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SC Court of Appeals

STATE OF SOUTH CAROLINA)
) IN THE COURT OF COMMON PLEAS
COUNTY OF YORK) SIXTEENTH JUDICIAL CIRCUIT

Robert Randall, M.D.,) Civil Action No. 2012-CP-46-167
)
Plaintiff,)
)
v.)
)
Amisub of South Carolina, Inc. d/b/a)
Piedmont Medical Center, Nathaniel)
Edwards, M.D., and Richard Patterson,)
M.D.,)
)
Defendants.)

ORDER GRANTING DEFENDANTS' MOTION FOR SUMMARY JUDGMENT

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DAVID HAMILTON
YORK CO. CLERK OF COURT

On August 5, 2013, Defendants filed a motion for summary judgment asserting that Plaintiff's claims for damages in this suit fail because Defendants are entitled to damages immunity under the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152. Defendants' motion also asserts that Plaintiff's causes of action fail as a matter of law for additional reasons.

On March 3, 2014, the Court convened a hearing on Defendants' motion. After carefully considering the parties' memoranda and the arguments of counsel made at the hearing, the Court *grants* Defendants' motion for summary judgment for the reasons set forth herein.

I. FACTS AND PROCEDURAL BACKGROUND

Defendant Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center ("Piedmont") is a hospital located in Rock Hill, South Carolina. Defendant Nathaniel Edwards, MD is a cardiologist who formerly served as the Chief of Staff at Piedmont. Defendant Richard Patterson, MD is a retired general surgeon who formerly served as

the Chief Medical Officer at Piedmont. Plaintiff Robert Randall, MD is a general surgeon who formerly held privileges to practice at Piedmont.

As the result of a physician peer review action at Piedmont, Dr. Randall's abdominal surgery privileges were suspended in October 2010 and ultimately revoked in July 2011.[1] On January 13, 2012, Dr. Randall filed this suit asserting conspiracy and defamation causes of action against Defendants. Dr. Randall alleges that his peer review action at Piedmont was a conspiracy undertaken for various improper reasons, including as retaliation for Dr. Randall selling his medical practice to a competing hospital.

A. Peer Review Committee and Credentials Committee

Dr. Randall's peer review action began when his care became the subject of focused review by the physicians on Piedmont's Peer Review Committee in 2009 and 2010. This review was triggered by complications Dr. Randall was experiencing in abdominal surgery cases. The Peer Review Committee reviewed and analyzed Dr. Randall's surgical cases and also sent his cases outside Piedmont for external review by a general surgeon.

This review caused the Peer Review Committee to believe that Dr. Randall's surgical technique and judgment were deficient. Among other things, the Peer Review Committee was concerned that during his surgeries Dr. Randall was all too often perforating his patients' organs, and his rough and hurried handling of abdominal tissue was causing unnecessary complications. The Peer Review Committee was also

[1] Dr. Randall's remaining privileges at Piedmont expired when Dr. Randall chose not to seek reappointment to the medical staff.

concerned that Dr. Randall's technical surgical errors were made worse by his failure to timely appreciate and repair the injuries he caused.

On June 10, 2010, Dr. Edwards, who at the time was Chair of the Peer Review Committee in addition to being the Chief of Staff, brought Dr. Randall's cases to the physicians serving on Piedmont's Credentials Committee for consideration. The Credentials Committee concluded that the new cases manifested some of the same deficiencies that were observed with Dr. Randall's surgical care in 2006, including the rough handling of the bowel and the failure to recognize when patients needed to be returned to the operating room.[2] On July 13, 2010, after meeting with Dr. Randall to discuss the cases under review, the Credentials Committee recommended that Dr. Randall be reappointed for one year -- instead of two years -- and further recommended concurrent review of 100% of his abdominal and herniorrhaphy surgery cases for six months.

The Credentials Committee's recommendation was subsequently reviewed by the physicians on the Medical Executive Committee ("MEC") at Piedmont, and the MEC recommended reappointing Dr. Randall for one year, but increased the monitoring period. The MEC also determined that further investigation of Dr. Randall's patient care would be conducted.

[2] In 2006, internal and external reviews of Dr. Randall's cases found problems with Dr. Randall's surgical judgment and technique. As a result, Dr. Randall's peers imposed a year-long, retrospective review of 100% of Dr. Randall's open hernia and carotid surgery cases. This review occurred during 2007, and after Dr. Randall's cases received acceptable scores during this review period, the review terminated in 2008.

B. **Ad Hoc Committee**

The additional investigation of Dr. Randall's surgical care contemplated by the MEC was primarily conducted by an Ad Hoc Committee at Piedmont that consisted of the physician members of the Peer Review Committee, the Credentials Committee, and the MEC. In September 2010, the Ad Hoc Committee provided Dr. Randall with the external reviews of the cases at issue and asked him to provide a written response addressing each case.

