."<sup>34</sup> If the spoliation is deemed to have been intentional, courts frequently impose a mandatory inference;<sup>35</sup> even when the spoliation is negligent, a jury is permitted to infer that the destroyed evidence was unfavorable to respondents.<sup>36</sup> A reasonable juror could infer from alterations to meeting minutes that Dr. Smigaj did not receive a fair process because PQAC members testified they could only

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<sup>34</sup> *Pier 67, Inc. v. King County*, 89 Wn.2d 379, 385-86, 573 P.2d 2 (Wash. 1977). See also, *Magana v. Hundai Motor America*, 167 Wn.2d 570, 594, 220 P.3d 191 (2009); *Smith v. Behr Process Corp.*, 113 Wn.App. 306, 325, 54 P.3d 665 (2002); *Henderson v. Tyrrell*, 80 Wn.App. 592, 605, 910 P.2d 522 (1996) ("[T]he common remedy [for spoliation] is an inference that the adversary's conduct may be considered generally as tending to corroborate the proponent's case and to discredit the adversary.") (internal quotations omitted).

<sup>35</sup> See, e.g. Maryland Civil Pattern Jury Instruction 1:10 ("If you find that the intent was to conceal the evidence, the destruction or failure to preserve must be inferred to indicate that the party believes that his or her case is weak and that he or she would not prevail if the evidence was preserved...."); *Knowlton v. Teltrust Phones, Inc.*, 189 F.3d 1177, 1182 (10<sup>th</sup> Cir. 1999).

<sup>36</sup> See, e.g. *Arndt v. First Union Nat. Bank*, 170 N.C.App. 518, 527, 613 S.E.2d 274 (N.C.App. 2005); *Zimmermann v. Associates First Capital Corp.*, 251 F.3d 376 (2<sup>nd</sup> Cir. 2001).

recall committee meetings by looking at the minutes.<sup>37</sup> A reasonable juror could infer from the destruction of documents and electronic drafts by Memorial's employees, and additions, deletions, and changes to meeting minutes by Memorial's attorneys and respondents that the action was not in furtherance of quality health care and was unwarranted by the facts known to respondents.<sup>38</sup>

Respondents Disregarded PQAC Motions. When Respondent Rowles and Memorial employee Kay Anyan urged the PQAC to take action against Dr. Smigaj, they were sometimes subtle. Dr. Rowles "reminded" the PQAC that HCQIA "grants immunity to healthcare professionals who engage in good faith evaluation of their peers."<sup>39</sup> Other urging was palpable. At one early *Ad Hoc* meeting, Anyan "indicated that an outside review of the case might be in order if the committee is considering recommending reduction or suspension of the Practitioner's privileges." CP 629. Later, Anyan "reminded" the PQAC "that the hospital would support the committee's decision/recommendations." CP 648.

But when it suited them, respondents disregarded the PQAC's actions. At its July 9th meeting, the PQAC passed respondent Rowles's motion "to

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<sup>37</sup> CP 1211 (Englehardt – "I couldn't be accurate"), 1539 (Olden – "no independent recollection"), 1179 (Davenport – "I can't recall without looking"), 2613 & 2615 (Johns – "I can't recall specific discussions" and "can't recall").

<sup>38</sup> *Trevino v. Ortega*, 969 S.W.2d 950, 960 (Tex. 1998) ("Moreover, by shifting the burden of proof, the presumption will support the nonspoliating party's assertions and is some evidence of the particular issue or issues that the destroyed evidence might have supported. The rebuttable presumption will enable the nonspoliating party to survive summary judgment, directed verdict, judgment notwithstanding the verdict, and factual and legal sufficiency review on appeal.")

<sup>39</sup> CP 628. Dr. Smigaj has not sued any volunteer PQAC members who were misled by misinformation Dr. Rowles, Dr. Olden, and Ms. Anyan spoon-fed them throughout summer 2008.

recommend to the MEC that [Dr. Smigaj] should not accept transfers from the outside community.”<sup>40</sup> Despite the vote, respondents did not refer the issue to the MEC. CP 1779, 1570. Respondents came up with a new plan to justify total suspension of Dr. Smigaj’s privileges: “we are developing a historical review of her cases.” CP 667. Similarly, on September 3rd, the PQAC recommended “that the Medical Executive Committee institute a precautionary suspension while proceeding forward with an outside review.” CP 656. But respondents did not present the recommendation to the MEC. CP 1621. Respondents’ coaching of the PQAC and their disregard of two motions are facts from which a reasonable juror could conclude that respondents manipulated the process and conclude that the action was not in furtherance of quality health care, not fair to Dr. Smigaj, and not warranted by the facts known to respondents.

C. A Reasonable Juror Could Conclude That The Investigation Was Deficient.

HCQIA’s immunity requires that the action be taken “after a reasonable effort to obtain the facts of the matter.”<sup>41</sup> Considering the harm to a physician’s reputation from a suspension, the investigation must be detailed and leads must be pursued.<sup>42</sup> A narrow investigation or one that overlooks important evidence does

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<sup>40</sup> CP 630. Although the bylaws prohibit them from voting, Dr. Rowles and Dr. Olden both voted for the motion. CP 512 (¶ (P)(1)(a), (b)(4)), 1345, 1569.

<sup>41</sup> 42 U.S.C. § 11112(a)(2).

<sup>42</sup> *Stratienko v. Chattanooga-Hamilton County Hosp. Auth.*, 2008 WL 4191275 \*4 (E.D. Tenn. Sept. 8, 2008)

not satisfy the standard.<sup>43</sup> Mere reliance on a report or an asserted fact is not sufficient; thorough investigation is required.<sup>44</sup> Conflicting evidence requires additional investigation.<sup>45</sup> When making a reasonable effort to obtain the facts, interviewing witnesses with firsthand knowledge is essential.<sup>46</sup> The reasonableness of the fact finding efforts is measured by an objective standard.<sup>47</sup>

Dr. Padilla. Ms. Anyan and the hospital's attorneys prepared the summary suspension letter for Dr. Padilla's signature before he was summoned. CP 1650, 1100. Dr. Padilla did not recall reviewing any documents other than the letter. CP 1650.<sup>48</sup> Dr. Padilla had a five or ten minute call with Dr. Rowles, who related that the PQAC had reviewed cases, and "to use their words, that she – not necessarily imminent risk or imminent danger, but was a risk to patients that she cares for."<sup>49</sup> Dr. Padilla talked with Kay Anyan; neither he nor Anyan could recall anything

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<sup>43</sup> *Brown v. Presbyterian Healthcare Serv.*, 101 F.3d 1324, 1333-34 (10th Cir. 1996) (expert witness testimony established that effort to obtain the facts was not reasonable).

<sup>44</sup> *Ritten v. Lapeer Regional Med. Ctr.*, 611 F. Supp. 2d 696, 720-21 (E.D.Mich. 2009).

<sup>45</sup> *Ritten*, 611 F. Supp. 2d at 720 (reasonable juror could conclude that CEO's efforts not reasonable because he took no steps to resolve a fundamental conflict in the evidence).

<sup>46</sup> *Summers v. Ardent Health Serv., LLC*, 226 P.3d 20, 23 (N.M. Ct. App. 2010), *cert. granted*, 240 P.3d 1049 (2010).

<sup>47</sup> *Summers*, 226 P.3d at 23.

<sup>48</sup> Dr. Padilla later submitted a declaration contradicting his deposition testimony. *Cf.* CP 1650, 1652, & 1684 (testifying during deposition that he couldn't recall if he reviewed any outside expert reports, couldn't be certain that he reviewed Dr. Conner's report on September 4<sup>th</sup>, and believes he received an oral summary from Ms. Anyan) with CP 1870 (declaration testimony that he reviewed one report of Dr. Tomlinson and also Dr. Conner's expert reports). Dr. Padilla's subsequent, contradictory testimony cannot justify summary judgment. *Marshall v. AC & S Inc.*, 56 Wn.App. 181, 185, 782 P.2d 1107 (1989); *see also McCormick v. Lake Washington School District*, 99 Wn.App. 107, 111, 992 P.2d 511 (1999) ("Self-serving affidavits contradicting prior depositions cannot be used to create an issue of material fact.").

<sup>49</sup> CP 1656. Dr. Rowles recalls nothing about the call. CP 1823.

about the conversation. CP 1654-55, 1684, 1100. Dr. Padilla, because he is an emergency room physician, “can’t critique practice in obstetrics.” CP 1667. He talked with Dr. Harrington, the OB department chair, but “didn’t think” to ask his opinion. CP 1652. He didn’t consider calling Dr. Tomlinson, even though “word of mouth isn’t enough for one of these things.” 1654, 1683. Dr. Padilla mistakenly believed that the PQAC had “discussed the cases thoroughly” during conference calls with Dr. Tomlinson, and “I based my decision on the decision by the Perinatal QA Committee.” CP 1684. Padilla believed the PQAC “spoke with [Dr. Tomlinson] via teleconference at this meeting of September 3rd”, and Anyan didn’t tell him otherwise. CP 1654-55. He did not know that the PQAC recommendation was directed to the full MEC, not to him. CP 1656-57. He knew “there wasn’t enough written information for the MEC to come in and review.” CP 1660. He knew that Dr. Tomlinson’s written opinion on WC and LH had not yet arrived, but the information he had orally received about Dr. Tomlinson’s reviews did not suggest that Dr. Smigaj presented any imminent danger. CP 1684, 1654. Identifying nine specific infirmities, Dr. Conner’s expert testimony concludes that Dr. Padilla’s investigation was deficient. CP 429-30.

The PQAC. Other than Dr. Smigaj, the PQAC did not interview any Memorial nurse or physician. CP 1159-60, 1170, 1513, 2637. It did not interview the Department Chair, Dr. Harrington, or review renewals of Dr. Smigaj’s privileges, which noted the absence of any issues. CP 1166, 1293, 1463-64, 997,

1003. The only quantitative data it considered showed that Dr. Smigaj delivered more babies with far fewer complications than her peers. CP 624, 1598-99, 1217, 1538. Although its meeting minutes recognize the need to rely upon medical literature, the PQAC did not discuss or review any literature or national standards; if it had, authoritative literature would have dispelled its concerns. CP 397, 1175, 416, 424, 1569. The Committee had a fifteen minute phone call with Dr. Tomlinson to hear his opinion about JA; although it promised Dr. Smigaj in writing that it would “review the written response from Dr. Tomlinson,” it never did. CP 574, 1123, 1572. The PQAC did not speak with Dr. Tomlinson about LH or WC and it failed to request or review Dr. Tomlinson’s written reports.<sup>50</sup> Although the summary suspension letter states that Dr. Smigaj failed to hospitalize LH to address high blood pressure, the PQAC failed to review Dr. Smigaj’s office record. CP 576, 1190, 2629. If the PQAC had reviewed Dr. Smigaj’s office notes for LH, it would have discovered that Dr. Smigaj “encouraged [LH] to be hospitalized for blood pressure management and she stated absolutely not.” CP 610. The summary suspension cited, but the PQAC did not review, “disruptive physician reports.” CP 398, 1170, 2639, 1344. If the PQAC had read the disruptive physician reports, it would have learned that one

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<sup>50</sup> CP 2626, 2634, 1129, 2632. Dr. Tomlinson prepared his written report of WC and LH on August 26th and September 3rd respectively. CP 614, 1857. Respondents communicated with Dr. Tomlinson by email and overnight mail and could have promptly obtained his reports. CP 1842. Anyan asked Dr. Tomlinson to prepare written reports, but gave him no sense of urgency, even though she knew the PQAC was meeting that evening. CP 1863-64.

was stale, one was trivial, and one was unfounded.<sup>51</sup> CP 398. After detailing PQAC members misunderstanding of significant facts due to a failure to investigate, Dr. Conner's expert testimony concludes that the PQAC investigation was "inadequate and unreasonable." CP 397-400, 415-17, 425-28.

If the PQAC had reviewed Dr. Tomlinson's written report on LH and WC, it would have known that Dr. Tomlinson was not critical of Dr. Smigaj's care, and that Dr. Rowles's August 15th description of WC and Ms. Anyan's September 3rd version of Tomlinson's opinion on LH were both fundamentally inaccurate. CP 1259, 404, 406. If the PQAC had interviewed Dr. Harrington, he could have told the PQAC that the three cases they were considering would not support a summary suspension. CP 1284. Further, Dr. Harrington could have told the PQAC that no policy or procedure required Dr. Smigaj to personally evaluate JA within one hour. CP 1282, 403. If the PQAC interviewed Dr. Nadig, it would have discovered that Dr. Olden lied to the PQAC in 2007 when he told them that Dr. Nadig had referred the JS case and was critical of Dr. Smigaj. CP 1512. If the PQAC had interviewed Dr. Rowles, it could have learned

why more of Dr. Smigaj's cases than Dr. Rowles' cases came before the PQAC: Dr. Rowles, in violation of peer review process, reviewed his own cases.<sup>52</sup>

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<sup>51</sup> CP 398. PQAC members acknowledged the importance of written documentation to the medical profession. CP 1547, 2629, 2632-34, 11820.

<sup>52</sup> CP 618 ("An individual functioning as a peer reviewer may not have performed any medical management on the patient whose case is under review."), CP 1757-58.

But even Dr. Rowles's case involving the death of a fetus was never considered by the PQAC, although it should have triggered an automatic review. CP 1758, 1769, 420.

A reasonable juror could also draw negative inferences from Ms. Anyan's destruction of notes, the erasure and "clean up" of PQAC meeting minutes, and changes to meeting minutes made by the hospital's attorneys. See ¶ B (above). Construing Dr. Conner's expert witness testimony and the facts most favorably to Dr. Smigaj, a reasonable juror could conclude that neither Dr. Padilla nor the PQAC made a reasonable effort to obtain the facts.

D. A Reasonable Juror Could Conclude That The Process Was Unfair.

Congress intended "the physician under review [to have] every opportunity to defend his or her record."<sup>53</sup> Thus, "a professional review action must 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."<sup>54</sup> When it used the phrase "such other procedures as are fair to the physician under the circumstances," it meant that "other procedures that are afforded to a physician must be those generally recognized by courts . . .".<sup>55</sup> "A physician is entitled to proper notice of a proposed peer review action and a

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<sup>53</sup> 132 Cong. Rec. H9954-01, 1986 WL 788373 \*26 (10/14/1986).

<sup>54</sup> 42 U.S.C. § 11112(a)(3).

<sup>55</sup> 132 Cong. Rec. H9954-01, 1986 WL 788373 \*14 (10/14/1986).

fair hearing in which he or she can challenge the proposed action.”<sup>56</sup> Notice must be “given in a way that protects the interests of the physicians against whom the action is proposed.”<sup>57</sup> A failure to inform the physician that a suspension of privileges is being considered is inadequate notice.<sup>58</sup> Notice of the proposed action must be made before the professional review action.<sup>59</sup>

Failure to give notice of the proposed action. Over the course of 76 days, the defendants, the hospital’s attorneys, and the PQAC evaluated suspending Dr. Smigaj’s privileges more than twelve times.<sup>60</sup> But no one informed Dr. Smigaj that suspension of her privileges was being considered until Dr. Padilla called her on September 4th. CP 3266, 1662. Dr. Rowles invited Dr. Smigaj to a June 20th PQAC meeting without identifying any specific concerns or telling her that suspension would be discussed in her absence. CP 3263. Rowles’ July 16th letter misled Dr. Smigaj by enclosing the Peer Review Policy; that policy addresses performance improvement, not disciplinary action. CP 570, 615, 1166-67.

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<sup>56</sup> *Perry v. Rado*, 155 Wn.App. 626, 640, 230 P.3d 203 (2010).

<sup>57</sup> H.R. Rep. No. 99-903.

<sup>58</sup> *Islami v. Covenant Medical Center, Inc.*, 822 F. Supp. 1361, 1372 (N.D. Iowa 1992); see also 42 U.S.C. ¶ 11112(b)(1) (“Notice of proposed action”).

<sup>59</sup> *Chudacoff v. University Medical Center of Southern Nevada*, 609 F. Supp. 2d 1163, 1176 (D. Nev. 2009).

<sup>60</sup> CP 627/1240 (6/20/08 PQAC), 630 (7/9/08 PQAC), 3112 (7/15/08 Atty. Walerius), 3112 (7/15/08 Atty. Kenny) 3113 (7/16/08 Atty. Zech), 973 (7/17/08 Atty. Kenny), 982 (7/22/08 PQAC), 3114 (7/22/08 Atty. Zech), 3114 (7/25/08 Atty. Walerius), 3114 (7/25/08 Atty. Walerius and Linneweh), 3114 (7/25/08 Atty. Zech), 3115 (7/28/08 Atty. Zech and Linneweh), 3115 (7/30/08 Atty. Zech with Linneweh and Olden), 691/3116 (8/6/08 Linneweh), 3116 (8/13/08 Atty. Kenny and Anyan), 1382 (8/15/08 PQAC), 653 (8/29/08 PQAC), and 656 (9/3/08 PQAC).

Failure to give notice of allegations. Although respondent Linneweh conceded that “the practitioner needed to know specifically what the issues were,” Dr. Smigaj was not informed of several allegations upon which the PQAC and Dr. Padilla relied. CP 1478, 417-18. After Dr. Smigaj refuted three written PQAC concerns about the LH case, Dr. Rowles belatedly accused Dr. Smigaj of “performing an elective induction on an unripe cervix” and failing to consider using Piper forceps for the delivery.<sup>61</sup> But Dr. Rowles never told Dr. Smigaj or gave her an opportunity to rebut either allegation.<sup>62</sup> The PQAC and Dr. Padilla also relied upon unidentified “disruptive physician reports.” CP 576, 628, 3111. But no one ever asked Dr. Smigaj about them. CP 3263, 569, 1569. Third, without informing Dr. Smigaj, the PQAC was provided an “accumulative review.” CP 634-39, 574, 1781, 2648. Dr. Smigaj could have pointed out the omission of documents that would cause a reader to reach a different conclusion. CP 1497. Dr. Smigaj was not allowed to be present during the phone call Dr. Tomlinson had with the PQAC, or when the respondents presented their version of phone calls they had with Tomlinson.<sup>63</sup>

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<sup>61</sup> CP 655, 1196. Dr. Rowles’ criticism was rebutted by Dr. Harrington who testified that the use of Piper forceps is “relatively rare in this day and age.” CP 1298.

<sup>62</sup> CP 1197, 3266, 2646. HCQIA’s legislative history recognizes that an additional concern might develop during a peer review process. If so, “a supplemental notice of such additional reasons [for the proposed action] might well satisfy due process.” H.R. Rep. No. 99-903, 1986 U.S.C.C.A.N. 6384, 6394.

<sup>63</sup> CP 3263, 1546. “The elements of such a fair hearing generally encompass full notice and a reasonable opportunity to be heard — including the right to present evidence and the right to confront and cross-examine witnesses.” *Milne v. Int’l Assoc. of Bridge, Structural, Ornamental &*

Respondents reprised this tactic during the litigation. Although the PQAC never suggested that Dr. Smigaj violated any hospital policy in the JA, WC, or LH cases, respondents argued to the superior court that Dr. Smigaj was suspended because she “violated multiple hospital medical staff rules, regulations, and policies.” CP 4264. This theory was created out of whole cloth by Memorial’s attorneys in June 2010, as evidenced by an entry on their billing record: “Continue revising Dr. Rowles’ declaration and identifying policies disregarded by Dr. Smigaj over her years at Memorial.” CP 3848. The theory is unsupported even by the heavily massaged PQAC 2008 meeting minutes and it certainly doesn’t appear in Dr. Padilla’s suspension letter. CP 670-674, 576-77.

Action Taken By An Improperly Composed Committee Is Void. Even when an organization has the authority to do an act, it must exercise its authority properly.<sup>64</sup> “It is well settled that an administrative body must follow its own rules and regulations when it conducts a proceeding which can deprive an individual of some benefit or entitlement.”<sup>65</sup> In this case, the Medical Staff Bylaws limit the “functions and duties” of the PQAC: “To improve performance by assessing

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*Reinforcing Iron Workers, AFL-CIO Local 15*, 156 F. Supp. 2d 172, 178 (D. Conn. 2001). See also 42 U.S.C. §11112(b)(3).

<sup>64</sup> *Ritter v. Board of Commissioners of Adams County Public Hospital Dist. No. 1*, 96 Wn.2d 503, 516, 637 P.2d 940 (1981).

<sup>65</sup> *Ritter*, 96 Wn.2d at 507 (“Because the Board failed to follow its own rules in summarily dismissing Dr. Ritter, that act was improper.”). See also *Service v. Dulles*, 354 U.S. 363, 388, 77 S.Ct. 1152, 1 L. Ed. 2d 1403 (1957) (Secretary of State’s failure to follow regulation rendered termination of a foreign service officer invalid), and *Hartstene Point Ass’n v. Diehl*, 95 Wn. App. 339, 341, 979 P.2d 854 (1999) (Architectural Control Committee action “void” because committee not properly constituted under association’s governing documents).

problems, processes, and outcomes of care, reaching conclusions and making recommendations to the practitioners or departments involved. Actions necessary to improve performance are the responsibility of the appropriate Medical Staff Department Chairperson and the M.E.C.” CP 512. But “Yakima Valley Memorial Hospital administration transformed the PQAC into an investigative committee that failed to provide any of the protections afforded physicians by the Medical Staff Bylaws. As a result, an unauthorized body performed an improper investigation of Dr. Smigaj’s practice . . . ” CP 396-97. PQAC members were completely unaware of limitations on the PQAC’s functions and authority. CP 1165, 1884.

Involvement By Dr. Smigaj’s Competitors. HCQIA anticipates a hearing officer or panel “not in direct economic competition with the physician involved.” 42 U.S.C. § 11112(b)(3)(A)(iii). Memorial’s Fair Hearing Plan prohibits competitors from being decision makers. CP 534. Yet PQAC participants Rowles, Olden, Johns, and Davenport are Dr. Smigaj’s competitors. CP 389, 2608.

42 U.S.C. § 11112(c)(1)-(2) identifies two exceptions to subsection 11112(a)(3)’s notice and hearing requirement. But the presumption enunciated in to § 11112(a) does not apply to § 11112(c).<sup>66</sup> Thus, respondents have the burden of establishing the exceptions. The exception in § 11112(c)(1)(B) applies to

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<sup>66</sup> *Harris v. Bradley Memorial Hosp. and Health Center*, 2005 WL 1433841 \*6 (Conn. Super. 2005), affirmed in part on other grounds, 296 Conn. 315, 994 A.2d 153 (Conn. 2010); CONN. SUP. CT. R. 5-9 (citation to unpublished Conn. Sup. Ct. Opinions permitted).

suspensions of less than fourteen days but only if “an investigation is being conducted to determine the need for a professional review action.” Here, the PQAC completed a three-month investigation of Dr. Smigaj’s practice on September 3, 2008 and no one undertook any further investigation. CP 1258, 1659. When it met on September 16th, under Article II of the Corrective Action Policy, the MEC undertook a “review,” not an investigation. CP 529 (§2.2). An “investigation” entails a referral to the Department Chair or appointment of an *Ad Hoc* Investigative Committee. CP 526. The receipt of Dr. Tomlinson’s written reviews, which the PQAC and Dr. Padilla could have and should have obtained before considering action, is not an “investigation.” The second exception permits the immediate suspension or restriction of clinical privileges 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). Dr. Smigaj did not pose a threat of imminent danger to any patient on September 3, 2008; neither impartial reviewer who evaluated the WC and LH cases even felt that she provided substandard care. CP 395-396, 1312, 594-601. PQAC members and Dr. Padilla acknowledged the absence of any precipitating event. CP 1210, 1654. Because the evidence establishes a myriad of disputed material facts, § 11112(c) does not excuse compliance with the due process requirements enunciated in § 11112(a)(3) as a matter of law.

The phrase “fair to the physician under the circumstances,” captures an important aspect of due process: it is measured with “due regard being had to the

nature of the proceeding and the character of the rights which may be affected by it.”<sup>67</sup> Physicians go to school for years, then spend years gaining clinical experience and building their reputations; a summary suspension can eliminate their livelihood. The circumstances required substantial procedural protections for Dr. Smigaj, and a reasonable juror could conclude that the process was unfair.

E. A Reasonable Juror Could Conclude That The Summary Suspension Was Taken Without A Reasonable Belief That It Was Warranted Or In Furtherance of Quality Health Care.

HCQIA’s first and fourth elements require a reasonable belief that the summary suspension was in furtherance of quality health care and was warranted:

a professional review action must be taken--

(1) in the reasonable belief that the action was in the furtherance of quality health care,

... 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). 42 U.S.C. § 11112(a)(1), (4).

“The standard for a summary suspension is the threat of imminent danger to patient safety such that a physician’s privileges must be suspended immediately until an investigation can be undertaken to determine whether the physician is in fact a threat to safety.” CP 395. “Summary suspension is a drastic measure which is justified only when a doctor presents an imminent danger to patient health

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<sup>67</sup> *Dohany v. Rogers*, 281 U.S. 362, 369, 50 S.Ct. 299, 74 L.Ed. 904 (1930).

and/or safety; that is to say, poses such an imminent, serious harm to patients that the physician's privileges must be suspended immediately before any notice or hearing. Typically, these events include alcoholism, drug abuse, a patient death caused by gross negligence, repeated disruptive behavior, or physical violence to another person. CP 452. Absent objective evidence that a physician poses a substantial likelihood of immediate injury, a defendant cannot establish a reasonable belief that a summary suspension is warranted.<sup>68</sup>

At its September 3rd meeting, the PQAC asked the MEC, not Dr. Padilla, to institute a "precautionary" suspension.<sup>69</sup> The MEC's next meeting was two weeks away, demonstrating the lack of urgency. CP 577. Yet the hospital and its attorneys immediately drafted a summary suspension letter for Dr. Padilla's signature then summoned him to the hospital. CP 3270, 1650. The PQAC's meeting minutes identified "judgment, practice patterns and behavior placed other members of the medical staff and hospital at increased risk of liability exposure."<sup>70</sup> But a cascade of evidence demonstrates the absence of objective evidence that Dr. Smigaj was an imminent threat to any patient.

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<sup>68</sup> *Ritten v. Lapeer Reg'l Med. Ctr.*, 611 F.Supp.2d 696, 721 (E.D.Mich. 2009).

<sup>69</sup> CP 3110. "Precautionary" is a euphemism. Dr. Padilla's letter uses "summary suspension" on page 2. CP 577.

<sup>70</sup> CP 3110. Memorial's lawyers inserted the phrase "may place patients at risk." CP 3110, 1391. Later, the PQAC reported to the MEC that it acted "because they felt that was the "best and safest thing to do for patients." CP 661. The lawyers changed that phrase to read "failure to initiate an immediate suspension may result in an imminent danger to patients." CP 661, 1116.

Physician & Expert Opinions. After Dr. Harrington reviewed the file compiled for the MEC meeting, he concluded that “none of the three cases would justify an immediate suspension of Dr. Smigaj’s clinical privileges.” CP 1284. When he eventually reviewed written reports, Dr. Padilla characterized Dr. Tomlinson’s concerns as “minor” and concluded “there wasn’t any huge or major violation of the standard of care, nor was there any significant discrepancy between her outside reviewers and the ones that were hired by the hospital.” CP 1666, 1664; see also CP 3526. In his detailed written review of LH and WC, Dr. Stephen Brisbois in Spokane concluded that the cases do not “raise any competency concerns that would lead to termination of privileges.” CP 605. In five pages of his forty page declaration, Dr. Smigaj’s expert peer review witness, Dr. Mize Conner, explained the reasons that no reasonable person could conclude on September 3rd or 4th that Dr. Smigaj’s practice could result in imminent danger to the health and safety of any individual. CP 407-414; see also 3526 (“criticisms were relatively minor”); CP 2088 (MEC looking for “metrics”).<sup>71</sup>

The PQAC’s Admissions. By September 3rd Dr. Englehardt knew that Dr. Tomlinson would not opine that Dr. Smigaj fell below the standard of care. CP 1265. At its November 21st meeting, other PQAC members admitted that Dr. Tomlinson “wouldn’t commit to substandard care,” and that Dr. Tomlinson’s

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<sup>71</sup> *Brown v. Presbyterian Healthcare Services*, 101 F.3d 1324, 1334 (10th Cir. 1996) (reasonable juror could conclude from expert witness testimony that peer review panel lacked a “reasonable basis for concluding Dr. Brown posed a threat to patient safety”).

reviews were “not very strong.” CP 670. PQAC members could not identify any specific event justifying a **summary** suspension:

There wasn't a precipitating event right before the 2008 meeting. There had been a number of cases and a cumulative review that culminated with that decision to suspend privileges. CP 1210; see also CP 1264, 1230.

