THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

J. Ernest Kinard, Jr., Circuit Court Judge

Case No. 2012-CP-46-00167
Appellate Case No. 2014-000913

Robert Randall, M.D., ...	Appellant,
v.	
Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., ...	Respondents.

FINAL BRIEF OF RESPONDENTS

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QUESTIONS PRESENTED

1. Did the circuit court correctly find that Defendants have damages immunity and Dr. Randall's claims fail pursuant to the Health Care Quality Improvement Act?

2. Did the circuit court correctly find that Dr. Randall's causes of action fail for additional reasons arising under state law?

STATEMENT OF THE CASE

This is an appeal from a circuit court order granting summary judgment to Defendants on March 28, 2014. The circuit court held that the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 ("HCQIA"), provides Defendants damages immunity and requires dismissal of Dr. Randall's claims. The circuit court also held that Dr. Randall's conspiracy and defamation causes of action fail for additional reasons arising under state law.

On April 28, 2014, Dr. Randall served his notice of appeal. Upon information and belief, this appeal of a HCQIA damages immunity determination is a case of first impression for the Court.

SUMMARY OF THE FACTS

This suit arises from Dr. Randall's peer review action at Piedmont Medical Center. This peer review action began in 2009 when review of Dr. Randall's cases revealed that he was experiencing a large number of bad outcomes caused by poor medical judgment and deficient surgical technique. During abdominal surgeries, Dr. Randall was all too often perforating organs, and his rough and hurried handling of abdominal tissue was causing other unnecessary complications.

Dr. Randall's technical surgical errors were made worse by his failure to recognize and repair the injuries he caused in a timely manner, resulting in excessive bleeding, life-threatening infections, extended hospital stays, and, in the worst cases, death. As an anesthesiologist on Piedmont's medical staff succinctly put it, Dr. Randall had become a physician who caused "general concern that a routine case could become something very different." (R. at 172:19-173:10).[1]

Unbeknownst to the peer reviewers at Piedmont, Dr. Randall's practice, owned by Presbyterian Healthcare (Novant), was also investigating Dr. Randall's care during this time.[2] As part of this investigation, Dr. Randall's surgeon partners and other professionals in his 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."
>
> 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."

(R. at 323-324).

Dr. Randall's partners also reported that his surgical care had become so compromised that they would no longer participate in follow-up care of Dr. Randall's

[1] This anesthesiologist also testified that he insisted upon using a larger gauge IV during Dr. Randall's cases because "there seemed to be some tendency for some blood loss at times that wasn't expected and things of that nature." (R. at 172:1-14).

[2] Defendants learned of this investigation through discovery.

patients, and one partner reported that he would leave the practice if Dr. Randall remained. (R. at 324). After this investigation, Dr. Randall was terminated by his practice because the malpractice risk of continuing to employ him became too great.[3] (R. at 329:8-330:23).

Because Dr. Randall's surgical care was falling below the standard expected by his peers, the physicians on Piedmont's Medical Executive Committee ("MEC") ultimately recommended terminating Dr. Randall's abdominal surgery privileges. Shortly after the MEC's recommendation, the Chief of Staff learned about another bad outcome. A surgical misadventure that occurred during an operation to remove a gallbladder[4] caused Dr. Randall's patient to suffer a massive, eleven-unit blood loss.[5] Faced with this case and the others, the Chief of Staff felt he had no choice but to suspend Dr. Randall's abdominal surgery privileges to protect Piedmont's patients from harm. The MEC voted unanimously to continue the suspension imposed by the Chief of Staff.

Dr. Randall challenged the MEC's recommendations regarding his privileges. Thereafter, Dr. Randall's medical care was reviewed by a five-physician hearing panel, the Appellate Review Committee, and Piedmont's Board of Governors. All these peer review bodies voted to affirm the termination of Dr. Randall's abdominal surgery

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[3] Two of the cases under review in Dr. Randall's peer review action at Piedmont were also the subject of medical malpractice suits. Dr. Randall's insurer paid a large sum to settle one, and the other was pending at the time of Dr. Randall's deposition. (R. at 347:20-348:17).

