DA 24-0101

IN THE SUPREME COURT OF THE STATE OF MONTANA

2025 MT 28

THOMAS C. WEINER, M.D.,

Plaintiff and Appellant,

v.

ST. PETER'S HEALTH, a Montana Domestic Nonprofit Corporation, d/b/a St. Peter's Hospital, WADE JOHNSON, JAMES TARVER, M.D., KERRY HALE, M.D., SHELLY HARKINS, M.D., TODD WAMPLER, M.D., RANDY SASICH, M.D., and JOHN DOES 1-5,

Defendants and Appellees.

APPEAL FROM: District Court of the First Judicial District,
In and For the County of Lewis And Clark, Cause No. ADV-2020-1988
Honorable Mike Menahan, Presiding Judge

COUNSEL OF RECORD:

For Appellant:

J. Devlan Geddes, Trent M. Gardner, Jeffrey J. Tierney, Henry J. K. Tesar, Goetz, Geddes & Gardner, P.C., Bozeman, Montana

For Appellees:

David McLean, McLean & Associates, PLLC, Missoula, Montana

Michael J. Miller, Kathleen Abke, Axel Trumbo, Strong & Hanni, Salt Lake City, Utah

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Submitted on Briefs: October 16, 2024

Decided: February 11, 2025

Filed:

Clerk

Justice Laurie McKinnon delivered the Opinion of the Court.

¶1 Thomas C. Weiner, M.D., (Weiner) appeals from an Order entered in the First Judicial District Court, Lewis and Clark County, denying his motion for summary judgment and granting summary judgment to St. Peter's Health and other named defendants (collectively, SPH). We affirm.

¶2 We restate the dispositive issue:

¶3 *Whether SPH is entitled to immunity from damages because it acted within the scope of its peer-review obligations under the Health Care Quality Improvement Act (HCQIA).*[1]

FACTUAL AND PROCEDURAL BACKGROUND

¶4 Weiner is a physician board-certified in oncology and licensed to practice medicine in Montana. In 1996, Weiner joined the medical staff at SPH, where he practiced until the SPH Board of Directors revoked his medical staff membership and clinical privileges in 2020. Weiner's employment agreement with the SPH Medical Group, dated May 9, 2019, required he be a Medical Staff Member. The Medical Staff is governed by various committees, including the Medical Executive Committee (MEC), the Credentials Committee (CC), and the Peer Review Committee (PRC).

[1] Weiner believes part of his Complaint survives HCQIA immunity. He focuses primarily on two events: (1) an update to staff about Weiner's suspension, and (2) a disclosure about Weiner to staff, patients, and the public in December 2020. We have carefully examined his claims and facts. We conclude that all Weiner's claims relate to SPH's peer review and, therefore, fall within the scope of the HCQIA immunity, which applies to all damages "with respect to" the professional review action. Weiner's Complaint alleges facts which are integral and closely related to the professional review actions taken by SPH. An announcement of a change in a physician's status is inherently part of the professional review action. *Gabaldoni v. Wash. Cnty. Hosp. Ass'n*, 250 F.3d 255, 260 n.4 (4th Cir. 2001). Accordingly, the single dispositive issue is the application of the HCQIA to Weiner's peer review process.

¶5 SPH reports that, as early as 2018, Weiner's colleagues voiced concerns about his patient care. On February 6, 2020, the PRC requested an investigation into Weiner's practice, citing four areas of concern: (1) manipulation of patients' do not resuscitate (DNR) status without patient consent; (2) substandard care for inpatients' non-oncological medical issues; (3) application of inpatients' end-of-life care; and (4) continuation of cardiotoxic chemotherapy in patients, despite evidence by echocardiogram of reduced ejection fraction.

¶6 On February 10, 2020, Dr. Todd Wampler (Wampler), PRC Chief of Staff, and Dr. James Tarver (Tarver), CC Chair, met with Weiner to discuss the PRC's concerns, to notify Weiner these concerns were being presented to the CC, and to inform Weiner that six of his patient cases would be sent to the University of Utah for external review. On September 24, 2020, five of the six cases sent for external review had been returned to SPH. Based on these reviews, the PRC sent another letter to the CC requesting corrective action against Weiner.

¶7 The CC began its corrective-action investigation on September 28, 2020. It examined the external reviews and recent peer review cases. It then sent eighty additional randomized cases to the Greeley Company, a medical consulting firm, for external review. It also sought second opinions on thirteen nonrandomized cases that had either been reviewed by the University of Utah or had been sent to the PRC from SPH providers or staff. On October 12, 2020, the CC met to discuss the next steps to be taken and to review the final external review from the University of Utah. The University of Utah's review concluded that a case documentation for one of Weiner's patients (hereinafter, PT1) did not

support a malignancy and that Weiner erroneously diagnosed PT1 with lung cancer. Likewise, PT1's documentation did not support the corresponding eleven-year chemotherapy and immunotherapy treatment Weiner administered. Finally, the report concluded that PT1 died because of the chemotherapy. The CC met again on October 14, 2020 and decided to summarily suspend Weiner's medical staff membership and clinical privileges pending further investigation.

¶8 On October 15, 2020, Tarver and Dr. Kerry Hale (Hale)—who had replaced Wampler as the Chair of the CC—met with Weiner to discuss the CC's decision to suspend his medical staff membership and clinical privileges. Tarver and Hale presented Weiner with the CC's letter explaining its decision to proceed with summary suspension. The letter noted the CC's concerns regarding Weiner's clinical competency, stating that "an external review of your oncological treatment of a recent patient has concluded that you prescribed chemotherapy without documented, confirmed evidence of malignancy and that the patient died as a result of said chemotherapy." The letter explained the investigative process and informed Weiner that, instead of a summary suspension, he could voluntarily refrain from exercising his privileges during the suspension period. Weiner chose to voluntarily refrain from exercising his privileges, as of October 15, 2020.[2]

¶9 During Weiner's voluntary absence, the CC continued its investigation, sending five more cases to an independent medical oncologist for external review. The investigation

[2] As the District Court noted, there is "some dispute whether Weiner took a voluntary leave of absence or was voluntarily refraining from exercising his clinical privileges—and these terms are not interchangeable." However, as explained below, this distinction is not material to the instant proceeding.

revealed additional evidence that Weiner overprescribed narcotic medication without documentation, failed to have narcotic contracts, and treated non-cancer pain patients with narcotics or benzodiazepine for long periods of time at high dosages. Based on these findings, the CC summarily suspended Weiner on November 17, 2020. This suspension of his medical staff membership and clinical privileges immediately resulted in default termination of Weiner's employment with SPH. The CC's Notice of Summary Suspension, which Weiner received on November 17, 2020, informed him that the MEC would meet within 14 days to determine whether to expand, modify, or discontinue the suspension. Weiner met with the MEC on November 24, 2020. During this meeting, and after the parties discussed seven of Weiner's cases, the MEC voted unanimously to continue Weiner's summary suspension. Weiner met with the CC again on November 30, 2020. In this meeting, the committee focused on Weiner's approach to practice. Following this meeting, the CC concluded its investigation and voted to recommend revocation of Weiner's medical staff membership and clinical privileges.

