No. 09-____

In the Supreme Court of the United States

RAKESH WAHI, M.D.,

Petitioner,

v.

CHARLESTON AREA MEDICAL CENTER, *et al.*,

Respondents.

ON PETITION FOR A WRIT OF CERTIORARI TO THE UNITED STATES COURT OF APPEALS FOR THE FOURTH CIRCUIT

PETITION FOR A WRIT OF CERTIORARI

KENNETH W. STARR
24569 Via De Casa
Malibu, CA 90265
(310) 506-4621

GENE C. SCHAERR
Counsel of Record
ANDREW C. NICHOLS
Winston & Strawn LLP
1700 K Street, NW
Washington, DC 20006
(202) 282-5000

LETITIA NEESE CHAFIN
H. TRUMAN CHAFIN
The H. Truman Chafin Law Firm
P.O. Box 1799
Williamson, WV 25661
(304) 235-2221

Counsel for Petitioner

PUBLIC VERSION

WILSON-EPES PRINTING CO., INC. – (202) 789-0096 – WASHINGTON, D. C. 20002

Blank Page

QUESTIONS PRESENTED

1. The Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152, provides a hospital immunity from monetary damages for disciplining a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, the Act allows disciplining "immediately"—that is, *before* notice and a hearing or other "fair" procedures—only where "failure to take such an action may result in an imminent danger to the health of any individual." § 11112(c).

   Did the court below err in holding, in conflict with four other circuits, that a hospital can obtain immunity for disciplining a doctor immediately—before notice and a hearing—where the hospital concedes that it did not find or rely upon the possibility of imminent danger?

2. Under the Act, may an immunity determination be made by a jury, as the First and Tenth Circuits hold, or is a jury forbidden from making such a determination, as the Eleventh Circuit and Colorado Supreme Court hold—and as the Fourth Circuit effectively held here?

PARTIES TO THE PROCEEDINGS

Petitioner Rakesh Wahi was the plaintiff-appellant in the court below. Respondents Charleston Area Medical Center, Inc., Glenn Crotty, Jamal Kahn, H. Rashid, K.C. Lee, Andrew Vaughn, and John L. Chapman were defendant-appellees below. There are no other parties.

TABLE OF CONTENTS

CONTENTS OF APPENDIX

Page

Document

TABLE OF AUTHORITIES

Page(s)

CASES

TABLE OF AUTHORITIES (Cont.)

STATUTES

TABLE OF AUTHORITIES (Cont.)

Blank Page

INTRODUCTION

By twice misinterpreting the Health Care Quality Improvement Act, 42 U.S.C. §§ 11101-11152 ("HCQIA"), the decision below has created a new circuit split *and* widened a mature, acknowledged split on the federal standards for physician peer-review immunity. These twin errors are of signal importance to the health care industry and patients nationwide because they allow hospitals to summarily strip doctors of their credentials without any justification, depriving them of their livelihoods—and then take away their right to a jury.

The court of appeals' first error concerns immunity for a summary suspension of hospital privileges. Under the HCQIA, a hospital is immune from monetary damages for disciplining a doctor "*after*" providing "notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). By contrast, a hospital can discipline "immediately"—that is, *before* "notice and a hearing" or other "fair" procedures—only in "emergencies," when "failure to take such an action may result in an *imminent danger* to the health of any individual." § 11112(c)(2) (emphasis added). But even then, immunity is "subject to subsequent notice and hearing or other adequate procedures." *Ibid.*

Here, while conceding that petitioner was suspended immediately—that is, before receiving "notice and a hearing" or other "fair" procedures—the Fourth Circuit held that the hospital could ignore the "imminent danger" requirement and still obtain immunity if it *later* "me[t] the usual standard" of providing notice and a hearing or other fair procedures. In other words, under the decision below, a

doctor can be immediately suspended—without any "imminent danger"—so long as the hospital provides some procedures at some point.

This judicial rewriting of Congress' carefully calibrated regime is indefensible, as shown by four contrary circuit decisions squarely holding that, to preserve immunity for a summary suspension, imminent danger is required. Because the Fourth Circuit's reasoning is so obviously flawed, and because respondent *concedes* that it suspended petitioner "without a prior finding that he posed an imminent danger," Pet. 81a, the Fourth Circuit's resolution of this issue would be suitable for summary reversal.

With its second error, the decision below widens an acknowledged split over the availability of jury trials to determine federal immunity. The First Circuit holds that the statute "contemplates a role for the jury, in an appropriate case, in deciding whether a defendant is entitled to HCQIA immunity." *Singh* v. *Blue Cross/Blue Shield of Mass., Inc.*, 308 F.3d 25 (1st Cir. 2002). Indeed, "[t]he weight of authority" holds that the proper inquiry is "whether *a reasonable jury* could find that the defendants did not conduct the relevant peer review actions in accordance with one of the HCQIA standards." *Id.* at 33 (citing cases; emphasis added). The Tenth Circuit has reached the same conclusion. *See Brown* v. *Presbyterian Healthcare Servs*, 101 F.3d 1324 (10th Cir. 1994).

While the court below framed the issue in terms of what a "reasonable jury" could have concluded (see Pet. 14a), its application of this standard makes it clear that the Fourth Circuit will never send an HCQIA immunity issue to a jury. That court thus

aligned itself with the Eleventh Circuit, which, in acknowledged "*contradiction of the other circuits*," *Singh*, 308 F.3d at 34 n.7 (emphasis added), holds that "*[u]nder no circumstances* should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury," *Bryan* v. *James E. Holmes Regional Med. Ctr.*, 33 F.3d 1318, 1333 (11th Cir. 1994) (Tjoflat, C.J.). The Supreme Court of Colorado holds the same, *North Colorado Medical Center* v. *Nicholas*, 27 P.3d 828 (Colo. 2001), setting up an intra-state conflict with the Tenth Circuit.