[4] This case came to the attention of the Chief of Staff because the patient's husband raised concerns about the care his wife received. At his peer review hearing, Dr. Randall described this husband as wanting to "fix" the complaints of his "southern porcelain princess." (R. at 281; 316).

[5] Dr. Randall created concern among the physicians on the MEC when he described this as "a little bit of bleeding." (R. at 302, ¶ 24).

privileges. Dr. Randall's peer review action at Piedmont was over and this lawsuit began.

Dr. Randall's complaint alleges that his peer review action was a conspiracy perpetrated against him. Rather than a conspiracy, discovery confirmed the existence of a thoughtful and thorough peer review action undertaken by physicians, administrators, and board members who acted to protect patients. Because Defendants undertook a peer review action that both protected patients and provided Dr. Randall fair process, the circuit court found that Defendants are entitled to HCQIA damages immunity and summary judgment on Dr. Randall's causes of action.

STATEMENT OF THE FACTS

I. THE PARTIES

Defendant Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center 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.

II. DR. RANDALL'S PEER REVIEW AT PIEDMONT MEDICAL CENTER

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. (R. at 311-313). This review was triggered by complications Dr. Randall was experiencing in abdominal surgery cases. (R. at 311-313). 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. (R. at 312-313).

On June 10, 2010, Dr. Edwards, who was the 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. (R. at 386:9-387:10; 398). 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,[6] including the rough handling of the bowel and the failure to recognize when patients needed to be returned to the operating room. (R. at 386:9-387:10; 398). 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 review of 100% of his abdominal and herniorrhaphy surgery cases for six months. (R. at 400-404).

The Credentials Committee's recommendation was subsequently reviewed by the physicians on the MEC, and the MEC recommended reappointing Dr. Randall for one year, but increased the monitoring period. (R. at 405-407). The MEC also determined that further investigation of Dr. Randall's patient care would be conducted. (R. at 405-407).

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[6] In 2006, internal and external reviews of Dr. Randall's cases found problems with Dr. Randall's surgical judgment and technique. (R. at 335-338; 380). As a result, Dr. Randall's physician peers imposed a year-long review of Dr. Randall's open hernia and carotid surgery cases. (R. at 380-382). This review occurred during 2007, and after Dr. Randall's cases received acceptable scores during this review period, the review terminated in 2008. (R. at 383).

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. (R. at 385). 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. (R. at 408-410).

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.[7] (R. at 411-413).

C. MEC

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. (R. at 419). The MEC members reviewed the external reviews, the medical records, and the statements of Dr. Randall regarding the cases under review. (R. at 419). The MEC also considered additional cases that had recently been reviewed by the Peer Review Committee and the external reviewer, and data that

[7] 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. (R. at 416:8-417:11).

demonstrated Dr. Randall had experienced more unplanned returns to the operating room than other surgeons on the medical staff. (R. at 419).

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. (R. at 419; 396:9-25). 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. (R. at 420-421; 343:5-344:2).

D. Suspension

Shortly after the MEC made the recommendation to revoke Dr. Randall's abdominal surgery privileges, Dr. Edwards was made aware of a complaint made by the husband of a patient whose gallbladder had been removed by Dr. Randall. (R. at 388:22-389:8). This patient lost eleven units of blood and suffered through an extended stay in critical care. (R. at 390:8-16). In response to this case and the other cases, Dr. Edwards summarily suspended Dr. Randall's abdominal surgery privileges. (R. at 388:9-21). Dr. Edwards took this action because he believed that a suspension, which would take effect immediately, was necessary to protect patients from potential imminent harm. (R. at 391:16-24).