¶10 The CC completed its Report of Investigation and Recommendation and sent the report to the MEC. The CC notified Weiner of its recommendation on December 7, 2020. Two days later, the MEC met to consider the CC's recommendation, but it decided to continue the investigation and delay further action. On December 15, 2020, however, the MEC voted to adopt the CC's recommendation that Weiner's membership and privileges be revoked and additionally voted to continue Weiner's summary suspension beyond thirty days. Wade Johnson (Johnson), Chief Executive Officer of SPH, sent Weiner notice of the MEC's decision and Weiner's administrative fair-hearing rights on December 17, 2020.

On December 23, 2020, the SPH Board of Directors voted to revoke Weiner's medical staff membership and clinical privileges. Johnson notified Weiner of this decision by letter on December 29, 2020. In January 2021, Weiner requested his right to an administrative hearing under the SPH Bylaws.

¶11 Weiner filed his initial complaint against SPH on December 10, 2020. Weiner alleged the following claims: breach of contract; breach of implied covenant of good faith and fair dealing; wrongful termination; interference with prospective business advantage; defamation; violation of the Montana Unfair Trade Practices Act; civil conspiracy; violation of due process; and punitive damages. In response, SPH raised the affirmative defense of qualified immunity under the HCQIA. SPH also moved to stay proceedings until after the fair-hearing process had been completed. The District Court, over Weiner's objection, granted the stay pending exhaustion of Weiner's administrative remedies. The administrative hearing took place over six days in June 2021. On October 14, 2021, the Hearing Panel issued its Report and Recommendation, concluding: (1) the MEC's decision to summarily suspend Weiner's privileges was reasonable and supported by substantial evidence; (2) the MEC's recommendation to revoke Weiner's clinical privileges and medical staff membership was reasonable and supported by substantial evidence; and (3) Weiner did not prove the summary suspension or the MEC's recommendation was arbitrary or capricious.

¶12 Weiner requested appellate review before SPH's Board of Directors of the Hearing Panel's findings and recommendations. On December 7, 2021, the Board met to consider Weiner's appeal and consider its final action regarding the Hearing Panel's

recommendation. The Board voted to adopt the Hearing Panel's recommendations. It upheld the summary suspension of Weiner's privileges and the revocation of his medical staff membership.

¶13 Following exhaustion of Weiner's administrative remedies, the District Court resumed the pending judicial proceeding and considered the parties' competing motions for summary judgment. On August 31, 2023, the District Court denied Weiner's motion for summary judgment and granted SPH's motion for summary judgment, concluding that Weiner had failed to meet his burden of producing sufficient evidence that would allow a reasonable jury to find that SPH was not entitled to statutory immunity from damages under HCQIA. On September 8, 2023, the District Court issued an Addendum to its initial Order providing a more thorough and substantive analysis of Weiner's claim of defamation. As two claims had not been disposed of by the District Court's orders, Weiner moved pursuant to Rule 54(b) to certify both orders that addressed summary judgment and the HCQIA. The District Court noted a claim for defamation remained against a physician that had no relation to the peer review body or the issue of HCQIA immunity. Additionally, the District Court noted that SPH had a single count of breach of contract against Weiner which the District Court determined was unrelated to the issue of HCQIA immunity and not resolved by its orders on summary judgment. On February 14, 2024, the District Court entered an order granting Weiner's Rule 54(b) certification of the two summary judgment orders pertaining to HCQIA.

¶14 Weiner appeals only the District Court's orders of August 21, 2023, and September 8, 2023, that were certified by the District Court. On February 27, 2024, this Court ordered Weiner's appeal may proceed.

STANDARDS OF REVIEW

¶15 We conduct a *de novo* review of a district court's ruling on motions for summary judgment, using the same M. R. Civ. P. 56 criteria as the district court. *Chapman v. Maxwell*, 2014 MT 35, ¶ 7, 374 Mont. 12, 322 P.3d 1029 (citation omitted). "[O]ur *de novo* standard of review of summary judgment decisions allows us to review the record and make our own determinations regarding the existence of disputed issues of fact and entitlement to judgment as a matter of law." *Wurl v. Polson Sch. Dist. No. 23*, 2006 MT 8, ¶ 29, 330 Mont. 282, 127 P.3d 436.

DISCUSSION

A. Health Care Quality Improvement Act.

¶16 Peer review, the process by which physicians and hospitals evaluate and discipline staff doctors, has become an integral component of health care. The HCQIA was enacted to improve the quality of medical care. *Bryan v. James E. Holmes Reg'l Medical Ctr.*, 33 F.3d 1318, 1321 (11th Cir. 1994). Congress's rationale behind the HCQIA's professional peer review is included in its findings:

> The increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be undertaken by any individual State.

42 U.S.C. § 11101(1). Congress found that "the threat of private money damage liability under [state and] Federal laws, including treble damage liability under Federal antitrust

law, unreasonably discourages physicians from participating in effective professional peer review," § 11101(4), and that these problems "can be remedied through effective peer review," § 11101(3). To facilitate this goal, the HCQIA establishes a professional peer-review process. 42 U.S.C. §§ 11101–11152. Peer review improves the quality of medical care by "'encouraging physicians to identify and discipline other physicians who are incompetent or who engage in unprofessional behavior.'" *Bryan,* 33 F.3d at 1321 (quoting H.R. Rep. No. 99-903, at 2 (1986)). Congress acknowledged the "overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(5). To provide this protection, the HCQIA grants qualified immunity from damages to a professional review body if it "meets all the standards specified in [§ 11112(a)]." 42 U.S.C. § 11111(a)(1). Thus, HCQIA provides that if a "professional review action" (as defined by the HCQIA) meets certain due process and fairness requirements, "doctors and hospitals who have acted in accordance with the reasonable belief, due process, and other requirements of [the HCQIA] are protected from damages sought by a disciplined doctor." H.R. Rep. 99-903, at 3. The statute grants immunity from monetary damages to participants in properly conducted peer review proceedings while preserving causes of action for aggrieved physicians that are outside the provisions of the HCQIA.

¶17 The provision of the HCQIA that limits the availability of damages provides:

> If a professional review action (as defined in . . . this title) of a professional review body meets all the standards specified in section 11112(a) of this title, . . .
>
> (A) the professional review body,
>
> (B) any person acting as a member or staff to the body,

> (C) any person under a contract or other formal agreement with the body, and
> (D) any person who participates with or assists the body with respect to the action,
>
> shall not be liable in damages under any law of the United States or of any State (or political subdivision thereof) with respect to the action.