The need for this Court's review is heightened by important practical and policy considerations. Granting hospitals blanket immunity for issuing what amount to summary professional death sentences will seriously compromise our nation's health care system—ruining careers, wasting expertise, and depriving patients of innovative and compassionate medical care. Indeed, as the due process requirements of the HCQIA reveal, the statute is designed to protect patients *and* doctors—not (as here) hospitals that punish excellent doctors for entertaining employment opportunities with competing hospitals.

This Court has not yet construed the landmark, two-decades-old HCQIA. It is thus all the more important—and timely—that the Court make clear that the HCQIA means what it says about what is required to issue an immediate suspension, and that doctors who build powerful records like the one here are entitled to take their cases to a jury.

OPINIONS BELOW

The opinion of the district court is reprinted in the appendix to this petition at 43a-74a, and is reported at 453 F. Supp. 2d 942 (S.D.W. Va. 2006). The Fourth Circuit's opinion affirming the decision of the district court (1a-40a) is reported at 562 F.3d 599 (4th Cir. 2009). The Fourth Circuit's order denying rehearing *en banc* (41a-42a) is unreported.

JURISDICTION

The opinion of the Fourth Circuit was entered on April 10, 2009, and the order of the Fourth Circuit denying petitioner's petition for rehearing *en banc* was entered on May 8, 2009. On July 28, 2009, Chief Justice Roberts extended the time for filing this petition to and including September 15, 2009. This Court has jurisdiction pursuant to 28 U.S.C. § 1254(1).

STATUTORY PROVISIONS INVOLVED

This petition involves the HCQIA's "[s]tandards for professional review actions," 42 U.S.C. § 11112, which are reprinted in total in the appendix at 76a-79a, and which govern the federal immunity provided under section 11111 of the Act. Subsection (a) of those standards provides:

> **(a) In general**
>
> For purposes of the protection set forth in section 11111(a) of this title, a professional review action must be taken—
>
> (1) in the reasonable belief that the action was in the furtherance of quality health care,

(2) after a reasonable effort to obtain the facts of the matter,

(3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and

(4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

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

42 U.S.C. § 11112(a).

Subsection (c) provides:

(c) Adequate procedures in investigations or health emergencies

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

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

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

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

(2) precluding an immediate suspension or restriction of clinical privileges, subject to subsequent notice and hearing or other adequate procedures, where the failure to take such an action may result in an imminent danger to the health of any individual.

42 U.S.C. § 11112(c).

STATEMENT

In 1986, Congress passed the HCQIA to improve the quality of medical care by subjecting doctors' competence and professionalism to "effective professional peer review" that meets certain standards of due process. 42 U.S.C. §§ 11101(1), (3), 11112. In so doing, "[t]he statute attempts to balance the chilling effect of litigation on [physician] peer review with concerns for protecting physicians improperly subjected to disciplinary action." *Bryan*, 33 F.3d at 1333. In this case, the court below has dramatically altered that balance—in defiance of the HCQIA's plain language, in conflict with four other circuits, and at great cost to petitioner and our nation's health care system.

A. Statutory Framework

To strike the desired balance between effective peer review and protecting doctors from unjustified discipline, the HCQIA provides immunity from monetary damages for what the statute calls "professional review action[s]," 42 U.S.C. § 11111(a)(1), so long as those actions comply with certain statutory "safe harbor" procedures, § 11112(b). One safe harbor governs actions taken in the normal course of business, *ibid.*; a separate provision governs actions

taken "in investigations or health emergencies," 42 U.S.C. § 11112(c).

1. "Professional review actions." Under the HCQIA, "professional review action" is defined as:

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

§ 11151(9). Under this definition, a separate professional review action occurs *whenever* privileges are restricted. Thus, a suspension of privileges is a separate professional review action from outright revocation or a refusal to renew privileges. See *Poliner* v. *Texas Health Sys.*, 537 F.3d 368, 377 (5th Cir. 2008). Further, certain professional review actions must be reported to a national database, the National Practitioner Data Bank or NPDB, which a hospital must consult before hiring a physician. 42 U.S.C. §§ 11133-11135.

2. Due process requirements. For professional review actions not taken in "investigations or health emergencies" (42 U.S.C. § 11112(c)), the HCQIA provides a detailed list of procedures that, if followed, will enable a health care entity to be "deemed" protected under the statute. These include "adequate notice and hearing procedures"—which involve providing notice of the proposed action, the reasons for the action, and notice that the physician

has a right to request a hearing. §§ 11112(a)(3), 11112(b)(1). If the physician requests a hearing, the hospital "must" provide "notice stating—(A) the place, time, and date, of the hearing * * * and (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body." § 11112(b)(2)(A), (B).

While meeting these requirements automatically qualifies a health care entity for HCQIA protection, "failure to meet the [notice and hearing list of] conditions shall not, in itself, constitute failure to meet the [adequate notice and hearing procedures] standard." § 11112(b). Rather, the standard may be met by "[o]ther procedures that are fair to the physician under the circumstances." § 11112(a)(3). Further, a "professional review action shall be presumed to have met the [adequate notice and hearing standards] * * * unless the presumption is rebutted by a preponderance of the evidence." § 11112(a)(4).

3. "[I]mmediate suspension." All notice and hearing procedures can be temporarily foregone, however, in the case of "health emergencies." § 11112(c)(2). Thus, "an immediate suspension or restriction of clinical privileges" is not "preclude[ed]" "where the failure to take such an action may result in an imminent danger to the health of an individual" *and* "notice and hearing or other adequate procedures" are later provided. *Ibid.*

B. Background of This Dispute

A highly skilled heart surgeon whose professional training includes service at the legendary Mayo Clinic, Dr. Rakesh Wahi was recruited in 1992 from a successful surgical practice in Chicago by the Charleston Area Medical Center ("CAMC") in Charleston, West Virginia. JA 98. Measured by CAMC's own criteria and national standards, Dr. Wahi achieved the best patient outcomes at CAMC. PFN 37-38, 40.[1] The mortality rate for Dr Wahi's patients was three times *lower* than the national average; and CAMC entrusted Dr. Wahi with the care of its high-risk patients. PFN 37-38, 40. In July 1994, Dr. Wahi launched his own surgical practice and began exploring the possibility of associating with surgeons at a neighboring hospital, Raleigh General. .JA 967.