After considering the external reviews, the pertinent portions of the medical records, Dr. Randall's written responses, and Dr. Randall's oral presentation regarding the cases, the Ad Hoc Committee concluded that Dr. Randall's care was substandard and recommended to the MEC that Dr. Randall's privileges to perform abdominal surgery be revoked.[3]

C. **Dr. Randall's medical practice**

Unbeknownst to the physician peer reviewers at Piedmont, they were not the only group scrutinizing Dr. Randall's care during this time. In 2009, Dr. Randall's practice, owned by Presbyterian Healthcare (Novant), conducted an internal investigation of his care.[4] As part of this investigation, Dr. Randall's surgeon partners and other professionals in the practice reported the following:

Dr. Randall's "outcomes were less than optimal."

"[P]atients have not been prepared properly for procedures under Dr. Randall's care."

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[3] Notably, the Chairman of the Credentials Committee, who had previously recommended only monitoring, supported this new recommendation because he had become convinced that more needed to be done to protect patients.

[4] Defendants learned of this investigation through discovery in this case.

> Operating Room nurses reported that Dr. Randall's "cases are now bloody and there are numerous take-backs."
>
> Dr. Randall experienced "lots of personal complications – 'more than his share.'"
>
> When working with other surgeons on cases "Dr. Randall would 'take the case over,' handle tissues roughly and create unnecessary complications."

Dr. Randall's partners also reported that Dr. Randall's surgical care had become so compromised that they would no longer participate in follow-up care of Dr. Randall's patients, and one partner reported that he would leave if Dr. Randall remained a partner in the practice. Discovery revealed that after this investigation, Dr. Randall was terminated by the practice because the malpractice risk of continuing to employ him became too great.[5]

D. <u>MEC</u>

On October 11, 2010, the physicians on the MEC convened to consider the Ad Hoc Committee's recommendation that Dr. Randall's privileges to perform abdominal surgery be revoked. The MEC members reviewed the external reviews, the medical records, and the statements of Dr. Randall regarding the cases under review. The MEC also considered additional cases that had recently been reviewed by the Peer Review Committee and the external reviewer, and data that demonstrated Dr. Randall had experienced more unplanned returns to the operating room than other surgeons on the medical staff.

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[5] Discovery also revealed that two of the cases under review in Dr. Randall's peer review action at Piedmont were the subject of medical malpractice suits. Dr. Randall's insurer paid a large sum to settle one, and the other was still pending at the time Dr. Randall's deposition was taken.

The MEC ultimately concluded that the surgical judgment and technique exhibited by Dr. Randall in the cases under review fell below the standards of the medical staff, and, therefore, Dr. Randall's abdominal surgical privileges should be revoked. In a letter dated October 15, 2010, the Chief Executive Officer of Piedmont provided Dr. Randall notice of the MEC's adverse recommendation and notice that he had the right under the medical staff bylaws to challenge this recommendation.

E. Suspension

Shortly after the MEC made its' recommendation, Dr. Edwards was made aware of a recent complaint made by the husband of a patient whose gallbladder had been removed by Dr. Randall. This patient lost eleven units of blood and had an extended stay in critical care. In response to this new case and the previous cases, Dr. Edwards summarily suspended Dr. Randall's abdominal surgery privileges. Dr. Edwards testified that he took this action because he believed that a suspension, which would take effect immediately, was necessary to protect patients from potential imminent harm.

In a letter dated October 15, 2010, Dr. Randall received notice of the suspension and the reasons it was imposed. This letter also informed Dr. Randall that he had the right under the medical staff bylaws to address the MEC before the MEC considered whether to continue, terminate, or modify the suspension. By letter dated October 18, 2010, Dr. Randall was sent copies of the external reviews of the more recent cases that had been considered by the MEC and the data regarding unplanned returns to the operating room.

On October 25, 2010, Dr. Randall met with the MEC regarding the suspension. During this meeting, Dr. Randall addressed all the cases previously under

consideration, the additional cases considered by the MEC on October 11, the data on unplanned returns to the operating room, and the case that triggered his suspension.[6] After Dr. Randall had presented to the MEC, he was excused from the meeting, and the MEC deliberated. Thereafter, the MEC unanimously voted to continue the suspension.

By letter dated October 28, 2010, Dr. Edwards informed Dr. Randall that the MEC had voted to uphold his suspension. This letter also informed Dr. Randall that he had the right to challenge the suspension.

F. **Hearing**

Dr. Randall requested a hearing to challenge the MEC's adverse recommendations regarding his medical staff privileges, as he had the right to do under the medical staff bylaws. Thereafter, Dr. Randall received a hearing notice that identified the Hearing Officer and the proposed Hearing Panel. The notice also provided Dr. Randall with a detailed description of the grounds for the adverse actions including a list of the ten cases at issue. None of the five physicians selected to serve on the Hearing Panel were economic competitors of Dr. Randall. Dr. Randall was afforded the right to object to the service of any of the individual physicians on the panel and to have counsel represent him at his hearing.

Dr. Randall did not object to any individual Hearing Panel members, but he did object that his panel did not contain a general surgeon. Piedmont's medical staff bylaws prohibit service on the Hearing Panel by the reviewed physician's economic competitors, partners, or physicians who had participated in the patient cases under

[6] Dr. Randall created concern among the physicians on the MEC at this meeting when he described this patient as having suffered "a little bit of bleeding."

review. When these criteria from the bylaws were applied, there were no general surgeons on Piedmont's medical staff eligible to serve on the Hearing Panel, and therefore, Dr. Randall's objection was overruled by the Hearing Officer.