42 U.S.C. §11111(a)(1).

¶18 For purposes of the protection set forth in section § 11111(a), a professional review action must be taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
> (2) after a reasonable effort to obtain the facts of the matter,
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).
>
> A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in [§ 11111(a)] unless the presumption is rebutted by a preponderance of the evidence.

42 U.S.C. § 11112(a).

¶19 Determining whether a defendant's actions are covered by the immunity provisions of the HCQIA requires that the defendants' actions be done pursuant to a "professional review action," and not merely an "activity" apart from the peer review action. *See* 42 U.S.C. §§ 11151(9), (10). Distinguishing actions from activities is necessary because HCQIA immunity attaches specifically to actions, whereas HCQIA immunity attaches to activities only insofar as those activities lead to an action taken. 42 U.S.C. § 11151(a). Because "actions" may adversely affect the medical membership or clinical privileges of a physician, any action of the professional review body must adhere to

§ 11112(a)'s requirements before it can be deemed HCQIA-compliant and the professional review body entitled to immunity. In contrast, "activities" not associated with an action do not adversely affect the medical membership or clinical privileges of the physician and therefore the activity, while not obligated to be HCQIA-compliant, will not be immunized from damages pursuant to the HCQIA. Both "professional review actions" and "professional review activities" are defined in the HCQIA.

¶20 A "professional review action" is:

> an action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence or professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients) and which affects (or may affect) adversely the clinical privileges, or membership of a professional society, of the physician.

42 U.S.C. § 11151(9); *see also Austin v. McNamara*, 979 F.2d 728, 735 (9th Cir. 1992). A professional review action includes the professional review activities related to the action, but the term "professional review activity" has its own definition:

> an activity of a health care entity with respect to an individual physician—
> (A) to determine whether the physician may have clinical privileges with respect to, or membership in, the entity,
> (B) to determine the scope or conditions of such privileges or membership, or
> (C) to change or modify such privileges or membership.

42 U.S.C. § 11151(10); *see also Austin*, 979 F.2d at 735–36. Professional review activities comprise the reasonable efforts that the professional review body must take before it can compliantly take a professional review action. *Austin*, 979 F.2d at 735–36 (citing § 11151(10)(C)). Activities are the investigative steps which must be taken before a professional review action can be made. *Mathews v. Lancaster Gen. Hosp.*, 87 F.3d 624,

634 (3rd Cir. 1996). This is because "the action itself can *only* be taken after professional review activity to determine the facts." *Austin*, 979 F.2d at 737 (emphasis in original). The Ninth Circuit Court of Appeals has plainly held that HCQIA immunity covers not only actions, but also professional review activities:

> A manifest purpose of encompassing professional review activities within the definition of "professional review action" was to grant immunity to reviewing physicians for a wide range of acts, including not only suspensions but also investigations. We have already concluded that the professional review actions taken by the defendants were within the immunity. Section 11151(9) then sweeps within that immunity the investigations "relating to" those professional review actions. The professional review activities, while not qualifying on their own as professional review actions, are nevertheless a component (an inclusion) of those actions for purposes of immunity. Under § 11151(9), it is the *relation* of these activities to the immune action, and not the time of their occurrence, that brings them within the immunity.

Austin, 979 F.2d at 737 (emphasis in original). Professional review actions, not activities, directly affect a physician's privileges or memberships. Therefore, professional review activities need not meet HCQIA requirements—only professional review actions must comply with these requirements. 42 U.S.C. § 11112(c); *see Mathews*, 87 F.3d at 634 ("Because [the] letter was not a professional review action, the district court correctly held it did not have to meet the standards set forth in [§ 11112(a)]."). Relevant here, summary suspension is a professional review action. *Leal v. Sec'y U.S. Dept. of H.H.S.*, 620 F.3d 1280, 1287 (11th Cir. 2010). Furthermore, a voluntary abeyance may be deemed a professional review action where the only alternative is a summary suspension. *See Poliner v. Tex. Health Sys.*, 537 F.3d 368, 377–78 (5th Cir. 2008) (holding that a voluntary abeyance and the extension of that abeyance were each professional review actions because

the abeyances were de facto restrictions of privileges, for the only alternative in each instance was a summary suspension).

¶21 The HCQIA also is specific as to which party bears the burden of proof. Congress stated its intent to "allow defendants to file motions to resolve the issue of immunity in as expeditious a manner as possible" and that the question of whether the defendants had satisfied the requirements of § 11112(a) should be "determine[d] at an early stage of litigation." H.R. Rep. No. 99-903, at 12. Thus, the HCQIA establishes a rebuttable presumption of 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)(4). Having "the benefit of the statutory presumption, the nonmovant is relieved of the initial burden of providing evidentiary support for its contention at summary judgment that there is no genuine issue of material fact on its compliance with the HCQIA standards." *Singh v. Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25, 33 (1st Cir. 2002). Consequently, the standard for summary judgment on HCQIA claims is "somewhat unusual." *Austin*, 979 F.2d at 734.

> Due to the presumption of immunity contained in section 11112(a), we must apply an unconventional standard in determining whether [Defendant] was entitled to summary judgment—whether a reasonable jury, viewing all facts in a light most favorable to [Plaintiff], could conclude that he had shown, by a preponderance of the evidence, that [Defendant's] actions fell outside the scope of section 11112(a).

Gabaldoni v. Wash. Cnty. Hosp. Ass'n, 250 F.3d 255, 260 (4th Cir. 2001) (citing *Sugarbaker v. SSM Health Care*, 190 F.3d 905, 912 (8th Cir. 1999); *Brader v. Allegheny Gen. Hosp.*, 167 F.3d 832, 839 (3rd Cir. 1999)); *see also Austin*, 979 F.2d at 734.

¶22 Finally, whether the defendants' actions are outside the scope of § 11112(a) is decided on an objective, reasonable-belief standard. *Austin*, 979 F.2d at 734 ("The legislative history of § 11112(a) indicates that its reasonableness requirements were intended to create an objective standard, rather than a subjective good faith standard."); H.R. Rep. No. 99-903, at 10 ("[T]he Committee changed to a more objective 'reasonable belief' standard. The Committee intends that this test will be satisfied if the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their actions would restrict incompetent behavior or would protect patients."); *Singh*, 308 F.3d at 32 ("Our sister circuits have uniformly applied all the sections of § 11112(a) as objective standards."); *Imperial v. Suburban Hosp. Ass'n, Inc.*, 37 F.3d 1026, 1030 (4th Cir. 1994) ("The standard is an objective one which looks to the totality of the circumstances."); *Bryan*, 33 F.3d at 1335 (quoting *Austin*, 979 F.2d at 734) ("The test is an objective one, so bad faith is immaterial. The real issue is the sufficiency of the basis for the [Hospital's] actions."). Therefore, when reviewing whether HCQIA immunity applies, we will not consider any bad-faith argument, nor the correctness of SPH's conclusions.[3] Instead, we will apply an objective, reasonable-belief standard when

[3] As the District Court correctly held, "Any argument regarding the ultimate accuracy of the SPH Defendants' conclusions is irrelevant for this objective analysis."

analyzing whether the Defendants complied with each of the four requirements under § 11112(a).