1. CAMC's investigations and Dr. Wahi's exoneration. During the next few years, CAMC repeatedly investigated and temporarily suspended Dr. Wahi. Pet. 3a-4a. While these investigations were being conducted, however, the duly constituted peer review committee of CAMC charged with continuously monitoring CAMC's physicians evaluated Dr. Wahi's treatment of his patients and found it to be within the required standard of care. JA 967, 1015. And in April 1999, CAMC's Credentials Committee recommended Dr. Wahi's reappointment to the medical staff at CAMC for another year. JA 532, 963.

---

[1] "PFN" stands for "Plaintiff's Fact Number," and refers to the paragraph number in the Statement of Controverted Material Facts and Counterstatement of Material Facts in the district court.

But shortly thereafter, when Dr. Wahi began treating a patient who had been referred to Dr. Wahi by Bluefield Regional Hospital—approximately 100 miles away—the Credentials Committee abruptly rescinded its favorable recommendation without notifying Dr. Wahi. JA 572-73, 975. The Committee then formally asked CAMC's Chief of Staff to conduct an "investigation and an appropriate suspension of Dr. Wahi's clinical privileges for treating the Bluefield patient." JA 572.

Before the investigation began, however, the Committee tentatively concluded that treatment of the patient was outside the scope of Dr. Wahi's delineated clinical privileges. *Ibid.* Specifically, Dr. Wahi was accused of caring for a patient (who was in his fifties) that CAMC deemed too high-risk. There was no dispute that Dr. Wahi's surgery benefited the patient. JA 721, 730-732, 744.

Led by senior CAMC officials, the investigation report exonerated Dr. Wahi. With the help of an external reviewer, the Chief of Staff conducted the investigation along with the Chief of the Department. Together, they concluded that Dr. Wahi's treatment "did *not* fall outside of his delineated clinical privileges." JA 964. (emphasis added).

2. CAMC's summary suspension of Dr. Wahi. Despite this exculpatory report, CAMC took an adverse "peer review action" against Dr. Wahi, directing its Chief of Staff to immediately suspend Dr. Wahi's privileges. JA 189, 600-602, 965. Two days later, CAMC notified Dr. Wahi of the suspension. Notably, the letter was bereft of any suggestion that

Dr. Wahi posed an imminent danger to his patients or any "danger" at all. JA 586.

Indeed, CAMC's Chief of Staff was later asked: "If you had seen a danger to the patient would you have taken steps to stop it then?" He responded, "Absolutely." JA 609. Further, the Chief of Staff testified that "Dr. Wahi [was allowed] to manage the medical treatment of the two patients currently in-house" *after* his summary suspension. JA 605-06. And with respect to that continuing treatment, the Chief of Staff was asked and answered as follows:

> Q: Would you have allowed him to continue with that treatment after the suspension if you thought he posed an imminent danger to those two patients?
>
> A. No.

JA 605-06.

Further, the Chief of Staff's Note to file, dated two days after the summary suspension, and describing its rationale, makes no reference to imminent danger. Rather, it concerns Dr. Wahi's "inability to follow procedural guidelines outlined by the Committee" and "diminishing trust between us and him, as well as the Credentials Committee and him." JA 965. Witnesses, staff members, and physicians consistently disclaimed any finding of or reliance upon any imminent danger. JA 322, 600, 800, 830, 887, 1006-1008, 1012.

A second letter in August 2009 stated that Dr. Wahi was entitled to a hearing if a written request

was received within four weeks.[2] Less than two weeks later, Dr. Wahi submitted a written request for a hearing. JA 648. Dr. Wahi also requested: (i) a more particularized statement of the charges; (ii) the factual predicate for the charges; (iii) access to related documents in CAMC's possession; and (iv) a list of witnesses that CAMC intended to call. JA 649-650.

Almost three months later, CAMC notified Dr. Wahi that a panel had been appointed to hear his appeal. JA 672-78. The letter said that senior CAMC *lawyers* would both serve as the presiding officer and represent CAMC. *Ibid.* The letter did not, however, provide a date or time for the hearing; nor did it identify CAMC's proposed witnesses. Another letter was sent to the Board members, requesting that they work with the President to schedule a hearing. JA 654. CAMC's lawyer sent two letters to Dr. Wahi that, among other things, asked him to let CAMC know about any dates that were particularly bad. But CAMC never provided Dr. Wahi a witness list—which would have enabled him to determine how long he would need to prepare, whom he should call as *his* witnesses, and when they were available for a hearing. Nor did CAMC itself schedule the hearing even though, in its final letter, it assured Dr. Wahi that it *would* set the hearing. JA 699. CAMC, moreover, never provided Dr. Wahi with the required witness list. Pet. 26a, 30a.

---

[2] This letter also notified Dr. Wahi that the Credentials Committee had recommended that he be denied reappointment to the medical staff. JA 647. But that request has never been acted upon by CAMC's board.

Faced with CAMC's declared plan to set a hearing conducted by its own lawyers, and without providing a list of witnesses, in 2000 Dr. Wahi filed suit in West Virginia state court, requesting that a fair hearing panel review his suspension and denial of reappointment. JA 99-114. CAMC opposed Dr. Wahi's request, arguing that the state court need not intervene because CAMC was going forward with the hearing and would replace the panel members, including the presiding officer. JA 181, 183-187. Based on these representations, the court dismissed Dr. Wahi's suit without prejudice. JA 131-146.

3. Further exoneration by the West Virginia Board of Medicine. Rather than provide Dr. Wahi the hearing it promised, CAMC requested that the West Virginia Board of Medicine prosecute him. JA 147-150, 701. In November 2003, however, the Board dismissed CAMC's charges with prejudice, JA 254-265, as it had done with CAMC's two previous complaints against Dr. Wahi. The Board ordered all charges to be expunged from Dr. Wahi's record. JA 248-253.