In a letter dated October 15, 2010, Dr. Randall received notice of the suspension and the reasons it was imposed. (R. at 422; 349:9-350:16). 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.

(R. at 422; 349:9-350:16). 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. (R. at 437).

On October 25, 2010, Dr. Randall met with the MEC regarding the suspension. (R. at 458-459; 352:12-354:1). During this meeting, Dr. Randall addressed 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. (R. at 352-354). Thereafter, the MEC voted, unanimously, to continue the suspension. (R. at 458-459).

By letter dated October 28, 2010, Dr. Edwards informed Dr. Randall that the MEC voted to uphold his suspension. (R. at 460-461; 354:5-24). This letter also informed Dr. Randall that he had the right to challenge the suspension. (R. at 460-461).

E. 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. (R. at 355:22-25; 484-497). Thereafter, Dr. Randall received a hearing notice that identified a hearing officer and the proposed hearing panel. (R. at 475-483). 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. (R. at 357:8-358:17). None of the five physicians selected to serve on the hearing panel were economic competitors of Dr. Randall. (R. at 476). 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 this hearing. (R. at 476).

Dr. Randall did not object to any individual hearing panel members, but he did object that his panel did not contain a general surgeon. (R. at 361:11-21; 362:22-364:19; 441:21-442:20; 443:4-6). 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 cases under review. (R. at 489). When these criteria 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. (R. at 177:5-13; 303, ¶¶ 32-34; 392:6-15; 453:6-15).

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. (R. at 446:2-7; 359:13-360:7). Eight witnesses were called, including each side calling a surgeon who offered expert opinions regarding the cases under review. (R. at 222; 297).

The MEC called an expert surgeon who opined that Dr. Randall's care in eight of the ten cases under review was deficient. (R. at 188). These eight cases included: a nonviable colostomy that resulted in ischemia and necrosis of the bowel; a laparoscopic cholecystectomy that resulted in a perforated bowel; a bowel resection and reconnection that broke down and resulted in sepsis and short bowel syndrome; a laparoscopic cholecystectomy that resulted in a punctured colon; incorrect placement of a feeding tube that resulted in sepsis; a hernia surgery that resulted in a perforated bowl; an appendectomy that resulted in the death of a patient; and a laparoscopic cholecystectomy that resulted in a loss of 11 units of blood and sepsis. (R. at 304-316).

Dr. Randall offered the following critique of his expert witness who testified at the hearing:

> 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.

(R. at 367:4-10).

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 had considered the cases at issue. 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." (R. at 298-322; 365:10-366:1). The hearing panel unanimously decided that the MEC's recommendations to revoke and suspend Dr. Randall's abdominal surgery privileges should be upheld. (R. at 318-322). The hearing panel's decision included the following conclusions:

> 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.

(R. at 316, ¶¶ 1, 3 & 4).

F. 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. (R. at 369:4-12). Piedmont's Board assigned an Appellate Review Committee to consider Dr. Randall's appeal. After considering briefs, oral arguments, and the hearing record, the Appellate Review Committee upheld the hearing panel's decision. (R. at 449-506). The Appellate Review Committee reported their recommendation to Piedmont's Board. After considering the findings of the hearing panel and the Appellate Review Committee, and after reviewing the hearing transcript, the Board affirmed the termination of Dr. Randall's abdominal surgery privileges, effective July 12, 2011, completing Dr. Randall's peer review action.[8] (R. at 507-510; 370:11-371:16).

ARGUMENT

I. THE COURT SHOULD AFFIRM THE CIRCUIT COURT'S FINDING THAT DEFENDANTS HAVE DAMAGES IMMUNITY AND DR. RANDALL'S CLAIMS FAIL PURSUANT TO HCQIA

A. HCQIA

Under 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

[8] Dr. Randall's remaining privileges at Piedmont expired when Dr. Randall chose not to seek reappointment to the medical staff. (R at 333:17-334:9).