One PQAC member, Dr. Davenport voted to recommend a summary suspension; but after he had an opportunity to review Dr. Tomlinson's written report, as a MEC member, Davenport voted to reinstate Dr. Smigaj's privileges. CP 661, 1200. Although the PQAC received a retrospective of cases back to 1995, it could not identify any pattern of poor quality care. CP 1260-61. Even if the PQAC believed that Dr. Smigaj had too many QA reports in her file, Congress told them what to do: “Health care entities should bring a full-fledged professional review action where such instances repeatedly recur with regard to a specific physician.”<sup>72</sup> But the defendants did not do that because, as defendant Olden told the PQAC, at a full fledged “Fair Hearing,” there was “not enough substance to back up possible issues.”<sup>73</sup>

Voluminous evidence establishes that no reasonable person would have believed Dr. Smigaj to be an imminent threat to patient safety on September 3rd

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<sup>72</sup> H.R. Rep. 99-903, 1986 U.S.C.C.A.N. 6384, 6393.

<sup>73</sup> CP 670. Competitors cannot serve in a Fair Hearing, and the physician can be represented by an attorney, cross examine witnesses, introduce evidence, etc. CP 534.

or 4th.<sup>74</sup> Hence, a reasonable juror could conclude that the summary suspension was not warranted by the facts known after a reasonable effort to obtain the facts.<sup>75</sup> Moreover, the alteration and destruction of evidence by the defendants, as well as their rush to have Dr. Padilla endorse an action not even directed to him by the PQAC, would allow a reasonable juror to conclude that the suspension was not taken in the furtherance of quality health care.

F. The Court Erred By Dismissing Dr. Smigaj's Claim for Defamation.

Memorial's Chief of Staff, the Chairman of the Ob/Gyn Department and members of the PQAC all testified that summary suspension of a physician's privileges is drastic, "will certainly harm" her reputation and damage her career. CP 1653, 1294, 1232. Attacking a doctor's professional competence by imposing an unjustified summary suspension of clinical privileges is defamatory per se; additionally, Dr. Smigaj identified several other instances of defamation, including: (1) Respondents' announcement of her suspension to the labor and delivery nurses which falsely implied that Dr. Smigaj posed an imminent threat to patient safety (CP 576-77, 1671); (2) Dr. Olden falsely claiming that Dr. Nadig had concerns about the quality of Dr. Smigaj's care in the blood loss case in 2007 (CP 716, 554); (3) Dr. Rowles' false statements to the PQAC about Dr. Tomlinson's opinions regarding Dr. Smigaj's performance in the WC case (CP

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<sup>74</sup> *Stratienko*, 2008 WL 4191275 at \*4 (where cause of altercation was unclear or not known, reasonable jury could conclude that summary suspension was not warranted).

<sup>75</sup> *Ritten*, 611 F.Supp.2d at 721.

649); and (4) Ms. Anyan's statements to Dr. Padilla on September 4, 2008, falsely implying that Dr. Tomlinson said that Dr. Smigaj provided substandard care to patient LH (CP1101); Respondents' summary judgment motion and the court's opinion only addressed Mr. Linneweh's letter to Group Health. CP 4316-18, 3608. The court erred by failing to consider other defamatory statements and not interpreting all evidence in the light most favorable to Dr. Smigaj.<sup>76</sup>

The superior court also applied an incorrect legal standard to the Group Health letter. CP 3090-91. Under the Corrective Action policy, a summary suspension "shall not imply any final finding of responsibility." CP 529. Further, Mr. Linneweh conceded that an administrator would be concerned by his letter; hence the letter defamed Dr. Smigaj by falsely implying that she provided substandard medical care. CP 3090-91, 1481. And, after receiving a draft, Dr. Smigaj's attorney identified false and misleading statements to Memorial's attorney. CP 3093-95. Without elaboration, the court characterized the statements in the letter as "true." CP 3608. Washington law recognizes that "true" statements may be defamatory by implication or omission.<sup>77</sup> The superior court also held that the letter did not harm Dr. Smigaj because Group Health had not terminated Dr. Smigaj's contracts or her status as an approved provider. CP 3260. But numerous

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<sup>76</sup> *Fitzpatrick v. Okanogan County*, 169 Wn.2d 598, 605 (2010).

<sup>77</sup> *Mohr v. Grant*, 153 Wn.2d 812, 823, 108 P.3d 768 (2005); *Herron v. KING Broad. Co.*, 112 Wn.2d 762, 765, 776 P.2d 98 (1989); *Mark v. Seattle Times*, 96 Wn.2d 473, 483, 635 P.2d 1081 (1981); *Taskett v. KING Broad. Co.*, 86 Wn.2d 439, 445, 546 P.2d 81 (1976).

witnesses testified that a summary suspension of privileges seriously harms a physician's reputation and career.<sup>78</sup> CP 1653, 1294, 1232. The Court should reverse the superior court's dismissal of Dr. Smigaj's defamation claim.

G. The Court Erred By Awarding Defendants Their Attorney Fees.

The superior court held that respondents were a "prevailing party" under RCW 7.71.030(3).<sup>79</sup> Assuming this court reverses the superior court's 12(c) judgment, respondents have not prevailed. Even if the court affirms the dismissal, plaintiffs did not invoke RCW 7.71.030. CP 13-62. The attorney fee provision in RCW 7.71.030(3), unlike other statutes, does not allow invocation by a defendant.<sup>80</sup> Because Dr. Padilla's action was based on Dr. Smigaj's competence, this court should reverse the fee/cost award and judgment. CP 3993-95.

The superior court also awarded fees to respondents as prevailing parties under RCW 7.71.020/HCQIA. CP 3991. Because 42 U.S.C. § 11113 only applies "at the conclusion of the action," reversing the CR 56 order necessitates reversing the award. Additionally, 42 U.S.C. § 11113 only allows an attorney fee award "if the claim, or the claimant's conduct during the litigation of the claim, was

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<sup>78</sup> The trial court did not address an argument that the letter to Group Health was privileged under a release signed by Dr. Smigaj. But that release, pursuant to RCW 70.41.230(4) did not give Respondents the right to disparage Dr. Smigaj.

<sup>79</sup> CP 3990. Whether a party is a prevailing party is a mixed question of law and fact reviewed under an error of law standard." *Kyle v. Williams*, 139 Wn.App. 348, 356, 161 P.3d 1036 (2007).

<sup>80</sup> 42 U.S.C. § 11113 ("In any suit brought against defendant, to the extent that a defendant has met the standards set forth under section 412(a) . . .") (emphasis supplied); RCW 4.24.240 (anti-SLAPP statute)("Any person prevailing upon the defense provided for in this section is entitled to recover expenses and reasonable attorney fees . . ."); RCW 4.24.520; and RCW 4.28.185(5).

frivolous, unreasonable, without foundation, or in bad faith.” The superior court did not enter any finding or conclusion about “claimant’s conduct during the litigation,” nor did it find the claim frivolous or in bad faith. CP 3986-3992.

Yet it concluded “in light of the extensive case law at both the federal and state level interpreting and applying the HCQIA immunity, including three appellate decisions in Washington, Plaintiffs’ claim that Defendants were not entitled to the HCQIA immunity on the undisputed material facts of this case was unfounded and unreasonable.”<sup>81</sup> Still, two of the “three appellate decisions” were decided more than a year after appellant filed this lawsuit.<sup>82</sup> In the earlier case, *Morgan v. Peacehealth*, the court of appeals did “not find that Morgan’s claim is frivolous, unreasonable, without foundation or in bad faith.”<sup>83</sup> Second, appellant’s claim is supported by Drs. Brisbois and Conner’s detailed expert witness testimony.<sup>84</sup> Third, this action is not unfounded or unreasonable because the MEC reversed Dr. Padilla’s summary suspension.<sup>85</sup> “It is important that a district court resist the understandable temptation to engage in post hoc reasoning by

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<sup>81</sup> CP 3991. This court should review Conclusions of Law nos. 5-6 under the “error of law” standard. *Magnussen v. Tawney*, 109 Wn.App. 272, 275, 34 P.3d 899 (2001).

<sup>82</sup> CP 13 (November 7, 2008 filing date); *Cowell*, 153 Wn.App. 911 (decided December 28, 2009) and *Perry v. Rado*, 155 Wn.App. 626 (decided April 22, 2010).

<sup>83</sup> 101 Wn.App. 750, 788.

<sup>84</sup> CP392-447, 3523-3551, 602-605; *see Berg v. Shapiro*, 36 P.3d 109, 113 (Colo. Ct. App. 2001) (physician’s claims not without foundation when supported by expert testimony).

<sup>85</sup> *Muzquiz v. W.A. Foote Memorial Hospital, Inc.*, 70 F.3d 422, 432-33 (6th Cir. 1995) (physician “had a legitimate factual basis”); *Jeung v. McKrow*, 264 F.Supp. 2d 557, 574-75 (E.D. Mich. 2003) (claims not frivolous where record established animosity by hospital’s administrator); *Johnson v. Nyack Hospital*, 773 F.Supp. 625, 631 (S.D. N.Y. 1991), *aff’d*, 964 F.2d 116, 124 (2d Cir. 1992).

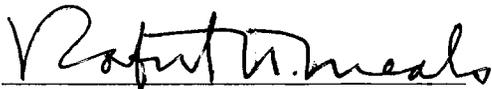
concluding that, because a plaintiff did not ultimately prevail, his action must have been unreasonable or without foundation.” The court committed an error of law by concluding that Dr. Smigaj’s claim was “unfounded and unreasonable.”<sup>86</sup>

#### V. CONCLUSION

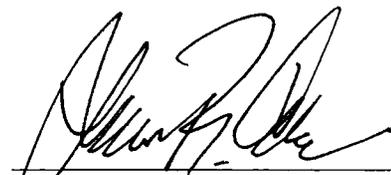
This court should reverse the order dismissing the Complaint [CR 12(c)] and the order granting summary judgment, direct the superior court to vacate the judgment, and remand for trial.

TODAY’S DATE is February 10, 2010.

Respectfully submitted,



Robert N. Meals, WSBA 19990  
Attorney for Appellants



Lawrence R. Cock, WSBA 20325  
Attorney for Appellants

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<sup>86</sup> *State ex rel. Washington Federation of State Employees, AFL-CIO v. Board of Trustees of Central Washington University*, 93 Wn.2d 60, 71, 605 P.2d 1252 (1980).

# APPENDIX A

### **7.71.010. Legislative finding**

The legislature finds the assurance of quality and cost-effectiveness in the delivery of health care can be assisted through the review of health care by health care providers. It also recognizes that some peer review decisions may be based on factors other than competence or professional conduct. Although it finds that peer review decisions based on matters unrelated to quality and utilization review need redress, it concludes that it is necessary to balance carefully the rights of the consuming public who benefit by peer review with the rights of those who are occasionally hurt by peer review decisions based on matters other than competence or professional conduct.

The legislature intends to foreclose federal antitrust actions to the extent Parker v. Brown, 317 U.S. 341 (1943), allows and to permit only those actions in RCW 7.71.020 and 7.71.030.

### **7.71.020. Federal law applicable in Washington state**

Pursuant to P.L. 99-660 Sec. 411(c)(2), Title IV of that act shall apply in Washington state as of July 26, 1987.

### **P.L. 99-660, Title IV, Part A**

#### **Subchapter I. Promotion of Professional Review Activities**

#### **42 U.S.C. § 11101 Findings**

The Congress finds the following:

- (1) The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.
- (2) There is a national need to restrict the ability of incompetent physicians to move from State to State without disclosure or discovery of the physician's previous damaging or incompetent performance.
- (3) This nationwide problem can be remedied through effective professional peer review.
- (4) The threat of private money damage liability under Federal laws, including treble damage liability under Federal antitrust law, unreasonably discourages physicians from participating in effective professional peer review.
- (5) There is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.

## **42 U.S.C. § 11111 Professional review**

### **(a) In general**

#### **(1) Limitation on damages for professional review actions**

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, except as pro-vided in subsection (b) of this section--

(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, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action. The preceding sentence shall not apply to damages under any law of the United States or any State relating to the civil rights of any person or persons, including the Civil Rights Act of 1964, 42 U.S.C. 2000e, et seq. and the Civil Rights Acts, 42 U.S.C. 1981, et seq. Nothing in this paragraph shall prevent the United States or any Attorney General of a State from bringing an action, including an action under section 15c of Title 15, where such an action is otherwise authorized.

#### **(2) Protection for those providing information to professional review bodies**

Notwithstanding any other provision of law, no person (whether as a witness or otherwise) providing information to a professional review body regarding the competence or professional conduct of a physician shall be held, by reason of having provided such information, to be liable in damages under any law of the United States or of any State (or political subdivision thereof) unless such information is false and the person providing it knew that such information was false.

### **(b) Exception**

If the Secretary has reason to believe that a health care entity has failed to report information in accordance with section 11133(a) of this title, the Secretary shall conduct an investigation. If, after providing notice of noncompliance, an opportunity to correct the noncompliance, and an opportunity for a hearing, the Secretary determines that a health care entity has failed substantially to report information in accordance with section 11133(a) of this title, the Secretary shall publish the name of the entity in the Federal Register. The protections of subsection (a)(1) of this section shall not apply to an entity the name of which is published in the Federal Register under the previous sentence with respect to professional review actions of the entity commenced during the 3-year period beginning 30 days after the date of publication of the name.

(c) Treatment under State laws

(1) Professional review actions taken on or after October 14, 1989

Except as provided in paragraph (2), subsection (a) of this section shall apply to State laws in a State only for professional review actions commenced on or after October 14, 1989.

(2) Exceptions

(A) State early opt-in

Subsection (a) of this section shall apply to State laws in a State for actions commenced before October 14, 1989, if the State by legislation elects such treatment.

(B) Effective date of election

An election under State law is not effective, for purposes of [FN1], for actions commenced before the effective date of the State law, which may not be earlier than the date of the enactment of that law.

**42 U.S.C. § 11112 Standards for professional review actions**

(a) In general

For purposes of the protection set forth in section 11111(a) of this title, 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 after meeting the requirement of paragraph (3).

A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.

(b) Adequate notice and hearing

A health care entity is deemed to have met the adequate notice and hearing requirement of sub-section (a)(3) of this section with respect to a physician if the following conditions are met (or are waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating--

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

(2) Notice of hearing

If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--

(A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and

(B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.

(3) Conduct of hearing and notice

If a hearing is requested on a timely basis under paragraph (1)(B)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

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.

(c) Adequate procedures in investigations or health emergencies

For purposes of section 11111(a) of this title, nothing in this section shall be construed as--

(1) requiring the procedures referred to in subsection (a)(3) of this section--

(A) where there is no adverse professional review action taken, or

(B) in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action; or

(2) precluding an immediate suspension or restriction of clinical privileges, 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.

## **42 U.S.C. § 11113 Payment of reasonable attorneys' fees and costs in defense of suit**

In any suit brought against a defendant, to the extent that a defendant has met the standards set forth under section 11112(a) of this title and the defendant substantially prevails, the court shall, at the conclusion of the action, award to a substantially prevailing party defending against 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. For the purposes of this section, a defendant shall not be considered to have substantially prevailed when the plaintiff obtains an award for damages or permanent injunctive or declaratory relief.

...

### **P.L. 99-660, Title IV, Part C**

## **42 U.S.C. § 11151 Definitions**

In this chapter:

- (1) The term "adversely affecting" includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity.
- (2) The term "Board of Medical Examiners" includes a body comparable to such a Board (as determined by the State) with responsibility for the licensing of physicians and also includes a subdivision of such a Board or body.
- (3) The term "clinical privileges" includes privileges, membership on the medical staff, and the other circumstances pertaining to the furnishing of medical care under which a physician or other licensed health care practitioner is permitted to furnish such care by a health care entity.
- (4)(A) The term "health care entity" means--
  - (i) a hospital that is licensed to provide health care services by the State in which it is located,
  - (ii) an entity (including a health maintenance organization or group medical practice) that provides health care services and that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary), and
  - (iii) subject to subparagraph (B), a professional society (or committee thereof) of physicians or other licensed health care practitioners that follows a formal peer review process for the purpose of furthering quality health care (as determined under regulations of the Secretary).

(B) The term “health care entity” does not include a professional society (or committee thereof) if, within the previous 5 years, the society has been found by the Federal Trade Commission or any court to have engaged in any anti-competitive practice which had the effect of restricting the practice of licensed health care practitioners.

(5) The term “hospital” means an entity described in paragraphs (1) and (7) of section 1395x(e) of this title.

(6) The terms “licensed health care practitioner” and “practitioner” mean, with respect to a State, an individual (other than a physician) who is licensed or otherwise authorized by the State to provide health care services.

(7) The term “medical malpractice action or claim” means a written claim or demand for payment based on a health care provider’s furnishing (or failure to furnish) health care services, and includes the filing of a cause of action, based on the law of tort, brought in any court of any State or the United States seeking monetary damages.

(8) The term “physician” means a doctor of medicine or osteopathy or a doctor of dental surgery or medical dentistry legally authorized to practice medicine and surgery or dentistry by a State (or any individual who, without authority holds himself or herself out to be so authorized).

(9) The term “professional review action” means 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. In this chapter, an action is not considered to be based on the competence or professional conduct of a physician if the action is primarily based on--

(A) the physician’s association, or lack of association, with a professional society or association,

(B) the physician’s fees or the physician’s advertising or engaging in other competitive acts intended to solicit or retain business,

(C) the physician’s participation in prepaid group health plans, salaried employment, or any other manner of delivering health services whether on a fee-for-service or other basis,

(D) a physician’s association with, supervision of, delegation of authority to, support for, training of, or participation in a private group practice with, a member or members of a particular class of health care practitioner or professional, or

(E) any other matter that does not relate to the competence or professional conduct of a physician.

(10) The term “professional review activity” means 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.

(11) The term “professional review body” means a health care entity and the governing body or any committee 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.

(12) The term “Secretary” means the Secretary of Health and Human Services.

(13) The term “State” means the 50 States, the District of Columbia, Puerto Rico, the Virgin Is-lands, Guam, American Samoa, and the Northern Mariana Islands.

(14) The term “State licensing board” means, with respect to a physician or health care provider in a State, the agency of the State which is primarily responsible for the licensing of the physician or provider to furnish health care services.

**7.71.030. Actions by health care peer review body--Exclusive remedy**

(1) This section shall provide the exclusive remedy for any action taken by a professional peer review body of health care providers as defined in RCW 7.70.020, that is found to be based on matters not related to the competence or professional conduct of a health care provider.

(2) Actions shall be limited to appropriate injunctive relief, and damages shall be allowed only for lost earnings di-rectly attributable to the action taken by the professional review body, incurred between the date of such action and the date the action is functionally reversed by the professional peer review body.

(3) Reasonable attorneys' fees and costs as approved by the court shall be awarded to the prevailing party, if any, as determined by the court.

(4) The statute of limitations for actions under this section shall be one year from the date of the action of the professional review body.

# **APPENDIX B**

FILED

2019 MAY 17 PM 3:00

KIM M. TATE  
EX OFFICIO CLERK  
SUPERIOR COURT  
YAKIMA WASHINGTON

IN THE SUPERIOR COURT OF WASHINGTON  
IN AND FOR THE COUNTY OF YAKIMA

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

CAUSE NO. 08-2-04305-2

Plaintiff,

DECLARATION OF MIZE CONNER, M.D.

v.

YAKIMA VALLEY MEMORIAL  
HOSPITAL ASSOCIATION, RICHARD W.  
LINNEWEH, JR., ROGER ROWLES, M.D.  
and CARL OLDEN, M.D.,

Defendants.

I, Mize Conner, M.D., state and declare as follows:

1. My name is R. Mize Conner, M.D. I reside in Issaquah, Washington. I have personal knowledge of the following facts.

2. I am a physician and surgeon licensed to practice medicine and surgery in the State of Washington. I have been licensed to practice medicine in Washington continuously since 1980. I was engaged in the fulltime practice of obstetrics and gynecology ("OB/Gyn") in Bellevue, Washington from 1980 until 2009 and I am still practicing OB/Gyn on a part-time basis.

ORIGINAL

DECLARATION OF MIZE CONNER, M.D. - 1

CABLE, LANGENBACH,  
KINERK & BAUER, LLP  
29415 3-000000392

(206) 292-8800

1           3.     I am Board Certified in Obstetrics & Gynecology. During my career in Bellevue,  
2 I have been President of the Washington State Obstetrical Association, Chief of the Medical  
3 Staff at Overlake Hospital in Bellevue, Washington and have served as the hearing officer in  
4 several cases involving the suspension of a physician's medical staff privileges. A true and  
5 correct copy of my curriculum vitae is attached as an exhibit to this declaration.  
6

7           4.     Prior to becoming a physician I obtained a Bachelor of Science degree in  
8 electrical engineering at Louisiana State University in 1966 and a law degree at the University  
9 of Mississippi in 1968. I practiced law for four years before returning to the University of  
10 Mississippi to begin medical school in 1972.

11           5.     I obtained my M.D. in 1976 and completed my residency training in Obstetrics &  
12 Gynecology at the University of Mississippi in Jackson, Mississippi in 1980. A copy of my  
13 curriculum vitae is attached as Exhibit A.  
14

15           6.     Because I am a physician who also has a law degree, I have reviewed OB/Gyn  
16 medical records for insurance companies, hospitals and attorneys for many years. The cases I  
17 have reviewed have been divided roughly equally between plaintiff and defense cases and  
18 between physicians and hospital medical staffs.

19           7.     I have been retained by Robert Meals and Lawrence Cock, attorneys for Diana  
20 Smigaj, M.D., to render expert opinions regarding OB/Gyn clinical issues and medical peer  
21 review issues raised in the case of *Diana P. Smigaj, M.D., et al. v. Yakima Valley Memorial*  
22 *Hospital, et al.* pending in the Superior Court of Yakima County.  
23

24           8.     I have reviewed the following depositions, exhibits and declarations regarding  
25 this matter:

26           a.     Deposition of Mark Tomlinson, M.D. taken January 21, 2009  
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- b. Deposition of Brian Padilla, M.D. taken May 29, 2009
- c. Deposition of Nathaniel Davenport, M.D. taken June 2, 2009
- d. Deposition of Robert Cooper, M.D. taken June 2, 2009
- e. Deposition of Kevin Harrington, M.D. taken June 15, 2009
- f. Deposition of Beth Engelhardt, M.D. taken June 16, 2009
- g. Deposition of Kay Anyan taken on September 11, 2009
- h. Deposition of Carl Olden, M.D. taken October 22, 2009 & January 7, 2010
- i. Deposition of Richard W. Linneweh, Jr. taken November 2, 2009 & January 15, 2010
- j. Deposition of Roger Rowles, M.D. taken on November 4, 2009 & January 20, 2010 & April 7, 2010
- k. Deposition of Daniel Nadig, M.D. taken November 12, 2009
- l. Deposition of Dana Kenny, Esq. taken March 2, 2010
- m. Declaration of Ted Rudd, M.D.
- n. Declaration of Barbara Hood
- o. Medical records of patients JS, JA, WC and LH
- p. Medical records of Dr. Rowles' patient Nina Sanchez
- q. Deposition exhibits 1-93 including minutes of regular meetings of the Yakima Valley Memorial Hospital's Perinatal Quality Assurance Committee on May 30 and August 15, 2008 and special meetings of the Ad Hoc Perinatal Quality Assurance Committee on June 20, July 9, July 21, July 30, August 29 and September 3, 2008 and the written evaluations of Dr. Smigaj's cases by the hospital's reviewer, Dr. Mark Tomlinson and by Dr. Smigaj and her other reviewer, Dr. Stephen Brisbois.

1           9.     After a detailed review of all of the medical information and file materials I have  
2 formed several opinions and reached the following conclusions regarding this matter. First,  
3 there was no reasonable basis for summarily suspending Dr. Smigaj's privileges on September  
4 4, 2008. Summary suspension is a drastic action that can result in permanent damage to a  
5 physician's reputation and ability to earn a livelihood and it should be imposed only when there  
6 is a reasonable belief that failure to do so may result in imminent danger to health or safety.  
7

8           10.    The standard for a summary suspension is the threat of imminent danger to  
9 patient safety such that a physician's privileges must be suspended immediately until an  
10 investigation can be undertaken to determine whether the physician is in fact a threat to safety.  
11 The threat almost always arises from a precipitating event such as a sudden unexplained death  
12 of a patient on the operating room table, or a physician coming to the hospital in an inebriated  
13 condition. Summary suspension is justified when time is needed to investigate an incident that  
14 reasonably appears to pose an imminent threat of harm to patient safety when the circumstances  
15 are unclear or unknown. In Dr. Smigaj's case there was no precipitating event and the  
16 circumstances were never urgent.  
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18           11.    The recommendation in this case was made following an unauthorized review of  
19 Dr. Smigaj's practice initiated by administration officials who gathered false and misleading  
20 information about her practice dating back thirteen years and presented it to a committee  
21 dominated by her competitors, Dr. Rowles, Dr. Johns, Dr. Davenport and Dr. Jach.  
22

23           12.    The summary suspension was based primarily on three cases performed by Dr.  
24 Smigaj on February 26-27, 2008; June 16, 2008; and August 3, 2008, respectively. These three  
25 cases were reviewed by two external reviewers, one chosen by Dr. Smigaj and one chosen by  
26 the hospital. Both reviewers essentially agreed that there were no violations of the standard of  
27

1 care except in one case that predated the imposition of the summary suspension by over six  
2 months when Dr. Smigaj failed to evaluate a transfer patient in a timely fashion.  
3 Notwithstanding, the patient experienced a good outcome and Dr. Smigaj accepted the criticism  
4 and promised to respond within one hour in the future. The Perinatal Quality Assurance  
5 Committee (hereafter abbreviated as PQAC) agreed that Dr. Smigaj's promise to see all transfer  
6 patients within an hour resolved their criticism and there were no recurrences of this behavior.  
7 The concerns of the PQAC about the remaining two cases were not supported by either one of  
8 external reviewers and therefore did not remotely suggest that a reasonable person would find  
9 that Dr. Smigaj's practice posed an imminent danger to the health or safety of anyone.  
10

11 13. The improper imposition of the summary suspension of Dr. Smigaj's privileges  
12 is further supported by the fact that neither Yakima Valley Memorial Hospital nor the PQAC  
13 performed any additional investigation after Dr. Smigaj's privileges were summarily suspended  
14 on September 4, 2008 and no one who subsequently reviewed the materials available to the  
15 meeting of the PQAC on September 3, 2008 when the suspension was recommended found any  
16 basis for the immediate suspension of Dr. Smigaj's privileges.  
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18 14. Second, the three month review process that preceded summary suspension of  
19 Dr. Smigaj's privileges on September 4, 2008 was so devoid of the fundamental attributes of  
20 fairness that an objective and reasonable assessment of her practice was impossible. The  
21 ultimate goal of proper peer review is education. It is designed to measure and improve clinical  
22 performance. It is not intended to be disciplinary or punitive in nature. In this case, Yakima  
23 Valley Memorial Hospital administration transformed the PQAC into an investigative  
24 committee that failed to provide any of the protections afforded physicians by the Medical Staff  
25 Bylaws. As a result, an unauthorized body performed an improper investigation of Dr. Smigaj's  
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1 practice which led to the immediate suspension of her privileges on September 4, 2008 that  
2 cannot be justified by any objective standard.

3 15. The investigative process was unreasonable because a majority of the members  
4 of the PQAC were Dr. Smigaj's economic competitors.

5 16. The investigation was inadequate and unreasonable because objective standards  
6 were not used; because medical literature and national standards were not used; because Dr.  
7 Smigaj's accounts of her care of the three patients were ignored without explanation; because  
8 criticisms she clearly and convincingly refuted were continued without explanation; because she  
9 was not given notice or an opportunity to respond to several old criticisms that were used to  
10 support the recommendation to suspend her privileges immediately on September 3, 2008; and  
11 because the members of the PQAC were not provided the written reports of the hospital's  
12 outside reviewer who did not support any of the criticism of the last two cases that Dr. Rowles  
13 and Ms. Anyan reported to the PQAC on August 15, 2008 and September 3, 2008.

14 17. The investigation was unreasonable and inadequate because Dr. Rowles and Ms.  
15 Anyan repeatedly presented false or misleading information to the PQAC. The hospital's own  
16 external reviewer's opinions were misrepresented to the PQAC and the committee was told  
17 falsely that a surgeon witness, Dr. Daniel Nadig, was critical of Dr. Smigaj's care of a patient  
18 that she treated in January 2007. Dr. Nadig denied under oath that he ever spoke with Dr.  
19 Rowles about the case in question and he further testified he was not critical of her work in that  
20 case.