B. The HCQIA applied to SPH's peer review of Weiner.

1. Professional review actions and activities.

¶23 Applying the HCQIA to the facts here, we first must determine which conduct constitutes a professional review *action* and which constitutes a professional review *activity*. As in *Poliner*, Weiner was offered the choice to take a voluntary leave of absence or be summarily suspended.[4] Like *Poliner*, Weiner chose the leave of absence. This is a "forced abeyance." *Poliner*, 537 F.3d at 374–75. As such, it is a de facto summary suspension. *Poliner*, 537 F.3d at 374. SPH contests this, arguing that there was no adverse professional review action taken, so the requirement for adequate notice and hearing procedures under § 11112(a)(3) was not implicated when Weiner opted for a leave of absence on October 15, 2020. SPH further argues that because the summary suspension of November 17, 2020, was a suspension or restriction of clinical privileges for a period of no longer than 14 days (on November 23, 2020, CC acted and continued the suspension), the requirement for adequate notice and hearing procedures under § 11112(a)(3) did not arise. *See* 42 U.S.C. § 11112(c)(1)(B) ("For purposes of [§ 11111(a)] nothing in this section

[4] This summary suspension was voted on by the CC, which SPH's CEO states does not have the authority under the Bylaws to summarily suspend a physician. However, as in *Poliner*, this Court is tasked with answering "whether these 'peer review actions' satisfy the HCQIA's standards, and not whether the 'abeyances' satisfy the bylaws." *Poliner*, 537 F.3d at 378. Moreover, "HCQIA immunity is not coextensive with compliance with an individual hospital's bylaws." *Poliner*, 537 F.3d at 380; *see also Braswell v. Haywood Reg'l Med Ctr.*, 234 F. App'x 47, 55 (4th Cir. 2007).

shall be construed as . . . requiring the procedure referred to in (a)(3) . . . in the case of a suspension or restriction of clinical privileges, for a period of not longer than 14 days, during which an investigation is being conducted to determine the need for a professional review action . . . ."). Consequently, SPH asserts that neither the leave of absence on October 15, 2020, nor the summary suspension on November 17, 2020, are professional review actions. Thus, SPH maintains that because no professional review action was taken until November 23, 2020, when the CC acted to continue the November 17 suspension beyond 14 days, SPH's peer review actions were exempt from the notice and process provisions of § 11112(a)(3).

¶24 SPH's argument is incongruent with the purpose behind § 11112(c)(1), which is to avoid an indefinite suspension of clinical privileges without affording adequate notice and hearing procedures. *Poliner*, 537 F.3d at 384 (quoting *Rogers v. Columbia/HCA of Cent. La., Inc.*, 971 F. Supp. 229, 236 (W.D. La. 1997)). If peer review bodies could threaten to summarily suspend a physician unless they "voluntarily" refrain from exercising their clinical privileges, review bodies could effectively take an adverse professional review action without incurring their obligations under § 11112(a). Such "forced abeyances" would allow peer review bodies to circumvent HCQIA requirements. Allowing this would fail to account for the due process rights and "significant interests of the physician." *Poliner*, 537 F.3d at 384. Thus, like the District Court, we find *Poliner* is persuasive and conclude Weiner's voluntary abeyance on October 15, 2020, was a de facto summary suspension that constituted a professional review action.

¶25 Addressing SPH's argument that pursuant to § 11112(c)(1)(B) the November 17, 2020 summary suspension did not last longer than 14 days because the CC acted on November 23, 2020, we note that the de facto summary suspension of October 15, 2020, *did* last for over 14 days and thus does not meet the qualifications of § 11112(c)(1)(B). Moreover, the CC's decision to continue Weiner's summary suspension on November 17, 2020, likewise does not meet the qualifications under § 11112(c)(1)(B) because it served as an extension of the de facto summary suspension of October 15, 2020. Therefore, the District Court correctly identified four professional review actions at issue:

(1) the CC's October 14, 2020, de facto summary suspension of Weiner's privileges;

(2) the November 17, 2020, summary suspension of Weiner's privileges;

(3) the November 23, 2020, CC recommendation to revoke Weiner's privileges; and

(4) the December 15, 2020, MEC vote to adopt the CC's recommendation.

¶26 Each of these four professional review actions must comply with § 11112(a); otherwise, SPH's presumed qualified immunity under the HCQIA may be defeated for any one of the actions. *Brown v. Presbyterian Healthcare Servs.*, 101 F.3d 1324, 1333 (10th Cir. 1996) ("[I]f a plaintiff challenging a peer review action proves, by a preponderance of the evidence, any one of the four requirements was not satisfied, the peer review body is no longer afforded immunity from damages under the Health Care Quality Improvement Act." (citations omitted)). We will consider each action and whether it met the requirements of § 11112(a).

2. Whether the professional review action was taken "in the reasonable belief that the action was in the furtherance of quality health care." 42 U.S.C. § 11112(a)(1).

¶27 On February 6, 2020, the PRC requested an investigation into Weiner's practice citing four areas of concern: (1) manipulation of patients' DNR status without patient consent; (2) substandard care for inpatients' non-oncological medical issues; (3) application of inpatients' end-of-life care; and (4) continuation of cardiotoxic chemotherapy in patients, despite evidence by echocardiogram of reduced ejection fraction.

¶28 The initial five case reviews from the University of Utah were delivered to SPH on October 9, 2020. These external reviews indicated that Weiner's practice fell below the standard of care, which in at least one instance may have caused the death of a patient. This posed grave concerns for patient safety. Considering these circumstances objectively as the District Court did, this decision was made on the reasonable belief that the action was in the furtherance of ensuring the quality of health care. Applying the objective, reasonable-belief standard, this first requirement under § 11112(a) was satisfied because "the reviewers, with the information available to them at the time of the professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients." H.R. Rep. No. 99-903, at 10. Consistent with these findings and review, the CC voted to summarily suspend Weiner on October 15, 2020, and commence an investigation. The CC's action was taken in the reasonable belief that it was in furtherance of the quality of health care.

¶29 The CC's November 17, 2020 letter announcing Weiner's summary suspension identified the following concerns: (i) patients receiving treatment for conditions which Weiner failed to provide documented evidence to support the diagnosis; (ii) patients experiencing a progression or recurrence of disease due to Weiner's failure to appropriately refer the patients to other specialists for testing and diagnosis; (iii) clinical documentation insufficient to justify the therapies and medications Weiner prescribed or to support diagnoses for which his patients were receiving care; (iv) the prescription of high doses of narcotics to patients for conditions outside the scope of Weiner's clinical privileges or in quantities that were dangerous and inappropriate for the patients' complaints or medical history; (v) failure to identify medications in patients' current medication lists; and (vi) prescribing high-dosage opioids to patients without requiring patients to sign a pain contract and without monitoring patients for signs of abuse, performing urine drug tests and pill counts, or properly documenting a chronic treatment plan. Given these facts, which the peer reviewers had at the time of their decision, we have little difficulty concluding that the CC reasonably believed—as any peer review body would under these circumstances—that the decision to summarily suspend Weiner on November 17, 2020, would further the quality of health care.