States or of any State. . . ."); *Moore v. Williamsburg Reg. Hosp.*, 560 F.3d 166, 171 (4th Cir. 2009); *Wieters v. Roper Hosp. Inc.*, 58 Fed. Appx. 45 (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 and reporting the results of peer review to a national databank are core components of federal policy designed to protect patients from incompetent and potentially dangerous physicians who could otherwise move from hospital to hospital without disclosure of their past problems. 42 U.S.C. § 11101(2).

B. Presumption of compliance with HCQIA and the resulting summary judgment standard

Affording 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).

This statutory presumption 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) ("[T]he 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)(R. at 790)("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 raising a genuine issue of material fact as to whether one of the HCQIA standards is satisfied. *Moore*, 560 F.3d at 175-77; *Wieters*, 58 Fed. Appx. at 16; *Hein-Muniz v. Aiken Reg. Med. Ctrs.*, 532 Fed. Appx. 342, 343-344 (4th Cir. 2012).

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

C. Defendants satisfy the HCQIA standards

1. Dr. Randall's peer review action was undertaken in the reasonable belief that it 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); *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, protect patients, or otherwise further quality healthcare, standard one is satisfied. *Gabaldoni*, 250 F.3d at 261.

Defendants satisfy HCQIA standard one because there is abundant evidence in the record that Dr. Randall's peer review action was undertaken to ensure quality care and patient safety, and this action was reasonable in light of Dr. Randall's serious and well-documented problems with abdominal surgery. The meeting minutes and testimony from the physician members of the Peer Review Committee, the Credentials Committee, the Ad Hoc Committee, and the MEC reflect a thorough review of Dr. Randall's care which caused these physicians to believe that Dr.. Randall's surgical judgment and technique is substandard. *Supra* Stmt. of Facts at § II.A., B., & C. The surgeon called to testify by the MEC at Dr. Randall's hearing opined that Dr. Randall's abdominal surgical care was deficient. *Supra* Stmt. of Facts at § II.E. After Dr. Randall challenged the MEC's recommendation, the physicians on the hearing panel and the members of the Appellate Review Committee and the Board considered Dr. Randall's surgical care and upheld the MEC's recommendation. *Supra* Stmt. of Facts at § II.E. & F.

Dr. Randall's counsel deposed many of the peer review participants, and their testimony provides additional confirmation that his 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.

(R. at 396:9-25). 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.

(R. at 456:6-14). 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.

(R. at 512:13-20). 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.

(R. at 514:4-14).

Discovery also revealed that Dr. Randall's physician partners reviewed his care and found it to be seriously deficient. (R. at 323-325). These physicians had such strong negative opinions about Dr. Randall's care that he was ultimately terminated from the practice. (R. at 329:8-330:23). This evidence provides additional assurance -- from outside the peer review process -- that undertaking a peer review action of Dr. Randall under these circumstances was a reasonable measure.

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. *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 evidence would have no effect upon the HCQIA analysis.[9]

While Dr. Randall makes unsupported allegations of conspiracy against Dr. Edwards and Dr. Patterson, Dr. Randall concedes that the peer review bodies that voted in favor of terminating his privileges, and the bodies that reviewed and upheld these recommendations, did not act in bad faith. (R. at 344:18-346:6)(Dr. Randall disagrees with conclusions of MEC but has "no problem with the motivations for their action"); (R. at 368:3-11)(Dr. Randall agrees that Hearing Panel was not motivated by animus or bias); (R. at 372:5-374:8)(Dr. Randall agrees that neither Appellate Review Committee nor Board acted with animus or bad faith). Therefore, even if Dr. Edwards and Dr. Patterson acted out of bias or bad faith, which they did not, the concession that

[9] Though it is not relevant to the appropriate HCQIA analysis there is abundant evidence that establishes Dr. Randall's peer review was not a conspiracy motivated by improper purposes. (R. at 393:21-394:4; 457:17-24; 415:4-14; 516:19–517:22).

these peer review bodies acted in good faith makes Dr. Randall's allegations of conspiracy against these individuals immaterial for this additional reason.