21 18. The investigation was unreasonable and inadequate because the members of the  
22 PQAC took a cavalier approach to their unauthorized investigation of Dr. Smigaj's practice.  
23 The members of the PQAC were unfamiliar with the pertinent provisions of the Medical Staff  
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1 Bylaws regarding investigations; the committee knowingly changed from a peer review  
2 committee to investigative body without authorization; the committee accused Dr. Smigaj of  
3 being a “disruptive physician” without reviewing her credentials file which contained only three  
4 or four incident reports, all of which predated 2008—one had nothing to do with disruptive  
5 behavior, another was trivial and a third one involved a dispute with another physician for  
6 which she apologized in 2006; the committee made no attempt to ascertain the number of  
7 patients Dr. Smigaj had treated and made no adjustments for their complexity compared with  
8 other Ob/Gyns on the medical staff; the PQAC did not properly evaluate the independent,  
9 external reviews of the three cases obtained by the hospital or Dr. Smigaj; other than Dr.  
10 Rowles, who was completely compromised and biased, and Dr. Johns, who competes with Dr.  
11 Smigaj, none of the other members of the PQAC had the knowledge of high-risk obstetrics  
12 needed to properly evaluate the three cases in issue and thus the members of the committee had  
13 a substantial misunderstanding of the facts; the PQAC used subjective standards to criticize the  
14 three cases; and Dr. Harrington, the Chairman of the Ob/Gyn Department was never consulted  
15 about the concerns that the PQAC undertook to investigate.

18       19.     The investigation was not objective because Yakima Valley Memorial Hospital  
19 had significant competing economic interests with Dr. Smigaj and her practice, known as  
20 Cascade Women’s Healthcare Associates. It owns or controls several practices whose  
21 physicians compete with Dr. Smigaj and her practice.

23       20.     The investigation of Dr. Smigaj’s practice was not objective because she was not  
24 treated equally with other Ob/Gyn physicians on the medical staff at Yakima Valley Memorial  
25 Hospital. Dr. Smigaj was held to a different standard of care than the other OB/Gyn  
26 practitioners on the medical staff. Her cases were scrutinized far more than any of the other  
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1 Ob/Gyn physicians. The Chairman of the PQAC, Dr. Rowles, performed initial reviews of all  
2 Ob/Gyn cases that fell out for review. He reviewed his own cases in violation of the hospital's  
3 peer review policy and he never referred any of his own cases for further review by the PQAC  
4 despite the fact that some cases clearly met the criteria for review by the committee. It is not  
5 possible for a physician who reviews his or her own cases to objectively evaluate his or her own  
6 clinical performance. Another Ob/Gyn physician in the department is well known for his  
7 disruptive behavior but the hospital has tolerated his inappropriate behavior for years. Other  
8 practitioners in the Ob/Gyn department have had multiple adverse patient outcomes but their  
9 privileges have never been suspended.  
10

11           21. The immediate suspension of Dr. Smigaj's privileges on September 4, 2008 was  
12 unreasonable and not based on objective evidence because the request for suspension was  
13 deficient on its face. It was also unreasonable because Dr. Padilla, the Chairman of the Medical  
14 Executive Committee who imposed the summary suspension, did not adequately investigate or  
15 evaluate the merits of the PQAC's recommendation to suspend her privileges. The PQAC met  
16 with senior members of hospital administration, including the Chief Executive Officer on the  
17 evening of September 3, 2008 and made a recommendation to the Medical Executive  
18 Committee to suspend Dr. Smigaj's privileges immediately, but the hospital did not wait to  
19 submit the matter to the Medical Executive Committee even though objectively, there was no  
20 urgency to the situation. Early the next morning, September 4, 2008 hospital administration  
21 contacted the Chief of Staff, Dr. Padilla, an emergency physician who knew practically nothing  
22 about the matter, and presented him a letter to sign that had been prepared by the hospital  
23 attorneys imposing the suspension without waiting for the Medical Executive Committee to  
24 consider the matter and without waiting to receive the hospital's outside reviewer's written  
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DECLARATION OF MIZE CONNER, M.D. - 8

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1 report. The hospital's outside reviewer's report was received by the hospital on September 9,  
2 2008 and it materially contradicted what Dr. Rowles and Kay Anyan claimed he said about two  
3 of the three cases the recommendation was based upon.

4 22. Dr. Padilla spoke with Dr. Rowles on the morning of September 4, 2008. Based  
5 on what Dr. Rowles told him about Dr. Smigaj's practice, Dr. Padilla signed the letter prepared  
6 by the hospital attorneys suspending Dr. Smigaj's privileges without performing any reasonable  
7 investigation of Dr. Rowles' allegations.

9 23. When the Medical Executive Committee met on September 16, 2008 and  
10 objectively reviewed the evidence, it reinstated Dr. Smigaj's privileges immediately. It did not  
11 vote to approve the initial suspension of her privileges on September 4, 2008.

12 24. One of the older cases that several members of the PQAC attached significance  
13 to as it related to their criticism of Dr. Smigaj's judgment and skills was number 57-14-18, a  
14 case she performed on January 27, 2007. The case is known as the Patient JS "hemorrhage"  
15 case. Review of the case also reveals a troubling pattern of conduct exhibited by Dr. Rowles  
16 and the PQAC. I was asked to review this case in 2007 by Dr. Smigaj's attorney, Mr. Meals,  
17 and I had no criticism of Dr. Smigaj, Dr. Nadig, Dr. Jones, the anesthesiologist, or the nursing  
18 staff. I was, however, critical of the hospital and the laboratory for not having a plan to provide  
19 blood products rapidly in an emergency hemorrhage case. The details of my evaluation of the  
20 case are contained in my letter of July 17, 2007 attached as Exhibit B.

21 25. The PQAC reviewed this case and at their meeting on August 22, 2007 they  
22 noted my review, but discounted it because I did not have access to additional information, such  
23 as "interviews of the other surgeons, nursing personnel, and blood bank personnel." However,  
24 it is doubtful that interviews with other surgeons actually occurred as there are no notes of such  
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1 interviews, there is no mention of such interviews in the minutes, and Dr. Nadig, the trauma  
2 surgeon, denies ever talking to Dr. Rowles, the PQAC, or anyone from YVMH about this case.  
3 (Nadig 21-22).

4 26. Dr. Smigaj was also criticized for "not having the knowledge or expertise to  
5 recognize the management of the hemorrhage." However, in my review I could find nothing to  
6 criticize in her management, and Dr. Nadig stated that he had "no reason to question her skills  
7 or ability to handle an acute hemorrhage" (Nadig 18).

9 27. The PQAC was critical that no pelvic exam was done and there was no  
10 documentation of steps taken to control hemorrhage prior to returning to the operating room  
11 (PQAC minutes 3/23/07 and 5/16/07). The nurses' notes indicate light vaginal bleeding,  
12 decreasing blood pressure, and a distended abdomen. These observations are diagnostic of intra-  
13 abdominal bleeding, and there was no option other than return to the operating room. A pelvic  
14 exam would have been meaningless and would have only delayed the appropriate therapy.

16 28. Dr. Smigaj was also criticized for calling Dr. Jones, as Dr. Smigaj "should be  
17 able to perform a hysterectomy." (PQAC minutes 8/17/2007). Dr. Smigaj explained that as an  
18 obstetrician, she does not usually perform hysterectomies and "the expertise of a gynecologist  
19 would better serve the patient." (PQAC minutes 8/17/2007, 3/23/2007). Dr. Nadig testified that,  
20 in his opinion that showed good judgment by Dr. Smigaj. (Nadig 16).

22 29. The PQAC minutes of 5/16/07 state that this case was reviewed at the request of  
23 the trauma surgeon, but this is directly contradicted by Dr. Nadig's sworn testimony. (Nadig  
24 19-22).

25 30. Despite the lack of evidence of improper management of hemorrhage, the PQAC  
26 recommended Dr. Smigaj take additional training in the management of hemorrhage. Later, her  
27

1 declining to take an unnecessary course would be cited as evidence that she had "an inability to  
2 learn from previously-identified poor practice patterns." (PQAC minutes September 3, 2008).

3           31. Dr. Smigaj was also charged with having poor surgical skills (PQAC minutes  
4 September 3, 2008), and specifically Dr. Rowles, was critical of her opening the retroperitoneal  
5 space, based on comments from Dr. Nadig. However, Dr. Nadig denied speaking to Dr. Rowles  
6 (Nadig 21-23) and further states that he was making the decisions about how the  
7 retroperitoneum would be examined (Nadig 27). In fact the left edge of the uterine incision was  
8 opened slightly, a suture removed, and additional sutures were placed to control the bleeding.  
9 Technically this qualifies as opening the retroperitoneum, but failure to do so to control obvious  
10 bleeding would be inappropriate and a violation of the standard of care (Rowles, p. 455).  
11 Literature (see Gabbe: Normal and Problem Pregnancies, page 596 to 599; Williams Obstetrics,  
12 page 779) from authoritative textbooks states that opening the retroperitoneum in the face of a  
13 retroperitoneal hematoma is reasonable. Despite being shown this literature, Dr. Rowles  
14 testified this was inappropriate and continued his criticism. (Rowles, pp. 440-445) This refusal  
15 to recognize that an approach different than what he would do strongly suggests an underlying  
16 bias and prejudice.

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19           32. Neither I, nor the trauma surgeon in attendance, Dr. Nadig, had any concerns  
20 about Dr. Smigaj's surgical skills, judgment or management. Dr. Rowles' persistence in his  
21 criticism of opening the retroperitoneum in the face of my opinion and Dr. Nadig's opinion and  
22 of supportive literature from respected textbooks raises serious concerns about Dr. Rowles'  
23 objectivity. These concerns were reinforced by his claim that Dr. Nadig referred the case to the  
24 PQAC and criticized Dr. Smigaj's competence despite Dr. Nadig's sworn testimony to the  
25 contrary. (Nadig 18 to 27). See also Dr. Smigaj's letter of 8/16/07.  
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1           33.     I was asked to review case number 67-95-07, the "Patient JA case" in July 2008.  
2 I prepared a written evaluation of the case on July 24, 2008. A copy of my report is attached as  
3 Exhibit C: The PQAC asked an external reviewer, Dr. Mark Tomlinson, a perinatologist who  
4 practices at St. Vincent Hospital in Portland, Oregon to also review the case in July 2008. His  
5 conclusions are contained in his written report dated August 1, 2008 (Ex. 16) Comparison of  
6 my opinion and Dr. Tomlinson's opinion indicate there is no significant disagreement regarding  
7 our respective evaluations of the case. We both agree that Dr. Smigaj should have come in to  
8 personally evaluate the patient, but other than that, there were no other criticisms of Dr. Smigaj,  
9 although there were concerns about the nursing care. Dr. Smigaj agreed with this criticism and  
10 promised in the future to see transfer of patients "as soon as possible." (See Dr. Smigaj's Email  
11 to Kay Anyan, 7/18/08). (See also PQAC minutes of 7/30/08 indicating Dr. Smigaj agreed to  
12 see patients within one hour of transfer).  
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15           34.     There is no OB department policy at Memorial regarding the time frame in which  
16 to see transfer patients. When asked to establish such a policy, the department declined to do so.  
17 (PQAC minutes 7/9/08).

18           35.     A review of the transfer log indicated that most practitioners usually saw patients  
19 within a few hours of admission. None of these practitioners were cited.

20           36.     It should be noted that Dr. Tomlinson reported to the committee orally; his  
21 written report was never given to the PQAC members. The PQAC asked the referring  
22 physician, Dr. Meininger, to verify his ultrasound examination of J.A. which he had obtained  
23 prior to her transfer to Dr. Smigaj. Dr. Meininger replied by letter dated 8/4/08 (Ex. 15) that he  
24 had verified vertex presentation by ultrasound. Dr. Rowles testified that this was not  
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1 satisfactory because Dr. Meininger sent a letter instead of a report, and he accused Dr.  
2 Meininger of being untruthful (Rowles, p. 155).

3 37. I was asked to review case number 68-75-58, the "Patient WC case" in August  
4 2008. I prepared a written evaluation of the case on August 26, 2008. A copy of my report is  
5 attached as Exhibit D. I had no criticism of Dr. Smigaj's care in this case and I felt the  
6 criticisms leveled by Yakima Valley Memorial Hospital were without basis. In all likelihood,  
7 this infant died of overwhelming sepsis, probably around 2200, since no fetal heart rate was  
8 obtained after 2200 that was not identical to the maternal heart rate.

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10 38. Patient WC's case was also sent to the hospital's external reviewer, Dr. Mark  
11 Tomlinson, on 8/6/08. His review is contained in his written report dated September 3, 2008  
12 (Ex. 20) Comparison of the reports from the two external reviewers, myself and Dr. Tomlinson,  
13 reveals no significant differences, and neither of us had any significant criticisms of Dr.  
14 Smigaj's care. I clarified some issues in my report because Dr. Tomlinson did not have access  
15 to Dr. Smigaj's office notes. Dr. Tomlinson did not have access to Dr. Smigaj's office notes  
16 because he was forwarded the records on 8/6/08, before the committee had reviewed the case  
17 and without notice to Dr. Smigaj, so she had no opportunity to respond to the concerns.

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19 39. Dr. Tomlinson expressed his opinions on 8/13/08 in a telephone conference with  
20 Dr. Rowles, Dr. Olden, and Kay Anyan (Rowles, p. 411). Dr. Tomlinson testified that his  
21 opinions expressed in the telephone conference did not differ from his written report  
22 (Tomlinson, p. 28; p. 81), and that he did not share the PQAC's concerns. Dr. Rowles' report to  
23 the committee, however, significantly misrepresented Dr. Tomlinson's opinions an excerpt from  
24 the minutes of 8/15/08 shows:  
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"This case was reviewed with Dr. Mark Tomlinson, a perinatologist at St. Vincent's Medical Center in Portland. Dr. Tomlinson had concerns regarding the accuracy of the determination that the patient was not in labor, but agreed that if in the judgment of the practitioner, the patient was not in labor, arrangements for transfer were appropriate if facilities and staffing were not adequate for delivery resuscitation of a 25 week infant. Dr. Tomlinson felt that the practitioner should have remained on premises until the patient had been safely transported. Dr. Tomlinson also believes that management of the hypertension in the office setting did not meet standards of care and also raised concerns regarding the safety of administering Terbutaline as a uterine relaxant and the patient's significant hypertension. Dr. Tomlinson also commented that in his experience, consultation with neonatology regarding severe prematurity issues and prognosis should have been considered prior to transport, given the availability of an on-site neonatology services.

Recommendations/Action: The committee agreed that the following concerns required written response for practitioner 32629. Initially she will be invited to the next committee meeting for case review. Practitioner 16140 will be invited for his observations of the event."

1. The patient should have been admitted on her initial office visit on 7/30/08 for management of severe hypertension complicating pregnancy at 24 weeks.
2. Pre-term labor had not been adequately ruled out to insure safe transfer and no tocolytic medications apparently had been considered.
3. Neonatology was not consulted prior to or after ongoing transfer.

- 1 4. As the patient was being prepped for transfer, the practitioner left the hospital when the  
2 patient's condition declined; while awaiting practitioner 32629 to return, another  
3 practitioner had to assist with imminent issues.  
4  
5 5. Use of Terbutaline in a severely hypertensive patient.

6 Dr. Rowles claimed in his deposition (Rowles 412 – 420) that Dr. Tomlinson's oral report  
7 differs materially from Dr. Tomlinson's written report, although he has no notes from that  
8 conversation to verify his contention. This is the third physician Dr. Rowles has accused of  
9 being untruthful (Dr. Nadig, Dr. Meininger, and Dr. Tomlinson). Dr. Tomlinson's written  
10 report was never provided to the committee nor were the misrepresentations corrected before the  
11 committee made its final recommendations on 9/3/08. These material misrepresentations of Dr.  
12 Tomlinson's opinions would be expected to profoundly affect the PQAC's judgment. In her  
13 letter of 8/28/2008 Dr. Smigaj explained that the patient had refused hospitalization, leaving her  
14 no alternative other than outpatient management, which was successful. She explained her  
15 evaluation of the stability of WC for transport, which both Dr. Tomlinson and I felt was  
16 appropriate. Despite her explanations and providing her office notes (Rowles, p. 421), the  
17 PQAC continued these charges as part of the basis for the recommendation for summary  
18 suspension. This was unreasonable.  
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21 40. I was also asked to review case number 63-90-42, the "Patient LH case" in  
22 August 2008. My written evaluation of the LH case is contained in my letter dated August 26,  
23 2008. (Exhibit D). I found nothing in Dr. Smigaj's management of this case that deserved  
24 criticism. Dr. Tomlinson also reviewed this case on September 3, 2008. His evaluation is  
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1 contained in his letter dated September 3, 2008 and was received by Yakima Valley Memorial  
2 Hospital on September 9, 2008.

3           41. Comparison of the two opinions from Dr. Tomlinson and me reveal no  
4 significant differences. What minor differences there are exist because Dr. Tomlinson did not  
5 have access to all of the pertinent facts. The documentation of the cervical exam and  
6 presentation are documented on the induction scheduling form, which is in the mother's chart.  
7 It is routine practice at Memorial for the nurse to perform the initial exam to determine  
8 presentation on patients admitted for induction, and the obstetrician does not routinely come in  
9 (Rowles, p. 208). Dr. Tomlinson's criticisms were all directed to the hospital and nursing staff.  
10 He related his opinions to Kay Anyan, a non-medical employee who is a senior member of  
11 Memorial's administration, in a telephone call on 9/3/08, and she presented his opinions to the  
12 committee. Again, his opinion was substantially misrepresented to the committee as Ms. Anyan  
13 stated that, "Dr. Tomlinson shared that substandard care was provided to the patient." Dr.  
14 Tomlinson did not say that about Dr. Smigaj and Ms. Anyan awkwardly explained that when  
15 she said that she meant the nursing staff. It is unlikely that the PQAC understood it that way.  
16

17           42. On 9/3/08 the PQAC met with the CEO, Mr. Linneweh; the COO, Mr. Myers;  
18 and Mr. Zech, the hospital's attorney (who appeared by telephone) and recommended a  
19 "precautionary" suspension because it was the PQAC's judgment that Dr. Smigaj's continued  
20 practice constituted an unacceptable risk to patients. The PQAC based its recommendation on  
21 several concerns, none of which was reasonable under the circumstances. The basis of my  
22 opinion is as follows:  
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24           A. Poor clinical judgment.  
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DECLARATION OF MIZE CONNER, M.D. - 16

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1. JA case – “failure to personally evaluate a high risk transport patient prior to treatment.”

a. Although the committee is holding Dr. Smigaj to a standard which the OB department specifically declined to adopt, Dr. Smigaj agreed voluntarily to come in within one hour.

b. This resolved the concerns raised by Dr. Tomlinson and Dr. Rowles (Rowles, p. 152; p. 437; Tomlinson, p. 62)

c. There had been no previous concerns of this nature.

d. There have been no recurrences.

e. There were mitigating factors

- Dr. Smigaj received a thorough report from the referring physician with whom she had a long-standing working relationship.
- Treatment had already been started and she was transferred for delivery, which implies the patient was aware of the planned treatment and had consented to it.
- She received ongoing reports from nursing and responded to them as is customary.
- She came in promptly when requested by the nursing staff.
- There was a good outcome.

2. LH case – Failure to document cervical exam and presentation

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- a. The exam had been done six days earlier and documented on the scheduling induction form (Smigaj letter 8/28/2008).
- b. The exam was done by the nurse on admission.
  - this is routine and customary at Memorial. (Rowles, p. 208)
  - Dr. Tomlinson agrees that this meets the standard of care. (Tomlinson letter 9/3/2008).
- 3. LH case – Performing an elective induction on an unripe cervix
  - a. Dr. Smigaj was not given notice of this accusation. (Rowles, p. 193-197).
  - b. Dr. Smigaj was not given a chance to respond to this charge (Rowles, p. 197)
  - c. The cervix was not unripe.
    - the cervix was a Bishop score of 5 in the office 6 days prior, and this is considered an intermediate cervix. (Williams Obstetrics, page 429)
    - The cervix was most likely ripe by the time of admission.
    - Use of Prostaglandin E in women with intermediate scores of 5 to 7 has been shown to trigger effective labor without subsequent need for Oxytocin (Williams Obstetrics 28<sup>th</sup> edition, page 429; Rowles, p. 223)
  - d. Dr. Tomlinson had no criticisms of this.
  - e. The labor was normal.
  - f. There is no increased risk of C-section if induced with an unripe cervix in a multiparous patient (Rowles, p. 222)

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4. W.C. case – Failure to admit patient at the time of her initial visit for blood pressure management.

a. In fact, Dr. Smigaj’s office notes indicated she recommended admission and the patient refused admission (Smigaj letter 8/28/08, Smigaj office notes 7/24/08).

b. All reviewers agreed this was not a valid criticism. (Tomlinson, p. 76; Conner letter 8/26/08; Brisbois letter 9/15/08).

c. Dr. Smigaj provided her office notes documenting LH’s refusal of admission before the suspension was imposed (Rowles, p. 421).

d. Dr. Rowles admits that outpatient management is reasonable when the patient refuses admission (Rowles, p. 425).

e. Outpatient management was successful (Rowles, p. 425).

5. WC case – Failure to determine stability prior to transfer.

a. Dr. Smigaj personally came in and evaluated this patient.

b. There were no complaints of contractions until 2200.

c. There was no documentation of the patient having contractions.

d. There was no cervical change.

e. There was no criticism of this by Dr. Tomlinson or Dr. Conner.

B. Ethical Concerns

1. J.A. – Failure to obtain informed consent.

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a. This is essentially a continuation of the criticisms made above in the JA case regarding failure to come in and see the patient a timely fashion and the same comments apply.

b. There is no pattern of failure to obtain informed consent.

c. The patient had knowledge of the plan from her referring physician and treatment had already been started.

2. JA case – Misleading dictation of the history and physical leading the reader to believe the practitioner had seen the patient at the time of admission.

a. The chart notes clearly indicate the time that Dr. Smigaj first saw the patient

b. The date and time of dictation are clearly indicated on the dictated history and physical.

c. Use of the present tense is a style issue as explained by Dr. Smigaj (Smigaj statement 9/16/08).

d. In the JS case, in 2007, the history and physical dictation was done four months after the patient's admission. It is also in the present tense, thus supporting Dr. Smigaj's explanation that this is a style issue.

e. This criticism does not remotely constitute an imminent danger to patient safety.

C. Interpersonal communications.

1. Disruptive practitioner reports – yelling, inappropriate conversation/inappropriate place.

a. There have been two instances in 13 years.

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- The April 2006 incident involved raising her voice in a disagreement with another physician.

- In July 2007 Dr. Smigaj conducted a private telephone conversation on hospital premises.

b. These two incidents do not constitute a "pattern" of disruptive behavior.

c. Dr. Smigaj was not given notice of this charge and had no opportunity to respond to it.

d. This charge does not even remotely constitute an imminent danger to patient safety.

2. Communication with hospital personnel is disruptive to patient care as evidenced in the practitioner's file.

- There are no such reports in her file other than the two referenced above.
- None of the PQAC members have been able to document any episodes of communication disruptive to patient care.

D. Skills

1. JS case – not recognizing complications associated with Cesarean section

a. The co-surgeon, Dr. Nadig, had no criticism of Dr. Smigaj's skills. (Nadig, p. 23)

b. Dr. Nadig testified he had no reasons to question her skills. (Nadig, p. 18)

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c. Dr. Nadig testified he never complained or referred this case for review to the PQAC (Nadig, p. 19)

d. Dr. Nadig testified that he had no reason to question her skills or her ability to handle an acute hemorrhage. (Nadig, p. 18)

e. I had no criticisms.

E. Inability to learn from poor practice patterns

1. There was only one valid criticism -- failure to come in to personally evaluate the patient in a timely fashion.

2. This does not constitute a pattern.

3. She learned from that criticism.

a. She admitted her error.

b. She promised not to repeat it.

c. There have been no recurrences.

d. She committed to a standard that the OB department expressly declined to adopt for themselves.

4. Unfounded criticisms (JS case) do not demonstrate a failure to learn.

In summary, a detailed review of two out of the three cases the PQAC relied on to summarily suspend Dr. Smigaj's privileges by two objective reviewers shows that the external reviewers agreed that there were no deviations from the standard of care in those two cases (WC and LH) and no significant criticisms of Dr. Smigaj's care of the JA case with the exception of criticism

1 of not seeing the patient in a timely fashion. Dr. Smigaj agreed with that criticism and agreed to  
2 see patients within one hour, a standard which the OB department refused to impose upon itself.  
3 Both Dr. Tomlinson (Tomlinson, p. 62) and Dr. Rowles (Rowles, p. 152) agreed that her  
4 commitment to see transfer patients in a timely fashion resolved their concerns. A third  
5 reviewer, Dr. Brisbois, reviewed the WC and LH cases and he had no criticisms of Dr. Smigaj's  
6 care either. He also stated that, "It is my opinion that neither of these two cases, nor the  
7 combination of both of these cases raise any clinical concerns that would warrant or justify  
8 termination of privileges." (Brisbois letter 9/15/08).

10 43. Based on my review of the cases cited, it is my opinion that no reasonable person  
11 could conclude that Dr. Smigaj's practice could result in imminent danger to the health and  
12 safety of any individual.

14 44. In my opinion, the process employed by Yakima Valley Memorial Hospital in its  
15 evaluation of Dr. Smigaj was so substandard and deficient that there was practically no  
16 likelihood that the PQAC or Memorial could make a reasonable determination about her  
17 competence and professional conduct. My analysis of the conduct of the PQAC, the medical  
18 staff and the hospital is as follows:

20 A. Transformation of the PQAC into an investigative committee

21 The goals of the PQAC are primarily educational (Rowles, p. 84) and disciplinary actions  
22 are not included within its function, duties, or goals (YVMH bylaws pp. 32- 33; YVMH peer  
23 review process; Anyan 80-81). If a member's practice is considered detrimental to patient  
24 safety, etc., the by-laws state that a request for investigation should be submitted to the Chair of  
25 the Medical Executive Committee (MEC). The Chair may commence an investigation by the  
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1 MEC or refer the matter to the department chair for review or appoint an Ad Hoc Investigative  
2 Committee to review the matter. Request for investigation triggers safeguards for the members  
3 including notice of the investigation, notification of the specific conduct in question, the right to  
4 appear and explain the issues, notice of any meetings, and in the case of an Ad Hoc  
5 Investigative Committee, a prohibition of economic competitors of the member on the  
6 committee (YVMH Fair Hearing Plan 1-3).  
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8 On 6/20/08 the PQAC essentially appointed itself as an investigative committee when "the  
9 options available to the committee, i.e., requiring additional training, mandatory proctoring,  
10 reprimand and/or reduction of privileges" were discussed (Rowles, p. 95; p. 189; PNQAC  
11 minutes 6/20/2008). In fact, none of these actions are available to the PQAC (YVMH Fair  
12 Hearing Plan, p. 3; (Rowles, p. 190; Olden, p. 87). At that time the PQAC began referring to  
13 itself as "an Ad Hoc" committee (PQAC minutes 6/20/08, 7/9/08, 7/21/08, 7/30/08, 8/29/08,  
14 9/3/08). Of the seven members of the PQAC, five are direct economic competitors of Dr.  
15 Smigaj (Rowles, Johns, Olden, Davenport and Jach).  
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18 **B. Adequacy of the investigation**

- 19 1. Objective standards and bench marks were not used in the evaluation of Dr. Smigaj.  
20 (Rowles, pp. 102-107; p. 215) as required by the bylaws (YVMH bylaws, p. 32,  
21 Linneweh, pp. 172-173). Dr. Rowles did not know the department rate of Apgars less  
22 than 6 nor did he know Dr. Smigaj's rate (Rowles, p. 215); in fact, Dr. Smigaj's rate of  
23 Apgars less than 6 was the lowest of any of the active members of the OB department  
24 (greater than 100 deliveries per year) and was less than 50% of the department average  
25 rate. (Anyan 70-72; YVMH statistics). These statistics also show that Dr. Smigaj had  
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the largest OB practice at YVMH. Bench mark analysis would have shown that her practice was in line with or exceeded departmental norms.

2. The PQAC did not consult literature or national standards in evaluating Dr. Smigaj's practice as suggested in the peer review process, page 4. (Rowles, p. 459; Davenport, p. 89).
3. When authoritative medical literature supportive of Dr. Smigaj's practice was presented, it was ignored. (Rowles, pp. 435-436; pp. 441-445)
4. Dr. Smigaj's explanations of her practice were often ignored.
  - a. Dr. Smigaj explained that in the WC case she had recommended the patient be admitted and the patient refused admission. Dr. Smigaj produced her office notes to verify her explanation. (Rowles, pp. 421-422; Davenport, pp. 151-152, 200).
  - b. Dr. Smigaj produced a letter from the transferring physician, Dr. Meininger, in the JA case verifying that he had performed an ultrasound prior to transfer and found the presentation be vertex. This was not accepted, and Dr. Meininger was accused of being untruthful. (Rowles, pp. 155, 397, 398)
  - c. Dr. Smigaj was accused of not documenting cervical examination and presentation prior to induction in the LH case. Dr. Smigaj explained to the PQAC that she had done this in the office (PQAC minutes 8/29/08, p. 3). The induction scheduling form verifies that this was done prior to admission, as Dr. Smigaj had explained. This form is in LH's hospital chart and was available to the PQAC.