C. This Litigation

That same year, Dr. Wahi filed suit alleging that CAMC's actions were taken, among other things, pursuant to a conspiracy by CAMC to monopolize thoracic and cardiovascular medicine and surgery "in the Charleston, Beckley, Bluefield, and Parkersburg area of West Virginia." Pet. 47a. CAMC defended on the ground that its actions were immune under the HCQIA. 48a.

1. The district court's grant of summary judgment without addressing the "imminent danger" requirement. The district court awarded summary judgment of HCQIA immunity to CAMC. It did so without considering Dr. Wahi's argument that his summary suspension was invalid because it was not justified by the requisite "imminent danger"—even though that issue had been raised and briefed extensively. Opp. to MSJ at 41-47.

Instead, the district court simply declared that Dr. Wahi received "procedures as are fair * * * under the circumstances" because he received, but had not responded, to two letters asking him to provide dates for a hearing. Pet. 57a, 60a. The district court did not explain how sending Dr. Wahi letters *after* his summary suspension remedied CAMC's failure to rely on any "imminent danger" in suspending him; how the letters constituted "procedures"; how such "procedures" were fair given CAMC's refusal to provide Dr. Wahi a witness list; why it was up to Dr. Wahi to set the hearing date when the HCQIA assigns that task to the hospital, 42 U.S.C. § 11112(b)(2)(A); or how to reconcile its conclusion with HCQIA's statement that "the right to the hearing may be forfeited," not if the doctor fails to provide hearing dates, but "if the physician fails without good cause to appear." 42 U.S.C. § 11112(b)(3)(B).

2. The Fourth Circuit's affirmance. The Fourth Circuit affirmed for essentially the reasons given by the district court—with one critical exception. Pet. 16a-31a. In contrast to the district court, the Fourth Circuit acknowledged Dr. Wahi's argument that the summary suspension was not supported by any "imminent danger." But it held that

the HCQIA's "emergencies" provision—subsection (c)—was not violated because it is *optional*.

Though CAMC had never suggested the idea, and without citing any precedent, the Fourth Circuit held that, as compared with the statute's main immunity provision—subsection (a)—the "health emergencies" provision in subsection (c) "sets out distinct ways in which a health care entity can be immune under the HCQIA *without* having complied with the usual requirements for claiming immunity." Pet. 17a; *accord id.* (health emergencies provision "presents additional routes to HCQIA immunity beyond that set forth in [adequate notice and hearing provisions]").

Consequently, the court reasoned, "[a]lthough Wahi may be correct that the facts show CAMC cannot assert immunity based on [the "health emergencies" provision of subsection (c)(2)], the only significance is that CAMC must meet the *usual* standard of qualifying for immunity set forth in [the adequate notice and hearing provisions of subsection (a)(3)]." Pet. 17a-18a. Thus, the panel concluded that the [redacted] Pet 18a n.18.

Having thus set aside the "imminent danger" requirement, the Fourth Circuit struggled to explain how Dr. Wahi received "procedures" that were "fair"—and indeed, extensively criticized CAMC. For example, the court stated that "CAMC's path to immunity in this case is not a recommended model."

Pet. 30a. In addition, "CAMC should have followed its Bylaws and the Procedures manual and provided Wahi a witness list." *Ibid.* Further, CAMC should have "simply set a prompt hearing." *Ibid.* According to the court, these were all "failures by CAMC." *Ibid.*

Whether CAMC would be immune despite these many "failures," the court acknowledged, would turn on "whether a reasonable jury, viewing all facts in a light most favorable to [Wahi], could conclude that he had shown, by a preponderance of the evidence, that [CAMC's] actions fell outside the scope" of the HCQIA's adequate notice and hearing provisions. Pet. 14a. But because Dr. Wahi did not provide "dates for a hearing" when asked—and solely for that reason—the Court concluded that Dr. Wahi had not "rebut[ted] the presumption that CAMC's actions satisfied" the HCQIA. *Id.* at 21a, 30a. And on that basis, the Fourth Circuit affirmed.

REASONS FOR GRANTING THE PETITION

Review is needed to resolve two circuit splits—one created by the decision below, the other widened by it. Moreover, by immunizing summary suspensions without the statutorily required possibility of imminent danger, and then denying the doctor an possibility of a jury trial, the Fourth Circuit has handed hospitals an all-purpose shield that will immunize them in virtually every case. Individually, each of the Fourth Circuit's errors flouts the HCQIA; but together they effectively make the HCQIA useless to protect doctors from sham peer review. Left uncorrected, the cost of this judicial failure will be counted, not only in ruined careers, but in artificially high prices caused by lack of competition, dimin-

ished innovation, and lack of adequate care for high-risk patients—particularly those residing within the Fourth Circuit.

I. With its misreading of the HCQIA, the decision below creates a conflict with decisions of the Third, Fifth, Eighth, and Ninth Circuits.

Reflecting the congressionally ordained balance between quality care and fairness, the HCQIA's general provisions—in subsection(a)—provide a hospital with immunity from damages when it disciplines a doctor "*after*" providing "adequate notice and hearing" or other "fair" procedures. § 11112(a)(3) (emphasis added). Different standards apply, however, if the hospital disciplines the doctor "immediately"—that is, *before* notice and a hearing or other "fair" procedures. In that situation, the subject of subsection (c), immunity is "preclude[d]"—unless "failure to take such an action may result in an imminent danger to the health of any individual" *and* "subsequent notice and hearing or other adequate procedures" are provided. § 11112(c)(2) (emphasis added).[3] The Fourth Circuit re-wrote this sensible standard and, in so doing, placed itself in conflict with several other circuits.

---

[3] Subsection (c)(1) also allows a hospital to suspend a doctor pending an "investigation." *Id.* § 11112(c)(1). But CAMC has never invoked this provision, no doubt because the record shows that the hospital's "investigation"—such as it was—had *already* been completed when Dr. Wahi was suspended.