¶30 Occurring one week after the second professional review action, the third professional review action was taken on November 23, 2020. It continued Weiner's summary suspension from November 17, 2020. This action was based on the same evidence that supported the November 17, 2020, action and, like the second action, was made in the furtherance of quality health care.

¶31 On December 15, 2020, the MEC voted to revoke Weiner's medical memberships and privileges and to continue Weiner's summary suspension for an additional 30 days. MEC's action was made after the Report of Investigation and Recommendation had been completed and delivered by the CC. This report aggregated the findings of the investigation and explained the reasoning behind the review body's recommendations to revoke Weiner's medical membership and clinical privileges. The findings considered the external reviews conducted by the University of Utah and the Greeley Company. The findings documented Weiner's substandard clinical practices which jeopardized patient safety, as evidenced by at least one patient death. Thus, objectively, this final professional review action was taken "in the reasonable belief that the action was in the furtherance of quality health care."

¶32 We conclude the District Court did not err when it found that all four professional review actions satisfied the requirements of § 11112(a)(1) because they were actions taken in the furtherance of quality health care.

3. Whether the professional review action was taken "after a reasonable effort to obtain the facts of the matter." 42 U.S.C. § 11112(a)(3).

¶33 Preliminarily, Weiner contests the professional review body's reliance on external peer reviewers, positing that the law necessitates SPH's reviewers conduct their own thorough investigation instead of merely relying on outside reviewers' reports. Weiner relies on *Smigaj v. Yakima Valley Mem'l Hosp. Ass'n*, 269 P.3d 323, 333 (Wash. Ct. App. 2012) (citing generally *Brown*, 101 F.3d at 1333–34). In response, Defendants argue that the "HCQIA does not require the ultimate decisionmaker to investigate a matter

independently" and may "rely on the reports and investigations of the various committees . . . in rendering its decision." *Gabaldoni*, 250 F.3d at 261 (citing *Bryan*, 33 F.3d at 1335). Further, SPH notes that because SPH did not employ any medical oncologists aside from Weiner, an external peer review was necessary to access the expertise needed to competently review Weiner's oncology cases. This argument is compelling, as it contemplates peer review in areas less populated and with with fewer specialized providers whereby access to a broad range of health care services is limited. It further comports with one of the peer review process's primary purposes: permitting and facilitating physicians' ability to identify incompetent or unprofessional physicians. *See* H.R. Rep. No. 99-903, at 2. The statute's plain language does not limit the source of "a reasonable effort to obtain the facts" to an internal review or suggest that the hospital could not seek independent third-party review. Thus, we are persuaded by the reasoning in *Gabaldoni* and *Bryan* that allows a peer review body to rely on outside peer reviewers when conducting a professional review action.

¶34 Weiner also argues that SPH began targeting his employment because he had threatened to resign in April 2020. The lack of a noncompetition agreement between Weiner and SPH could have potentially allowed him to work for a competing health system in oncology which had announced its intent to construct a medical clinic in Helena. Weiner's argument asserts bad faith from SPH to "destroy his ability to practice medicine to end his threat of competition," which is not considered under the objective, reasonable-belief standard applicable here. *See Bryan*, 33 F.3d at 1335 (quoting *Austin*, 979 F.2d at 734) ("Bryan's 'assertions of hostility do not support his position [that the

Hospital is not entitled to the HCQIA's protections] because they are irrelevant to the reasonableness standards of § 11112(a). The test is an objective one, so bad faith is immaterial.'"). We also will not consider bad-faith allegations when analyzing whether SPH made reasonable efforts to obtain the facts of the matter.

¶35 Finally, Weiner cites two unpublished opinions to assert that, where a reasonable jury could conclude that SPH deliberately misrepresented facts, summary judgment for HCQIA immunity should not be granted. Weiner relies on § 11111(a)(2), which provides that immunity from damages is not available under § 11111(a)(1) where the "information is false and the person providing it knew that such information was false." Importantly, however, HCQIA immunity is still conferred to a person who reports false information if that person is "'without knowledge of the falsity of the information contained in the report.'" *Brown*, 101 F.3d at 1334 (quoting § 11137(c)). Thus, to be successful in his argument, Weiner must provide sufficient evidence of falsity and knowledge that a reasonable jury could find, at the time the professional review action was made, SPH knowingly shared false information to the external peer reviewers.

¶36 Here, Weiner argues that Defendants purposely withheld vital information from the external peer reviewers. However, Weiner does not offer sufficient evidence demonstrating Defendants knowingly excluded critical medical records. On the contrary, the email exchange in the record depicts a willingness on the part of SPH to share all medical records necessary for a competent and comprehensive external review to be conducted. Moreover, SPH provided additional records when requested by the external reviewers. Having thus

addressed all the preliminary matters, we turn to whether the professional review body took reasonable efforts to obtain the facts of the matter when taking each of the four actions.

¶37 Section 11112(a)(3) requires the professional review action be taken only "after reasonable effort to obtain the facts of the matter" has been made. This requirement asks the question "'whether the totality of the process leading up to the Board's professional review action . . . evidenced a reasonable effort to obtain the facts of the matter.'" *Brader*, 167 F.3d at 841 (quoting *Mathews*, 87 F.3d at 637). As of February 10, 2020, SPH informed Weiner that six of his patient cases would be sent to the University of Utah for external review. After receiving five of those six cases on September 24, 2020, the PRC sent a letter to the CC requesting corrective action against Weiner based on concerns raised by the external reviews. On September 28, 2020, CC began its corrective action investigation, examining the external reviews and recent peer review cases. Next, it sent eighty randomized cases to the Greeley Company for external review. It also sought second opinions on thirteen nonrandomized cases that had either been reviewed by the University of Utah or had been sent to the PRC from SPH providers or staff. On October 12, 2020, the CC met to discuss any further steps to be taken and to consider the final external review from the University of Utah. Two days later, the CC decided to summarily suspend Weiner or, as an alternative, offer Weiner the option of a voluntary abeyance. These steps taken by the peer review body from February 10, 2020, until the professional review action was taken on October 15, 2020, demonstrate a "reasonable effort to obtain the facts of the matter" before taking the action.

¶38 During Weiner's voluntary absence, the CC continued its investigation, sending five more cases to an independent medical oncologist for external review. Its investigation revealed additional evidence that Weiner overprescribed narcotic medication without documentation, failed to have narcotic contracts, and treated non-cancer pain patients with narcotics or benzodiazepine for long periods of time at high dosages. Additionally, the CC reviewed and discussed the sixth case received from the external reviewers at the University of Utah. This record clearly establishes that the CC took reasonable efforts to obtain the facts of the matter before it issued its November 17, 2020, summary suspension.