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5. Charges used to justify summary suspension were continued despite having been resolved or shown to be unfounded.
- a. Concern regarding failure to see a transfer of patient in a timely manner in the JA case had been resolved by Dr. Smigaj's agreement on 7/18/09 to see all such patients in one hour. (Rowles, pp. 437-438; Davenport, pp. 95-96, 115-116; Engelhardt, p. 177).
  - b. Failure to admit WC for blood pressure management when WC refused admission (Rowles, p. 421; Davenport, pp. 150-151, 200).
  - c. Failure to remove the charge of induction with unripe cervix when Dr. Rowles knew that in a multiparous patient, which LH was, there was no increase in risk (Rowles, p. 222) and that it was not below the standard of care. (Rowles, p. 222). Dr. Rowles also knew that use of prostaglandin in a multipara with a Bishop score of 5 to 7 has been shown to trigger labor without subsequent need for oxytocin and that she had a successful induction and a normal labor. (Rowles, p. 223).
6. Dr. Smigaj was not given notice of several charges and was not given an opportunity to respond to them.
- a. Failure to use Piper forceps in the LH case (Rowles, pp. 194-196, 214, 220-221).
  - b. Induction with unripe cervix in LH (Rowles, pp. 194-197, 221).
  - c. Disruptive practitioner reports; in fact, none of the PQAC itself had seen disruptive practitioner reports in Dr. Smigaj's file (Rowles, p. 524) nor did they ask to see her

1 credentials file. (Davenport, pp. 66-68) Nor could they name specific instances of  
2 disruptive behavior (Engelhardt, p. 230).

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4 d. Not recognizing complications associated with Cesarean section. This relates to  
5 the JS case in 2007, and Dr. Smigaj was given no notice of ongoing concerns  
6 regarding this case after the PQAC transformed itself into an Ad Hoc Investigative  
7 Committee. Thus she had no opportunity to defend her actions and to point out the  
8 many troubling aspects regarding the veracity of charges made against her. (Nadig,  
9 pp. 18-27)

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11 7. The PQAC never received Dr. Tomlinson's written reports of JA, LH, or WC.  
12 (Rowles, pp. 428-429; Olden, p. 202; Anyan, pp. 178-179, 234)

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14 8. The decision to recommend a summary ("precautionary") suspension was  
15 unreasonable.

16 a. Of the 21 separate criticisms made by the PQAC, only two were supported by the  
17 two external reviewers, Dr. Tomlinson and Dr. Conner. Both of these related to  
18 the timeliness of seeing the transfer patient JA. Both of these concerns were  
19 resolved by Dr. Smigaj's promise to come in within one hour, which she kept.

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21 b. All subsequent reviewers -- Dr. Brisbois; Dr. Harrington, the OB department chair;  
22 Dr. Padilla, the chair of the MEC; and all members of the MEC -- have concluded  
23 the suspension was unreasonable. These reviews were based on information  
24 known to or reasonably available to the PQAC and to Dr. Padilla at the time of the  
25 recommended suspension and no new investigations had been carried out since  
26 that time. (Linneweh, p. 329; Anyan, p. 239; Davenport, p. 186).  
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1 C: False and misleading information was given to the PQAC

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- 3 1. Dr. Tomlinson's opinions on patient WC were misrepresented to the PQAC by Dr.
- 4 Rowles' oral report on 8/15/08.
- 5 a. Dr. Tomlinson did not say Dr. Smigaj should remain on the premises until
- 6 transport arrived, nor did he say that he had concerns about the accuracy of the
- 7 determination that the patient was not in labor (Tomlinson letter 9/3/08).
- 8
- 9 b. Dr. Tomlinson did not say that outpatient management of hypertension did not
- 10 meet the standard of care (Tomlinson letter 9/3/08).
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- 12 c. Dr. Tomlinson did not say that there should have been a neonatology consult
- 13 (Tomlinson letter 9/3/08).
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- 15 d. Dr. Tomlinson testified that there is no material difference nor immaterial
- 16 difference between his oral and written reports. He used his notes to prepare both
- 17 reports. (Tomlinson, p. 28)
- 18 2. Dr. Tomlinson's report on LH was given to the PQAC by Kay Anyan, a lay hospital
- 19 employee with no medical training. (PQAC minutes 9/3/08)
- 20 3. Dr. Tomlinson's report on LH was misrepresented to the PQAC on 9/3/08. Dr.
- 21 Tomlinson did not say that Dr. Smigaj had provided substandard care to LH
- 22 (Engelhardt, pp. 219, 227; Rowles, pp. 466; Tomlinson, p. 115).
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- 24 4. The PQAC was falsely told that Dr. Nadig was critical of Dr. Smigaj's care in the JS
- 25 case. (Nadig, p. 18-27; Rowles, p. 129).
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- 5. The PQAC was falsely told Dr. Nadig had referred the JS case for review (Nadig, p. 19; letter 5/16/07 Rowles to Smigaj; PQAC minutes 2/16/07).
- 6. The PQAC was falsely told Dr. Smigaj did not seem to have the knowledge or expertise to recognize the management of hemorrhage (Rowles, p. 114), but Dr. Nadig expressly testified that he had no reason to question Dr. Smigaj's ability to handle acute hemorrhage (Nadig, p. 18).

D: Dr. Smigaj was treated unequally from other physicians on the PNOAC.

- 1. She was scrutinized more thoroughly than other physicians (Harrington, p 92; Padilla, pp. 98-99).
- 2. Dr. Rowles selects cases for review by the PQAC. (Rowles, p. 72).
- 3. Dr. Rowles reviews his own cases (Rowles pp. 74-76), although this is prohibited by the peer review policy (Peer Review Policy page 4), and he is aware of this policy (Rowles, p. 83).
- 4. Dr. Rowles has never referred any of his cases to the PQAC for review. (Rowles, p. 74).
- 5. Dr. Rowles has had at least one case of an infant fetal death. (Rowles, p. 268).
- 6. This case of fetal death was not forwarded for review by Dr. Rowles (Rowles, pp. 268, 274), even though he stated that intrapartum fetal demise would be a sentinel event which usually triggers an automatic review of the case. The peer review policy states that unanticipated deaths are considered an indicator for all departments (Peer Review

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Policy, page 7) and are to be reviewed by the peer review process (Peer Review Policy page 4).

7. Another practitioner (Dr. Naiden) – is well known for his disruptive behavior (Linneweh, pp. 177–180; Rowles, pp. 208; Harrington, pp. 155-161).
8. No restrictions have been placed on Dr. Naiden’s privileges because of his disruptive behavior (Linneweh, p. 178) nor have there been any interventions. (Harrington, p. 161).
9. Dr. Naiden has had several lawsuits (Linneweh, pp. 140-143, 181-182), and he has not had his privileges suspended even though one case resulted in a crushed skull and another in a shoulder dystocia injury.
10. Dr. Smigaj has had one malpractice claim; it was dismissed without payment or finding of fault.

E: POAC members took a cavalier approach to the investigation

1. They were not familiar with the bylaws regarding the corrective action policy and the peer review process. (Engelhardt, pp. 111, 113; Davenport, pp. 46-54; Rowles, pp. 96-98).
2. They knowingly changed from a peer review process to a disciplinary investigation without a referral from the MEC as required by the bylaws (Engelhardt, pp. 107-111; Rowles, pp. 95, 189).
3. The PQAC charged Dr. Smigaj as a “disruptive physician,” but
  - a. None of them had seen her credentials file. (Davenport, pp. 66-67)

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- b. They did not request to see her file. (Davenport, pp. 66-68)
  - c. They could not name specific instances of disruptive behavior (Engelhardt, p. 230; Rowles 207-208)
  - d. Dr. Rowles cited one example of yelling at the blood bank because blood was not provided in a timely fashion in the JS case (Rowles, p. 207). Under the circumstances this would be understandable, but Dr. Nadig testified that he did not recall her raising her voice during that case (Nadig, p. 18).
  - e. They did not provide Dr. Smigaj with notice of this charge, and she was given no opportunity to explain or defend.
4. They made no attempt to determine the number of cases Dr. Smigaj had delivered (Engelhardt, pp. 50, 154; Davenport, p. 120; Rowles, p. 102).
5. They did not properly evaluate the external reviews or the opinion of the Chariman of the Ob/Gyn department.
- a. "partly to insure fairness" (Engelhardt, p. 29)
  - b. "but don't give them greater weight" (Engelhardt, p. 30)
  - c. "I respect Dr. Harrington's opinion ... I don't think it would have changed my opinion" (Engelhardt, pp. 33-34)
  - d. Dr. Davenport did not review my report on JS and based his opinion solely on the opinions of the other PQAC members (Davenport 68-70). He is not a surgeon.
  - e. Having Dr. Tomlinson's written report prior to voting was not important (Davenport, p. 143)

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- f. Dr. Davenport may not have reviewed my report on patient WC before voting (Davenport, p. 154).
  - g. Dr. Davenport admitted he does not have experience with breech deliveries and for that reason did not consider Dr. Tomlinson's opinion. (Davenport, p. 173).
  - h. Dr. Engelhardt thought I might possible be biased but she had no basis for believing that. (Engelhardt, p. 207)
6. Committee members had inadequate knowledge
- a. Dr. Engelhardt has no surgical training, yet is critical in the JS case about placement of a suture. (Engelhardt, pp. 55, 61)
  - b. Dr. Engelhardt thinks Dr. Smigaj did not have the knowledge to recognize or manage hemorrhage, because she asked another OB do to the hysterectomy. (Engelhardt, p. 59) Dr. Smigaj does not perform hysterectomies in her practice but Dr. Engelhardt admitted that it was actually good judgment to ask for help. (Engelhardt, p. 60) Dr. Rowles agreed that calling for help showed good judgment. (Rowles, p. 114) Dr. Nadig agreed this showed good judgment (Nadig, p. 16).
  - c. Dr. Davenport has never delivered a breech, but that did not deter him from concluding that Dr. Smigaj should have used Piper forceps in the LH case. (Davenport, pp. 173-176) and saying that Dr. Tomlinson's opinions did not deserve much weight, despite the fact that Memorial submitted the medical records to Dr. Tomlinson for an objective review.

- 1 d. Dr. Davenport then demonstrated his lack of knowledge of breech deliveries by  
2 suggesting that Dührssen's incisions should have been used. (Davenport, pp. 174-  
3 176) The average medical student knows that it is impossible to make Dührssen's  
4 incisions (which are incisions in the cervix) when the cervix is completely dilated  
5 as it would be in the LH case.  
6
- 7 c. Dr. Davenport, while admitting that he is "not an expert" (in surgical skills) and  
8 "haven't gone through surgical training" (Davenport, p. 62), nevertheless  
9 concludes that Dr. Smigaj's surgical skills were below par in the JS case  
10 (Davenport, p. 70). He did not interview Dr. Nadig (Davenport, p. 68) who has  
11 testified that he did not support any of the criticisms of Dr. Smigaj (Nadig 18-27);  
12 Dr. Davenport also admitted he did not review the chart in JS (Davenport, pp. 68 –  
13 69). Dr. Davenport was not a member of the PQAC in 2007 when the JS case was  
14 reviewed.  
15
- 16 f. Dr. Olden has no experience with massive hemorrhage nor does he perform  
17 Cesarean sections or hysterectomies (Olden, pp. 42-47).  
18
- 19 g. Dr. Rowles was unaware that two authoritative obstetrical textbooks, Williams  
20 Obstetrics and Gabbe: Normal and Abnormal Problem Pregnancies both support  
21 opening the retroperitoneum in the case of a retroperitoneal hematoma. (Rowles,  
22 pp. 441-445).  
23
- 24 h. Dr. Rowles charged Dr. Smigaj of performing an induction with an unripe cervix  
25 (Bishop Score = 5) but Williams Obstetrics 20<sup>th</sup> edition page 429 states that a  
26 Bishop Score of 5 is not unripe, it is intermediate.  
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7. PQAC members used subjective standards.
- a. "That is not the way I personally would have taken care of this patient." (Engelhardt, p. 91).
  - b. "I basically do not trust anything I haven't done myself." (Engelhardt, pp. 93-94).
  - c. "No way they (external reviewers) can understand the context in which care is delivered." (Olden, pp. 102).
  - d. The PQAC discounted my evaluation of the JS case because they said I did not have access to "interviews with the other surgeons, nursing, and blood bank personnel" in the JS case. (PQAC minutes 8/17/07)
    - There is no evidence from the PQAC minutes that any other surgeon, nurse or blood bank person ever appeared before the committee.
    - Dr. Nadig, the trauma surgeon has specifically testified that he never talked to the PQAC, Dr. Rowles, Dr. Olden or any one from YVMH about this case (Nadig, pp. 18-27).
    - It appears that the PQAC got its information informally from another surgeon, Dr. Conroy, who was not scrubbed in the case; not involved in the surgery; and was described by Dr. Nadig as "standing in the doorway for a few minutes." (Nadig 9-10; Davenport 97-101; Engelhardt 57-58; Olden 138-140)
8. Some of the PQAC members have significant misunderstanding of the facts in these cases.

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- a. Dr. Engelhardt thought that Dr. Smigaj had refused the nurse's request to come in the JA case (Engelhardt, p. 86); this is not true.
  
- b. Dr. Davenport thought that Dührssen's incisions should have been performed in the LH case. He failed to notice that the cervix was completely dilated, and it would have been impossible to do this. An attempt to do would have likely caused catastrophic bleeding. (Davenport, p. 174).
  
- c. In the WC case, Dr. Rowles thought that Terbutaline was given to relax the uterus to deliver the head, when in fact it was given after the general anesthetic was induced to facilitate delivery of the placenta. (Rowles, p. 437).
  
- d. In the WC case, Dr. Rowles attributed death of the fetus to entrapment of the head and felt that Dr. Smigaj could have done a C-section and had a potentially different outcome. (Rowles, pp. 426-427). The autopsy report and my report both felt death was due to sepsis. Dr. Tomlinson felt that Dr. Smigaj's management had no relationship to the baby's death, and he stated that "an emergency Cesarian section ...likely could not have been achieved." I would be very critical of any obstetrician who subjected a 333-pound woman to a C-section for a 25 week fetus who almost certainly had overwhelming sepsis in the face of tumultuous labor.
  
- e. Dr. Rowles was critical of Dr. Smigaj's management of the JS case because he could not tell whether the patient was having heavy vaginal bleeding when she was taken back to the operating room. (Rowles, p. 126). The patient's records show that the nurse's notes described light bleeding; this was also confirmed in the PQAC minutes of 3/23/07.

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- f. Dr. Rowles claims to have spoken to Dr. Tomlinson about the LH case on 8/13/08 but this is clearly not possible since Dr. Tomlinson did not receive the LH records until 9/3/08. Dr. Tomlinson testified that he spoke to Kay Anyan about the LH case on 9/3/08 (Tomlinson, p. 34) and denied speaking to anyone else at YVMH. (Tomlinson, p. 94) (Anyan, pp. 199-200; Rowles, p. 462; Ex. 149).
- g. Dr. Olden claims to have discussed all three cases, JA, WC and LH, with Dr. Tomlinson. (Olden, p. 83) This is not possible because Dr. Tomlinson did not receive the LH case records until 9/3/07, and on that date he spoke only to Kay Anyan (Anyan, pp. 199-200, 209; Tomlinson, p. 94; Olden, p. 226).
- h. Dr. Olden stated that "Dr. Smigaj had little or no ability to see where she was placing sutures." (Olden, p. 144) This statement is attributed to the trauma surgeon. The only trauma surgeon present was Dr. Nadig, and he testified that he never spoke to Dr. Olden and has no criticism of Dr. Smigaj's management or skills. (Nadig, p. 18-27) This statement then was either made up from whole cloth or it came from Dr. Conroy, who was present in the doorway for a few minutes (Nadig, p. 9) where he could not possibly have made an accurate assessment of Dr. Smigaj's ability to place sutures.
- i. Dr. Olden attributed several statements to Dr. Nadig, allegedly made during an interview with Dr. Nadig. Dr. Nadig allegedly said that Dr. Smigaj did not have the expertise to manage hemorrhage properly. (Olden, p. 138). He also purportedly "prevented further digging into the retroperitoneum," and "told people to get their hands up." (Olden, p. 157). No notes or other records of

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this interview exist. These statements are incompatible with Dr. Nadig's testimony in which he states he has no criticism of Dr. Smigaj and that he has "no reason to question her skills or ability to handle an acute hemorrhage." He specifically denies ever talking to Dr. Olden regarding this case. (Nadig, pp. 18-27).

9. The PQAC did not ask the Chairman of the OB department, Dr. Harrington, who probably had the best insight into the department members, for his opinions.

F: YVMH had competing economic interests

1. YVMH owned several practices in which the physicians practice obstetrics. (Linneweh, pp. 83-88).
2. The hospital practices have lost \$12 to \$16 million over the past six to seven years (Linneweh, p. 89).
3. Having more obstetrical patients would reduce the losses. (Linneweh, p. 93).
4. Dr. Smigaj and her midwives have the largest obstetrical practice at YVMH (YVMH statistical data; Anyan, pp. 70-72).
5. If Dr. Smigaj lost her privileges, her patients and those of her midwives would have to be distributed among the other obstetrical providers at YVMH. (PQAC minutes 7/9/08; Rowles, p. 180).
6. This was discussed by the PQAC. (PQAC minutes 7/9/08).

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7. Of the seven PQAC members, five are direct economic competitors of Dr. Smigaj – Dr. Rowles, Dr. Johns, Dr. Olden, Dr. Davenport, Dr. Jach – despite their denials they are her competitors. (Rowles, p. 59; Davenport, p. 81).

8. Of the seven PQAC members, three have financial ties to YVMH.

- a. Dr. Rowles has four contracts with YVMH. (Linneweh, pp. 138-146).
- b. Dr. Olden is paid \$300,000 per year in addition to fringe benefits such as health insurance, 401-K contributions, malpractice insurance, life insurance, disability insurance, professional dues and licenses, and phone service (Olden, pp. 50-59).
- c. Dr. Johns was given a guarantee of up to \$400,000 plus moving expenses when he was recruited by YVMH (Linneweh, p. 110; 116-120; Harrington, p. 140).

G: Dr. Padilla was negligent in evaluating the request for precautionary suspension

- 1. The request for precautionary suspension was deficient on its face.
  - a. The request was from a peer review committee.
  - b. He had not received a request for corrective action from the committee.
  - c. He had not appointed them as an Ad Hoc Investigative Committee.
  - d. The PQAC contained a majority of economic competitors – 5 of 7.
  - e. While a request deserves serious attention, it demands critical evaluation. Dr. Padilla blindly trusted what Ms. Anyan and Dr. Rowles told him on September 4, 2008 and did not investigate the facts underlying what they told him.
- 2. Dr. Padilla made an inadequate evaluation of the recommendation of the PQAC.

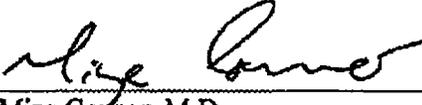
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- a. He did not understand the by-laws. (Padilla, pp. 101, 152)
- b. He did not review the by-laws. (Padilla, pp. 51)
- c. He did not evaluate the two independent external reviews that were available (Padilla, pp. 43, 178) even though he had plenty of time to do so. (Padilla, p. 84).
- d. He did not consider calling Dr. Tomlinson. (Padilla, p. 59)
- e. He was aware that the most recent case occurred one month previously (Padilla 46) so he knew there was no urgency to act before the PQAC's recommendation was considered by the MEC at its next meeting scheduled 12 days later.
- f. He relied solely on the PQAC even though there was no report from them. (Padilla, p. 97)
- g. He did not ask Dr. Harrington, OB department Chair, his opinion even though he spoke to him the morning of the suspension. (Padilla, pp. 50, 51)
- h. He felt he had to act on the morning of September 4, 2008 but admitted that the PQAC's recommendation did not necessarily pose a risk of imminent danger. (Padilla, p. 68)
- i. After he reviewed the file, he felt there was no major violation of the standard of care and that there was no significant discrepancy between my reviews of Dr. Smigaj's cases and Dr. Tomlinson's reviews. (Padilla, p. 98) All of the information that was reasonably available to him on the morning of 9/4/08 should have indicated to any reasonable physician that there was no need to summarily suspend Dr. Smigaj's privileges at that time.

1 45. It is my opinion that an improperly constituted committee of economic competitors  
2 dominated by a very senior obstetrician conducted an investigation of Dr. Smigaj's practice  
3 without authorization and without the safeguards and basic rights afforded by the YVMH  
4 bylaws in a superficial and negligent fashion resolving every question against Dr. Smigaj,  
5 disregarding the unanimous concordant opinions of independent outside reviewers, persistently  
6 levying charges that had been disproved, in a setting of economic opportunism for Yakima  
7 Valley Memorial Hospital, ultimately culminating in a request for suspension of her privileges  
8 which was imposed by a poorly informed Chair of the MEC who failed to conduct a  
9 rudimentary investigation that would have exposed the groundless nature of the charges which  
10 were apparent to everyone else who subsequently reviewed the file.  
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13 I declare under penalty of perjury of the laws of the State of Washington that these are  
14 my opinions and the facts are true and correct.

15 Dated: May 14, 2010 at Issaquah, Washington.

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Mize Conner, M.D.

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# APPENDIX C

interlocutory motion or motion to dismiss, without permission of the judicial authority.

(P.B. 1978-1997, Sec. 293.)

**Sec. 5-9. Citation of Opinion Not Officially Published**

An opinion which is not officially published may be cited before a judicial authority only if the person making reference to it provides the judicial authority and opposing parties with copies of the opinion.

(P.B. 1978-1997, Sec. 294.)

**Sec. 5-10. Sanctions for Counsel's Failure to Appear**

Counsel who fails to appear on a scheduled date for any hearing or trial or who requests a continuance without cause or in any other way delays a case unnecessarily will be subject to sanctions pursuant to General Statutes § 51-84.

(P.B. 1978-1997, Sec. 983.)

**Sec. 5-11. Testimony of Party or Child in Family Relations Matter When Protective Order, Restraining Order or Standing Criminal Restraining Order Issued on Behalf of Party or Child**

(a) In any court proceeding in a family relations matter, as defined in General Statutes § 46b-1, or in any proceeding pursuant to General Statutes § 46b-38c, the court may, except as otherwise required by law and within available resources, upon motion of any party, order that the testimony of a party or a child who is a subject of the proceeding be taken outside the physical presence of any other party if a protective order, restraining order or standing criminal restraining order has

been issued on behalf of the party or child, and the other party is subject to the protective order or restraining order. Such order may provide for the use of alternative means to obtain the testimony of any party or child, including, but not limited to, the use of a secure video connection for the purpose of conducting hearings by videoconference. Such testimony may be taken outside the courtroom or at another location inside or outside the state. The court shall provide for the administration of an oath to such party or child prior to the taking of such testimony as required by law.

(b) Nothing in this section shall be construed to limit any party's right to cross-examine a witness whose testimony is taken pursuant to an order under subsection (a) hereof.

(c) An order under this section may remain in effect during the pendency of the proceedings in the family relations matter.

(Adopted June 21, 2010, to take effect Jan. 1, 2011.)

COMMENTARY—2011: The above section adopts the provisions of Public Act 08-67, § 1 (codified as General Statutes § 46b-15c), which expands the circumstances under which a person may testify outside the courtroom and permits the use of videoconferencing to provide such testimony.

In all cases in which a court orders testimony to be taken pursuant to this section, the manner in which and the means whereby the testimony is taken must be consistent with the right to confrontation guaranteed by the federal and state constitutions. U.S. Const., amends VI, XIV; Conn. Const., art. I, § 8. The federal and state confrontation clauses provide a criminal defendant with two protections: "the right physically to face those who testify against him, and the right to conduct cross-examination." *Pennsylvania v. Ritchie*, 480 U.S. 39, 51, 107 S. Ct. 989, 94 L. Ed. 2d 40 (1987); see also *State v. Jarzbek*, 204 Conn. 683, 529 A.2d 1245 (1987), cert. denied, 484 U.S. 1061, 108 S. Ct. 1017, 98 L. Ed. 2d 982 (1988) .

Subsection (b) expressly protects a party's right to cross-examination.

Not Reported in A.2d, 2005 WL 1433841 (Conn.Super.)  
(Cite as: 2005 WL 1433841 (Conn.Super.))

**H**  
Only the Westlaw citation is currently available.

UNPUBLISHED OPINION. CHECK COURT RULES BEFORE CITING.

Superior Court of Connecticut,  
Judicial District of New Britain.  
Stephen HARRIS, M.D.

v.

BRADLEY MEMORIAL HOSPITAL  
AND HEALTH CENTER.

No. CV020516962S.  
May 19, 2005.

Mary Leonhardt, Moore Leonhardt LLC,  
Hartford, for Stephen Harris.

O'Brien Tanski & Young LLP, Hartford,  
for Bradley Memorial Hospital and Health  
Center Inc.

BURKE, J.

\*1 This case arises from the suspension of the clinical privileges of the plaintiff surgeon, Dr. Stephen Harris, by the defendant hospital, Bradley Memorial Hospital and Health Center, Inc. The plaintiff alleges that the defendant's actions violated state and federal laws and constitutional due process provisions, and thereby constituted breach of contract, breach of the implied covenant of good faith and fair dealing, tortious interference with business expectancies, and violation of the Connecticut Unfair Trade Practices Act (CUTPA). The plaintiff seeks injunctive relief, damages, attorneys fees and punitive damages. The defendant moves for summary judgment on the ground that the plaintiff is unable to rebut the statutory presumption of

immunity created by the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101 through 11152. The plaintiff claims that there exist genuine issues of material fact concerning whether the defendant's actions satisfy the statutory criteria for immunity.

Congress enacted the Health Care Quality Improvement Act (HCQIA) in response to "an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(5). The statute provides immunity from damages to any "professional review body" that engages in a "professional review action" that meets certain statutory standards. 42 U.S.C. § 11111(a)(1). Hospitals are expressly included within the protections of the act 42 U.S.C. §§ 11111(a)(1); 11151(4), (11).

A professional review action is defined 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." 42 U.S.C. § 11151(9).

For immunity to attach, the professional review action "must be taken-(1) in the reasonable belief that the action was in the

Not Reported in A.2d, 2005 WL 1433841 (Conn.Super.)  
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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).” 42 U.S.C. § 11112(a). Moreover, “[a] professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence.” 42 U.S.C. § 11112(a).

\*2 The parties do not dispute that the defendant is an entity covered by the act whose activities in the course of deciding to suspend the plaintiff's clinical privileges constitute at least one professional review action as defined by the act. The parties disagree about whether the defendant engaged in more than one professional review action and whether the defendant's actions meet the statutory criteria for immunity.

Neither the court nor the parties have identified any binding state or federal precedent.<sup>FN1</sup> Without controlling precedent, the court seeks guidance from the considerable federal case law interpreting the immunity provisions of the act. Ordinarily, summary judgment will enter when the moving party submits proof that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law. Practice Book § 17-49. “The party seeking summary judgment has the burden of showing the absence of any genuine issue [of] material facts which, under applicable principles of substantive

law, entitle him to a judgment as a matter of law ... and the party opposing such a motion must provide an evidentiary foundation to demonstrate the existence of a genuine issue of material fact.” (Citation omitted; internal quotation marks omitted.) *Barrett v. Montesano*, 269 Conn. 787, 791-92, 849 A.2d 839 (2004). “In deciding a motion for summary judgment, the trial court must view the evidence in the light most favorable to the nonmoving party.” (Internal quotation marks omitted.) *Appleton v. Board of Education*, 254 Conn. 205, 209, 757 A.2d 1059 (2000).

FN1. Two superior courts have considered motions for summary judgment based on HCQIA. See *Munch v. Charlotte Hungerford Hospital*, Superior Court, judicial district of Litchfield, Docket No. CV 00 0082892 (April 22, 2002, DiPentima, J.); *Chadha v. Administrator, CHH*, Superior Court, judicial district of Litchfield, Docket No. CV 99 0079598 (July 31, 2001, Cremins, J.), aff'd on other grounds, *Chadha v. Charlotte Hungerford Hospital*, 272 Conn. 776, 865 A.2d 1163 (2005). Both courts granted summary judgment, concluding that the defendants had satisfied the statute's requirements for immunity from damages liability.