A. The decision below flouts the plain language of the HCQIA.

In the court below, Dr. Wahi argued that CAMC "cannot claim immunity" because it summarily suspended him "without first finding that he posed an imminent danger to his patients." Pet. 16a. But the Fourth Circuit held that, even where summary suspension is at issue, the possibility of imminent danger is *optional*:

> [S]ubsection (c) presents additional routes to HCQIA immunity beyond that set forth in subsection (a)(3). Although Wahi may be correct that the facts show that CAMC cannot assert immunity based on (c)(1) or (c)(2), the only significance is that CAMC must meet the usual standard of qualifying for immunity set forth in subsection (a)(3).

Pet. 17a. Consistent with that logic, the Fourth Circuit reasoned that, as to the "imminent danger" provision, [redacted] Pet 18a n. 18.

1. The Fourth Circuit's approach violates the plain text of the "emergencies" provision. By its terms, that provision "*preclude*[s]" immunity for an "immediate suspension" unless two conditions are met: first, it must be the case that "failure to take such action may result in an imminent danger to the health of an[] individual"; and second, the doctor must be provided "subsequent notice and hearing or other adequate procedures." 42 U.S.C. § 11112(c)(2) (emphasis added).

It cannot be true, then, that a hospital can take an alternative "route" to immunity for a summary suspension merely by "meet[ing] the usual standards of qualifying for immunity set forth in subsection (a)(3)." Pet. App. 17a-18a. To meet the standard of subsection (a)(3), the required notice, hearing, and/or "other procedures" must occur "*before*" the "*proposed*" peer review action—here, a suspension. § 11112(a)(3), (b)(1) (emphasis added). By definition, however, in the case of an immediate suspension such procedures occur *after* the suspension—by which point the "proposed" action is not merely "proposed," but has already occurred. Such post-discipline procedures therefore cannot satisfy the requirement that the procedures come "before" the discipline.

Furthermore, the Fourth Circuit's reading would eliminate from the "emergencies" provision the phrase "imminent danger." The substantive requirements of subsection (a)(3)—"adequate notice and hearing" or "other fair procedures"—are repeated in the "emergencies" provision, which expressly requires such procedures "subsequent" to an immediate suspension. § 11112(c)(2). Thus, Congress considered whether providing later procedures constituted an "additional route[]" to immunity (Pet. 17a), and decided that it did—but only "*where the failure to [suspend] may result in an imminent danger.*" § 11112(c)(2) (emphasis added). The decision below reads this phrase out of existence, rendering the "additional" route no different than the original. This is re-drafting in the guise of interpretation.

2. The Fourth Circuit's interpretation also contravenes the "emergencies" provision's express pur-

pose. By creating a provision for "emergencies," Congress ensured that, when a hospital issues what amounts to a nationally published professional death sentence, there is an exigent reason for it—namely, that patient health "may" be in "imminent danger." § 11112(c)(2).

It is thus preposterous to suppose, as the Fourth Circuit's holding requires, that Congress intended hospitals (1) to be able to defrock doctors without warning when there is no "emergenc[y]," and (2) to cure that assault on a doctor's rights by providing him "notice and a hearing" later on. Notice of what? By then the doctor has already lost his job and livelihood—information he will have *already* learned when his summary suspension letter arrives in the mail or he arrives at the hospital only to be turned away.

This deeply flawed interpretation should not be allowed to stand. Indeed, if the Court so chose, it would be a good candidate for summary reversal.

B. The decision creates a conflict with decisions in four other circuits.

Whereas no court has taken the course of the Fourth Circuit here, four circuits squarely hold that, when a hospital such as CAMC imposes a summary suspension, a showing of "imminent danger" is required. The decision below thus creates a circuit split that subjects doctors in the Fourth Circuit to a substantial risk not faced by doctors practicing in the rest of the Nation.

1. The Ninth Circuit's decision in *Fobbs* v. *Holy Cross Health Sys. Corp.*, 29 F.3d 1439 (9th Cir. 1994), *partially overruled on other grounds in Davi-*

ton v. *Columbia/HCA Healthcare Corp.*, 241 F.3d 1131 (9th Cir. 2002), is particularly instructive. There, a doctor argued that "defendants' manner of giving him notice" of his discipline was unfair "barring an emergency 'threatening imminent danger.'" *Fobbs* v. *Holy Cross Health Sys. Corp.*, 789 F. Supp. 1054, 1068 (E.D. Cal. 1992). But the district court ducked the question whether "imminent danger" justified the notice afforded, changing the subject by pointing out that "[t]here is no dispute that plaintiff was given notice" of *later* "hearings." *Ibid.*

The Ninth Circuit rejected the district court's attempt to rely on this later notice; instead, it published a decision holding that a finding of imminent danger *is* required. Then, in response to the doctor's argument that "the statute requires that there *be* 'imminent danger to the health of any individual' before there may be a summary restriction," the Ninth Circuit held that the statute "*requires* that the danger *may* result." 29 F.3d at 1443 (first emphasis added).

Here, by contrast, instead of ducking the question of imminent danger, the Fourth Circuit erroneously and inexplicably construed it as optional. But *Fobbs* forbids that as well. Because *Fobbs* holds that the HCQIA "requires" (*ibid.*) that danger may result, and because the decision plainly teaches that notice of a later hearing is not enough (else the opinion would not have been published), the Fourth Circuit's holding that later notice and procedures *are* enough is in plain conflict with *Fobbs*.

2. The decision below also conflicts with decisions of the Fifth, Eighth, and Third Circuits.

In *Poliner*, for example, a doctor's privileges were temporarily suspended "to allow for an investigation to determine whether other action, such as a suspension, was necessary." 537 F.3d at 382. After the investigation committee "concluded that [the doctor] gave substandard care in half of the cases reviewed, and considering the seriousness of the diagnostic error" in a "cardiac catheterization," the Fifth Circuit reasoned that "Defendants were fully warranted in concluding that failing to impose further temporary restrictions 'may result' in imminent danger." *Ibid.*

Nor was this conclusion optional: The Fifth Circuit held that a finding that "failure to act 'may result in an imminent danger to the health of any individual" was "*require[d].*" *Ibid.* (quoting 42 U.S.C. § 11112(c)(2)) (emphasis added).