The record of Dr. Randall's peer review action and testimony from the peer reviewers constitute overwhelming evidence that Dr. Randall's peer review action was objectively reasonable under the circumstances. Dr. Randall's claims of conspiracy are irrelevant and immaterial. For these reasons and because Dr. Randall does not contest Defendants' compliance with HCQIA standard one, the Court should find that Defendants satisfy 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 HCQIA standard two). The hospital's board of directors, 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.

Dr. Randall's peer review action was a multi-level process that included a thorough investigation of the facts. *Supra* Stmt. of Facts at § II.A.-F. 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. *Supra* Stmt. of Facts at § II.A., B., & C. These multiple levels of review involved numerous physicians considering the relevant medical records, external

reviews, and Dr. Randall's written and oral comments. *Supra* Stmt. of Facts at § II.A., B., & C.

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. *Supra* Stmt. of Facts at § II.E. The Appellate Review Committee then accepted briefs and oral argument by counsel before the matter was ultimately considered and decided by the Board. *Supra* Stmt. of Facts st § II.F.

For the reasons set forth above and because Dr. Randall does not contest Defendants' compliance with HCQIA standard two, the Court should find that Dr. Randall's peer review action included a reasonable investigation that satisfies 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*, 58 Fed. Appx. at 46 ("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 (R. at 793)("With compliance, there is no second-guessing or judicial review of the hospital's disciplinary decision.").

Because section 11112(b) 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 HCQIA 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").

Dr. Randall received timely and appropriate notices and procedures that complied with the requirements in subsection 11112(b). *Supra* Stmt. of Facts at § II.A.-F. Dr. Randall conceded that he received appropriate notices and procedures. (R. at 378:23-379:4). Dr. Randall nonetheless alleges four violations of HCQIA standard three. For the reasons set forth below Dr. Randall's allegations should be rejected.

a. Suspension

Dr. Randall claims he should have been provided notice and hearing procedures *before* his suspension was imposed. Randall Br. at 10-13. 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 absence of a pre-suspension hearing in Dr. Randall's peer review action cannot establish non-compliance with standard three.

The following statutory provision regarding suspensions 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 bleeding. *Supra* Stmt. of Facts at § II.D. This case and the others caused the Chief of Staff, and thereafter the entire MEC, to believe that a suspension was necessary to protect patients from potential imminent harm. *Supra* Stmt. of Facts at § II.D. After the suspension was imposed, Dr. Randall received the "subsequent notice and hearing" provided for by section 11112(c)(2). *Supra* Stmt. of Facts at § II.E.

Dr. Randall's suspension and post-suspension hearing occurred, therefore, 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.

Dr. Randall contends that the federal district court's order in *Guanciale v. McLeod Regional Medical Center* supports his claim that a pre-suspension hearing was required in his peer review action. Randall Br. at 13. Dr. Randall is mistaken. The court in *Guanciale* found that the suspension of Dr. Guanciale's privileges did not comply with HCQIA standard three because Dr. Guanciale's peer review action provided him no opportunity to contest his suspension. *Guanciale*, Order at 12-21 (R. at 794-803). The 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 (R. at 798). The court

also recognized that a hearing provided to Dr. Guanciale after the imposition of the suspension would have complied with HCQIA standard three. *Id.* at 21 (R. at 803).

In sharp contrast to Dr. Guanciale's peer review action, Dr. Randall's peer review action included an evidentiary 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. *Supra* Stmt. of Facts at § II.D. The lack of any opportunity afforded to Dr. Guanciale to contest the adverse action taken against his privileges is clearly distinguishable from the multi-level process afforded to Dr. Randall.