In HCQIA cases, however, courts have uniformly recognized that the statutory presumption of immunity results in “an unconventional standard in determining whether [the defendant] was entitled to summary judgment—whether a reasonable jury, viewing all facts in a light most favorable to [the plaintiff], could conclude that he had shown, by a preponderance of the evidence, that [the defendant's] actions fell out-

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 (Cite as: 2005 WL 1433841 (Conn.Super.))

side the scope of section 11112(a).” *Gabaldoni v. Washington County Hospital Assn.*, 250 F.3d 255, 260 (4th Cir.2001). “In other words, the role of this court is not to substitute its judgment for that of the professional review body nor to reweigh the evidence before that body, but simply to determine whether a genuine issue of fact exists as to the hospital's compliance with HCQIA's conditions for immunity.” *Munch v. Charlotte Hungerford Hospital*, Superior Court, judicial district of Litchfield, Docket No. CV 00 0082892 (April 22, 2002, DiPentima, J.).

The defendant offers no evidence in support of its motion for summary judgment. The defendant rather looks to the allegations of the complaint and argues, based on the facts alleged, that the plaintiff cannot rebut the presumption that the statutory requirements for immunity were satisfied. The plaintiff responds with evidence that he claims proves that the hospital's actions were initiated in bad faith by an economic competitor, Dr. Joshua Morowitz, thereby tainting the entire process, and that the procedures used during the investigation violated his due process rights. The plaintiff's evidence includes the signed and sworn affidavit of the plaintiff and certified transcripts of deposition testimony of several witnesses, including Dr. Morowitz and other members of the defendant's staff.

\*3 The allegations of the complaint and the evidence offered by the plaintiff, which is undisputed by the defendant, largely present the same facts. The plaintiff began practicing surgery as an active member of the defendant's staff in 1994. In June 1999, his clinical privileges were renewed through the defendant's credentialing peer review procedure. In December 1999, the defendant conducted a peer review of one

of the plaintiff's cases that involved an error. The plaintiff acknowledged the error and voluntarily submitted to partial supervision for six months. In June 2000, the chairman of the department of surgery ended the supervision and fully restored the plaintiff's privileges. Between June 2000 and October 2000, no new issues arose concerning the plaintiff's care of his patients.

Sometime after June 2000, the defendant, without direction or prompting from the medical staff, retained an outside consultant to review twenty of the plaintiff's cases. One was the case for which the plaintiff previously admitted error and submitted to supervision. The other cases reviewed previously had been deemed not to warrant action after peer review at the surgery department's morbidity and mortality meetings. The consultant's report was critical of the plaintiff's clinical performance.

Dr. Joshua Morowitz, an economic competitor of the plaintiff, assumed the role of chairman of the department of surgery in September 2000, subsequent to which he was given a copy of the outside consultant's report. He initiated and conducted a preliminary review of all of the plaintiff's major surgical cases and some of his minor surgical cases, for the purpose of selecting a group of cases for review by a peer review committee. Dr. Morowitz selected the members of the committee, compiled and provided information for their review, including the outside consultant's report, and actively participated in the committee's review of thirty-three of the plaintiff's cases, despite the fact that he was not a member of the committee.

The plaintiff was not informed of the review conducted by the outside consultant until November 2000. He was given a copy

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of the report in December 2000, when he was advised that the defendant was convening a peer review committee to review his cases. He was not informed what cases would be reviewed by the committee. Two of the three members of the peer review committee were economic competitors of the plaintiff.

On January 15, 2001, the peer review committee met for five hours to review the plaintiff's cases. Dr. Morowitz participated in the review and discussion of the cases during this meeting. On January 29, 2001, the plaintiff was informed for the first time that he was expected to attend a meeting with the peer review committee and Dr. Morowitz that was scheduled to begin in two hours. At the meeting, he was subjected to a critical review of thirty-three of his cases. He was not informed of the subject of the meeting in advance and was unable to prepare. He was able to review a patient chart during the meeting only when the chart was placed in front of him by Dr. Morowitz during questioning about the particular case. The next day, the peer review committee issued a report recommending restriction of the plaintiff's privileges. Based on the reports of the peer review committee and the outside consultant, the defendant's medical executive committee voted on February 13, 2001 to summarily suspend the plaintiff's privileges, restricting him to "first assist only in the operating room." All other privileges were removed.

\*4 The plaintiff requested a hearing and, between July and November 2001, hearings took place before a three-person peer review hearing panel. The hearing panel recommended continuation of the suspension of the plaintiff's privileges. The plaintiff appealed to the defendant's board

of directors and presented evidence to a three-person appeal panel in support of his claim that the suspension was unwarranted, infected with the bad faith of Dr. Morowitz and impeded by the lack of due process.

Based on these facts, the plaintiff argues that the initiation of peer review was unwarranted and motivated by the bad faith of his competitor, Dr. Morowitz. <sup>FN2</sup> The plaintiff also argues that the defendant failed to satisfy the notice and hearing requirements of 42 U.S.C. § 11112(a)(3) because of the late notice of the meeting with the peer review committee. The plaintiff contends that the defendant's actions fail to meet the "safe harbor" provisions of 42 U.S.C. § 11112(b), by which the defendant may be deemed to have met the notice and hearing requirement of 42 U.S.C. § 11112(a)(3). Moreover, the plaintiff argues that the procedural deficiencies of the investigative process leading to the peer review committee's recommendations resulted in a failure by the defendant to engage in a reasonable effort to obtain the facts of the matter as required by 42 U.S.C. § 11112(a)(3). Because of these procedural deficiencies and the bad faith of Dr. Morowitz, the plaintiff contends that the entire peer review process was tainted and rendered unfair.

FN2. Although the plaintiff challenges the basis for the initiation of the process, the plaintiff does not contend that the actions taken as a result of that process failed to satisfy the requirements of 42 U.S.C. § 11112(a)(1) and (4) that they be taken in the reasonable belief that they were in furtherance of quality health care and that they were warranted by the facts. Thus, the plaintiff's claims about the impro-

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priety of the commencement of the process appear to be an element of his argument that the defendant did not satisfy the due process requirements of 42 U.S.C. § 11112(a)(2) and (3).

The defendant contends that case law clearly establishes that the alleged bad faith of Dr. Morowitz is irrelevant to the determination of immunity under HCQIA. The defendant further argues that even if the procedures preceding the peer review committee's recommendation were deficient, that deficiency did not result in a failure to satisfy the statutory criteria because the ultimate decision to suspend the plaintiff's privileges was made, after adequate notice and hearing, by the three-person peer review hearing panel, not by the peer review committee initially convened by Dr. Morowitz.

The court first considers the legal significance of the plaintiff's allegations of the defendant's bad faith. The plaintiff consistently grounds his specific complaints about the defendant's actions in a general complaint that the process was tainted by the bad faith of the defendant and Dr. Morowitz. The federal courts "have uniformly applied all the sections of § 11112(a) as objective standards." *Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 32 (1st Cir.2002). "Therefore, the good or bad faith of the reviewers is irrelevant." *Brader v. Allegheny General Hospital*, 167 F.3d 832, 840 (3rd Cir.1999). The plaintiff presents no specific evidence of such bad faith, other than the fact that Dr. Morowitz is an economic competitor. Even if the plaintiff had presented evidence of bad faith, the case law clearly establishes that bad faith is irrelevant to HCQIA claims. If the defendant's process was ob-

jectively reasonable and fair as required by the act, the defendant's bad faith, without more, will not suffice to strip the defendant of statutory immunity.

\*5 The parties next disagree about how many "professional review actions," as defined by HCQIA, were taken by the defendant. The act requires that a professional review action meet the requirements of 42 U.S.C. § 11112(a). In other words, for each professional review action in which the defendant engaged, it must have complied separately with the statutory requirements for immunity. See *Reyes v. Wilson Memorial Hospital*, 102 F.Sup.2d 798, 816-17 (S.D. Ohio 1998) (each of three professional review actions taken by defendant must be analyzed separately). Peer review proceedings that do not constitute professional review actions are considered to be "professional review activities," as defined by 42 U.S.C. § 11151(10),<sup>FN3</sup> and are not individually examined for their compliance with the statute. Rather, the professional review activities are considered to be a component of the overall professional review action, and the action will be evaluated by considering the totality of the process leading to the action, including the professional review activities. *Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*, *supra*, 308 F.3d at 37.

FN3. The statute defines "professional review activity" as "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

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“(C) to change or modify such privileges or membership.”

The defendant argues that only the ultimate decision of the three-person peer review hearing panel constituted a professional review action, and that the other proceedings were merely professional review activities to be judged as a part of the process leading to that one professional review action. Thus, the defendant argues, any failure to meet procedural requirements prior to the meeting with the peer review committee does not deprive the defendant of immunity because the statute's requirements were met by the time that the ultimate decision was made by the peer review hearing panel.

The plaintiff appears to argue that each decision and recommendation made during the peer review process constituted a separate professional review action and that the deficiencies during the initial stages of the process rendered each of those actions defective for purposes of statutory immunity. The plaintiff specifically attacks the process leading to the recommendation of the peer review committee, upon which the medical executive committee based its decision to suspend summarily the plaintiff's privileges. The plaintiff does not make any specific allegations of procedural deficiencies during the later proceedings.

After a review of the case law and the evidence, presented by the plaintiff, the court concludes that the plaintiff engaged in more than one professional review action and that the plaintiff has demonstrated the existence of a genuine issue of material fact concerning whether one of those actions satisfied the statutory requirements for immunity. The proceedings before the peer review committee led directly to the summary suspension of the plaintiff's priv-

ileges by the medical executive committee. This action by the medical executive committee constituted “an action ... based on the competence of an individual physician ..., which affects ... adversely the clinical privileges ... of the physician;” 42 U.S.C. § 11151(9); and thus satisfied the statutory definition of a professional review action.

\*6 Moreover, the plaintiff presents sufficient evidence to establish a genuine issue whether the proceedings leading to the summary suspension satisfied 42 U.S.C. § 11112(a)(2) and (3), which require the defendant to make a reasonable effort to obtain the facts and to provide adequate notice and opportunity to be heard to the defendant. The evidence reveals that the plaintiff received only two hours' notice of the meeting with the peer review committee, was not informed of the cases to be reviewed, and was given no opportunity to prepare. The recommendation issued the next day by the peer review committee led directly to the summary suspension of the plaintiff's privileges by the medical executive committee, without further opportunity to be heard. Thus, in the course of events leading to the summary suspension, the defendant clearly failed to meet the “safe harbor” requirements that the physician be given at least 30 days to request a hearing prior to the proposed action, with at least 30 days' notice in advance of the hearing, and that the physician be permitted, among other things, to be represented by an attorney and to present evidence. 42 U.S.C. § 11112(b). Although failure to meet the safe harbor provisions does not conclusively establish that the defendant does not satisfy the statutory notice and hearing requirements, in the alternative, the procedures must be “fair to the physician under the circumstances.” 42 U.S.C. § 11112(a)(3). The plaintiff's evidence that the plaintiff's no-

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tice of peer review committee's meeting was short and incomplete, and that his opportunity to be heard was significantly constrained by the nature of his notice and the manner in which the meeting was conducted, establishes a genuine issue of fairness sufficient to rebut the statutory presumption that the defendant satisfied the notice and hearing requirements of 42 U.S.C. § 11112(a)(3). This evidence, combined with the evidence of the manner in which that committee conducted its work, including the role of Dr. Morowitz and the scope of information before the committee, also gives rise to a genuine issue whether the defendant satisfied the requirement of 42 U.S.C. § 11112(a)(2) to make a reasonable effort to obtain the facts of the matter. Thus, the plaintiff's evidence is sufficient to demonstrate a genuine issue whether the professional review action of summarily suspending the plaintiff's privileges, in conjunction with the professional review activities leading to that action, satisfied the statutory requirements for immunity.

The defendant argues that, even if the proceedings leading to the summary suspension do not satisfy the provisions of 42 U.S.C. § 11112(a), the defendant need not meet those requirements if it engages in "an immediate suspension or restriction of clinical privileges ... where the failure to take such an action may result in an imminent danger to the health of any individual." 42 U.S.C. § 11112(c)(2). The defendant presents no evidence, however, that such a danger existed or that the medical executive committee even considered that question prior to issuing the summary suspension. Moreover, the language of the statute makes clear that HCQIA's rebuttable presumption of compliance applies only to the standards set forth in 42 U.S.C. § 11112(a), not the provisions of 42 U.S.C.

§ 11112(c). See 42 U.S.C. § 11112(a). Without the benefit of the statute's rebuttable presumption, the burden lies with the moving party to submit proof that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law. Practice Book § 17-49. The defendant's failure to present evidence to support its claim of imminent danger defeats its motion for summary judgment on this ground.

\*7 Although the record indicates that the defendant engaged in one or more professional review actions subsequent to the summary suspension, the plaintiff did not present specific evidence demonstrating that those actions failed to satisfy the statutory criteria. The plaintiff claims that the flaws preceding the summary suspension doom the remaining actions but, without evidence of flaws in those later proceedings, this claim is not sufficient to give rise to a genuine issue of material fact concerning the sufficiency of the later proceedings. See *Reyes v. Wilson Memorial Hospital*, *supra*, 102 F.Sup.2d at 816-17 (analyzing each professional review action separately).

Finally, the statutory immunity granted by HCQIA provides that the defendant "shall not be liable in damages under any law of the United States or of any State." 42 U.S.C. § 11111(a)(1).<sup>FN4</sup> "HCQIA immunity is limited to suits for damages; there is no immunity from suits seeking injunctive or declaratory relief." *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 918 (8th Cir.1999), cert. denied, 528 U.S. 1137, 120 S.Ct. 980, 145 L.Ed.2d 931 (2000). In this case, the plaintiff seeks "monetary damages," punitive damages, attorneys fees and injunctive relief. The defendant's motion for summary judgment, to the extent

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that it is successful, eliminates only the plaintiff's claims for monetary relief, and does not affect the plaintiff's claims for injunctive relief.

FN4. The statute excepts certain civil rights laws that are not implicated in this case.

Accordingly, the motion for summary judgment is denied as to the plaintiff's claims for injunctive relief and as to his claims for damages resulting from the summary suspension of the plaintiff's privileges by the defendant's medical executive committee. The motion for summary judgment is granted on all remaining claims.

Conn.Super.,2005.  
Harris v. Bradley Memorial Hosp. and Health Center  
Not Reported in A.2d, 2005 WL 1433841  
(Conn.Super.)

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Only the Westlaw citation is currently available.

United States District Court,  
D. Colorado.

Michael RYSKIN, Plaintiff,

v.

BANNER HEALTH, INC., an Arizona non-profit corporation, Michelle Joy, Shirley Nix, Thomas Soper, Joseph Bonelli, and John Elliff, Defendants.

Civil Action No. 09-cv-01864-MEH-KMT.  
Nov. 9, 2010.

Scott Martin Kleger, Mollie B. Hawes, Miller & Steiert, P.C., Littleton, CO, for Plaintiff.

Linda L. Siderius, Meghan Elizabeth Pound, Michael W. Schreiner, Sharon E. Caulfield, Caplan and Earnest, LLC, Boulder, CO, Carmen N. Decker, Kari Mackercher Hershey, Katrina A. Skinner, Hershey Skinner, LLC, Littleton, CO, for Defendants.

**ORDER ON MOTION FOR SUMMARY JUDGMENT RELATED TO QUALIFIED IMMUNITY**

MICHAEL E. HEGARTY, United States Magistrate Judge.

\*1 Before the Court is Defendants' Joint Motion for Summary Judgment Related to Qualified Immunity [*filed August 30, 2010; docket # 75*]. By Order of Reference to United States Magistrate Judge, this matter has been referred to me to conduct proceedings in this civil action pursuant to 28 U.S.C. § 636(c) and Fed.R.Civ.P. 73. The matter is fully briefed, and the Court orders that, for the reasons that follow, the motion is **granted in part and**

**denied in part.**

**STATEMENT OF MATERIAL FACTS**

1. Plaintiff is an obstetrician/gynecologist ("OB/GYN") who was employed by Banner Health to provide services at Sterling Regional MedCenter (SRMC) in Sterling, Colorado pursuant to a contract dated July 5, 2005. Final Pretrial Order, Stip Fact 4.3. In 2007, the contract was renewed for an additional two years until July 5, 2009. *Id.*, Stip Fact 4.4.

2. In November 2006, Plaintiff's hospital privileges had been renewed for a two-year period ending November 21, 2008. Pl. Exh. 2 at 19: 21-25; Defs. Exh. A-28, docket # 79-36.

3. In the absence of problems or concerns and if the physician's record is "clean," reappointment and renewal of privileges is usually for a term of two years. Pl. Exh. 2 at 22: 7-17.

4. SRMC is obligated, by law and accreditation standards, to have quality management and professional review processes in place for continued quality assurance and improvement of care. Final Pretrial Order, Stip Fact 4.7.

5. SRMC has adopted Bylaws of the Medical Dental and Podiatric Staff; included in those bylaws is a section relating to the creation and duties of a Peer Review Committee. Defs. Exh. A-26, docket # 79-26.

6. Article 13 of the Bylaws incorporates the referenced rules and regulations, fair hearing plan, professional review/corrective action plan and other medical staff policies. *Id.*; *see also* Pl. Exh. 4, "Medical Staff Focused Review Process (Peer Re-

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view Policy”); Pl. Exh. 6, “Professional Review/Corrective Action Plan”; Pl. Exh. 7, “Fair Hearing Plan of the Medical, Dental and Podiatric Staff.”

7. The stated purpose of the Peer Review Policy, which was in place at all times relevant to this matter, is “to guide the Medical Staff through an objective peer review process to maintain quality patient care, facilitate education, and improve performance at Sterling Regional MedCenter.” Pl. Exh. 4; Pl. Exh. 2 at 12:3-13.

8. The Peer Review Policy states that a physician will be notified and asked to attend a committee meeting if his or her case has been initially reviewed and found to have a “problem” defined by the policy. Pl. Exh. 4.

9. Defendant Nix served on the SRMC Peer Review Committee at all times relevant to this matter. Final Pretrial Order, Stip Fact 4.8. Defendant Bonelli served on the Peer Review Committee in 2007. Defs. Exh. D.

10. The peer review process is not a disciplinary process. Pl. Exh. 4. Rather, “[d]isciplinary actions are processed through the Medical Executive Committee in accordance with the Medical Staff Bylaws, Professional Review/Corrective Action Plan, Fair Hearing Plan and Medical Staff policies.” *Id.*

\*2 11. Defendants Nix, Soper, Bonelli and Elliff served on the Medical Executive Committee (“MEC”) at the SRMC at all times relevant to this matter. Final Pretrial Order, Stip Fact 4.8.

12. SRMC also has a Credentials Committee with responsibility for ensuring that providers allowed to practice in the facility

have the appropriate credentials and training to ensure patient safety. Pl. Exh. 2 at 16: 13-18. The committee is responsible for reviewing applications for credentials and privileges and makes recommendations for approval or disapproval of such applications to the MEC. *Id.* at 19: 8-10; Pl. Exh. 3 at 30: 6-25, 31: 1-5.

13. Defendant Nix served on the Credentials Committee for all times relevant to this matter. Pl. Exh. 2 at 8: 3-8.

14. In late fall 2007, Plaintiff received a letter from Nix notifying him that two of his cases were sent out for external peer review. Defs. Exh. A at 80: 16-25; Pl. Exh. 1 at 81: 1-10. The Plaintiff believed it was a letter of information, which was “very dry and descriptive” and contained the names of patients and the issues presented. Pl. Exh. 1 at 81: 11-25.

15. The outside review, performed by a board-certified OB/GYN, reflected a Standard of Care Determination of “Q-3: An occurrence in the medical/surgical care or process; significant or potentially significant impact on patient morbidity; opportunity for improvement” for both cases. Defs. Exh. B.

16. At a November 6, 2007 meeting, the MEC considered the outside review and a report by Nix of other issues, including Plaintiff's alleged failure to make daily rounds of his patients. Defs. Exh. C. The committee recommended that (1) Plaintiff be made aware of the findings, (2) the Peer Review Committee review all information about Plaintiff's performance, as well as the external reviewer's report; and (3) Plaintiff's practice information should be reviewed, including complication rate, length of stay and readmissions within 30 days. *Id.*<sup>FNI</sup>

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FN1. Defendants contend that the MEC made further recommendations, but the meeting minutes provided reflect only those recommendations listed herein. *See* Defs. Exh. C, docket # 75-3.

17. The SRMC CEO, Michelle Joy, verbally notified the Plaintiff that responses were received from the external review, that they were negative, and that he should expect to receive a letter from the MEC. Pl. Exh. 1 at 83: 4-14. The Plaintiff was alarmed because he had not been involved in the process and, now, he was expecting to receive a letter of discipline from the MEC. *Id.* at 14-25.

18. At a November 27, 2007 meeting, the Peer Review Committee considered the external review and other issues raised concerning Plaintiff's practice. Defs. Exh. D. The committee assigned several fact-finding "actions" and recommended that documentation be gathered to support the issues raised and that all matters be referred to the MEC for further action. *Id.*

19. Plaintiff expressed concerns that he was not involved in the peer review process to Lisa Sanford, CNO at SRMC. Pl. Exh. 1 at 85: 13-25, 86: 1-6. Plaintiff learned that the next meeting of the MEC would be the following day, December 4, 2007. *Id.* at 86: 19-25, 87: 1-12. At Ms. Sanford's suggestion, Plaintiff contacted Dr. Elliff to speak with him before the meeting. *Id.*

\*3 20. Elliff did not discuss the details of the issues raised by the peer review process with the Plaintiff before the meeting. Pl. Exh. 1 at 92: 3-14. Elliff instructed Plaintiff to wait for the outcome of the meeting. *Id.* at 92: 24-25, 93: 1-2.

21. At the December 4, 2007 meeting, the MEC considered the Peer Review Committee report and concerns raised by certain physicians about the Plaintiff's work, including:

a. Dr. Faycal expressed concern about a patient with high blood pressure who was told by Plaintiff that she could not take high blood pressure medicine. The patient miscarried at 24 weeks and was very dissatisfied with Plaintiff.

b. Dr. Nix reported dissatisfaction with Plaintiff's care of one of her patients because Plaintiff did not examine the patient despite the presence of a mass, which subsequently enlarged.

c. Dr. Soper reported a concern that Plaintiff discontinued his care of a patient upon requesting a consultation from Dr. Soper. Plaintiff referred to the patient as a "f 'ing whore and a c-u-n-t and that she was nuts, crazy, and didn't need to be in the hospital." Dr. Soper, however, believed that the patient "wasn't any of those things. She was sick, and you know, needed help."

d. Dr. Allen, who had come to SRMC to assist over the Thanksgiving holiday, complained about Plaintiff's hand-off of patients.

It was also reported to the MEC that nursing staff complained about Plaintiff failing to make daily rounds of patients, and that Plaintiff was performing circumcisions without privileges and with improper equipment. Defs. Exh. E; Defs. Exh. G; Ex. H; Ex. I.

22. The MEC also considered a number of patient complaints including:

a. A patient awaiting emergent surgery complained about overhearing Plaintiff

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“cussing and stating how mad he was to be in surgery at 3:00 am.”

b. A complaint that “the doctor I had an appointment with was very rude! When I asked a question, he told me not to concern myself and kept talking to his nurse.”

c. A complaint that Plaintiff did not come to see a patient “until the next day after I was admitted.”

d. A complaint from a patient with an ovarian mass that Plaintiff was rude and did not examine her.

e. A complaint that Plaintiff “never answered my questions or explained anything.”

Defs. Exh. J.

23. After this meeting, the MEC held a special meeting with the Plaintiff during the evening of December 4, 2007. The committee provided the Plaintiff with a copy of the external review, and he responded with detailed explanations of his care and why he believed the review was incorrect. Pl. Exh. 1 at 93: 8-25, 94:1-25, 95: 1-11.

24. Because he was not provided any documentation to review before the meeting, the Plaintiff also wrote a follow-up letter to the MEC on December 11, 2007 providing additional information and explanations concerning the issues raised. Defs. Exh. L. In that letter, Plaintiff also expressed his concerns regarding the peer review process. *Id.*

\*4 25. Satisfied with Plaintiff's response to the concerns raised at the December 4, 2007 meeting, the MEC sent Plaintiff a letter. Final Pretrial Order, Stip Fact 4.17. The December 18, 2007 letter to

Plaintiff, drafted by Elliff, described the purpose of the December 4, 2007 meeting as having a “colleague to colleague discussion,” informed Plaintiff that the December 11, 2007 letter would be reviewed at the MEC's next meeting, and reminded him of his obligations under bylaws, rules and regulations of SRMC. Defs. Exh. M.

26. The MEC informed Plaintiff that the 2007 proceedings were informal discussions, not an investigation. Final Pretrial Order, Stip Fact 4.18.

27. After thinking about the December 18, 2007 letter, the Plaintiff “realized that the entire ordeal was a travesty, yet it was in full compliance with the bylaws.” Defs. Exh. A at 128: 23-25, 129: 1-5. Thus, the Plaintiff sought to make changes to the SRMC bylaws. *Id.* at 129: 11-12; 130: 11-14.

28. In early 2008, Plaintiff introduced the concept of a Physician's Council to Soper and the entire medical staff. The Medical Staff approved the creation of the Council. Final Pretrial Order, Stip Fact 4.19.

29. According to the SRMC bylaws any amendments to the bylaws need to be approved by the Banner Board of Directors. Final Pretrial Order, Stip Fact 4.20.

30. It is required that physicians re-apply for privileges every two years. The standard appointment period is two years. In November 2008, Plaintiff's medical staff privileges at SRMC would have expired. Therefore, in April 2008, Plaintiff re-applied for medical staff privileges at SRMC. Final Pretrial Order, Stip Fact 4.21.

31. After completing his application, Plaintiff received a call from the medical

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staff office about his answer to question # 2 on page 28 of his application in which Plaintiff answered “no” to a question as to whether there had been any “proceedings or investigations” relating to his “clinical competence ... or professional conduct.” Final Pretrial Order, Stip Fact 4.22. Fleur-ette Groves, Medical Staff Services Manager, told Plaintiff on October 10, 2008 that, based on his current file, he would need to correct his answer to “yes.” Pl. Exh. 20. Plaintiff refused to do so. *Id.*

32. Plaintiff's application and file were then forwarded to the Credentials Committee. Final Pretrial Order, Stip Fact 4.23. The committee recommended that Plaintiff “not be reappointed” with a comment that “he answered no about previous proceedings/investigations.” Defs. Exh. A-28, docket # 79-36. The matter was then referred to the MEC. Final Pretrial Order, Stip Fact 4.23.

33. In the fall 2008, complaints arose concerning Plaintiff's use of privileged and confidential peer review information, his interactions with patients and their families, and his relationship with medical staff members and hospital staff. Defs. Exhs. N-Q, S, V.

34. In a November 4, 2008 meeting, the MEC reviewed the Credentials Committee recommendation not to reappoint the Plaintiff. Pl. Exh. 28. The MEC recommended that the Banner Board of Directors reappoint the Plaintiff for a period of three months, November 21, 2008 through February 21, 2009, “during which time the MEC [would] schedule a meeting with [Plaintiff] to discuss recent patient complaints and disruptive behavior complaints as well as his answer to the application question pertaining to current or past investigations/proceedings of clinical com-

petence or professional conduct.” *Id.*

\*5 35. This recommendation was accepted by the Banner Governing Board. Final Pretrial Order, Stip Fact 4.24.

36. On November 17, 2008, Joy wrote to Plaintiff informing him that his request for reappointment to the SRMC Medical Staff and for renewal of his clinical privileges was granted for a period of three months. Defs. Exh. T. Joy stated, “[t]his action was taken in order to afford the [MEC] the opportunity to address several outstanding issues that have arisen during the last few months regarding your professional conduct and clinical practice at SRM. The [MEC] will be scheduling a meeting with you shortly to discuss these issues in more detail.” *Id.*

37. On November 18, 2008, Plaintiff responded to Joy seeking review and investigation by the Physician's Council in accordance with the recently amended bylaws. Pl. Exh. 26. Plaintiff also requested that he be provided a detailed description and supporting documentation of the identified issues, “as [he] had not been approached with any questions or concerns regarding [his] conduct and [was] unaware of any.” *Id.*

38. On December 3, 2008, Elliff wrote to the Plaintiff on behalf of the MEC inviting him to attend a special meeting “as part of an informal, confidential intra-professional review process, prior to making any final recommendations.” Defs. Exh. V. Elliff further informed the Plaintiff that “no formal investigation has been initiated and no adverse action has been taken”; thus, Elliff asserted, Plaintiff was “not yet entitled to exercise any of the rights under the Medical Staff Professional Review/Corrective Action Plan or the Fair Hearing

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Plan.” *Id.* Furthermore, Elliff notified the Plaintiff that the proposed changes to the bylaws had not yet been approved by the governing board of Banner, and the MEC was the appropriate committee to address the outstanding issues. *Id.*

39. At Joy's request, Plaintiff met with Joy on December 9, 2008 regarding the outstanding issues. Pl. Exh. 14 at 59: 7-20. Joy informed Plaintiff of the complaints raised against him, and Plaintiff expressed his displeasure with Joy's performance as CEO. *Id.* at 60:17-63:13; Pl.Ex. 1 at 173:10-175:25.