On February 16 and 17, 2011, Dr. Randall's peer review hearing was conducted. At the hearing, both Dr. Randall and the MEC had the right to call witnesses and submit documents into evidence regarding the cases at issue. Both sides exercised that right. Eight witnesses were called, including each side calling a surgeon who offered expert opinions regarding the cases under review. In his deposition, Dr. Randall offered the following critique of his own expert witness:

> It was real apparent that he'd not very well reviewed the cases. He really didn't know them. He got up and they would ask him certain questions, and he wouldn't know or had to fumble through. He was not a very effective witness.

Numerous exhibits were entered into evidence including the relevant medical records, external reviews of Dr. Randall's cases, and minutes from the various hospital committees that considered the cases at issue.[7] The hearing generated a 482-page transcript. After the presentation of evidence, the Hearing Panel deliberated.

On April 16, 2011, the Hearing Officer issued the Hearing Panel's "Decision, Findings of Fact and Conclusions." The Hearing Panel unanimously decided that the MEC's recommendations to revoke and suspend Dr. Randall's abdominal surgery privileges should be upheld. The Hearing Panel's Decision included the following conclusions:

[7] The cases included the patient who suffered an 11-unit bleed after a gallbladder removal. At the hearing Dr. Randall described this patient's husband -- whose complaint caused this case to be reviewed -- as trying to "fix" the problem of his "southern porcelain princess."

Substantial evidence supports the conclusion that Dr. Randall has demonstrated a persistent pattern of judgment error and lack of technical proficiency with respect to abdominal surgery.

The evidence reasonably supports that these errors of judgment and skill led to the deaths of certain patients or caused others to suffer complications and prolonged hospitalizations. The outcomes for the patients at issue were adverse and severe in terms of morbidity and significant mortality.

The evidence reasonably supports that Dr. Randall did not demonstrate that he appreciated the severity of the problems that existed in his surgical performance.

G. Appellate Review Committee and Board of Governors

On May 6, 2011, Dr. Randall appealed the Hearing Panel's Decision to Piedmont's Board of Governors. Piedmont's Board assigned an Appellate Review Committee to consider Dr. Randall's appeal. After considering written briefs, oral arguments, and the hearing record, the Appellate Review Committee upheld the Hearing Panel's Decision. The Appellate Review Committee reported their recommendation to the full Board. After considering the Hearing Panel's and Appellate Review Committee's findings, and after reviewing the hearing trasncript, the Board affirmed the termination of Dr. Randall's abdominal surgery privileges effective July 12, 2011.

II. LEGAL STANDARD

A. The Health Care Quality Improvement Act

Under the Health Care Quality Improvement Act ("HCQIA"), if a professional review action (more commonly known as a "peer review action") complies with certain standards, hospitals, physicians, and others are entitled to immunity from claims for monetary damages that arise from peer review activities. 42 U.S.C. § 11111(a)(1)(if a peer review action satisfies the HCQIA standards peer reviewers

"shall not be liable in damages under any law of the United States or of any State. . . ."); *see also Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 171 (4th Cir. 2009); *Wieters v. Roper Hosp. Inc.*, 2003 W.L. 550327 at *4 (4th Cir. 2003).

There are four HCQIA standards. Peer reviewers are entitled to immunity from damages if the peer review action at issue was 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 requirements of paragraph (3).

42 U.S.C. § 11112(a).

Congress granted peer reviewers this immunity to encourage physicians to engage in peer review and take action to protect patients, including suspension and revocation of privileges, without fear of reprisal in the form of suits seeking monetary damages. *Oksanen v. Page Mem. Hosp.*, 945 F.2d 696, 704 (4th Cir. 1991)(noting that Congress intended HCQIA to protect peer reviewers from the threat of damages, and further that Congress expressly recognized "'[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review.'")(quoting 42 U.S.C. § 11101(5)). Rigorous peer review coupled with the reporting of sanctions to a national databank is a core component of federal policy to protect patients from incompetent or potentially dangerous physicians who could otherwise move from hospital to hospital without discovery and disclosure of their past problems. 42 U.S.C. § 11101(2).

B. HCQIA summary judgment standard

Providing further protection to peer reviewers, HCQIA provides a statutory presumption that the peer review action at issue satisfies the standards necessary to obtain damages immunity.

> 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)(emphasis added).

The statutory presumption provided by HCQIA shifts the burden of proof and persuasion at the summary judgment stage onto the physician plaintiff. *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 33, n.5 (1st Cir. 2002)("Since HCQIA immunity may only be overcome by a preponderance of the evidence, the statutory presumption in favor of the health care entity shifts to the plaintiff 'not only the burden of producing evidence but the burden of persuasion as well.'")(internal citations omitted). Summary judgment for the peer reviewers should be granted unless a reasonable jury, viewing the facts in the best light for the plaintiff, could conclude that the plaintiff has shown by a preponderance of evidence that defendants' actions fail to satisfy the HCQIA standards. *Moore*, 560 F 3d. at 175; *Gabaldoni v. Washington Cty. Hosp.*, 250 F.3d 255, 260 (4th Cir. 2001).