The court then explained how "the process provisions of the HCQIA work in tandem":

> legitimate concerns [i.e., the possibility of imminent danger] 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. The hearing process is allowed to play out unencumbered by the fears and urgency that would necessarily obtain if the physician were midstream returned to full privileges during the few days necessary for a fully informed and considered decision * * * *.

537 F.3d at 384 (emphasis added). When the doctor in *Poliner* countered that summary suspension was only allowed in "extraordinary cases in which a physician suddenly becomes impaired or grossly incom-

petent," the Fifth Circuit ruled that "the plain language of the statute is not so limited"—but in so doing cited multiple cases from other courts *requiring* at least the possibility of "imminent danger." *Id.* at 382-383 & n.48.

At every turn, CAMC departed from this statutory roadmap—including skipping the required judgment about imminent danger. To begin with, the Chief of Staff conducted his investigation, which paralleled an outside investigation, *without* suspending Dr. Wahi. This suggests that there was no imminent danger to anyone—a conclusion confirmed when the Chief of Staff reported that Dr. Wahi's treatments "did *not* fall outside of his delineated clinical privileges." JA 964 (emphasis added).

Then, however, as CAMC admitted, "CAMC * * * suspend[ed] [Dr. Wahi] *without* a prior finding that he posed an imminent danger." Pet. 81a (emphasis added). And on that same day, Dr. Wahi was allowed to treat two patients. JA 605-606. It was only afterward that the parties began negotiating over the hearing that became the focus of the Fourth Circuit's decision. See Pet. 27a-31a.

By that time, though, the statutory scheme described in *Poliner* had already been shredded. Albeit under protest, Dr. Wahi was negotiating for a hearing under a statutorily invalid summary suspension. Under the plain language of the HCQIA and the holding of *Poliner*, CAMC had already forfeited its immunity—by suspending Dr. Wahi *without* concluding that there was any possibility of imminent danger.

Like the doctor in *Poliner*, the doctor in *Sugarbaker* v. *SSM Health Care*, 190 F.3d 905 (8th Cir. 1999), also argued that the defendant hospital's "precautionary suspension was improper." *Id.* at 917. The Eighth Circuit upheld the suspension, however, only because "review of 24 of Dr. Sugarbaker's surgical cases raised concerns" about patient safety, and because "under the HCQIA's emergency provisions, summary suspensions * * * do not result in the loss of immunity 'where the failure to take such an action may result in an imminent danger to the health of any individual.'" *Ibid.* (quoting 42 U.S.C. § 11112(c)(2)). When the doctor objected that he had no patients at the time of the suspension and thus any supposed danger could not have been imminent, the court observed that the statute merely "*requires*" the possibility of imminent danger—a condition amply met there. *Ibid.* (quoting *Fobbs*, 29 F.3d at 1443 (emphasis added)). Chief Judge Becker reached the same conclusion for the Third Circuit in *Brader* v. *Allegheny General Hospital*, 167 F.3d 832 (3d Cir. 1999).[4]

---

[4] There, a doctor challenged a hospital's decision to "summarily suspend" his privileges to repair abdominal aortic aneurisms ["AAA"] after, among other things, the director of the Division of General Surgery observed a patient die on the operating table "from bleeding from the injuries" sustained *during surgery*. 167 F.3d at 835. The doctor complained that the hospital "did not give [him] advance warning" before his AAA privileges were "summarily suspended." *Id.* at 842. The Third Circuit, however, held that the suspension was "covered by § 11112(c), which provides that the [adequate notice and hearing provisions] do not preclude an immediate suspension * * * where the failure to take such an action may result in an imminent danger to the health of any individual." *Ibid.*

In these circuits, the cases foreclose the Fourth Circuit's holding that a finding of imminent danger is optional. All four circuits have already held it is required. *Fobbs*, 29 F.3d at 1443 ("requires"); *Poliner*, 537 F.3d at 382 ("requires"); *Sugarbaker*, 190 F.3d at ("requires"); *Brader*, 167 F.3d at 842 (immunized suspension not "preclude[d]" with finding of imminent danger).

C. The decision below is an especially attractive candidate for review because CAMC concedes it did not rely on any imminent danger.

This case is a particularly good candidate for review and resolution of this issue because there is no question whether CAMC made a finding of imminent danger or relied upon any such finding in suspending Dr. Wahi. CAMC has expressly conceded it did not.

In the court below, Dr. Wahi focused extensively in his opening brief on the lack of a finding of imminent danger, noting that this destroyed CAMC's immunity under the plain language of the statute. Appellant's Br. at 20-24. In response, CAMC readily agreed that it did not rely on any imminent danger: It acknowledged that Dr. Wahi had been "suspend[ed] * * * without a prior finding of imminent danger," Pet. 81a, but argued that it did not thereby "violate * * * HCQIA." *Id.* According to CAMC, it nevertheless remained immune because the summary suspension was allowed under its *procedures manual.*

Because in the Ninth, Fifth, Eighth, and Third Circuits imminent danger is "required," CAMC's

concession that it suspended Dr. Wahi "without a finding of imminent danger" would have voided CAMC's immunity as a matter of law. The lack of a material factual question on this dispositive point makes this case an especially good candidate for review—and, indeed, summary reversal on this issue.

II. The Fourth Circuit widened a recognized circuit split over whether a hospital's federal immunity can be decided by a jury.

In addition to creating a circuit split over the proper construction of the HCQIA's "immediate suspension" provisions, this case deepens a pre-existing and acknowledged split involving an HCQIA plaintiff's access to a jury. This Court has long instructed that "[m]aintenance of the jury as a fact-finding body is of such importance that any seeming curtailment of the right to a jury trial should be scrutinized with the utmost care." *Chauffeurs, Teamsters, & Helpers, Local 391* v. *Terry*, 494 U.S. 558, 565 (1990) (citation omitted). Yet the decision below denies that right in all cases, in conflict with decisions of the First and Tenth Circuits, but in accord with decisions of the Eleventh Circuit and Supreme Court of Colorado.