Dr. Randall contends that *Estate of Blum v. Marian Heath Center*, 503 F. Supp.2d 1103 (N.D. Iowa 2007) supports his claim that he was entitled to notice and a hearing "prior to imposition of suspension." Randall Br. at 13. Dr. Randall misreads *Blume*. The court in *Blume* found that HCQIA standard three was not satisfied because the peer reviewers did not tell Dr. Blume the basis for his suspension or provide him a hearing after Dr. Blume was suspended. *Blume*, 503 F. Supp. 2d at 1110, 1112, & 1115. *Blume* does not hold that a physician is entitled to a pre-suspension hearing.[10]

Dr. Randall also appears to contend that Defendants' compliance with HCQIA standard three is jeopardized by Dr. Edwards imposing the suspension upon Dr. Randall precipitously. Randall Br. at 14, n. 3. This argument should be rejected because it does not implicate any of the section 11112(b) safe harbor elements. This argument should also be rejected because an allegedly precipitous suspension is of no

[10] The court's judgment against the hospital in *Blume* was vacated on appeal. *Estate of Blume v. Marian Health Ctr.*, 516 F.3d 705 (8th Cir. 2008)(hospital immune from damages pursuant to medical staff bylaws).

moment when the full MEC convened several days after the suspension and voted to affirm it. *Supra* Stmt. of Facts at § II.D.[11]

b. 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 meeting of the MEC,[12] and because Dr. Patterson allegedly made misstatements at the MEC meeting about the procedural options under the medical staff bylaws and Dr. Randall's patient care. Randall Br. at 11 & 14-15. 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 at MEC meetings do not implicate any of the procedures in section 11112(b)'s safe harbor, Dr. Randall's allegations cannot establish a lack of compliance with HCQIA standard three.[13]

[11] Dr. Randall tries to support this claim (and one other) by reference to comments made by the circuit court judge during the hearing. Randall Br. at 14, n.3. However, it is the circuit court's written order -- not a stray comment made during the hearing before the order was issued – that is relevant on appeal. *Woodson v. DLI Properties, LLC*, 406 S.C. 517, 528, 753 S.E.2d 428, 433 (2014)("[W]hat the circuit court 'might' have stated during the hearing on the motion for summary judgment is irrelevant, as a written order constitutes a final order and final judgment of the lower court.").

[12] When Dr. Randall attempted to bring counsel to the 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. (R. at 439-440; 452:10-25).

[13] Though it is entirely irrelevant to the HCQIA standard three analysis, Dr. Randall's allegation that Dr. Patterson misrepresented procedural options and facts about Dr. Randall's patient care at an MEC meeting is unsupported by the evidence in this case. (R. at 822:20-824:4).

c. 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. Randall Br. at 15-16. 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). Therefore, the complaint Dr. Randall makes regarding the timing of his hearing cannot establish non-compliance with HCQIA standard three.

Dr. Randall's claim that his hearing had to occur within 90 days is also belied by the medical staff bylaws. The medical staff bylaws provide that the hearing can be continued beyond 90 days for "good cause shown." (R. at 489). The MEC requested and was granted two continuances of the hearing by the hearing officer. Dr. Randall's counsel consented to the first continuance. (R. at 444:12-445:10). 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. (R. at 498; 454:13-455:18).

d. 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. Randall Br. at 16. 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 should fail.

While Dr. Randall's panel did not contain a general surgeon with laparoscopic experience, it did contain an oral surgeon and an orthopedic surgeon who, along with the other panel members,[14] had the benefit of hearing testimony from general surgeons called as expert witnesses by the MEC and Dr. Randall. (R. at 321-322).

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) <u>before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved</u>;

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.

Dr. Randall offers the following legislative history in support of his claim that the absence of a general surgeon on Dr. Randall's hearing panel violates HCQIA standard three: "it may not be feasible to find physicians who are of the same specialty as the respondent but who are not in direct in economic competition. Nevertheless, the Committee expects the professional review body to make every reasonable effort to find appropriate officers or members of the panel, even if this requires bringing in reviewers from out of town <u>. . .</u>" Randall Br. at 16 (quoting H.R. Rep. No. 903, 99th

[14] The panel also included a pathologist, oncologist, and anesthesiologist. (R. at 318-320).