HCQIA creates a summary judgment standard that differs greatly from the traditional Rule 56 summary judgment standard. *Guanciale v. McLeod Reg. Med. Ctr.*, Order at 8 (D.S.C. Mar. 8, 2004)("Under this unconventional standard, [physician] bears the burden of providing by a preponderance of the evidence that the defendant's

peer review process did not satisfy § 11112(a)."). A physician plaintiff cannot, therefore, avoid summary judgment by merely raising a genuine issue of material fact as to whether one of the HCQIA standards is satisfied. *See, e.g.*, *Moore*, 560 F.3d at 175-77; *Wieters*, 2003 W.L. 550327 at *6; *Hein-Muniz v. Aiken Reg. Med. Ctrs*, 2013 W.L. 3359277 at *3 (4th Cir. 2012).

HCQIA essentially requires the Court to act as a gatekeeper, weighing evidence at the summary judgment stage. If a physician's evidence of non-compliance with the HCQIA standards does not outweigh the peer reviewers' statutory presumption of compliance and evidence of compliance with the HCQIA standards, summary judgment for the peer reviewers is appropriate. *Moore*, 560 F.3d at 180.

III. ANALYSIS

A. HCQIA Standards

1. In the reasonable belief that the action was in the furtherance of quality healthcare

The first standard of HCQIA is satisfied if, looking at the totality of the circumstances, the peer review action was undertaken by Defendants "in the reasonable belief that the action was in the furtherance of quality healthcare." 42 U.S.C. § 11112(a)(1). HCQIA calls for a "generous application of the concept of reasonableness" at the summary judgment stage similar to the "typical judicial review of administrative decisions and of such things as internal procedures for terminating membership in voluntary associations." *Lee v. Trinity Lutheran Hosp.*, 2004 W.L. 212548 at *7 n. 5 (W.D. Mo. 2004), *affirmed* 408 F.3d 1064 (8th Cir. 2005); *see also* *Freilich v. Upper Chesapeake Health, Inc.*, 313 F.3d 205, 212 (4th Cir.

2002)(describing the HCQIA reasonableness standard as one that "embodies the discretion that health care professionals have traditionally exercised in determining whether or not their peers meet a requisite level of professional competence.").

This HCQIA standard does not require that the peer review decision be correct or that the decision actually improve the quality of health care. *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994). As long as the record contains evidence that would support a reasonable belief that the action in question would restrict incompetent behavior, would protect patients, or otherwise further quality healthcare, standard one is satisfied. *Gabaldoni*, 250 F.3d at 261.

Defendants offered abundant evidence that Dr. Randall's peer review action was undertaken to ensure quality care and patient safety. Defendants provided meeting minutes and testimony from physician members of the Peer Review Committee, the Credentials Committee, the Ad Hoc Committee, and the MEC regarding the lengthy and thorough review of Dr. Randall's surgical care that caused these physicians to believe that Dr. Randall's surgical judgment and technique was substandard. Additionally, Defendants submitted the testimony of the surgeon called to testify by the MEC at Dr. Randall's hearing who found Dr. Randall's abdominal surgical care deficient.

After Dr. Randall challenged the MEC's recommendation, the Hearing Panel, the Appellate Review Committee, and the Board considered Dr. Randall's surgical care and upheld the MEC's recommendation. The Court finds that the record of this peer review action contains overwhelming evidence that this peer review action was undertaken in the reasonable belief that it was in furtherance of quality health care.

Dr. Randall's counsel deposed many of the peer review participants, and their testimony provides additional confirmation that the peer review action was undertaken in the reasonable furtherance of quality healthcare. Dr. Edwards, the Chief of Staff, testified as follows:

> Q: Why did you vote to revoke – to recommend the revocation of privileges?
>
> A: Because I was concerned that there had been a -- there had been a body of cases in which there were problems with pre-operative assessment, intraoperative technique, and post-operative care, as well as – I think, that meeting, we also had the return-to-OR data suggesting a high volume of return to OR. And, during the whole process, we had – I don't recall other cases coming in that were of concern from any other general surgeon. We continued to have a large volume of cases coming in with Dr. Randall, and they continued to come in throughout the process more – more. And they were raised by physicians, hospital employees, as well as patient families. So it wasn't all coming from one source.

Dr. Patterson, the Chief Medical Officer, offered the following testimony:

> Q: . . . Why did the MEC take the action that they took, the revocation –
>
> A: Right –
>
> Q: -- the recommendation of revocation?
>
> A: The general sense of – of my listening to their concerns was that the gravity, the number of complications, the similarity, suggesting technique deficiencies and lack of insight into the difficulties.

A physician on the MEC testified as follows:

> Q: . . . You mentioned there was some sentiment. "Gosh why can't we just pass this [Dr. Randall's problems with surgical care] on to others?"
>
> A: Yes.
>
> Q: Why didn't you pass it on to others?

A: You are asking me personally?

Q: Yeah.

A: Because I felt a responsibility to do something for the patients and the community.

Another physician on the MEC offered the following:

Q: Why did the MEC vote to uphold the suspension of his privileges?