40. During the meeting, Joy and Plaintiff mutually agreed to execute the 90-day termination notice of Plaintiff's contract with Banner so long as the MEC would take no further action on the outstanding issues. Pl. Exh. 14 at 68: 24-25, 69: 1-10; Pl. Exh. 1 at 176: 18-24.

41. The following day, December 10, 2008, Joy informed Plaintiff by email that the MEC would still need to meet with the Plaintiff informally “to bring closure to the medical staff side of things.” Defs. Exh. X. Joy gave Plaintiff the choice of meeting with the MEC or with Doug Webster, SRMC Medical Director. *Id.*

42. Plaintiff responded that the “[m]eeting on Friday will void the agreement we came to yesterday.” *Id.* Joy responded that since the “[e]mployment contract and medical staff are two separate issues,” she “did not have the authority to overrule the decision of the [MEC] for an informal meeting.” *Id.* Plaintiff responded, “I understand. I will meet with Dr. Webster.” *Id.*

\*6 43. On December 11, 2008, Plaintiff wrote a letter to Joy, Dr. Webster and

members of the MEC referring to the termination of his contract saying, “Let us document that it will be a unilateral action taken by Banner Health, Inc. and I made no requests to [Joy] or to any of you as conditions for this action.” Pl. Exh. 15.

44. That same day, Plaintiff met with Dr. Webster. Webster memorialized this meeting in a January 6, 2009 memo to the MEC (copied to Joy) in which he recommended that “the MEC consider the accusations presented and a pattern of behavior agreed upon, which, if followed, would prevent further similar issues from arising.” Pl. Exh. 16. Further, Webster recommended that “as the issues represent uninvestigated accusations and as there were no documented adverse clinical outcomes involved, the MEC should consider the issues closed.” *Id.* The Plaintiff presented his letter to Webster at the meeting. *Id.*

45. The December 12, 2008 special meeting with the MEC was canceled. Defs. Exh. A-38.

46. On January 7, 2009, Soper wrote a letter to Plaintiff informing him that the MEC reviewed the information provided by Webster and “concluded that the outstanding issues have been satisfactorily addressed and are considered closed.” Defs. Exh. A-40, docket # 79-48.

47. Plaintiff's request for Medical Staff membership and clinical privileges were extended to March 25, 2009 at Plaintiff's request to be consistent with the notice of termination of Plaintiff's contract with Banner. *Id.*

48. Plaintiff later told an employment recruiter that he had not had any adverse action as to his clinical privileges. Defs. Exh. DD at 320: 15-20. <sup>FN2</sup>

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FN2. Defendants assert that Plaintiff “agrees, and reports to employers, that his privileges have not been subject to any adverse action”; however, the pages of the deposition transcript to which they refer for support are not attached to the motion. See docket # 75 at 8, ¶ 35.

### DISCUSSION

#### I. Standards of Review

##### A. *Fed.R.Civ.P.* 56

Summary judgment serves the purpose of testing whether a trial is required. *Heideman v. South Salt Lake City*, 348 F.3d 1182, 1185 (10th Cir.2003). The Court shall grant summary judgment if the pleadings, depositions, answers to interrogatories, admissions, or affidavits show there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. Fed.R.Civ.P. 56(c). A fact is material if it might affect the outcome of the suit under the governing substantive law. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 248 (1986). The moving party bears the initial responsibility of providing to the Court the factual basis for its motion and identifying the pleadings, depositions, answers to interrogatories, and admissions on file, together with affidavits, if any, which reveal that there are no genuine issues as to any material facts, and that the party is entitled to summary judgment as a matter of law. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323 (1986). However, the non-moving party has the burden of showing that there are issues of material fact to be determined. *Id.* at 324.

That is, if the movant properly supports a motion for summary judgment, the opposing party may not rest on the allegations

contained in his complaint, but must respond with specific facts showing a genuine factual issue for trial. Fed.R.Civ.P. 56(e); *Hysten v. Burlington Northern & Santa Fe Ry.*, 296 F.3d 1177, 1180 (10th Cir.2002). These specific facts may be shown “‘by any of the kinds of evidentiary materials listed in Rule 56(c), except the mere pleadings themselves.’” *Pietrowski v. Town of Dibble*, 134 F.3d 1006, 1008 (10th Cir.1998) (quoting *Celotex*, 477 U.S. at 324). “[T]he content of summary judgment evidence must be generally admissible and ... if that evidence is presented in the form of an affidavit, the Rules of Civil Procedure specifically require a certain type of admissibility, *i.e.*, the evidence must be based on personal knowledge.” *Bryant v. Farmers Ins. Exch.*, 432 F.3d 1114, 1122 (10th Cir.2005). “The court views the record and draws all inferences in the light most favorable to the non-moving party.” *Pepsi-Cola Bottling Co. of Pittsburg, Inc. v. Pepsico, Inc.*, 431 F.3d 1241, 1255 (10th Cir.2005).

##### B. *Health Care Quality Improvement Act (“HCQIA”)*

\*7 The HCQIA “provide[s] qualified immunity from damages actions for hospitals, doctors and others who participate in professional peer review proceedings.” *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 (10th Cir.1996). The HCQIA provides, in pertinent part:

If a professional review action (as defined in section 11151(9) of this title) of a professional review body meets all the standards specified in section 11112(a) of this title, ...-(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

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person who participates with or assists the body with respect to the action, shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

42 U.S.C.A. § 11111(a)(1). The Act defines “professional review body” as “a health care entity and the governing body or any committee 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.” 42 U.S.C. § 11151(11) (2010); *see also Pfenninger v. Exempla, Inc.*, 116 F.Supp.2d 1184, 1198 (D.Colo.2000). “Professional review activity” is defined as “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.” 42 U.S.C. § 11151(10) (2010).

Under these provisions of the HCQIA, Defendants Banner, Joy, Soper, Elliff, Nix and Bonelli are entitled to immunity from money damages stemming from “professional review actions” so long as the standards for such actions set out in § 11112(a) have been satisfied. *See Brown*, 101 F.3d at 1333; *Pfenninger*, 116 F.Supp.2d at 1198-99. Pursuant to section 11112(a), the 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 after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a); *Pfenninger*, 116 F.Supp.2d at 1199.

A professional review action is presumed to have met these standards necessary for immunity. 42 U.S.C. § 11112(a). Courts apply an objective standard in determining whether a professional review action is reasonable under 42 U.S.C. § 11112(a). *Brown*, 101 F.3d at 1333. “[T]he party contesting immunity ‘bears the burden of proving that the peer review process was not reasonable.’ “ *Pfenninger*, 116 F.Supp.2d at 1201 (quoting *Bryan v. Holmes Regional Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir.1994)).

\*8 If a plaintiff challenging a professional review action proves, by a preponderance of the evidence, any one of the four requirements was not satisfied, the professional review body is no longer afforded immunity from damages under the HCQIA. *Brown*, 101 F.3d at 1333 (citing *Islami v. Covenant Med. Ctr., Inc.*, 822 F.Supp. 1361, 1377-78 (N.D.Iowa 1992)). Therefore, in considering a motion for summary judgment based upon HCQIA immunity, the Court must ask “[m]ight a reasonable jury, viewing the facts in the best light for [the nonmovant], conclude that he has shown, by a preponderance of

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the evidence, that the defendants' actions are outside the scope of § 11112(a)?" *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 32 (1st Cir.2002) (citing *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir.1992) (concluding that summary judgment would not be proper if the plaintiff raised a genuine issue of fact material to the determination of whether the defendant met one of the HCQIA standards)).

### C. Colorado Professional Review Act ("CPRA")

Similarly, the Colorado Professional Review Act ("CPRA") provides qualified immunity to those who participate in the professional review process. Part I of the CPRA states, in part:

(1) A member of a professional review committee, a witness before a professional review committee, or any person who files a complaint or otherwise participates in the professional review process shall be immune from suit in any civil or criminal action, including antitrust actions, brought by a physician who is the subject of the review by such professional review committee, if such member made a reasonable effort to obtain the facts of the matter as to which he acted, acted in the reasonable belief that the action taken by him was warranted by the facts, and otherwise acted in good faith within the scope of such professional review committee process and if such witness or participant acted in good faith within the scope of such professional review committee process.

(2) The governing board, the individual members of such board, and the entity which has established a peer review committee pursuant to section 12-36.5-104, the board's staff, any person acting as a witness or consultant to the board, any

witness testifying in a proceeding authorized under this article, and any person who lodges a complaint pursuant to this article shall be immune from liability in any civil action brought against him or her for acts occurring while acting in his or her capacity as board member, staff, consultant, or witness, respectively, if such individual was acting in good faith within the scope of his or her respective capacity, made a reasonable effort to obtain the facts of the matter as to which he or she acted, and acted in the reasonable belief that the action taken by him or her was warranted by the facts. Any person participating in good faith in lodging a complaint or participating in any investigative or administrative proceeding pursuant to this article shall be immune from any civil or criminal liability that may result from such participation.

\*9 Colo.Rev.Stat. § 12-36.5-105 (2010). The enactment of Part II of the CPRA was "necessary for the state to comply with the provisions of the federal [HCQIA]." *Id.* at § 12-36.5-202. Part II provides immunity from damage liability to professional review committees and those who participate in the review process in conformance with the provisions of the HCQIA. *See id.* at § 12-36.5-203.

## II. Analysis

Defendant seeks immunity in this case pursuant to the federal HCQIA and the state CPRA. Though the statutes are similar in many respects, they contain certain differing standards and provisions that may apply to this action. Therefore, the Court will analyze application of the statutes separately.

### A. HCQIA Immunity

In the present motion, Defendants seek immunity for actions by the SRMC Peer

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Review Committee and the MEC regarding the Plaintiff's conduct in both 2007 and 2008. Plaintiff asserts that Defendants failed to meet their statutory obligations with respect to "adverse actions" taken during the fall 2007 peer review process, in October 2008 when the Credentials Committee recommended that he not be reappointed, and in November 2008 when the MEC reappointed him and renewed his privileges for three months, as opposed to the standard two-year appointment.

Under the HCQIA, the term "professional review action" means

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.

42 U.S.C. § 11151(9) (2010). "The term 'adversely affecting' includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." *Id.* at § 11151(1). In contrast, professional review *activities* (defined *supra* at I.B., p. 12) are generally precursors to professional review actions. *Singh*, 308 F.3d at 36. The Third Circuit explains the difference as follows:

The definition of "professional review

action" encompasses decisions or recommendations by peer review bodies that directly curtail a physician's clinical privileges or impose some lesser sanction that may eventually affect a physician's clinical privileges. "Professional review actions" do not include a decision or recommendation to monitor the standard of care provided by the physician or fact-finding to ascertain whether a physician has provided adequate care. These are "professional review activities."

\*10 *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624, 634 (3d Cir.1996). Immunity under the HCQIA does not depend upon whether the actions surrounding a professional review *activity* comply with the statute but, rather, whether a professional review *action* meets the statutory requirements. *Wood v. Archbold Med. Ctr., Inc.*, --- F.Supp.2d ---, 2010 WL 3717294, \*55 (M.D.Ga. Sept. 13, 2010); *see also Mathews*, 87 F.3d at 634 ("Because [defendant's] letter was not a professional review action, the district court correctly held it did not have to meet the standards set forth in 42 U.S.C. § 11112(a).").

With these principles in mind, the Court will analyze each instance identified by Plaintiff to determine first whether the challenged actions are "professional review actions" subject to a reasonableness inquiry under the HCQIA and, if so, whether disputed facts exist concerning whether the actions were taken in compliance with the HCQIA.

#### 1. Fall 2007 Proceedings

In the fall 2007 the following peer review activity took place: (1) Defendant Nix sent two of Plaintiff's cases out for external review; (2) the MEC considered the external review and other issues concerning the Plaintiff at a regular meeting, then referred

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the matters to the Peer Review Committee; (3) the Committee gathered additional information, considered it at their regular meeting and recommended further action by the MEC; (4) the MEC met to review the Peer Review Committee recommendation, then held a special meeting with the Plaintiff; and (5) the MEC considered the Plaintiff's input and explanations regarding the outstanding issues and determined that the issues were closed.

Plaintiff contends that, although Defendants consistently characterized the proceedings involving the Peer Review Committee and MEC in the fall 2007 as "informal" and "peer to peer discussions," the Defendants later redefined the proceedings as an "adverse action" when SRMC questioned Plaintiff's negative response to a question on his 2008 application for reappointment asking "[a]re there presently or has there previously been any proceedings or investigations taken place at any hospital or other organization relating to your clinical competence or your professional conduct?" The Plaintiff refers to his application, a copy of which is docketed at # 79-28 through # 79-34, and to the subsequent recommendation to deny Plaintiff reappointment and privileges.

The Court disagrees that any questions regarding Plaintiff's application response necessarily imply that Defendants considered the fall 2007 proceedings to constitute an "adverse action." The application question at issue is found at docket # 79-33, p. 1, and is the second question on the page (the document contains no page numbers). *See also* Pl. Exh. 20. A review of the questions reveals that only the first question referred to the term "adverse action" and asked whether the applicant has suffered any adverse actions with respect

to privileges and/or staff appointment. Docket # 79-33. None of the other questions, including the second question, referred to the term "adverse action."

\*11 Moreover, the Court disagrees that the fall 2007 proceedings constitute adverse review actions because they supposedly resulted in a recommendation to deny reappointment and clinical privileges. The stated reason for the recommendation to deny reappointment, made nearly one year after the fall 2007 proceedings, was the Plaintiff's negative answer to the attestation question Plaintiff gave on his application. *See* Defs. Exh. A-28, docket # 79-36. The Plaintiff has presented no evidence from which a reasonable jury could conclude that the recommendation was made as a result of any discussions and/or investigations taken during the 2007 peer review proceedings.

Rather, the Court looks at the actions themselves to determine whether they meet the statutory definition of "professional review action." With respect to the MEC's initial actions in sending two of Plaintiff's cases out for external review, then considering the review and other issues raised concerning Plaintiff's practice at a regular meeting and referring the matters to the Peer Review Committee, the Court finds such actions to be fact-finding activities not subject to the reasonableness inquiry.

Likewise, actions taken by the Peer Review Committee amount simply to fact-finding as evidenced by the several "action/assignments" and the Committee's recommendations to procure documentation to support allegations made against the Plaintiff, which are listed on the November 27, 2007 meeting minutes. Defs. Exh. D. In fact, Plaintiff sets forth in the briefing that "[t]he peer review process is not intended

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to be a disciplinary process” but, rather, “the [MEC] is the intended vehicle through which disciplinary actions are processed.” Docket # 89 at 4, ¶¶ 12, 13.

Thereafter, the Peer Review Committee referred the matters to the MEC for further action; the MEC then met to review the Peer Review report and consider the outstanding issues regarding the Plaintiff. The MEC held a special meeting with the Plaintiff the same day to continue its fact-finding activities; once the Plaintiff provided his own input and further information concerning the outstanding issues (including at the meeting and in a follow-up letter), the MEC closed its proceedings.

The Plaintiff has failed to provide sufficient evidence that would allow a jury to conclude that Defendants engaged in “professional review actions” in the fall 2007, which would necessitate an inquiry into the reasonableness of the actions. Thus, the Court finds that all peer review proceedings conducted during the fall 2007 regarding the Plaintiff were “fact-finding” in nature and do not constitute “professional review actions” pursuant to the HCQIA. No inquiry into the reasonableness of the 2007 peer review proceedings is necessary. The motion is **granted** in this respect and the Court finds Defendants are immune from any damages arising from the fall 2007 proceedings.

## 2. 2008 Credentials Committee Recommendation on Reappointment

\*12 The SRMC Credentials Committee gathers information and makes recommendations to the MEC “regarding the credentials of all applicants for appointment and reappointment” for medical staff membership and clinical privileges. Defs. Exh. A-26, docket # 79-26. It functions as a “document review” committee and has re-

sponsibility for ensuring that providers allowed to practice at the SRMC have the appropriate credentials and training to ensure patient safety. Pl. Exh. 2 at 16: 13-25, 17: 1-5. On “rare” occasions, the committee interviews an applicant. *Id.*

The form “Recommendation of Credential Committee for Reappointment” lists several factors the committee may consider in determining whether to recommend approval or denial of reappointment applications, including the physician's health status, conduct, clinical knowledge, technical proficiency and competence. Defs. Exh. A-28, docket # 79-36. In addition, the committee may recommend not only approval or denial of the application, but also that the applicant be reappointed with certain “provisions.” *Id.* Thus, as an entity authorized to gather information and make recommendations for the approval or denial of clinical privileges, the Credentials Committee is a “professional review body” (“any committee of a health care entity which conducts professional review activity”) pursuant to 42 U.S.C. § 11151(11) that engages in “professional review activity” (“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”) pursuant to 42 U.S.C. § 11151(10).

Defendant Nix served on the Credentials Committee in 2008. Pl. Exh. 2 at 8:10-14. On October 20, 2008, the Credentials Committee recommended that Plaintiff “not be reappointed” for medical staff membership and clinical privileges. The Court finds that this recommendation

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is a “professional review action” within the meaning of 42 U.S.C. § 11151(9) (“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 ... and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician”). Thus, to determine whether Nix is immune from any money damages resulting from this action, the Court will proceed to analyze whether the Plaintiff has raised a genuine issue of fact material to the determination of whether Nix failed to meet any one of the HCQIA standards.

Plaintiff asserts that all four standards have not been met by Defendant. However, the Court finds that Plaintiff has demonstrated disputed issues as to the second, third and fourth standards concerning whether the committee made a reasonable effort to obtain facts concerning the reappointment, whether Plaintiff was afforded adequate notice and hearing procedures or other procedures as are fair to him under the circumstances, and whether the recommendation was made with a reasonable belief that the action was warranted by any facts known after meeting the notice and hearing requirements. *See* 42 U.S.C. § 11112(a).

#### a. Reasonable Investigation

\*13 For HCQIA immunity to attach to a professional review action, the decision must be made “after a reasonable effort to obtain the facts of the matter.” 42 U.S.C. § 11112(a)(2); *see also Brown*, 101 F.3d at 1333. The relevant inquiry under § 11112(a)(2) is whether the totality of the process leading up to the professional review action evidenced a reasonable effort

to obtain facts. *Mathews*, 87 F.3d at 637.

Although the Plaintiff received a call from Ms. Groves, Medical Staff Manager, FN3 saying that she believed he incorrectly answered “no” to a question on the application, there is no evidence that she or anyone else questioned the Plaintiff about the remainder of his application or notified the Plaintiff that the committee was considering recommending denial of his request for reappointment. In addition, there is no evidence that the Committee sought any facts concerning Plaintiff’s application. Considering this dearth of information, a reasonable jury could find that the committee took its action after an unreasonable effort to obtain facts about the application. *Cf. Pfenninger*, 116 F.Supp.2d at 1202 (court found reasonable effort to obtain facts where committee reviewed 20 years’ patient care history, sought input from physicians and nurses with first-hand knowledge of complaints, and allowed plaintiff to present his side of the story).

FN3. There is no indication whether Ms. Groves is/was a member of the Credentials Committee.

#### b. Adequate Notice and Procedures

A professional review action must 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.” 42 U.S.C. § 11112(a)(3). The following relevant conditions, if met, satisfy the notice and hearing requirement of § 42 U.S.C. § 11112(a)(3):

A health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3) of this section with respect to a physician if the following conditions are met (or are

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waived voluntarily by the physician):

(1) Notice of proposed action

The physician has been given notice stating-

(A)(i) that a professional review action has been proposed to be taken against the physician,

(ii) reasons for the proposed action,

(B)(i) that the physician has the right to request a hearing on the proposed action,

(ii) any time limit (of not less than 30 days) within which to request such a hearing, and

(C) a summary of the rights in the hearing under paragraph (3).

...

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) (2010). Under these principles, the Court must ask whether the Plaintiff "has shown by a preponderance of the evidence, that the defendants did not provide him with fair and adequate process under the circumstances." *Singh*, 308 F.3d at 40.

Plaintiff claims he was afforded no notice nor opportunity to be heard before the recommendation was issued. Docket # 89 at 13, ¶ 49. Because there is no evidence that the Credentials Committee contacted the Plaintiff prior to issuing its recommendation for denial, a jury might reasonably conclude that the Defendants failed to provide Plaintiff fair and adequate process.

\*14 Defendants argue that SRMC's Fair Hearing Plan "provides that a recommendation for denial of reappointment is only deemed adverse (triggering formal notice and hearing processes) when recommended by the [MEC]." Docket # 95 at 2. The Fair Hearing Plan states, in pertinent part,

A recommendation or action listed in Section 1-1 shall be deemed adverse action only when it has been:

A. Recommended by the Medical Executive Committee; or ...

E. Imposed automatically.

Pl. Exh. 7 at 2, § 8.1.2. The plan does not define "imposed automatically"; however, if an action is taken without any investigation or fact-gathering, then one must assume the action is taken "automatically."

Nevertheless, "HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws. Rather, the statute imposes a uniform set of national standards." *Poliner v. Texas Health Sys.*, 537 F.3d 368, 380 (5th Cir.2008) ("Provided that a peer review action as defined by the statute complies with [its] standards, a failure to comply with hospital bylaws does not defeat a peer reviewer's right to HCQIA immunity from damages."). Thus, the Court need not determine whether an action complies with SRMC's bylaws to find immunity under the HCQIA. Instead, the Court analyzes the action in accordance with statutory standards.

Here, the Court finds the Plaintiff has provided sufficient evidence from which a jury may conclude that Defendant Nix failed to meet HCQIA's second, third and fourth standards for her participation in the

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Credentials Committee recommendation to deny Plaintiff's reappointment.

The motion is denied with respect to HCQIA immunity for the 2008 Credentials Committee recommendation.

### 3. 2008 MEC Recommendation on Reappointment and Privileges

The Credentials Committee recommendation was made to the MEC, on which Defendants Nix, Soper, Bonelli, El-liff and Joy served in 2008. Pl. Exh. 28. The MEC met on November 4, 2008 to consider the recommendation together with issues that had recently arisen regarding Plaintiff's conduct. The MEC determined at that meeting to recommend reappointing the Plaintiff for a period of three months, rather than the requested two years, "during which time the MEC [would] schedule a meeting with [Plaintiff] to discuss recent patient complaints and disruptive behavior complaints as well as his answer to the application question pertaining to current or past investigations/ proceedings of clinical competence or professional conduct." *Id.* The Banner Governing Board approved the recommendation on November 13, 2008. Defs. Exh. A-28, docket # 79-36.

As stated above, a "professional review action" includes a "recommendation 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) "The term 'adversely affecting' includes reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges or membership in a health care entity." *Id.* at § 11151(1). The parties stipulate that the standard appointment period is

two years. Final Pretrial Order, Stip Fact 4.21. Here, Plaintiff applied for a two-year reappointment of his privileges; yet, the MEC rejected his request and granted him reappointment for only three months to review his competence and complaints raised against him. The Court finds the MEC's recommendation to be a "professional review action" in which the MEC reduced or restricted Plaintiff's requested clinical privileges. *See Mathews*, 87 F.3d at 634 ("[t]he definition of 'professional review action' encompasses decisions or recommendations by peer review bodies that directly curtail a physician's clinical privileges"); *see also Pfenniger*, 116 F.Supp.2d at 1201 (finding a recommendation and approval of conditional reinstatement of privileges to be a "professional review action").

\*15 In addition, the Court finds the Plaintiff has raised genuine issues of fact material to the determination of whether Defendants met the third and fourth standards necessary for HCQIA immunity. A professional review action must 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." 42 U.S.C. § 11112(3). The Court must ask whether the Plaintiff "has shown by a preponderance of the evidence, that the defendants did not provide him with fair and adequate process under the circumstances." *Singh*, 308 F.3d at 40.

Plaintiff claims that he was first notified of the MEC's recommendation on November 17, 2008, nearly two weeks after it was made and four days after it was approved by Banner. Defendants do not dispute Plaintiff's claim. Thus, the recommendation was made and approved without the Plaintiff's knowledge or input in the

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process. Under these circumstances, a jury might conclude that the MEC gave the Plaintiff insufficient notice and no opportunity to be heard before the recommendation was made.

Defendants argue that the “MEC rejected the [Credentials Committee] recommendation and granted [Plaintiff’s] request for renewal of his clinical privileges for three months.... Conclusory allegations aside, renewal of privileges is not, by definition, an action or recommendation “reducing, restricting, suspending, revoking, denying, or failing to renew clinical privileges.” Docket # 95 at 3. The Court disagrees. Defendants stipulate that two years is a standard reappointment period at SRMC; thus, any recommendation to reduce that period, particularly a reduction of 21 months, “may affect adversely the clinical privileges or membership.”

Defendants also contend that, because Plaintiff subsequently did not apply for an extension of his privileges past his termination date for fear the MEC might deny them, the Plaintiff “cannot defeat immunity by complaining about a lack of process when he openly acknowledges avoiding the process for fear of a bad outcome.” *Id.* Defendants’ argument is misplaced. If Defendants were to argue that Plaintiff failed or refused to participate in the process *before* the recommendation was made, the argument may be persuasive. Nevertheless, the argument itself raises simply fact questions that should be resolved by a jury as to the reasonableness of the MEC’s actions.

Finally, Defendants argue that Plaintiff “reports to employers that his privileges have not been subject to any adverse action.” *Id.* at 5. Defendants cite to a portion of Plaintiff’s deposition transcript that is not attached to the motion. A portion that

*is* attached reflects Plaintiff’s testimony that he answered “no” to a recruiter’s question whether he had ever had any adverse action to his privileges. Defs. Exh. DD at 320: 15-20. This testimony, if anything, simply raises credibility questions that cannot be resolved on summary judgment (and may provide impeachment material at trial).

\*16 The Court finds the Plaintiff has provided sufficient evidence from which a jury may conclude that Defendants Nix, Soper, Bonelli, Elliff, Joy and Banner failed to meet HCQIA’s third and fourth standards for their participation in the MEC recommendation to reappoint the Plaintiff to medical staff and renew clinical privileges for a period of three months. The motion is **denied** with respect to HCQIA immunity for the 2008 MEC recommendation.

#### B. CPRA Immunity

As set forth above, the CPRA contains two parts; the first provides immunity from suit under certain circumstances ( Colo.Rev.Stat. § 12-36.5-105) and the second provides immunity from damages in accordance with the HCQIA ( Colo.Rev.Stat. § 12-36.5-203). Although the CPRA is similar in many respects to the HCQIA, a primary difference is that the CPRA does not impart a presumption that professional review activities are undertaken for the purpose of assuring quality care and patient safety. *North Colorado Med. Ctr., Inc. v. Nicholas*, 27 P.3d 828, 841 n. 7 (Colo.2001) (en banc). Thus, under the second part of the CPRA, which is “intended to be responsive to the specific requirements” of the HCQIA and grants immunity from damages to professional review bodies, their members, parties in contract with them, and other participants in

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the professional review process when they act in accordance with the HCQIA (*see id.* at 845), the Court finds that, for the foregoing reasons, Defendants Nix, Soper, Bonelli, Elliff, Joy and Banner have demonstrated no issues of material fact exist with respect to the 2007 peer review proceedings, but have failed to demonstrate there exist no genuine issues of fact material to the determination of whether they met HCQIA standards in the 2008 Credentials Committee recommendation and 2008 MEC recommendation. Thus, with respect to Defendants' request for immunity provided by Part II of the CPRA, the Court **grants the motion in part** regarding the 2007 peer review proceedings, and **denies the motion in part** regarding the 2008 Credentials Committee recommendation and 2008 MEC recommendation.

Under Part I of the CPRA, the criteria for immunity depends upon the status of the party seeking immunity. *Id.* at 841 (citing Colo.Rev.Stat. § 12-36.5-105). Here, both a governing board (Banner) and participants not affiliated with the governing board (individual Defendants) serving in a professional review process seek immunity.

#### 1. Peer Review Process Participants

Defendants Nix, Soper, Bonelli, Elliff and Joy seek immunity from the peer review processes concerning the Plaintiff in 2007 and 2008. "The plain language of § 12-36.5-105(1) addresses immunity for two different types of parties: members of professional review committees and participants in the peer review process who are not professional review committee members." *Nicholas*, 27 P.3d at 842-43. Committee members are immune from suit if: (1) the member made a reasonable effort to obtain the facts of the matter; (2) the mem-

ber acted in the reasonable belief that the action taken was warranted by the facts; and (3) the member otherwise acted in good faith within the scope of the review process. *Id.* at 843. Participants who are not committee members are entitled to immunity from suit if they have acted in good faith within the scope of the professional review process. *Id.*

\*17 The CPRA defines "professional review committee" as "any committee authorized under the provisions of this article to review and evaluate the professional conduct of and the quality and appropriateness of patient care provided by any physician licensed" in Colorado. *Id.* at 844 (quoting Colo.Rev.Stat. § 12-36.5-102(3)). "Authorized professional review committees must satisfy the following statutory conditions: (1) they must be composed of a majority of physicians; (2) they must be established by the hospital's medical staff, its governing board, or a combination thereof; and (3) they must operate pursuant to written bylaws, approved by the hospital's governing board, that are in compliance with the CPRA." *Id.* (citations omitted). At issue here are the Peer Review Committee and the MEC in 2007 and the Credentials Committee and the MEC in 2008. No party disputes that these committees fall within the statutory definition of "professional review committees."