¶39 Following Weiner's suspension, the MEC met with him on November 24, 2020. During this meeting, the parties discussed seven of Weiner's cases and focused on Weiner's approach to practice, allowing Weiner to discuss, explain, or refute any evidence that had been presented. Weiner also met with the CC on November 30, 2020, during which Weiner had "the opportunity to respond and offer his explanation" as to the concerns raised by the CC. The CC voted to recommend revocation of Weiner's medical staff membership and clinical privileges. The CC thereafter completed its Report of Investigation and Recommendation, recommending to the MEC that Weiner's clinical privileges be revoked. These two November meetings with Weiner, in conjunction with the other reasonable efforts to obtain facts made prior to the meetings, demonstrate the CC made reasonable efforts to obtain the facts before taking its third professional review action on November 23, 2020, revoking Weiner's privileges.

¶40 After considering the CC's Report of Investigation and Recommendation on December 9, 2020, the MEC chose to continue the investigation and delay further action.

On December 15, 2020, the MEC voted to adopt the CC's recommendation to revoke Weiner's privileges and memberships. The MEC's decision to continue the investigation before voting on the CC's recommendation indicates another reasonable effort to obtain helpful facts. Considering the efforts made by SPH leading up to the December 15, 2020, MEC professional review action, we conclude the District Court was correct when it found Weiner had failed to demonstrate that SPH did not make a reasonable effort to obtain the facts about Weiner's substandard medical care.

¶41 Weiner makes numerous assertions that attack the adequacy of SPH's review. In particular, he claims SPH did nothing to confirm the accuracy of the external reviews, did not know what records the reviewers had or whether the reviewers were aware of pertinent facts contradicting the reviews, that SPH hand-picked what cases were to be reviewed, and that he was not allowed to respond or interview the doctors, nurses and patients involved. However, Weiner misunderstands the nature of the inquiry into whether a "reasonable effort" was made to obtain the facts. We are unwilling to conclude that a failure to include every conceivable factor in a quality assurance review, or one or several mistaken attributes in a host of data, undermine an otherwise thorough investigation. SPH and the external reviewers had ample evidence that Weiner's patient care was substandard. Weiner has failed to produce sufficient evidence that SPH and the external reviewers could not reasonably have concluded that suspending Weiner's privileges was in the best interests of Weiner's patients. The real issue is the sufficiency of the basis for SPH's actions. The "reasonable belief" standard articulated in § 11112(a)(i) will be satisfied "if the reviewers, with the information available to them at the time of the professional review action, would

reasonably have concluded that their actions would restrict incompetent behavior or would protect patients." *Mathews*, 87 F.3d at 635 (quoting H.R. Rep. No. 99-903, at 10). The District Court was correct when it concluded that SPH's review was sufficient, that it had made a reasonable effort to obtain the facts, and that SPH had a reasonable belief that its action was necessary to protect patients and quality health care.

4. Whether the professional review action was taken "after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." 42 U.S.C. 11112(a)(3).

¶42 Every "peer review action must comport with due process." *Freilich v. Upper Chesapeake Health*, 313 F.3d 205, 211 (4th Cir. 2002). Section 11112(a)(3) facilitates this aim by requiring "adequate notice and hearing procedures" be afforded before a professional review action may be taken. 42 U.S.C. § 11112(a)(3). Section 11112(b) provides guidance on when a "health care entity is deemed to have met the adequate notice and hearing requirement of subsection (a)(3)." However, "failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3)." 42 U.S.C. § 11112(b)(3). Significantly, if the failure to immediately suspend or restrict clinical privileges could "result in an imminent danger to the health of any individual," then the procedures of § 11112(a)(3) need not be followed. 42 U.S.C. § 11112(c)(2) ("For purposes of [§ 11111(a)], nothing 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 action may result in an imminent danger to the health of any individual."). This is

known as the "imminent harm" exception to the HCQIA's § 11112(a)(3)'s notice and process requirements.

¶43 The imminent harm exception furthers the HCQIA's primary purpose—to improve the quality of health care. This exception is aligned with the widely recognized due-process exception acknowledging that "where a State must act quickly, or where it would be impractical to provide predeprivation process, postdeprivation process satisfies the requirements of the Due Process Clause." *Gilbert v. Homar*, 520 U.S. 924, 930 (1997). Multiple courts have held that "medical staff privileges are a valuable property interest and that notice and hearing should precede termination of these privileges absent an 'extraordinary situation where a valid government or medical interest is at stake.'" *Brandner v. Providence Health & Servs.*, 394 P.3d 581, 589 (Alaska 2017) (quoting *Ne. Ga. Radiological Assocs., P.C. v. Tidwell*, 670 F.2d 507, 511 (5th Cir. Unit B 1982)) (citing *Shahawy v. Harrison*, 875 F.2d 1529, 1533–34 (11th Cir. 1989); *Osuagwu v. Gila Reg'l Med. Ctr.*, 850 F. Supp. 2d 1216, 1223 (D.N.M. 2012)). Thus, when an extraordinary situation involving a medical interest is at stake—i.e., when "public health, safety, or welfare require[s] summary action"—predeprivation hearing requirements may be excused. *Brandner*, 394 P.3d at 589 (citing *Graham v. State*, 633 P.2d 211, 216 (Alaska 1981) (quoting *Frontier Saloon, Inc. v. Alcoholic Beverage Control Bd.*, 524 P.2d 657, 661 (Alaska 1974))); *accord Patel v. Midland Mem. Hosp. & Med. Ctr.*, 298 F.3d 333, 339–42 (5th Cir. 2002). For imminent harm to exist, the criterion is not whether danger would result prior to the summary suspension; rather, imminent harm exists where "danger *may* result if the restraint is not imposed." *Sugarbaker*, 190 F.3d at 917 (quoting *Fobbs v. Holy*

Cross Health Sys. Corp., 29 F.3d 1439, 1442 (9th Cir. 1994)) *overruled on other grounds Daviton v. Columbia/HCA Healthcare Corp.*, 241 F.3d 1131, 1132 (9th Cir. 2001) (emphasis in original).

¶44 In *Smigaj*, the court determined the imminent harm exception did not apply because the defendants "did not act in a manner that suggested an imminent danger" by not recommending suspension until 19 days after becoming aware of the patient case. *Smigaj*, 269 P.3d at 335. Similarly, in *Brandner*, the court concluded that the physician's dishonesty did not "rise to the level of a 'realistic or recognizable threat' requiring an emergency termination of hospital privileges." *Brandner*, 394 P.3d at 590. Contrarily, in *Patel*, the court held that "the MEC had ample reason to believe that Dr. Patel's methods posed a danger to patient safety," so the committee's quick suspension of his privileges did not violate his due process rights, as a "pre-suspension process was not practical under these circumstances." *Patel*, 298 F.3d at 340.