Cong., 2nd Sess. 1986, 1986 U.S.C.C.A.N. 6384, at 6393)(emphasis added). Dr. Randall's ellipsis replaces the following important clause: "or using physicians of a different specialty." 1986 U.S.C.C.A.N. at 6393 (emphasis added). Because Dr. Randall's hearing panel was made up of "physicians of a different specialty" who were not Dr. Randall's economic competitors, the hearing panel's composition does not violate section 11112(b) or conflict with legislative intent.

e. Conclusion

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, the Court should find that Dr. Randall's peer review action complies with HCQIA standard three.[15]

4. In the reasonable belief that the action was warranted by the facts known after the investigation

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,* 532 Fed. Appx. at 345 (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

[15] Even if Defendants did not satisfy every element of section 11112(b), which is denied, Defendants should still be found to satisfy HCQIA standard three because the process Dr. Randall received during his peer review action was "fair to the physician under the circumstances." 42 U.S.C. § 11112(a)(3); *Hein-Muniz*, 532 Fed. Appx. at 344.

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 were 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. Because the decision to terminate Dr. Randall's abdominal surgery privileges was not obviously mistaken under these circumstances, the Court should find that Defendants satisfy standard four of HCQIA.[16]

5. Conclusion as to HCQIA damages immunity

Defendants offered a large quantity of probative evidence establishing that Dr. Randall's peer review action satisfies the 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. The circuit court's finding that Defendants have damages immunity under HCQIA should, therefore, be affirmed.

[16] 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." Randall Br. at 12. As set forth above, whether a question of fact exists regarding compliance with a HCQIA standard is not the appropriate inquiry.

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 circuit court's dismissal of Dr. Randall's claims pursuant to HCQIA should be affirmed.

II. THE COURT SHOULD AFFIRM THE CIRCUIT COURT'S FINDING THAT DR. RANDALL'S CAUSES OF ACTION FAIL FOR ADDITIONAL REASONS ARISING UNDER STATE LAW

A. Dr. Randall's conspiracy claim fails

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, then the Chief Medical Officer at Piedmont, and Dr. Edwards, then the Chief of Staff at Piedmont, are the conspirators in a peer review conspiracy. (R. at 374:2-7). 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, summary judgment on this claim is appropriate.

Dr. Randall argues that *Anthony v. Ward*, 336 Fed. Appx. 311 (4th Cir. 2009) holds that the intra-corporate immunity doctrine does not apply to the "agent-agent" conspiracy allegedly present in this case. Randall Br. at 19-20. Dr. Randall is mistaken. In *Anthony*, the appellate court held that the 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. Appx. at 315 (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)(emphasis added).

Dr. Randall also contends that Defendants' intra-corporate immunity is overcome by the "self-interest and malice" that allegedly motivated Drs. Edwards and Patterson. Randall Br. at 19. This contention should be rejected because Dr. Randall has not identified any economic benefit that Dr. Patterson, a non-practicing surgeon, or Dr. Edwards, a cardiologist, stood to gain by participating in this alleged conspiracy to revoke Dr. Randall's privileges. *ePlus Tech., Inc.*, 313 F.3d 166, 179-80 (4th Cir.