A. The decision below effectively denies all HCQIA plaintiffs a jury trial, aligning the Fourth Circuit with the Eleventh and against the First and Tenth Circuits.

As we have shown, the summary suspension was invalid as a matter of law because CAMC concededly made no prior finding that Dr. Wahi may have posed an imminent danger. See discussion. *supra*, at 17-25. The court below avoided this conclusion only by

misreading the HCQIA's "imminent danger" requirement. But in holding that CAMC avoided that requirement by *later* providing "fair" procedures, the Court brought itself into conflict with decisions of other circuits that, at a minimum, would have required a jury to decide that question.

1. According to the Fourth Circuit, whether the procedures were "fair * * * under the circumstances" (§ 11112(a)(3)) was an exceedingly close question. Rather than applauding CAMC's approach, the Fourth Circuit firmly admonished that CAMC "should have followed its Bylaws and Procedures Manual," not to mention the requirements of the HCQIA, "and provided Wahi a witness list." Pet. 30a. Likewise, CAMC should have "simply set a prompt hearing." And so, because of these "failures by CAMC," the Fourth Circuit declared that CAMC's "path to immunity in this case is not a recommended model." *Ibid.*

Rather than send this case to a jury, however, the Fourth Circuit purported to break the tie on the issue of whether Dr. Wahi received "fair" procedures by invoking the HCQIA's presumption that hospital procedures are fair. Pet. 30a-31a. But Dr. Wahi had already overcome that presumption by establishing that CAMC had never set a hearing or provided him its list of witnesses. Indeed, if Dr. Wahi's showing had been any stronger, he would have failed to receive a jury trial for a different reason: He would have been entitled to judgment as a matter of law. Under the Fourth Circuit's reasoning, then, the category of HCQIA plaintiffs who receive jury trials is an empty set.

By effectively creating this no-jury standard, the Fourth Circuit has aligned itself with the Eleventh Circuit and the Supreme Court of Colorado. In *Bryan,* the Eleventh Circuit held that "[u]nder no circumstances should the ultimate question of whether the defendant is immune from monetary liability under HCQIA be submitted to the jury," *Bryan*, 33 F.3d at 1333.[5] The Supreme Court of Colorado reached the same conclusion in *North Colorado Medical Center* v. *Nicholas*, 27 P.3d 828, 838 (Colo. 2001) ("[i]mmunity under the HCQIA is a question of law for the court to decide").

2. At the same time that it effectively sided with these courts, the Fourth Circuit set itself against the First and Tenth Circuits, which hold that under the HCQIA jury trials may be and often are required.

For example, according to the First Circuit's decision in *Singh*, "entry of summary judgment *does* * * * *violence* to the plaintiff's right to a jury trial" unless "there are no genuine disputes over material historical facts, and * * * the evidence of reasonableness * * * is so-one sided that no reasonable jury could find that the defendant health care entity failed to meet the HCQIA standards." 308 F.3d at 36 (emphasis added). In so holding, moreover, the First Circuit recognized its square conflict with the Eleventh Circuit's decision in *Bryan*:

---

[5] Indeed, the Fourth Circuit's reasoning is more extreme than the Eleventh Circuit. At least the Eleventh Circuit allows a jury to consider certain immunity-related fact questions. *Bryan*, 33 F.3d at 1333; see also *Singh*, 308 F.3d at 34 n.7 (noting overlap between fact questions related to immunity and ultimate immunity determination).

> [g]iven *Bryan*'s internal inconsistency, and its contradiction of the other circuits' holding that a jury may in principle make a HCQIA determination we decline to adopt its designation of HCQIA determinations as pure questions of law off limits to a jury.

Id. at 35. Before the decision below, then, there was already an acknowledged circuit split over whether a jury could consider the immunity question in this case.

The decision below also pits the Fourth Circuit against the Tenth Circuit, which likewise requires jury trials when merited in HCQIA cases—and indeed, has granted such a trial. In *Brown* v. *Presbyterian Healthcare Services*, 101 F.3d 1324 (10th Cir. 1994), the court awarded a jury trial where the doctor presented only one expert witness, who was contradicted by the hospital's many experts. Despite the obvious imbalance, keeping such a difference of opinion from a jury, the court held, "would be in direct contravention to Congress' intention * * * and would abrogate the jury's responsibility to weigh the evidence and determine the credibility of witnesses." *Id. at* 1334 n.9.

Responding to an argument that in light of the strength of the hospital's case the doctor's single witness could not raise a material issue, the Tenth Circuit noted that the "entire jury system is anchored to the jurors' determination of credibility of witnesses and the weight to be given to their testimony." *Ibid.* (citation omitted). And on that basis the court *granted* a jury trial to the doctor—in

clear conflict with the Eleventh Circuit, the Colorado Supreme Court, and the decision below.

Moreover, in light of Colorado Supreme Court's later rejection of jury trials in HCQIA cases (see *North Colorado Medical Center*, *supra*), a litigant in Colorado can obtain a jury trial in federal court—under *Brown*—but *not* in state court.

In sum, by using the statutory presumption to resolve the fact issues that were clearly presented in the evidence below, the Fourth Circuit effectively created a no-jury-trial rule and thus widened an established conflict.

B. This case is an excellent vehicle with which to resolve the conflict.

This case provides an effective vehicle by which to resolve the acknowledged split on the availability of a jury trial in HCQIA cases, because there is no doubt that the Tenth and First Circuits, if they had reached the issue, would have awarded a jury trial as to either (1) whether there was the possibility of imminent danger, or (2) whether CAMC's procedures were "fair" under the circumstances, or both.