¶45 SPH did not afford Weiner a pre-suspension process prior to taking its professional review actions on October 15, 2020, and November 17, 2020, so SPH can only satisfy the third requirement if § 11112(c)(2)'s imminent harm exception applies. Thus, if the peer reviewers involved in the actions reasonably believed, based on an objective standard at the time of the decision, that imminent harm may result unless they imposed the restraint (i.e., the summary suspension or revocation of Weiner's medical membership or privileges), then the imminent harm exception may apply.

¶46 In *Smigaj*, the court held that the peer review body "did not act in a manner that suggested an imminent danger" when it waited 19 days from the time it had been presented

with the case to the time it recommended suspension. *Smigaj*, 269 P.3d at 335. Here, Weiner argues that the CC "did not act in a manner that suggested an imminent danger" when it received the external review on October 9, 2020, reviewed the case on October 12, 2020, voted to suspend Weiner on October 14, 2020, and waited until the end of the day on October 15, 2020, to deliver the notice letter to Weiner. We disagree.

¶47 Here, the peer reviewers were made aware of a case involving a patient who died from gemcitabine toxicity resulting from chemotherapy treatments which, according to the reports given to the peer reviewers, were not medically necessary. Objectively, this information would lead a peer review body to reasonably believe that if they did not impose a restraint on the physician who prescribed the clinically questionable chemotherapy that resulted in the death of a patient, harm may occur. Balancing Weiner's significant interests and the public health ramifications of allowing incompetent physicians to practice while the slow wheels of justice grind, the peer review body took three deliberate steps over the course of six days from the time it received the external review on October 9, 2020. These facts do not support Weiner's argument that SPH "did not act in a manner that suggested an imminent danger."

¶48 SPH, again, did not afford Weiner a pre-suspension process prior to issuing its November 17, 2020, summary suspension, so we must consider whether the imminent harm exception applies. Weiner alleges that, since October 2020, he "was on a voluntary leave of absence unrelated to clinical competency." Although an email from SPH's counsel uses the term "leave of absence," SPH contests that this was the status of Weiner's clinical privileges, claiming instead Weiner was voluntarily refraining from exercising his clinical

privileges. Whether Weiner was taking a leave of absence or refraining from exercising clinical privileges could impact whether the imminent harm exception applies to the November 17, 2020, summary suspension. If Weiner was on a leave of absence, he would have had to request reinstatement before exercising his clinical privileges; the additional step of requesting and being reinstated would have mitigated the risk for imminent harm. Alternatively, if Weiner was refraining from exercising his clinical privileges, he would not have had to request reinstatement and, pursuant to his counsel-represented email agreement with SPH, could have begun exercising his clinical privileges as early as December 1, 2020. Such a short timeline increased the risk for imminent harm.

¶49 The District Court held here, in reliance on the reasoning in *Sugarbaker*, that the imminent harm exception applied even though the physician had no patients admitted at the time of the suspension. *See Sugarbaker*, 190 F.3d at 908–09. However, unlike the physician in *Sugarbaker*, Weiner opted for a voluntary leave of absence. Weiner is correct that if a physician must request and receive reinstatement before being permitted to practice medicine, then the contention that patient harm may result if a suspension is not imposed would be inapposite, for there would be no potential danger until the physician had been reinstated. Under such circumstances, the imminent harm exception might not apply—meaning this third criteria would not be satisfied, resulting in the disqualification of HCQIA immunity. In contrast, SPH relies on *Poliner* which reasoned the requirements of § 11112(a) "work in tandem: legitimate concerns lead to temporary restrictions and an investigation; an investigation reveals that a doctor may in fact be a danger; and in response, the hospital continues to limit the physician's privileges." *Poliner*, 537 P.3d at

384. Here, the question is not whether Weiner was taking a leave of absence or refraining from exercising his clinical privileges. Rather, the question is whether, objectively, peer reviewers in this situation would reasonably believe imminent harm existed; that is, whether harm may result if they did not impose a restraint. *Poliner*, 537 P.3d at 384. Objectively, the peer reviewers here reasonably believed imminent harm *may* result if they declined to impose a restriction on Weiner's clinical privileges.

¶50 Because it was unclear under which status Weiner was declining to practice medicine, the professional review body thought Weiner may begin admitting patients as soon as December 1, 2020. Moreover, SPH believed that Weiner was actively participating in patients' care plans even during his abeyance. This gave the professional review body concern that imminent harm may result if they failed to act. Due to the uncertainty surrounding Weiner's abeyance, along with reports that Weiner continued to influence patient care despite being on leave, peer reviewers held an objective, reasonable belief that danger may result if they did not summarily suspend Weiner. The District Court correctly concluded that, under these circumstances, whether Weiner was on a voluntary leave of absence or was voluntarily refraining from exercising his clinical privileges was immaterial because, under either scenario, it was objectively reasonable for the peer reviewers to believe imminent harm may exist.

¶51 The imminent harm exception does not apply to the CC's November 23, 2020 or the December 15, 2020 professional review actions because, at this point, Weiner had conclusively been suspended and the imminent harm exception would have had no application to future actions. Accordingly, to secure the immunity protections of

§ 11112(a), SPH was obligated to provide certain due process protections—"adequate notice and hearing procedures are [to be] afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances." 42 U.S.C. § 11112(a)(3). The HCQIA provides, in § 11112(b), standards by which courts may determine whether the professional review body provided the physician with adequate notice and hearing procedures before taking an action. Among several standards enumerated, a health care entity is deemed to have met the adequate notice and hearing requirement of § 11112(a)(3) if the physician is provided notice of the action, reasons for the action, notice of the physician's rights, a hearing, and provided rights during the hearing. However, "failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet the standards of subsection (a)(3)." 42 U.S.C. § 11112(b). Thus, even without adhering to every condition enumerated under § 11112(b), a peer review body may nevertheless qualify for HCQIA immunity. *Wahi v. Charleston Area Med. Ctr., Inc.*, 562 F.3d 599, 607–09 (4th Cir. 2009); *Brader*, 167 F.3d at 841–43. While § 11112(b) promulgates procedures by which a health care entity can always meet "the adequate notice and hearing requirement of subsection (a)(3)," the "fair . . . under the circumstances" requirement of § 11112(a)(3) allows courts to exercise broader discretion on a case-by-case basis.