A: I think the question has been and that's for the Peer Review Committee – after reviewing several cases, it was felt that his surgical procedures in regards to abdominal surgeries, including herniorrhaphy, was suboptimal, had a lot of complications, and from patient's safety point of view, there was unanimously agreed and recommended that his privileges should be suspended effective immediately.

In response to this evidence, Dr. Randall's complaint offers allegations that his peer review action was a conspiracy. In his deposition, Dr. Randall alleged that Drs. Edwards and Patterson acted against him for improper purposes. Dr. Randall's allegations, however, are not relevant to the appropriate analysis under HCQIA.

The test under HCQIA is whether an *objectively reasonable basis* existed for the peer review action in question. *Freilich*, 313 F.3d at 212; *Imperial*, 37 F.3d at 1030. The sufficiency of the basis for the peer reviewers' action -- not alleged personal bias, malice, or bad faith on the part of the peer reviewers -- is relevant under HCQIA. *Id.; see also Sugarbaker v. SSM Health Care*, 190 F.3d 905, 914 (8th Cir. 1999)("[T]he subjective bias or bad faith of the peer reviewers is irrelevant."); *Austin v. McNamara*, 979 F.2d 728, 734 (9th Cir. 1992)(alleged personal animosity of peer reviewers is "irrelevant to the reasonableness standards of § 11112(a). . ." because "[t]he test is an objective one, so bad faith is immaterial."). Therefore, even if Dr. Randall had

evidence that his peer review action was based upon personal animus, bad faith, or malice, this would have no effect upon the HCQIA analysis.

Though it is not relevant to the appropriate HCQIA analysis, it should also be noted that Defendants offered abundant evidence -- in the form of deposition testimony taken in this case from Dr. Edwards, Dr. Patterson, and others -- that Dr. Randall's peer review was *not* a conspiracy motivated by improper purposes.

The record of Dr. Randall's peer review action and the testimony from the peer reviewers constitutes overwhelming evidence that the peer review action of Dr. Randall was objectively reasonable under the circumstances. Dr. Randall's claims of conspiracy are irrelevant and immaterial, and they fall far short of the preponderance-of-the-evidence showing necessary to overcome the presumption HCQIA provides to Defendants. For these reasons, and because Dr. Randall did not contest Defendants' assertion that HCQIA standard one has been satisfied in his memorandum, the Court finds that Defendants have satisfied standard one of HCQIA.

2. <u>After a reasonable effort to obtain the facts of the matter</u>

Standard two of HCQIA requires that the peer reviewers engage in a reasonable effort to obtain the facts relevant to the peer review action. 42 U.S.C. § 11112(a)(2). A peer review action that consists of multiple levels of investigation and review generally satisfies this element of HCQIA. *Moore,* 560 F.3d at 175-76 (three-tier peer review process after suspension held to satisfy standard two). The hospital's Board, the ultimate decision-maker in a peer review action, is entitled to rely upon investigation conducted by the previous levels of the peer review process. *Gabaldoni*, 250 F.3d at 261-62.

Dr. Randall's peer review action was a multi-level process that included a thorough investigation of the facts. Dr. Randall's surgical care was reviewed over two years during numerous meetings of the Peer Review Committee, the Credentials Committee, the Ad Hoc Review Committee, and the MEC. These multiple levels of review involved numerous physicians considering the relevant medical records, external reviews, and Dr. Randall's written and oral comments.

Defendants' peer review process included a two-day hearing that allowed Dr. Randall and the MEC to present witnesses, offer documentary evidence, and cross-examine each other's witnesses. The Appellate Review Committee then accepted briefs and oral argument of counsel before the matter was ultimately considered and decided by the Board.

For the reasons set forth above, and because Dr. Randall did not contest compliance with HCQIA standard two in his memorandum, the Court finds that Defendants' evidence regarding the entirety of this peer review investigation established the existence of a reasonable investigation. Defendants have, therefore, satisfied the second HCQIA standard.

3. <u>After adequate notice and hearing procedures</u>

In order to obtain immunity under HCQIA, peer reviewers must provide a physician adequate notices and hearing procedures during the peer review process. 42 U.S.C. 11112(a)(3). HCQIA provides a list of notices and hearing procedures that should be afforded to a physician in a peer review action. 42 U.S.C. § 11112(b). If the peer reviewers provide the notices and hearing procedures set forth in section 11112(b), the peer review action satisfies a "safe harbor," and the presumption of compliance

with HCQIA standard three becomes a *finding* of compliance. *Wieters v. Roper Hosp. Inc.*, 58 Fed. App'x 40, 46 (4th Cir. 2003)("If a hospital follows the procedures laid out in § 11112(b), it is deemed to have satisfied § 11112(a)(3)."); *Smith v. Ricks*, 31 F. 3d 1478, 1487 (9th Cir. 1994)("[Section] 11112(b) lists certain procedures, which, if satisfied, guarantee a shield from liability."); *Guanciale*, Order at 11 ("With compliance, there is no second-guessing or judicial review of the hospital's disciplinary decision.").