#### a. 2007 Peer Review

Under the CPRA, "a challenge to the peer review process is only allowed after the hospital's governing board has made its final decision." *Crow v. Penrose-St. Francis Healthcare Sys.*, 169 P.3d 158, 166 (Colo.2007) (citing Colo.Rev.Stat. § 12-36.5-106(8)). In 2007, the Banner Governing Board made no decision with respect to the peer review process concerning

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the Plaintiff. Thus, Plaintiff's claims, if any, arising from the 2007 peer review process are not ripe because he has not exhausted his administrative remedies in the peer review process. *Id.* at 168. The motion is **granted** in this respect and Defendants Nix, Soper, Bonelli, Elliff and Joy are immune under the CPRA from suit as to Plaintiff's first, second and fourth claims to the extent they arise from the 2007 peer review process.

b. 2008 Peer Review

As set forth above, in 2008, the Banner Governing Board approved the MEC's recommendation to limit Plaintiff's request for reappointment to three months (following the Credentials Committee's recommendation to deny reappointment). The Court finds Plaintiff has exhausted his remedies as to the 2008 peer review process leading up to the Board's decision. *See Crow*, 169 P.3d at 168. Thus, the Plaintiff must demonstrate genuine issues of fact exist that are material to the determination of whether Defendants Nix, Soper, Bonelli, Elliff, Joy and Banner acted in good faith during the peer review process.

(1) Nix, Soper, Bonelli, Elliff

Committee members are immune from suit if: (1) the member made a reasonable effort to obtain the facts of the matter; (2) the member acted in the reasonable belief that the action taken was warranted by the facts; and (3) the member otherwise acted in good faith within the scope of the review process. *Nicholas*, 27 P.3d at 843.

The only Defendant to serve on the Credentials Committee in 2008 is Nix. As set forth above, the Court finds that, because the committee made the recommendation to deny reappointment without notifying the Plaintiff, a jury may conclude that the committee took its action after an

unreasonable effort to obtain facts about the application. In the same vein, a jury might determine that, without sufficient facts, Nix could not have had a reasonable belief that the action was warranted. As such, the Court **denies** the motion and finds that Nix is not immune from claims arising from the 2008 Credentials Committee recommendation to deny reappointment.

\*18 Likewise, Nix, Soper, Bonelli and Elliff served on the MEC in 2008 and determined to recommend three months reappointment as opposed to Plaintiff's requested (and the standard) two years. The MEC reached its determination without notifying the Plaintiff; thus, as set forth above, the Court finds a reasonable jury may conclude the recommendation was made without the Plaintiff's knowledge or input in the process and, thus, was unwarranted without sufficient facts. The Court **denies** the motion and finds Nix, Soper, Bonelli and Elliff are not immune from claims arising from the 2008 MEC recommendation to limit reappointment to three months.

(2) Joy

Although Joy is listed as an attendant at the November 4, 2008 MEC meeting (as well as the November 6, 2007 meeting), there is no indication whether she was a committee member. Because she was a hospital administrator, the Court will assume she was not a member and will treat her as a peer review participant for purposes of analyzing whether she acted in good faith during the peer review process in 2008.

The evidence reflects that, although Joy participated in the November 4, 2008 meeting, she did not notify Plaintiff of the recommendation to limit his reappointment

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until after it was made and approved by the Board. A reasonable jury might conclude that, as a result, Joy failed to act in good faith within the scope of the peer review process. The motion is **denied** with respect to Joy's participation in the 2008 peer review of the Plaintiff.

## 2. Banner Governing Board

Banner seeks immunity from Plaintiff's second claim for relief for "conspiracy." The sole requirement for immunity for a governing board and its members is good faith. *Nicholas*, 27 P.3d at 841. " 'Good faith presupposes: (1) reasonable reliance upon the review committee's recommendations, unless there is knowledge that would render reliance unwarranted; (2) consideration of facts previously unknown to the review committee; (3) reasonable belief that the action taken was warranted by the facts; and (4) otherwise acting in good faith.' *Id.* Good faith is not presumed if the Board or its individual members willfully ignore facts not previously considered that are pertinent to its review. *Id.* at 842.

Here, good faith is presumed for the Board's action in approving the MEC's recommendation. The Plaintiff has proffered no facts demonstrating an issue as to whether the Board unreasonably relied on the MEC's recommendation or failed to consider facts previously unknown. Thus, to the extent that the Plaintiff's conspiracy claim against Banner concerns the 2008 peer review process, the Court finds Banner is immune from suit on such claim. The motion is **granted** in this respect.

## CONCLUSION

Pursuant to 28 U.S.C. § 636(c) and Fed.R.Civ.P. 73, I therefore ORDER that Defendants' Joint Motion for Summary Judgment Related to Qualified Immunity [ filed August 30, 2010; docket # 75 ] is

**granted in part and denied in part** as follows:

\*19 1. All Defendants are granted immunity pursuant to the HCQIA and CPRA from Plaintiff's first, second and fourth claims for relief to the extent they arise from the 2007 peer review process;

2. Defendants Nix, Soper, Bonelli, El-liff, and Joy are denied immunity pursuant to the HCQIA and CPRA from Plaintiff's first, second and fourth claims for relief to the extent they arise from the 2008 peer review process; and

3. Defendant Banner is granted immunity pursuant to the CPRA from Plaintiff's second claim for relief to the extent it arises from the 2008 peer review process.

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**H**  
Only the Westlaw citation is currently available.

United States District Court, W.D. Wash-  
ington,  
at Seattle.

Brian PLASKON, Plaintiff,

v.

PUBLIC HOSPITAL DISTRICT NO. 1 OF  
KING COUNTY d/b/a Valley Medical  
Center, et al., Defendants.

No. C06-0367RSL.  
Nov. 16, 2007.

Brian Plaskon, Bellevue, Wa, pro se.

Daniel Andrew Brown, Miller Nash LLP,  
Seattle, WA, for Defendants.

ORDER GRANTING DEFENDANTS'  
MOTION FOR SUMMARY JUDGMENT  
ROBERT S. LASNIK, District Judge.

### I. INTRODUCTION

\*1 This matter comes before the Court on a motion for summary judgment (Dkt.# 32) filed by all defendants, who include Valley Medical Center ("VMC" or the "hospital"), Drs. Eric Waterman, Terrence Block and Andrew Oliveira, and certain members of VMC's Board of Commissioners, including Carolyn Purnell, Michael Miller, and Dr. Gary Kohlwes (collectively, "defendants"). Plaintiff, who was a surgeon at VMC, argues that defendants terminated some of his clinical privileges to practice at VMC and publicized stigmatizing information about him in retaliation for his complaints about staffing and patient care. Plaintiff asserts a claim under 42 U.S.C. § 1983 based on alleged violations of his First Amendment and due process rights.<sup>FNI</sup> According to his com-

plaint, plaintiff seeks monetary damages and reinstatement of "full clinical privileges."

FNI. Because the Court finds that this matter can be decided on the memoranda, declarations, and exhibits, defendants' request for oral argument is denied.

Plaintiff, who is also a licensed attorney and is proceeding *pro se*, sent the Court a letter requesting an extension of time to respond to the motion, claiming that he needed additional time to obtain affidavits from unnamed "out of state witnesses." The Court denied the request. (Dkt.# 37). Plaintiff has not filed any response to defendants' motion.

For the reasons set forth below, the Court grants defendants' motion.

### II. DISCUSSION

#### A. Background Facts.

Plaintiff applied for initial appointment to the surgery department at VMC in October 1998. In his application, he stated that his specialty was general surgery. Plaintiff's request for clinical privileges to practice as a general surgeon was granted in June 1999.

VMC uses a peer review decision-making process in granting privileges at the hospital. After obtaining an initial appointment to VMC's active staff, physicians are required to apply for renewal of their privileges every two years to remain on active staff at the hospital. The physician bears the burden of establishing that he is qualified and competent to hold each privilege he requests, each time he reapplies for the privileges. Declaration of Dr. Terrence

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Block, (Dkt.# 32-2) ("Block Decl.") at ¶ 3.

In May 2002, Dr. Oliveira, who was the Chair of the Professional Performance Committee ("PPC"), submitted a memorandum to various VMC personnel informing them that VMC intended to adopt a concept called "core privileging." The core privileges for each specialty "were those procedures which a physician within that specialty would commonly have residency training and board certification to perform and which would be necessary in that specialty." Declaration of Andrew Oliveira, (Dkt.# 32-8) ("Oliveira Decl.") at ¶ 2. In June 2003, VMC formally changed its handling of privileges for surgeons, including plaintiff, so that the hospital would grant them only those privileges that fell within the list of core competencies as established by the department chief.

Plaintiff applied to renew his privileges in 2002. When he did so, he signed a form acknowledging that as an applicant for "recredentialing," he had "the burden of producing adequate information for proper evaluation of [his] competence ... and other qualifications." Oliveira Decl., Ex. 8. Plaintiff's application was initially approved by the Chief of the Department of General Surgery and the PPC. It was then sent to the Medical Executive Committee ("MEC") for further review. Dr. Waterman, the acting Chief of Staff for the MEC, approved plaintiff's re-application only in part. He noticed that plaintiff applied for privileges outside of the core privileges, including ear, nose and throat privileges (the "ENT privileges"). Dr. Waterman noted on the approval document that plaintiff would need to show training and clinical activity establishing his competency to perform the ENT privileges. Plaintiff's application was then returned to the PPC for further review.

When Dr. Oliveira asked plaintiff about his request, plaintiff confirmed that he had not performed the procedures since he began practicing at VMC and did not have any plans to do so. Dr. Oliveira asked plaintiff if he would withdraw his request for ENT privileges, and plaintiff refused.

\*2 In August 2002, the PPC reviewed plaintiff's application further. It recommended that his application be approved with the exception of the ENT privileges because plaintiff had not performed any of the ENT privileges while practicing at VMC and because the privileges were outside of the core privileges. The MEC then reviewed, and ultimately confirmed, the PPC's recommendation in September 2002. Plaintiff chose not to attend the meeting or provide evidence of his competency, despite having been invited to do so. Nevertheless, over the next several months, the MEC invited him three more times to attend an MEC meeting and provide evidence of his competency to perform the ENT privileges. Plaintiff declined each time. The MEC also reminded plaintiff that he could withdraw his request for ENT privileges without any further action by the hospital, but he refused.

In October 2002, plaintiff requested a Fair Hearing. Defendant Dr. Gary Kohlwes, acting as Chairman of the Board of Commissioners ("BOC"), provided plaintiff with a list of VMC's witnesses for the hearing and provided other information about the process. During the hearing, plaintiff did not call any witnesses, claiming that they were unavailable. He declined an offer for a continuance to obtain witnesses. When discussing the ENT privileges at the hearing, he admitted: "I don't expect I'll do these privileges. It's just very uncommon for a general surgeon to do

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these at Valley Medical Center.” Block Decl. at ¶ 30. In February 2003, the Fair Hearing Panel unanimously confirmed the PPC's and the MEC's decisions. Plaintiff appealed the decision to the BOC. The BOC is the entity that takes official action to grant or deny privileges based on the recommendations made to it by the MEC. Once again, plaintiff was invited to provide any evidence of his clinical activity for any of the ENT privileges, and he again failed to do so. In March 2003, the BOC issued its decision accepting the recommendations of the PPC, the MEC, and the Fair Hearing Panel.

By letter dated November 8, 2002, plaintiff informed Dr. Waterman that the decision not to grant him ENT privileges was required by federal mandate to be reported to the National Practitioner Data Bank (“NPDB”). Block Decl., Ex. 18. Therefore, in March 2003, VMC submitted information about the limitation of plaintiff's privileges to the NPDB. Block Decl., Ex. 37. The letter explained the reasons for the action as “surgeon requested seven ENT privileges not performed in over three years; physician felt to be ineligible for these privileges based upon our inability to judge current clinical competence. Also privileges are not ‘core’ for a general surgeon.” *Id.*

#### **B. Summary Judgment Standard.**

On a motion for summary judgment, the Court must “view the evidence in the light most favorable to the nonmoving party and determine whether there are any genuine issues of material fact.” *Holley v. Crank*, 386 F.3d 1248, 1255 (9th Cir.2004). All reasonable inferences supported by the evidence are to be drawn in favor of the nonmoving party. *See Villiarimo v. Aloha Island Air, Inc.*, 281 F.3d 1054, 1061 (9th

Cir.2002). “[I]f a rational trier of fact might resolve the issues in favor of the nonmoving party, summary judgment must be denied.” *T.W. Elec. Serv., Inc. v. Pacific Elec. Contractors Ass’n*, 809 F.2d 626, 631 (9th Cir.1987).

#### **C. Analysis.**

\*3 Defendants claim that plaintiff's claims are barred by the one-year statute of limitations in RCW 7.71.030, which provides the “exclusive remedy for any action taken by a professional peer review body of health care providers ... that is found to be based on matters not related to the competence or professional conduct of a health care provider.” RCW 7.71.030(1). In this case, it is unclear whether that statute applies because the decisions appear to have been based on plaintiff's “competence.” Defendants also argue that plaintiff's claims for monetary relief are barred by the Health Care Quality Improvement Act (“HCQIA”), 42 U.S.C. § 11101, *et seq.* According to the plain language of the statute, however, immunity does not apply to civil rights cases. 42 U.S.C. § 11111(a); *Austin v. McNamara*, 979 F.2d 728, 733 (9th Cir.1992) (noting that the immunity provision “excludes from its coverage suits brought under 42 U.S.C. § 1983”). Defendants are therefore not entitled to immunity under the HCQIA. Nevertheless, plaintiff's claims fail for the reasons set forth below.

#### **1. Due Process Claims**

This Court will not review the merits of VMC's decision. Instead, the review is limited to whether plaintiff was afforded due process and “whether an abuse of discretion by the hospital board occurred, resulting in an arbitrary, capricious or unreasonable exclusion.” *Lew v. Kona Hosp.*, 754 F.2d 1420, 1425 (9th Cir.1985); *see also*

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*Ritter v. Bd. of Comm'rs*, 96 Wn.2d 503, 515-516 (1981). "Administrative action is not arbitrary or capricious if there are grounds for two or more reasonable opinions and the agency reached its decision honestly and with due consideration of the relevant circumstances." *Ritter*, 96 Wn.2d at 515. In this case, although plaintiff alleges that Dr. Waterman had a conflict of interest, he does not explain what the conflict was or how it affected his decision. Instead, the hospital reached the decision honestly and after considering the circumstances in numerous stages of review. Ample grounds support defendants' decision, including the fact that the privileges were not core privileges, plaintiff had not performed the ENT privileges while employed at the hospital, he did not plan to do so, and he refused to produce any evidence of his competence to perform the procedures, despite repeated invitations to do so.

Plaintiff also claims that he was denied procedural due process. To evaluate that claim, the Court considers "(1) whether the interest plaintiff asserts rises to the level of a property interest, and if so, (2) whether, in light of the competing interests of the individual and the state, the procedures afforded plaintiff before termination satisfied due process." *Lew*, 754 F.2d at 1424 (citing *Mathews v. Eldridge*, 424 U.S. 319, 335 (1976)). Plaintiff had no property right to the ENT privileges because he had to re-apply periodically to obtain privileges and had no contractual right to renewed privileges. *See, e.g., Ritter*, 96 Wn.2d at 509 (explaining that, under Washington law, a physician does not have a protected property interest in continued renewed privileges at a public hospital unless he has a specific contractual right to them).

\*4 Plaintiff also argues that defendants

violated his liberty interest by publicly disclosing the denial of privileges to the NP-DB. However, plaintiff does not allege, and there is no evidence to show, that the disclosure seriously damaged his reputation, foreclosed his opportunities to obtain other employment, or resulted in his dismissal. *See, e.g., Ritter*, 96 Wn.2d at 510; *Jablon v. Trustees of Cal. State Colleges*, 482 F.2d 997 (9th Cir.1973). Furthermore, the information communicated was accurate. *See, e.g., Ulrich v. City & County of San Francisco*, 308 F.3d 968, 982 (9th Cir.2002) (explaining that plaintiff "must show the public disclosure of a stigmatizing statement by the government, the accuracy of which is contested ..."). Accordingly, plaintiff was not denied a property right or a liberty interest.

Even if plaintiff was deprived of those rights, he was afforded due process. Plaintiff received numerous and adequate procedural steps before the hospital decided not to grant him ENT privileges. He received written notice of the Fair Hearing and the issue to be decided, and he had an opportunity to present a defense including cross-examining and calling witnesses. At each step, the hospital's decisions were carefully considered and based on substantial evidence. *Lew*, 754 F.2d at 1424. In fact, plaintiff chose not to pursue some of the processes available to him, including presenting evidence at the Fair Hearing and attending any of the many MEC meetings to which he was invited. The hospital had a clear interest in requiring some evidence of competency for the requested privileges, and plaintiff never provided any such evidence. Accordingly, defendants did not violate plaintiff's due process rights.

## 2. First Amendment Claim

Plaintiff alleges that his reapplication

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for privileges was denied “shortly after” he complained about staffing and patient care protocols. Complaint at ¶ 1.1; *id.* at ¶ 4.3. A plaintiff arguing retaliation for the exercise of First Amendment rights must show the following: (1) that he or she engaged in protected speech, (2) that the employer took adverse employment action, and (3) that his or her speech was a substantial or motivating factor behind the adverse employment action. *See, e.g., Coszalter v. City of Salem*, 320 F.3d 968, 973 (9th Cir.2003). After plaintiff makes that showing, the “burden shifts to the public employer to demonstrate either that, under the balancing test established by *Pickering v. Bd. of Educ.*, 391 U.S. 563, 568 (1968), its legitimate administrative interests outweighed [plaintiff’s] First Amendment rights or that, under the mixed motive analysis established by *Mount Healthy City Sch. Dist. v. Doyle*, 429 U.S. 274, 287 (1977), it would have reached the same decision even in the absence of the Plaintiff’s protected conduct.” *Ulrich*, 308 F.3d at 976. Even if plaintiff’s speech was protected by the First Amendment, plaintiff has not provided any evidence of retaliation. His assertion that his application was partially denied “shortly” after his protected conduct is too vague and conclusory to defeat summary judgment. In addition, plaintiff has provided no evidence that his employer expressed any opposition to his speech. Defendants have provided a reasonable explanation for the hospital’s decision, and plaintiff has not offered any evidence that the reason was false or pretextual. *See, e.g., Keyser v. Sacramento City Unified Sch. Dist.*, 265 F.3d 741, 751 (9th Cir.2001) (explaining the potential ways a plaintiff can show that retaliation was a substantial or motivating factor behind the adverse employment action). Accordingly, plaintiff’s First Amendment

claim fails.

### III. CONCLUSION

\*5 For all of the foregoing reasons, the Court GRANTS defendants’ motion for summary judgment (Dkt.# 32). The Clerk of the Court is directed to enter judgment in favor of defendants and against plaintiff.

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Only the Westlaw citation is currently available.

United States District Court, E.D. Tennessee.

Alexander A. STRATIENKO, M.D.,  
Plaintiff,

v.

CHATTANOOGA-HAMILTON  
COUNTY HOSPITAL AUTHORITY et  
al., Defendants.

No. 1:07-CV-258.  
Sept. 8, 2008.

James S. McDearman, John P. Konvalinka,  
Grant, Konvalinka & Harrison, PC, Chat-  
tanooga, TN, for Plaintiff.

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Husch, Blackwell, Sanders LLP, J. Bartlett  
Quinn, Nathaniel S. Goggans, Chambliss,  
Bahner & Stophel, PC, Leah M. Gerbitz,  
W. Randall Wilson, Miller & Martin,  
James S. McDearman, John P. Konvalinka,  
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tanooga, TN, for Defendants.

#### MEMORANDUM

CURTIS L. COLLIER, Chief Judge.

\*1 Defendants Chattanooga-Hamilton  
County Hospital Authority and Mel Twiest,  
M.D. ("Twiest") ("Moving Defendants")  
move for summary judgment<sup>FN1</sup> and to  
dissolve the temporary restraining order  
("TRO")<sup>FN2</sup> (Court File No. 6). In ac-  
cordance with the following, the Court will  
**DENY** the Moving Defendants' motion  
(Court File No. 6).

FN1. Moving Defendants' motion to

dismiss is converted to a motion for  
summary judgment because it  
presents matters outside the plead-  
ings. See Federal Rule of Civil Pro-  
cedure 12(d).

FN2. The Circuit Court of Hamilton  
County, Tennessee issued the TRO  
on September 20, 2004, based upon  
Plaintiff's complaint (Court File No.  
70, Exhibit 3). Although both  
parties still refer to the order which  
enjoins Plaintiff's summary suspen-  
sion as a TRO, it appears that ter-  
minology is inaccurate. Pursuant to  
Tennessee Rule of Civil Procedure  
65.03(5), a TRO without notice to  
the other party must expire within  
fifteen days of being issued. This is  
similar to the Federal Rule of Civil  
Procedure 65(b)(2), which limits  
this time period to ten days. Thus,  
the September 20, 2004 TRO has  
long since expired. However, both  
parties continue to adhere to the  
terms of the TRO.

This may be due to the Court be-  
ing unaware of a subsequent pre-  
liminary injunction being ordered  
by the state court, pursuant to  
Tennessee Rule of Civil Proced-  
ure 65.04(5); an agreement  
between the parties; or other cir-  
cumstances. Regardless, as both  
parties, having superior know-  
ledge of the state court proceed-  
ings and issues in the case, have  
treated the injunction of Plaintiff's  
suspension as a temporary injunc-  
tion-remaining in force until  
modification or resolution of the  
case-the Court will do so as well.  
See 28 U.S.C. § 1450 ("All in-

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junctions, orders, and other proceedings had in such action prior to its removal shall remain in full force and effect until dissolved or modified by the district court.”); *see also Nordin v. Nutri/Sys., Inc.*, 897 F.2d 339, 343 (8th Cir.1990) (A temporary restraining order, where it has no expiration date on its face and exceeds the ten-day limit, must be treated as a preliminary injunction.); *Chicago United Indus., Ltd. v. City of Chicago*, 445 F.3d 940, 943 (7th Cir.2006) (A temporary restraining order was appealable as a preliminary injunction where it was in force for more than twenty days without the consent of the parties).

Therefore, the TRO referred to by Moving Defendants is and will be referred to as a preliminary injunction.

## I. FACTS

On September 16, 2004, there was an altercation between Plaintiff Alexander A. Stratienco (“Plaintiff”) and defendant V. Stephen Monroe, Jr. (“Monroe”) (Court File No. 1, Exhibit 1, p. 5). At some point before that date, Plaintiff conveyed concern to defendant Daniel F. Fisher (“Fisher”) as to whether Monroe was qualified to serve on a committee which credentialed physicians to place carotid stents, as Plaintiff believed Monroe to lack sufficient experience and credentials (*id.*). When Monroe learned of this conversation, he confronted Plaintiff in the break room (*id.*, p. 6). According to Plaintiff,<sup>FN3</sup> Monroe, who was standing in the doorway, demanded Plaintiff stop questioning his training and threatened to sue Plaintiff (*id.*). Plaintiff, with one hand, moved Monroe

aside and excited through the now-open doorway (*id.*). Monroe immediately reported the incident (*id.*).

FN3. Not surprisingly, each side characterizes the situation differently—particularly the degree of menace Monroe exhibited before and during the confrontation and the force with which Plaintiff moved Monroe out of the doorway. These basic facts are presented here for background purposes, taken from the Plaintiff’s Second Amended Complaint (Court File No. 1, Exhibit 1). They are not intended as an endorsement by the Court of any issue of fact.

Based upon this altercation, a peer review was conducted and Plaintiff was suspended for thirty days (*see* Court File No. 50, p. 2; Court File No. 51, Exhibit B). Plaintiff filed a complaint in state court and obtained a temporary restraining order, which prevented Moving Defendant from continuing Plaintiff’s suspension pending resolution of the complaint (Court File Nos. 50, p. 2; 70, Exhibit 3). That temporary restraining order led to the preliminary injunction the Court addresses below (*see supra*, n. 2).

## II. STANDARD OF REVIEW

When a motion to dismiss pursuant to Federal Rule of Civil Procedure (“Fed. R. Civ.P.”) 12(b)(6) presents matters outside the pleadings, the motion must be treated as one for summary judgment. Fed.R.Civ.P. 12(d). Summary judgment is proper when “the pleadings, the discovery and disclosure materials on file, and any affidavits show that there is no genuine issue as to any material fact and that the movant is entitled to judgment as a matter of law.” Fed.R.Civ.P. 56(c). The moving

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party must demonstrate no genuine issue of material fact exists. *Celotex Corp. v. Catrett*, 477 U.S. 317, 323, 106 S.Ct. 2548, 91 L.Ed.2d 265 (1986); *Leary v. Daeschner*, 349 F.3d 888, 897 (6th Cir.2003). That is, the moving party must provide the grounds upon which it seeks summary judgment, but does not need to provide affidavits or other materials to negate the non-moving party's claims. *Celotex*, 477 U.S. at 323. The Court views the evidence, including all reasonable inferences, in the light most favorable to the non-movant. *Matsushita Elec. Indus. Co., Ltd. v. Zenith Radio Corp.*, 475 U.S. 574, 587, 106 S.Ct. 1348, 89 L.Ed.2d 538 (1986); *Nat'l Satellite Sports, Inc. v. Eliadis Inc.*, 253 F.3d 900, 907 (6th Cir.2001). However, the non-movant is not entitled to a trial based solely on its allegations, and must submit significant probative evidence to support its claims. *Celotex*, 477 U.S. at 324; *McLean v. Ontario, Ltd.*, 224 F.3d 797, 800 (6th Cir.2000). The moving party is entitled to summary judgment if the non-movant fails to make a sufficient showing on an essential element for which it bears the burden of proof. *Celotex*, 477 U.S. at 323. In short, if the Court concludes a fair-minded jury could not return a verdict in favor of the non-movant based on the record, the Court may enter summary judgment. *Anderson v. Liberty Lobby, Inc.*, 477 U.S. 242, 251-52, 106 S.Ct. 2505, 91 L.Ed.2d 202 (1986); *Lansing Dairy, Inc. v. Espy*, 39 F.3d 1339, 1347 (6th Cir.1994).

### III. ANALYSIS

\*2 Moving Defendants first seek summary judgment, arguing they are immune from damages resulting from Plaintiff's summary suspension based upon several grounds (Court File No. 8, pp. 14-41). Second, Moving Defendants move the Court to dissolve the preliminary injunc-

tion, enjoining them from executing Plaintiff's summary suspension (Court File No. 8, pp. 10-16).

#### A. Motion for summary judgment

Moving Defendants seek summary judgment, asserting they are immune from damages pursuant to the Health Care Quality Improvement Act ("HCQIA"), 42 U.S.C. §§ 11111(a)(1), 11112(a); the Tennessee Peer Review Law, Tenn.Code Ann. § 63-6-219; the Tennessee Governmental Tort Liability Act, Tenn.Code Ann. § 29-20-310(c), and The Chattanooga-Hamilton County Hospital Authority's Medical Staff Bylaws ("Bylaws") (Court File No. 8, pp. 14-41). In accordance with the discussion below, the Court will DENY Moving Defendants' motion for summary judgment (Court File No. 6).

#### 1. Health Care Quality Improvement Act

In order to promote full and good faith professional review activities in medical facilities, Congress provides immunity from damages to professional review bodies, members, staff, and those who assist the review. *See* 42 U.S.C. § 11111(a)(1). However, in order to qualify for this immunity, the 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

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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).

Here, the Court is faced with two issues: (1) was Plaintiff's summary suspension a "professional review action," as defined under the HCQIA; (2) if so, did Plaintiff's summary suspension satisfy the requirements of 42 U.S.C. § 11112(a).

**a. Plaintiff's summary suspension is a professional review action**

A "professional review action" is defined 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." 42 U.S.C. § 11151(9). "Professional review activity" includes "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 ..." § 11151(10).

\*3 Plaintiff's summary suspension affected his clinical privileges. Therefore, Moving Defendant's determination to suspend, and the summary suspension of, Plaintiff were professional review actions,

and are thus regulated by the HCQIA.