¶52 We agree, as cautioned by the *Wahi* Court, that attempting to satisfy the notice and due process requirements for HCQIA immunity without following the conditions set forth in § 11112(b) "is not a recommended model." *Wahi*, 562 F.3d at 613. Nonetheless, Congress "included the 'other procedures appropriate . . . under the circumstances'

language contained in the statute in contrast to the specific 'notice and hearing' language." *Wahi*, 562 F.3d at 609. The 1986 House Report gives insight into Congress's rationale for drafting § 11112(a)(3) in this way:

> The due process requirement [i.e., subsection (a)(3)] can always be met by the procedures specified in subsection (b). . . . If other procedures are followed, but are not precisely of the character spelled out in [subsection (b)], the test of "adequacy" may still be met under other prevailing law. The Committee is aware, for example, that some courts have already carefully spelled out different requirements for certain professional review activities or actions, such as procedures for decisions regarding applicants for clinical privileges at a hospital. In those situations, compliance with applicable law should satisfy the "adequacy" requirement even where such activities or actions require different or fewer due process rights than the ones specified under [subsection (b)]. In any case, it is the Committee's intent that physicians receive fair and unbiased review to protect their reputations and medical practices.

Wahi, 562 F.3d at 609 (citing H.R. Rep. No. 99-903, at 10–11). Thus, when analyzing whether the "fair . . . under the circumstances" requirement of § 11112(a)(3) was met, courts view the facts under "the totality of the circumstances against the measuring stick of objective reasonableness," considering whether the plaintiffs met their "burden of proof to rebut the presumption of immunity under the HCQIA." *Wahi*, 562 F.3d at 614.

¶53 Here, Weiner's argument that he was denied notice and due process concerns only his October 15, 2020 summary suspension and his November 17, 2020 summary suspension, which we have concluded were exempt from predecisional process because imminent danger to the health of an individual may have occurred absent the peer reviewers taking action. Weiner received the notice and due process in accordance with the standards set forth in § 11112(b) for the professional actions occurring on November 23, 2020, and December 15, 2020. Therefore, with respect to all four professional review actions, SPH

provided adequate notice and hearing procedures, or was otherwise exempt from doing so under the imminent harm exception.

5. Whether the professional review action was taken "in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the [third] requirement. . . ." 42 U.S.C. § 11112(a)(4).

¶54 The CC summarily suspended Weiner on October 15, 2020, in response to the University of Utah's review of an oncology case where Weiner prescribed chemotherapy and immunotherapy for 11 years to PT1 despite the absence of a confirmed diagnosis of cancer. Even if PT1 were to have had cancer, Weiner's clinical practices fell below the standard of care when he repeatedly altered the patient's treatment without receiving repeat biopsies documenting malignancy. After receiving this report, the peer reviewers determined to elevate the peer review to the CC and launch a full investigation. The CC summarily suspended Weiner's privileges so it could conduct its investigation without the risk of more cases jeopardizing an individual's health like the one that prompted the investigation. The CC acted in the reasonable belief that this action was warranted pursuant to § 11112(a).

¶55 SPH received additional reports from external peer reviewers. These reports concluded that several of Weiner's patients were receiving treatment for conditions for which he had failed to provide documented evidence to support the diagnosis. The reports further noted that some patients' conditions worsened due to Weiner's substandard care. Additionally, the reports indicated that Weiner prescribed high doses of narcotics to patients for conditions that were outside the scope of his clinical privileges or in quantities that were

dangerous and inappropriate. Weiner also failed to have his opioid-prescription patients sign pain contracts and to monitor these patients for signs of abuse. In addition to the first case reviewed, six more cases were categorized as demonstrating substandard care. To ameliorate future patient harm, the peer reviewers decided to continue Weiner's summary suspension on November 23, 2020. Weiner's numerous, significant deviations from sound clinical practices warranted this second action, which was objectively reasonable under the circumstances.

¶56 On November 30, 2020, the CC met with Weiner as it contemplated what corrective action it might recommend to the MEC. During the discussion, Weiner acknowledged that his patient volume had been "extraordinary [sic] high for many years," often seeing 70 patients per day, but he was unsure whether this negatively influenced his ability to adequately document patient charts. The CC inquired into Weiner changing patients' code status without their consent; he denied doing so. The CC inquired into Weiner's patients being prescribed phenobarbital and dying soon after receiving the prescribed dosage. At the conclusion of the meeting, the CC voted to recommend revoking Weiner's clinical privileges. The professional review action in revoking Weiner's privileges and memberships was reasonable and warranted due to the quantity and severity of Weiner's inappropriate patient care.

¶57 Finally, the MEC's December 15, 2020 decision to adopt the CC's recommendation of revocation of Weiner's medical membership and privileges was warranted based on the facts and information known by the peer reviewers. The MEC wholistically reviewed the investigation's findings. This included a review of 20 cases peer reviewed by the PRC, six

cases peer reviewed by the University of Utah, 93 cases peer reviewed by Greeley Consulting, and five cases peer reviewed by an independent medical oncologist. The concerns raised from these reports were grouped into six categories: "patient volume, conduct, coordination with other providers, medical errors, documentation, and controlled substance prescribing." Considering the CC's recommendation which was based on peer-reviewed cases and facts, the MEC voted to adopt the CC's recommendation to revoke Weiner's privileges. We conclude the December 15, 2020 professional review action was taken in the reasonable belief that it was warranted based on the facts at the time the decision was made. Weiner had appropriate notice and process regarding both the November 17, 2020 and December 15, 2020 professional review actions.

¶58 Applying the objective, reasonable-belief standard here, the fourth requirement of § 11112(a) was satisfied for all four actions because SPH, with the information available to them at the time of each professional review action, would reasonably have concluded that their action would restrict incompetent behavior or would protect patients.

¶59 The facts here validate the statutory presumption that the professional review body complied with the HCQIA, as the MEC's decision to revoke Weiner's privileges at each of the four professional review actions objectively was reasonable and warranted. Weiner has failed to satisfy his burden of producing sufficient evidence that would allow a reasonable jury to conclude by a preponderance of the evidence that SPH is not entitled to statutory immunity under the HCQIA. SPH, accordingly, may not be found liable for damages arising from their professional review actions. The HCQIA provides that no professional review body or any person acting as a member or staff of that body or who assists the

professional review body with respect to the action shall be liable in damages under any law of the United States or of any state. SPH is entitled to immunity for damages because there is no dispute of material fact that Weiner has not rebutted the presumption of immunity for damages and that SPH has met all obligations under the HCQIA.

CONCLUSION

¶60 The parties filed cross motions for summary judgment contending that there was no material dispute of fact and that each was entitled to judgment as a matter of law. The District Court considered the material facts and concluded that Weiner had not rebutted the presumption contained in the HCQIA that SPH's professional review actions met the HCQIA standards and were therefore entitled to immunity. The District Court did not err. After a thorough review of the record and Weiner's claims, we conclude that all his claims arose out of the professional review actions taken by SPH and that Weiner has failed to rebut the presumption entitling SPH to immunity against damages for the claims addressed in the District Court's certification order.

¶61 Affirmed.

/S/ LAURIE McKINNON

We Concur:

/S/ JAMES JEREMIAH SHEA
/S/ INGRID GUSTAFSON
/S/ BETH BAKER
/S/ JIM RICE