Because section 11112 provides a "safe harbor" for peer review actions that provide the delineated procedures, a claim of unfair process that does not involve a specific provision in section 11112(b) is immaterial to the standard three analysis. *Moore*, 560 F.3d at 176 (rejecting physician's argument of flawed process because "it is not based on the statutory requirement").

Defendants' evidence established that Dr. Randall received timely and appropriate notices and procedures during his hearing that complied with the requirements in subsection 11112(b). Moreover, Dr. Randall conceded that he received the appropriate notices and procedures during his deposition.

Dr. Randall does however, allege four violations of HCQIA standard three which will be addressed *seriatim*.

i. Suspension

Dr. Randall claims he should have been provided a hearing *before* his suspension was imposed. There is no provision in HCQIA standard three that provides for notice and a hearing *before* a suspension is imposed. 42 U.S.C. 11112(b). As a pre-suspension hearing is not a procedure set forth in section 11112(b)'s safe

harbor, the Court finds that the absence of a pre-suspension hearing in Dr. Randall's peer review action cannot establish non-compliance with standard three.

Moreover, the following statutory provision regarding suspensions also appears in HCQIA:

> [N]othing in this section shall be construed as—
>
> . . .
>
> (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. 11112(c)(2)(emphasis added). Dr. Randall's abdominal surgery privileges were suspended when the Chief of Staff learned that a patient of Dr. Randall's whose gallbladder had been removed experienced an inordinate amount of internal bleeding. This case, coming on the heels of the other cases that had been reviewed, caused the Chief of Staff, and thereafter the entire MEC, to believe that a suspension was necessary to protect patients from potential imminent harm. After the suspension was imposed, Dr. Randall received the "subsequent notice and hearing" provided for by section 11112(c)(2).

Dr. Randall's suspension and post-suspension hearing occurred in exactly the manner and order prescribed by HCQIA. The suspension to protect patients was imposed first, and then the hearing came second. For this additional reason, the absence of a pre-suspension hearing in Dr. Randall's peer review action is of no moment, and the Court rejects this claim of non-compliance with HCQIA standard three.

Dr. Randall contends that the Federal District Court's order in *Guanciale v. McLeod Regional Medical Center* (attached to Dr. Randall's memorandum) supports his claim that a pre-suspension hearing was required in his peer review action. Dr. Randall is mistaken. The District Court found that the suspension of Guanciale's privileges did not comply with HCQIA standard three because Guanciale's peer review action provided him with *no opportunity whatsoever* to contest his suspension. *Guanciale*, Order at 12-21. The District Court recognized that a personal appearance before the MEC, or perhaps even as little as the opportunity to submit a written statement to the MEC, would have complied with HCQIA standard three. *Id.* at 16. The District Court also recognized that a hearing provided to Guanciale after the imposition of the suspension would have complied with HCQIA standard three. *Id.* at 21.

In sharp contrast to Guanciale's peer review action, Dr. Randall's peer review action included a full-blown hearing followed by an appellate review. Before that, Dr. Randall was permitted to submit a written statement to, and make a personal appearance before, the MEC. The lack of any opportunity afforded to Guanciale to contest the adverse action taken against his privileges is clearly distinguishable from the multi-level process afforded to Dr. Randall.

Finally, Dr. Randall contends that Dr. Edwards acted too precipitously when he imposed the suspension. While there may be evidence that Dr. Edwards acted too precipitously with respect to the summary suspension, the Court finds that this argument does not implicate any of the elements of the safe harbor in section 11112(b). The Court also rejects this argument because shortly after Dr. Edwards suspended Dr.

Randall's abdominal surgery privileges, the MEC voted to affirm the suspension and, thereafter, the Hearing Panel affirmed that the suspension was a reasonable measure taken to protect patients from potential imminent harm.

ii. MEC meeting

Dr. Randall claims that his peer review action violates HCQIA standard three because he was not permitted to have counsel represent him at a MEC meeting,[8] and Dr. Patterson allegedly made misstatements at the MEC meeting regarding the procedural options under the medical staff bylaws and Dr. Randall's patient care. There are no provisions in HCQIA standard three requiring physicians to be represented by counsel at MEC meetings or that otherwise govern MEC meetings in any way. 42 U.S.C. § 11112(b). Because Dr. Randall's allegations of flawed process and inappropriate conduct[9] at MEC meetings do not implicate any of the procedures in section 11112(b)'s safe harbor, the Court finds that these allegations cannot establish a lack of compliance with HCQIA standard three.

iii. Hearing date

Dr. Randall claims that his peer review action violates HCQIA standard three because his hearing did not occur within 90 days after the MEC's decision to continue his suspension. HCQIA standard three does not contain a provision that requires peer review hearings to occur within 90 days after MEC decisions. 42 U.S.C. § 11112(b).

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[8] When Dr. Randall attempted to bring counsel to a MEC meeting, counsel was informed that the medical staff bylaws did not provide for legal counsel at this meeting – for either the reviewed physician or the MEC – and counsel departed.

[9] It should also be noted that Defendants submitted deposition testimony from a physician on the MEC that refuted Dr. Randall's claim that Dr. Patterson misstated procedural options and facts at the MEC meeting.