2002) ("personal stake exception" to intra-corporate immunity applied where defendant stood to "personally benefit" financially from conspiracy); *Holter v. Moore and Co.*, 702 F.2d 854, 857 n. 8 (10th Cir. 1983)("independent personal stake" exception applies only "when the officer has an outside economic interest such as ownership of a competing corporation, through which he will benefit from the restraint"). Dr. Randall has also not come forward with any evidence -- or any reasonable inference from the evidence – supporting his claim that Defendants engaged in conspiratorial conduct for the purpose of injuring him. *Moore,* 560 F.3d at 178 (conspiracy claim failed as physician had no evidence "that formal peer review process was 'conspiratorial' in any real sense of the word").[17]

Finally, and most fundamentally, Dr. Randall's conspiracy claim should also fail 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 did suspend Dr. Randall's abdominal surgery privileges, days later Dr. Edwards's action was reviewed and approved by the entire MEC. *Supra* Stmt. of Facts at § II.D. Thereafter, the MEC's recommendations were reviewed by the hearing panel, the Appellate Review Committee, and the Board. *Supra* Stmt. of Facts at § II.E. & F. These bodies -- that did not include Drs. Edwards or Patterson -- affirmed the MEC's recommendations and thereby terminated Dr. Randall's abdominal surgery privileges. Importantly, Dr. Randall concedes that these peer review bodies acted in good faith. (R. at 344:18-346:6; 368:3-11; 372:5-373:8). Therefore, even if Dr.

[17] If Drs. Edwards and Patterson were acting in bad faith, surely Dr. Randall or his counsel would have raised this misconduct during the peer review action. No such claims were made. (R. at 447:13-450:13).

Randall had evidence that Drs. Edwards and Patterson acted in bad faith, which he does not, because these undisputedly malice-free peer review bodies made the ultimate decisions regarding Dr. Randall's privileges, Dr. Randall's allegations of conspiracy are immaterial.

B. Dr. Randall's defamation claim fails

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. (R. at 375:9-377:13). Because Dr. Randall concedes the statement upon which his defamation claim rests is true, this claim should fail.

Piedmont is required by federal law to report Dr. Randall's adverse peer review action to the NPDB. 42 U.S.C. § 11133. Therefore, even if the NPDB report were false and defamatory, which it is not, Piedmont's report is privileged, and thus it cannot

constitute defamation. *Swinton Creek Nursery v. Edisto Farm Credit, ACA*, 334 S.C. 469, 514 S.E.2d 126 (1999).[18]

CONCLUSION

For the reasons set forth above, Defendants respectfully request that the Court affirm the circuit court's order.

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[18] Dr. Randall offers *Wuchenich v. Shenandoah Mem'l Hosp.*, 215 F.3d 1324 (4th Cir. 2000) in support of his defamation claim. Randall Br. at 22. This case is inapposite. Dr. Wuchenich's privileges were suspended and later reinstated. *Wuchenich*, 215 F.3d at *5. Because the hospital failed to notify the NPDB of Dr. Wuchenich's reinstatement in a timely manner, the NPDB report -- that was originally accurate -- became false, and Dr. Wuchenich's defamation claim survived a motion to dismiss. *Id.* at *15-16.

THE STATE OF SOUTH CAROLINA
In The Court of Appeals

APPEAL FROM YORK COUNTY
Court of Common Pleas

J. Ernest Kinard, Jr., Circuit Court Judge

Case No. 2012-CP-46-00167
Appellate Case No. 2014-000913

Robert Randall, M.D., ... Appellant,

v.

Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center, Nathaniel Edwards, M.D., and Richard Patterson, M.D., ... Respondents.

CERTIFCATE OF COUNSEL

The undersigned certified that this Final Brief of Respondents of Amisub of South Carolina, Inc., d/b/a Piedmont Medical Center complies with Rule 211(b), SCACR and complies with South Carolina Supreme Court Order of August 13, 2007.

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Columbia, South Carolina

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PROOF OF SERVICE

I certify that I have served Amisub of South Carolina, Inc. d/b/a Piedmont Medical Center's Final Brief of Respondents via hand delivery on November 5, 2014 on Robert Randall, M.D., addressed to his attorney of record, James M. Griffin, Esq., Lewis, Babcock & Griffin, LLP, 1513 Hampton Street, Columbia, SC 29201.

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