**b. A reasonable jury could find Moving Defendants did not act reasonably in summarily suspending Plaintiff**

Pursuant to 42 U.S.C. § 11112(a), "[a] professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence." Thus, a plaintiff has the burden of demonstrating, by preponderance of the evidence, that the requirements of § 11112(a) have not been met in his peer review. This inquiry as to the reasonableness of a defendant's actions is an objective test; the question is whether there was a sufficient basis for the defendant's actions. "Bad faith" arguments are immaterial to this objective standard. *See, e.g., Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir.1992) ("this test 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 actions would restrict incompetent behavior or would protect patients.")

In the context of a summary judgment motion and for Plaintiff to overcome the presumption of immunity, Plaintiff must demonstrate that a reasonable jury could determine that Moving Defendants did not conduct the relevant peer review actions in accordance with the requirements of 42 U.S.C. § 11112(a). *See Singh v. Blue Cross/Blue Shield of Massachusetts, Inc.*, 308 F.3d 25, 32 (1st Cir.2002) (citing *Austin*, 979 F.2d at 734); *Bryan v. James E. Holmes Regional Medical Center*, 33 F.3d 1318, 1333-34 (11th Cir.1994), *cert. denied* 514 U.S. 1019, 115 S.Ct. 1363, 131 L.Ed.2d 220 (1995). Because a reasonable

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jury could determine Moving Defendants' conduct did not satisfy the § 11112(a) requirements, summary judgment predicated on HCQIA immunity is inappropriate.

In taking a professional review action, Moving Defendants must first afford Plaintiff with "adequate notice and hearing procedures" or "such procedures as are fair to the physician under the circumstances." See 42 U.S.C. § 11112(a)(3). Here, the incident—an alleged assault by Plaintiff—occurred on September 16, 2004 between 1:00 and 1:30 pm (Court File No. 84, p. 4). The decision to summarily suspend Plaintiff was made no later than 3 pm on that day (Court File No. 84, p. 5), although Moving Defendants assert that decision was "fluid," i.e. subject to change should new information arise (Court File No. 8, pp. 6-7). Regardless, Moving Defendant Twiest informed Plaintiff at approximately 12:00 pm on September 17, 2004 that he would be summarily suspended from clinical privileges until further evaluation (Court File No. 8, p. 6). At that time, Moving Defendant Twiest provided Plaintiff with a copy of a letter dated September 16, 2004, detailing Plaintiff's suspension (*id.*).

\*4 Although Plaintiff has the burden to show, by preponderance of the evidence, that Moving Defendants failed to satisfy the requirements of § 11112(a), the Court still views the facts in the light most favorable to Plaintiff—the non-moving party for the purposes of summary judgment. See *Singh*, 308 F.3d at 32. Viewed in the light most favorable to Plaintiff, the facts indicate the decision to summarily suspend Plaintiff was made little more than an hour after the incident occurred (see Court File No. 84, p. 5). Even if the Court were permitted to view the facts as interpreted by Moving Defendants, the "fluid" nature of

Plaintiff's suspension could be challenged, considering Moving Defendant Twiest carried with him a copy of a letter, dated the day before, detailing Plaintiff's suspension when confronting Plaintiff on the matter for the first time (Court File No. 8, p. 6). A reasonable jury could find that Moving Defendants had at least made a tentative decision to suspend Plaintiff prior to providing Plaintiff with notice or an opportunity to be heard. See 42 U.S.C. § 11151(9) (a "professional review action" includes "an action or recommendation of a professional review body.")

Furthermore, a reasonable jury could find Moving Defendants failed to make a "reasonable effort to obtain the facts of the matter." See 42 U.S.C. § 11112(a)(2). Drs. Nita Shumaker and Fisher, having been involved in the decision to summarily suspend Plaintiff, have stated at the time they were consulted, they were unaware of the actions of Monroe, the allegedly-assaulted party, before and during the incident (see Court File No. 84, pp. 12, 15, 20).<sup>FN4</sup> Several witnesses have testified Monroe was angry with Plaintiff prior to the altercation, and indeed was actively seeking him out to confront him because Plaintiff questioned his qualifications (Court File No. 84, pp. 7-8). Monroe is alleged to have said he was "going to have to take [Plaintiff] down in public" (*id.*, p. 8). A reasonable jury could find that Moving Defendants did not make reasonable efforts to obtain the facts, where they either completely failed to inquire as to the reason for the altercation, or did so in a manner that failed to uncover relevant facts witnessed by no less than four individuals (see *id.*, pp. 7-8). See 42 U.S.C. § 11112(a)(2).

FN4. The Court cautions all parties to assure any and all citations to de-

positions or supporting documentation are clearly cited, *including where those documents are filed in the record*. Merely citing a document as, for example, “Ables Deposition at 38-39” does not inform the Court where that deposition is. The citation should include the court file number and exhibit number provided in the docket; for example, Court File No. 85, Exhibit B, pp. 38-39. When the document is not already in the record, the citation should include a clear identification of the relevant filing; for example, Plaintiffs Notice (1/22/2008), Exhibit B, pp. 38-39.

Finally, a reasonable jury could determine Moving Defendants did not take action “in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after [adequate notice and hearing].” 42 U.S.C. § 11112(a)(4). A reasonable jury could find that a person could not reasonably believe that a physician should be suspended from clinical privileges based upon an altercation, the cause of which was unclear or not known, and without informing or questioning that physician until after deciding suspension is, or is likely to be, necessary.

Because Plaintiff has shown, by preponderance of the evidence, that a reasonable jury could find that Moving Defendants have failed to satisfy the requirements of 42 U.S.C. § 11112(a), *see Singh*, 308 F.3d at 32, the Court will DENY Moving Defendants' motion for summary judgment predicated on HCQIA immunity (Court File No. 6).<sup>FN5</sup>

FN5. Moving Defendants argue, in passing, that the “adequate notice and hearing” requirement, 42

U.S.C. § 11112(a)(3), need not be satisfied here, because Plaintiff's summary suspension falls under exceptions to this requirement, as provided in § 11112(c) (*see* Court File No. 8, p. 13; 99, pp. 9-10, 11). This argument is moot because, as above, Moving Defendants did not satisfy two of the other subsections for the purposes of HCQIA immunity, and thus excuse from satisfying the “adequate notice and hearing” requirement is immaterial.

Furthermore, none of the exceptions applies here. The exception under § 11112(c)(1)(B) applies only to suspensions for periods no longer than fourteen days. Plaintiff's summary suspension was for a thirty-day period (Court File No. 50, p. 2). The exception under § 11112(c)(2) applies “where the failure to take such an action may result in an imminent danger to the health of any individual.” Presuming, without deciding, that these exceptions share the same rebuttal presumption found in § 11112(a), Plaintiff has at least provided sufficient evidence that a reasonable jury could determine that there was no imminent danger (*see* Court File No. 84, pp. 5, 9-10, 13, 28).

## 2. Tennessee Peer Review Law

\*5 Under the Tennessee Peer Review Law, Tenn.Code Ann. § 63-6-219(d)(1), all hospitals, physicians, and hospital administrators and employees are immune from liability for furnishing information to a peer review committee, and immune from damages resulting from any decision, opinion, or action rendered by such a committee.

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See *Eyring v. Fort Sanders Parkwest Medical Center, Inc.*, 991 S.W.2d 230, 235 (Tenn.1999) (hospitals are included in the immunity afforded by the Tennessee Peer Review Law). Members of the peer review committee are presumed to have acted in good faith and without malice.<sup>FN6</sup> Tenn.Code Ann. § 63-6-219(d) (3). The party seeking to overcome the immunity has the burden of proving bad faith and malice. *Id.* For summary judgment review, as here, the evidence is viewed in the light most favorable to the non-moving party and all reasonable inferences must be drawn in that party's favor. *Eyring*, 991 S.W.2d at 236.

FN6. Where an individual provides information to the review committee, but is not a member of the review committee, that person is immune from liability "unless such information is false and the person providing it had actual knowledge of such falsity." Tenn.Code Ann. § 63-6-219(d)(2). Whether that information was otherwise provided in good faith or with malice is immaterial. See *Ironside v. Simi Valley Hosp.*, 188 F.3d 350, 353 (6th Cir.1999); *Logan v. Everett*, 2006 WL 223708, \*4, 2006 Tenn.App. LEXIS 169, \*11-13 (Tenn.Ct.App. Jan.27, 2006).

If an individual is a member of the review committee, as here, a showing of bad faith or malice still removes the immunity. See Tenn.Code Ann. § 63-6-219(d)(3).

The Court of Appeals of Tennessee cited seven factors which it considered in weighing whether malice was sufficiently shown. *Eyring v. Fort Sanders Parkwest*

*Medical Center, Inc.*, 1997 WL 294457, \*7-8, 1997 Tenn.App. LEXIS 390, \*21-22 (Tenn.Ct.App. June 4, 1997), *aff'd*, 991 S.W.2d at 237 (citing P. Rosen, *Medical Staff Peer Review: Qualifying the Qualified Privilege Provision*, 27 Loyola L.Rev. 357 (1993)). These factors are:

1. Malice may be inferred when the complaint originates and is pursued outside the normal quality assurance procedure.
2. Malice may be inferred when stale charges are used.
3. Malice may be inferred by the manner in which the administration handled the initial complaints—was the doctor considered competent until proven incompetent; or was he summarily terminated from the medical staff.
4. Lack of due process is a circumstance from which legal malice may be inferred.
5. Malice should be implied when a physician did not have an opportunity to be meaningfully heard in response to the allegations.
6. Malice may be inferred by the disparate treatment of one doctor as compared to the doctor's colleagues.
7. Malice may be inferred when the severity of the hospital disciplinary action is disproportionate.

*Id.*

In reviewing these factors, there is some, even though not great, evidence to infer malice based upon the facts currently before the Court, and that evidence—viewed in the light most favorable to Plaintiff and drawing all reasonable inferences in his favor—is sufficient to raise a dispute of mater-

ial fact.

Based upon the evidence and reasonable inferences drawn in the light most favorable to Plaintiff, five of the seven factors above indicate malice. The first two factors-the origination of the complaint and whether the charges used are stale-do not indicate malice. *See Eyring*, 1997 WL 294457, at \*7. The third factor-the manner in which the initial complaint was handled-indicates some bad faith and malice. *See id.* at \*7. Within no more than an hour and a half after the incident, Moving Defendants decided to summarily suspend Plaintiff (Court File No. 84, p. 5). Shortly thereafter, Moving Defendant's attorneys drafted a letter to Plaintiff informing him of his suspension (Court File Nos. 8, p. 6; 84, p. 5). The decision to suspend was made prior to any investigation which explored the events leading up to the incident, and to any discussion with Plaintiff concerning the incident (*see* Court File Nos. 8, p. 6; 84, pp. 12, 15, 20). Moving Defendants argue the suspension decision, despite attorneys having already drafted the suspension letter, was "fluid," and subject to change pending a conversation with Plaintiff (Court File No. 8, p. 6). Even if the suspension decision was "fluid," and there is sufficient evidence that a reasonable jury could determine otherwise, assuming Plaintiff was at fault until proven otherwise indicates malice. *See Eyring*, 1997 WL 294457, at \*7 (Malice may be inferred where "the doctor was [not] considered competent until proven incompetent.")

\*6 The fourth and fifth factors-a lack of due process and meaningful opportunity to be heard-also support an inference of malice. *See Eyring*, 1997 WL 294457, at \*8. Here, the decision to suspend Plaintiff was made prior to notifying Plaintiff of the

disciplinary inquiry or providing him notice and opportunity to prepare for a hearing on the matter (*see* Court File No. 8, p. 6). One could infer malice where Moving Defendants decided to suspend Plaintiff without discussing the matter with him first. Furthermore, as above, even if the suspension decision was "fluid," Moving Defendants still determined suspension was likely without first notifying Plaintiff or providing him with a hearing.

The sixth factor-disparate treatment of Plaintiff in comparison to other colleagues-provides some basis to infer malice when viewed in the light most favorable to Plaintiff. *See Eyring*, 1997 WL 294457, at \*8. Although this sort of incident is fairly rare among adults in a professional setting, Plaintiff has provided evidence of another physician who grabbed a nurse's arms, leaving them "hurt and red," and was not summarily suspended for his actions (Court File No. 84, p. 20). Although this is only one incident and the decision to suspend a physician is very fact-specific, this does illustrate that Moving Defendants do not summarily suspend a physician based solely upon engaging in non-consensual, physical conduct with another staff member. Such instances apparently require further investigation-something which a reasonable jury could determine was not done here.

The seventh factor-disproportionate severity of the discipline in comparison with the conduct-also provides some basis to infer malice. *See Eyring*, 1997 WL 294457, at \*8. Moving Defendant Twiest and defendant Fisher-another doctor consulted in the disciplinary considerations-both agreed Plaintiff was not a threat to patients or staff (*see* Court File No. 84, pp. 5, 9-10, 13, 28). Moving Defendant Twiest

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instead testified the summary suspension was primarily to prevent disruption to hospital operation (*id.*, p. 10). However, if that were the case, there is some basis to infer malice where Plaintiff was summarily suspended to facilitate normal hospital operations, but no action was taken to determine whether Monroe should also be summarily suspended for the same reason (*id.*, p. 20).

The factors above, when applied here, provide a basis to infer malice. This is not a situation where the physician was provided with notification and a meaningful opportunity to respond to the allegations at a hearing, or was summarily suspended only after a reasonable investigation was conducted to determine the facts of the situation. *Cf. Eyring*, 991 S.W.2d at 237; *Curtsinger v. HCA, Inc.*, 2007 WL 1241294, \*1, 9-10, 2007 Tenn.App. LEXIS 268, \*2, 28-31 (Tenn.Ct.App. April 27, 2007). Because Plaintiff has provided sufficient evidence from which a reasonable jury could infer bad faith and malice, the Court will DENY Moving Defendants' motion for summary judgment based upon immunity under the Tennessee Peer Review Law (Court File No. 6).

### 3. Tennessee Governmental Tort Liability Act

\*7 The Tennessee Governmental Tort Liability Act provides as follows:

No claim may be brought against an employee or judgment entered against an employee for injury proximately caused by an act or omission of the employee within the scope of the employee's employment for which the governmental entity is immune in any amount in excess of the amounts established for governmental entities in § 29-20-403, unless the act or omission was willful, malicious, criminal, or performed for personal financial

gain ...

Tenn.Code Ann. § 29-20-310(c).

All members of boards, commissions, agencies, authorities, and other governing bodies of any governmental entity, created by public or private act, whether compensated or not, shall be immune from suit arising from the conduct of the affairs of such board, commission, agency, authority, or other governing body. Such immunity from suit shall be removed when such conduct amounts to willful, wanton, or gross negligence.

Tenn.Code Ann. § 29-20-201(b)(2).

Moving Defendants argue Moving Defendant Twiest, as well as the Credentials Committee and the Medical Executive Committee, were all functioning in the capacity of agents of Moving Defendant Chattanooga-Hamilton County Hospital Authority, a governmental authority covered under the Tennessee Governmental Tort Liability Act (Court File No. 8, pp. 39-41). Plaintiff concedes this characterization (*see* Court File No. 84, p. 41).

The Tennessee Governmental Tort Liability Act raises the issues of whether Moving Defendants were negligent or exhibited malice in their actions. *See* Tenn.Code Ann. §§ 29-20-201(b)(2), 310(c). Neither party has endeavored to argue which party has the burden of proof in demonstrating the presence or absence of negligence or malice, or how those terms are defined in relation to the Tennessee Governmental Tort Liability Act (*see* Court File No. 8, pp. 39-41; 84, pp. 40-43). The Court has already determined malice was sufficiently established at the summary judgment stage in relation to the Tennessee Peer Review Law. The Court has found no

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Tennessee case law clearly defining malice, in the context of the Tennessee Governmental Tort Liability Act, in a manner contrary to this Court's Tennessee Peer Review Law analysis. Furthermore, because the Tennessee Peer Review Law deals specifically with situations of professional review, as here, the Court is persuaded to adopt the malice standard utilized in that more-specific statute. Having determined that Plaintiff's previous showing of malice is sufficient to preclude summary judgment, the Court will DENY Moving Defendants' motion for summary judgment based upon immunity pursuant to Tenn.Code Ann. § 29-20-310 (Court File No. 6).

#### 4. The Chattanooga-Hamilton County Hospital Authority's Medical Staff Bylaws

Moving Defendants argue, because the Bylaws provide immunity to damages for peer review actions, Moving Defendants should be granted summary judgment (Court File No. 8, pp. 14-15). The Bylaws are, in pertinent part, as follows:

\*8 No representative of the Health System or medical staff shall be liable to a physician for damages or other relief for any action taken or statement or recommendation made within the scope of his duties as a representative, if such representative acts in good faith and without malice after a reasonable effort under the circumstances to ascertain the truthfulness of the facts and in the reasonable belief that the action, statement, or recommendation is warranted by such facts.

Bylaws, Sec. 5.4-1, Court File No. 6, Exhibit A, document pp. 15-16.

Thus, the Bylaws only provide immunity where a party acts "in good faith

and without malice," after a "reasonable effort" was made to ascertain the truth, and upon "reasonable belief" that the action was warranted by the facts (*id.*).<sup>FN7</sup> As discussed in the previous sections, a reasonable jury could find that the action was taken in bad faith and with malice, reasonable efforts were not made, and it was not reasonable to believe suspension was necessary based upon the facts available at the time the decision to suspend was made. As such, the Court will DENY Moving Defendants' motion for summary judgment based upon the Bylaws (Court File No. 6).

FN7. Moving Defendants make no effort to define "good faith," "malice," or "reasonable" in relation to the Bylaws (*see* Court File No. 8, pp. 13-16). As such, the Court applies the definitions under the HCQIA and Tennessee Peer Review Law.

#### 5. Conclusion

Because Moving Defendants have not sufficiently established and Plaintiff has sufficiently rebutted the immunity under HCQIA, 42 U.S.C. §§ 11111, the Tennessee Peer Review Law, Tenn.Code Ann. § 63-6-219, the Tennessee Governmental Tort Liability Act, Tenn.Code Ann. § 29-20-310(c), and the Bylaws, the Court will DENY Moving Defendants' motion for summary judgment (Court File No. 6).

#### B. Motion to dissolve preliminary injunction<sup>FN8</sup>

FN8. *See supra*, n. 2.

Moving Defendants also move the Court to dissolve the preliminary injunction issued by the Circuit Court of Hamilton County on September 20, 2004 (Court File No. 6). Moving Defendants ar-

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gue (1) the judiciary should not enjoin a summary suspension when it has been determined appropriate by medical experts, and (2) Plaintiff has failed to exhaust his administrative remedies (Court File No. 8, pp. 10-16).<sup>FN9</sup>

FN9. Normally, in issuing a TRO or preliminary injunction, or considering whether one already imposed should be modified or dissolved, the Court considers and balances the following four factors: (1) whether the movant has a “strong” likelihood of success on the merits; (2) whether the movant would otherwise suffer irreparable injury; (3) whether a preliminary injunction would cause substantial harm to others; and, (4) whether the public interest would be served by the issuance of a preliminary injunction. *McPherson v. Mich. High Sch. Athletic Ass’n, Inc.*, 119 F.3d 453, 459 (6th Cir.1997) (en banc). Moving Defendants do not address or dispute whether and in what way these factors weigh against the continuation of the current preliminary injunction.

### 1. Deference to peer review

Moving Defendants argue (Court File No. 8, p. 11) the judiciary should allow hospitals and qualified medical experts to determine whether a physician should enjoy clinical privileges, relying heavily upon the decision in *Early v. Bristol Memorial Hospital*, 508 F.Supp. 35, 37-38 (E.D.Tenn.1980). However, the reasoning in *Early* does not support Moving Defendants' position in this case. In *Early*, a physician's clinical privileges were terminated due to a determination that he was abusing drugs. *Id.* at 37. Based upon the serious-

ness of this behavior and the obvious risk to patients caused by a physician under the abusive influence of drugs, the *Early* court strongly cautioned against the judiciary substituting its own judgement for that of medical experts concerning “immeasurable harm” that could be suffered by patients. *Id.*

\*9 In explaining the extent of this deference, the *Early* court continued:

On the one hand, the public must be assured that each member of the medical staff of a hospital is fully competent to practice his profession at such facility; on the other hand, every effort must be made to insure that *no physician will be denied staff-privileges on the basis of incorrect information or without having been afforded a meaningful opportunity to refute the charges against him.* Each decision must be made with the best interest of the hospital in mind but with a full recognition of the rights of the individual physician. The termination of a physician's staff-privileges is serious business; a single precipitous decision of a medical committee could ruin a budding career.

508 F.Supp. at 38 (emphasis added).

The deference afforded to the factual situation in *Early* is unwarranted here for Moving Defendants' decision to suspend Plaintiff because (1) there is no evidence that Plaintiff poses any risk of harm to any patients (*see* Court File No. 84, pp. 5, 9-10, 13, 28), and (2) evidence exists which indicates Plaintiff's suspension was decided without adequate investigation of the incident, full consideration of what occurred, a meaningful opportunity for Plaintiff to refute the charges, and a clear justification for action as serious as a thirty-day suspension of clinical privileges (*see* Court File

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Nos. 8, p. 6; 50, p. 2; 84, pp. 5, 12, 15, 20).  
*See Early*, 508 F.Supp. at 38.

## 2. Judicial intervention is not premature

Moving Defendants argue any judicial involvement is premature for a variety of reasons (*see* Court File No. 8, pp. 12-16; 99, pp. 4-7). First, Moving Defendants argue the Bylaws permitted Moving Defendants to summarily suspend Plaintiff because “[w]henver a physician’s conduct requires that immediate action be taken to protect the life of any patient(s) or to reduce the substantial likelihood of immediate injury or damage to the health or safety of any patient, employee or other person present in the Health System, or to prevent disruption to hospital operation ... [authorized parties] shall have the authority to summarily suspend the medical staff membership status or all or any portion of the clinical privileges of such physician” (Bylaws, Sec. 4.2-1, Court File No. 6, Exhibit A, document p. 8). Assuming here, as Moving Defendants argue, that the parties are bound by the Bylaws (Court File No. 8, p. 14, n. 1), the language of the Bylaws begs the question. As previously discussed concerning the HCQIA, a reasonable jury could still determine that Plaintiff’s conduct did not “require” immediate action; that Plaintiff’s conduct did not threaten anyone’s safety or pose any danger (*see* Court File No. 84, pp. 5, 9-10, 13, 28); and a thirty-day suspension was not necessary to prevent the disruption of hospital operation.<sup>FN10</sup>

FN10. Moving Defendant Twiest did testify that Plaintiff was summarily suspended primarily to prevent disruption to hospital operations (Court File No. 84, p. 10). However, Moving Defendants have provided little to no evidence that

Plaintiff’s continued presence at the hospital did or was likely to disrupt hospital operations, or even that such a belief was reasonable at the time of Plaintiff’s summary suspension. There is still a material factual issue of whether this requirement is satisfied, particularly where this determination of Plaintiff’s likelihood of disrupting hospital operations was made without knowing the full facts of the incident, and without similarly suspending Monroe, who was also involved in the incident and whose presence could thus also disrupt hospital operations.

Second, Moving Defendants argue the peer review process must be fully completed prior to any action of this Court, because (1) the injury is only a “threatened injury” until the peer review process is complete, because that process may not result in Plaintiff’s continued suspension (Court File No. 8, p. 15); and, (2) “the Court will be unable to analyze the Authority’s compliance with HCQIA and the Tennessee Review Law” without the full administrative record (Court File No. 8, p. 13). These arguments, although superficially appealing, fail to grasp the nature of the action here.

\*10 Plaintiff’s summary suspension, although a preliminary act within the full peer review process, is still, in and of itself, a “professional review action” as defined by 42 U.S.C. § 11151(9) (A “professional review action” is “an action or recommendation by a professional review body which is taken or made *in the conduct of professional review activity* ... which affects ... adversely the clinical privileges ... of the physician.”) (emphasis added). Because

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Plaintiff's summary suspension is, individually, a professional review act, that act must conform to the requirements of 42 U.S.C. § 11112(a) in order to secure the immunity pursuant to § 11111(a)(1). The Court is not limited to considering only a final act of suspension, but can consider any professional review action within the relevant "professional review activity," which includes modification of a physician's clinical privileges. 42 U.S.C. § 11151(10)(C). This is similarly true under the Tennessee Peer Review Law, which involves "any decision, opinions, actions, or proceedings" of a peer review committee. *See* Tenn.Code Ann. § 63-6-219(d)(1).

As a practical matter, in most instances, individual professional review actions will not be challenged directly, but only as they relate to the sufficiency of the final decision of suspension. However, where, as here, a preliminary professional review action itself leads to a lengthy summary suspension, that action is likely to be challenged and the Court must determine whether it satisfies the requirements for HCQIA immunity.

Thus, in considering Moving Defendants' first argument concerning Plaintiff's summary suspension as only a "threatened injury" (Court File No. 8, p. 15), Plaintiff's summary suspension is an immediate injury and, although the peer review may ultimately conclude that a permanent suspension is not required, the injury sustained by the summary suspension-including loss of wages, tarnishing of reputation, and disruption of patient services-will have already occurred.

Regarding Moving Defendants' second argument concerning the lack of a full peer review record before the Court (Court File No. 8, p. 13), the Court's analysis of

Plaintiff's summary suspension, and the potential immunity for that action under 42 U.S.C. §§ 11111(a)(1), 11112(a), requires the Court to consider the efforts and actions of Moving Defendants prior to and at the time of Plaintiff's summary suspension. This inquiry does not require any information about Moving Defendants' further peer review actions after Plaintiff's summary suspension.

### **3. Relationship between the preliminary injunction and the completion of the peer review process**

Because there seem to be conflicting accounts of the scope and nature of the preliminary injunction in the parties' filings, the Court will address the scope of the preliminary injunction more specifically. The original TRO, leading to the preliminary injunction, is brief (*see* Court File No. 70, Exhibit 3), and provides a unique challenge for this Court to interpret it nearly four years later, out of context with the surrounding circumstances presented to that court in 2004. The TRO itself orders "that Defendants be and hereby are restrained from continuing the suspension of Plaintiff's medical staff privileges at Erlanger Hospital pending a hearing" (*id.*). The Order then sets an evidentiary hearing date for October 5, 2004, one which does not appear to have been held prior to removal to this Court (*see* Court File No. 70, p. 2).

\*11 According to Plaintiff, the original TRO anticipated the completion of the peer review process, prior to its reconsideration (Court File No. 84, pp. 36-39). Moving Defendants do not expressly dispute this, but indicate they are in some way precluded from completing this process due to the TRO (*see* Court File Nos. 8, pp. 12-16; 70, p. 3). This is incorrect.<sup>FNI1</sup> Moving De-

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defendants are not precluded from completing their investigations, hearings, or final determination in this matter. The preliminary injunction only precludes Moving Defendants from implementing Plaintiff's summary suspension. Moving Defendants are not enjoined from completing the review process and taking any final action which is deemed appropriate in light of the culmination of that review, which could include a temporary or permanent suspension.

FN11. Plaintiff asserts "the parties agreed to complete discovery prior to any review hearing" (Court File No. 84, p. 36). The parties, by mutual agreement, may have so limited their ability to continue with the peer review process; however, the Court is not aware of such an agreement and knows of nothing on the record memorializing the details of it.

As such, the final decision of the peer review will render the preliminary injunction moot, because the final decision will supersede the preliminary one.<sup>FN12</sup> Thus, if the final decision does not include suspension, there will be no need for a preliminary injunction. If the final decision does include suspension, Plaintiff may wish to file for another TRO or preliminary injunction against the execution of that professional review action-i.e. the final decision to suspend-and the Court will ultimately consider whether that final decision and suspension conformed with the requirements of 42 U.S.C. § 11112(a) to qualify for immunity under § 11111(a)(1), or whether the state statutes or Bylaws otherwise grant Moving Defendants immunity for that final professional review action.

FN12. However, as explained

above, the summary suspension is an individual "professional review action" and, if enacted, would cause irreparable harm until the peer review was completed.

#### 4. Summary

Because Moving Defendants have not provided an adequate basis for dissolving the preliminary injunction, the Court will **DENY** Moving Defendants' motion to dissolve the preliminary injunction (Court File No. 6).

#### IV. CONCLUSION

Because, at the summary judgment stage, the factual requirements to secure immunity for damages resulting from the professional review action involving Plaintiff's summary suspension, pursuant to the HCQIA, 42 U.S.C. §§ 11111, 11112; the Tennessee Peer Review Law, Tenn.Code Ann. 63-6-219; the Tennessee Governmental Tort Liability Act, Tenn.Code Ann. 29-20-310(c); and, Moving Defendants' Bylaws, have not been satisfied, the Court will **DENY** Moving Defendants' motion for summary judgment (Court File No. 6).

Because Moving Defendants have failed to provide an adequate basis upon which to dissolve the preliminary injunction against enforcing Plaintiff's summary suspension, the Court will **DENY** Moving Defendants' motion to dissolve the preliminary injunction (Court File No. 6).

An Order shall enter.

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