Therefore, the Court finds that the complaint Dr. Randall makes regarding the timing of his hearing cannot establish non-compliance with HCQIA standard three.[10]

iv. General surgeons on the hearing panel

Finally, Dr. Randall claims his peer review action violates HCQIA standard three because his hearing panel did not contain general surgeons with experience in laparoscopic abdominal surgery. HCQIA standard three does not contain a provision that requires hearing panels to have physician members who practice in the same specialty area as the physician under review. 42 U.S.C. § 11112(b). Because this claim, like Dr. Randall's other claims, does not implicate a safe harbor procedure, it too fails.

While Dr. Randall's panel did not contain a general surgeon, it did contain an oral surgeon and an orthopedic surgeon who, along with the other panel members, had the benefit of hearing testimony from general surgeons called as witnesses by the MEC and Dr. Randall.

HCQIA also contains the following provision regarding hearing panels:

> (A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)—
>
> . . .
>
> (iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

[10] The MEC requested and was granted two continuances of the hearing by the Hearing Officer. Dr. Randall's counsel consented to the first continuance. Dr. Randall's counsel objected to the second continuance, but the Hearing Officer found "good cause shown" under the medical staff bylaws for the second continuance because the MEC's expert unexpectedly and belatedly informed the MEC that he would not be available to testify at the hearing.

42 U.S.C. 11112(b)(3)(A)(emphasis added). Ironically then, if Piedmont would have appointed a general surgeon from a competing surgical practice to serve on Dr. Randall's hearing panel, this peer review action would have violated HCQIA standard three.

Defendants submitted overwhelming evidence showing that Dr. Randall's peer review action provided all the notices and procedures set forth in section 11112(b). Because Dr. Randall does not dispute this showing, and instead makes claims about alleged flaws in the peer review process that do not implicate the procedures in the safe harbor and that are otherwise invalid, the Court finds that Dr. Randall's peer review action complies with HCQIA standard three.

4. <u>In the reasonable belief that the action was warranted by the facts known after the investigation</u>

HCQIA standard four is violated if "the facts relied upon by the Board were so obviously mistaken or inadequate as to make reliance upon them unreasonable." *Hein-Muniz,* 2013 WL 3359277 at *3 (quoting *Meyers v. Columbia/HCA Healthcare Corp.*, 341 F.3d 461, 471 (6th Cir. 2003)). "[T]he role of the federal courts 'on review of [peer review] actions is not to substitute our judgment for that of the hospital's governing board or to reweigh the evidence regarding the . . . termination of medical staff privileges'." *Bryan v. James E. Holmes Reg. Med. Ctr.*, 33 F.3d 1318, 1337 (11th Cir. 1994)(internal citations omitted).

Dr. Randall's peers, after an exhaustive peer review process, concluded that Dr. Randall's poor surgical judgment and technique was causing bad outcomes. When the Board members that comprised the Appellate Review Committee and the full Board

considered whether Dr. Randall should continue to have abdominal surgery privileges at Piedmont, they had before them, among other things, the Hearing Panel's report and the transcript from the hearing. These materials were replete with negative facts, findings, and opinions regarding Dr. Randall's care. The Court finds that the decision to terminate Dr. Randall's abdominal surgery privileges was not "obviously mistaken" under these circumstances. The Court, therefore, finds Defendants satisfy standard four of HCQIA.[11]

5. <u>Conclusion as to HCQIA damages immunity</u>

Defendants have offered a large quantity of probative evidence establishing that Dr. Randall's peer review action satisfied the four HCQIA standards. Defendants also have the benefit of HCQIA's statutory presumption. Dr. Randall, on the other hand, has not offered evidence upon which a reasonable jury, viewing the facts in the best light for him, could find by a preponderance of the evidence that Defendants failed to meet the HCQIA standards. Therefore, the Court finds that Defendants are immune from damages under HCQIA.[12]

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[11] Dr. Randall's memorandum notes that there is a "question of fact" as to whether Defendants can meet "the third and fourth provisions of the [HCQIA] statute." As set forth above, whether a "question of fact" exists regarding compliance with a HCQIA standard is not the appropriate inquiry.

[12] Dr. Randall's complaint contains conspiracy and defamation causes of action. The sole remedy Dr. Randall seeks pursuant to these causes of action is damages. As HCQIA damages immunity has eliminated Dr. Randall's ability to recover damages from Defendants, these causes of action are no longer viable and the Court grants summary judgment on them.

B. Individual causes of action

Defendants assert that Dr. Randall's causes of action fail as a matter of law for additional reasons that arise under South Carolina state law. The Court agrees for the reasons set forth below.

1. Conspiracy

A civil conspiracy requires: (1) a combination of two or more persons; (2) for the purpose of injuring the plaintiff; and (3) causing plaintiff special damages. *Kuznik v. Bees Ferry Assocs.*, 342 S.C. 579, 610, 538 S.E.2d 15, 31 (Ct. App. 2000). A civil conspiracy, however, cannot arise "in the context of a principal-agent relationship because by virtue of the relationship such acts do not involve separate entities." *McMillan v. Oconee Mem. Hosp., Inc.*, 367 S.C. 559, 564, 626 S.E.2d 884, 886-87 (2006).

When a hospital's medical staff, administrators, and other agents conduct a peer review action they are considered a single person and therefore cannot conspire. *Moore*, 560 F.3d at 178; *Oksanen*, 945 F.2d at 699 ("[T]he Board of Trustees and the medical staff of Page Memorial comprised a single entity during the peer review process. Because an entity cannot conspire with itself, the Board and the staff lacked the capacity to conspire."); *Cohn v. Bond*, 953 F.2d 154, 159 (4th Cir. 1991)(holding medical staff are hospital's agents when undertaking credentialing for hospital and therefore defendants could not conspire for antitrust purposes).

Dr. Randall alleges that Dr. Patterson, the Chief Medical Officer at Piedmont, and Dr. Edwards, the Chief of Staff at Piedmont, are the conspirators in a peer review conspiracy. Because these physicians were both agents of Piedmont for the purpose of

conducting Dr. Randall's peer review acting within the scope of their duties under the medical staff bylaws, there is no "combination" of Defendants legally capable of conspiring, and, therefore, the Court finds that summary judgment on this claim is appropriate for this additional reason.[13]

Finally, and most fundamentally, the Court finds that Dr. Randall's conspiracy claim also fails because it is undisputed that the alleged conspirators in this case – Drs. Edwards and Patterson – did not make the ultimate decisions regarding Dr. Randall's privileges. While Dr. Edwards suspended Dr. Randall's abdominal surgery privileges, days later his action was reviewed and approved by the entire MEC as required under the medical staff bylaws. Dr. Randall concedes the MEC acted in good faith. Thereafter, the MEC's recommendations regarding Dr. Randall's privileges were reviewed by the Hearing Panel, the Appellate Review Committee, and the full Board. These bodies, that did not include Drs. Edwards or Patterson, affirmed the MEC's recommendations and thereby terminated Dr. Randall's abdominal surgery privileges. Dr. Randall concedes that these bodies acted in good faith. Therefore, even if Dr. Randall had evidence that Drs. Edwards and Patterson acted out of bias or bad faith,[14]

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[13] Dr. Randall argues that *Anthony v. Ward*, 336 Fed. App'x 311 (4th Cir. 2009), holds that the intra-corporate immunity doctrine does not apply to the "agent-agent" conspiracy allegedly present in this case. Dr. Randall is mistaken. In *Anthony*, the Fourth Circuit Court of Appeals held that the District Court erred when it failed to recognize that the intra-corporate immunity doctrine could apply in agent-agent conspiracies and correspondingly erred when it failed to give the jury a scope of employment charge. *Anthony*, 336 Fed. App'x at 316 (noting "no conspiracy can exist if the conduct challenged is a single act by a single corporation acting exclusively through its own directors, officers, and employees, each acting within the scope of his employment")(internal citations omitted).

[14] The Court also notes that Dr. Randall has not come forward with any evidence, or any reasonable inference from evidence, that supports the allegation that Defendants engaged in conspiratorial conduct for the purpose of injuring him. *Moore,* 560 F.3d at

because these peer review bodies that were undisputedly free of bias and bad faith made the ultimate decisions regarding Dr. Randall's privileges, Dr. Randall's allegations of conspiracy against Drs. Edwards and Patterson are immaterial.

2. Defamation

A defamation claim requires a plaintiff to establish: (1) a false and defamatory statement was made; (2) unprivileged publication of the statement to a third party; (3) the publisher was at fault; and (4) either the statement is actionable irrespective of harm or the publication of the statement caused special harm. *Williams v. Lancaster County Sch. Dist.*, 369 S.C. 293, 631 S.E.2d 286, 292 (Ct. App. 2006). Truth is an absolute defense to a defamation claim. *Parker v. Evening Post Pub. Co.*, 317 S.C. 236, 245, 452 S.E.2d 640, 645-46 (Ct. App. 1994).

Dr. Randall's defamation claim is based upon Piedmont's submission of a report to the National Practitioner Databank ("NPDB") concerning the suspension of Dr. Randall's privileges. Dr. Randall testified at his deposition that the report Piedmont made to the NPDB is factually accurate. Because Dr. Randall concedes the statement upon which his defamation claim rests is true, this claim fails as a matter of law.[15]

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178 (conspiracy claim failed as physician had no evidence "that formal peer review process was 'conspiratorial' in any real sense of the word"). Moreover, if such evidence existed, surely Dr. Randall's counsel would have informed the Hearing Panel, the Appellate Review Committee, and the Board of this conspiracy.

[15] Even if the NPDB report were false and defamatory, because Piedmont is required by federal law to report Dr. Randall's adverse peer review action to the NPDB, 42 U.S.C. § 11133, the Court also finds that Piedmont's report to the NPDB is privileged and cannot constitute defamation. *Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 514 S.E.2d 126 (1999).

IV. CONCLUSION

For the reasons set forth above, the Court grants summary judgment for Defendants on HCQIA damages immunity and grants summary judgment for Defendants on all of Dr. Randall's causes of action in the complaint.

AND IT IS SO ORDERED.

The Honorable J. Ernest Kinard, Jr.

Camden, South Carolina

3/28, 2014