1. To be sure, we believe Dr. Wahi was and is entitled to summary judgment as to his summary suspension: By failing to make any finding or showing of the possibility of imminent danger, CAMC could not, as a matter of law, invoke the immunity provided in paragraph (c)(2). And by failing to provide any notice, hearing or other procedures *before* the suspension, CAMC could not, as a matter of law, obtain immunity under the more general provision of (a)(3). See discussion, *supra*, at 17-25. But if that were not so, Dr. Wahi would certainly be entitled to

a jury trial on CAMC's immunity for his summary suspension.

The only evidence that could possibly create a fact issue on "imminent danger" came from the deposition testimony of the CAMC official who summarily suspended Dr. Wahi but allowed him to treat patients that same day. The official admitted that he would not have allowed Dr. Wahi to treat patients if he had been an imminent danger. [redacted] Pet. 18a n.18. But CAMC has never relied upon that assertion as its basis for the summary suspension, and as noted, it conceded it never made a finding of imminent danger. Pet. 81a. But even if CAMC had relied upon the Chief of Staff's assertion, that assertion *at best* creates a genuine dispute over a material historical fact and creates a question about the Chief of Staff's credibility. Both lie squarely within the unique province of the jury. See *Anderson* v. *Liberty Lobby, Inc.*, 477 U.S. 242, 249 (1986).

Indeed, keeping a jury from addressing this issue directly contravenes the holding of the Tenth Circuit in *Brown*, which awarded a jury trial on a far lesser showing to avoid "abrogat[ing] the jury's responsibility to weigh the evidence and determine the credibility of witnesses." *Brown*, 101 F.3d at 1334 n.9. So too under *Singh*, which declares that "entry of summary judgment *does* * * * *violence* to the plaintiff's right to a jury trial unless "there are no genuine disputes over material historical facts." 308 F.3d at 36 (emphasis added).

2. Even assuming the issue of "imminent danger" could be set aside, there are certainly material issues of fact as to whether CAMC's procedures were "fair to [Dr. Wahi] under the circumstances," 42 U.S.C. § 11112(a)(3). Here again, the Tenth and First Circuits undoubtedly would have come out the other way.

The circumstances here include multiple acknowledged "failures" by CAMC, including its refusal to provide Dr. Wahi a witness list, which is why the Fourth Circuit described its "path to immunity" as "not a recommended model." Pet. 30a. The salient circumstances also include Dr. Wahi's three exonerations—with prejudice—by the State Board of Medicine. JA 248-255.

Thus, Dr. Wahi's case is far stronger than that in *Brown*, which granted a jury trial to the doctor there. As noted, in *Brown*, the doctor had a single expert witness in his favor, and the Tenth Circuit held that a jury trial was required. 101 F.3d at 1334 & n.9. Here, by contrast, Dr. Wahi has far more than a single expert supporting his position on the key factual issues. But rather than sending this sharply disputed case to a jury, the Fourth Circuit improperly "weigh[ed] the evidence and determine[d] the truth of the matter" itself. *Anderson*, 477 U.S. at 249.

In so doing, the court allowed a *single* supposed fact—Dr. Wahi's lack of response to requests for dates for a hearing, *for which he had not been provided a witness list*—to be dispositive. Here again, the court ignored numerous countervailing issues, including the following:

- how Dr. Wahi could provide dates without knowing how many witnesses there would be, who they were, which witnesses *he* thus would need to call, and when they were available;
- that the last letter to Dr. Wahi promised that *CAMC* would set the hearing, JA 699; or
- that, according to the HCQIA, "the right to the hearing may be forfeited," but only "if the physician fails, without good cause, to *appear*." 42 U.S.C. § 11112(b)(3)(B) (emphasis added).

Whether CAMC provided procedures "fair" to Dr. Wahi under these circumstances was for a jury to decide. § 11112(a)(3); Pet. 19a. Indeed, if a physician cannot go before a jury of his peers under such circumstances, the jury trial right has become essentially worthless. Cf. *Clark* v. *Columbia/HCA Info. Serv's, Inc.*, 25 P.3d 215, 223 (Nev. 2001) (reversing summary judgment of HCQIA immunity because premised merely on "[o]ne instance of an objective basis for discipline").

In short, there is unlikely ever to be a better candidate to resolve the split between the two circuits—the First and Tenth—that require jury trials in cases like this, and the two circuits—the Eleventh and the Fourth—plus the Supreme Court of Colorado, that preclude them.

III. Left undisturbed, the decision will let hospitals run roughshod over physicians' rights, to the detriment not only of doctors, but of patients and the entire health-care system.

The decision below also merits review because it is exceptionally important to the nation's health care. As the amicus brief below by the Association of American Physicians & Surgeons ("AAPS") showed, there has long been a problem of anticompetitive manipulation of peer review to eliminate innovative or popular physicians and to retaliate against physicians deemed to provide "too much" care to high-risk or critically ill patients. AAPS Br. 14-18. The Fourth Circuit's decision will compound this problem, allowing hospitals to brand doctors with a professional "scarlet letter," which by statute they must wear in all fifty states, *before any problem is found with the doctor's competence.* Not only will this deprive patients of the services of extremely talented physicians like Dr. Wahi, it will also foil Congress' "attempt[] to balance the chilling effect of litigation on peer review with concerns for protecting physicians." *Bryan*, 33 F.3d at 1322.

1. The Fourth Circuit's holding that a hospital can suspend a doctor summarily without any justification gives hospitals enormous power. And that power is uniquely devastating, not only because it can be exercised capriciously, but because it enables hospitals to "kneecap" doctors at the very threshold of litigation—preventing them from effectively protesting both the suspension *and* any later professional review action. After all, when a doctor is summarily suspended, he loses his livelihood; and is

thus handicapped in hiring a talented lawyer who can mount a defense against a powerful and well-financed hospital or health system. This is contrary to the express purpose of the HCQIA, which, by allowing summary suspensions only on the basis of "imminent danger," forbids issuing professional death sentences where risk to patients is lacking.

By eliminating jury trials, the Fourth Circuit has done violence to HCQIA's overriding purpose. The statute is crafted not only to protect the peer review process from unmeritorious challenges, but also to guard doctors from being stripped of their professional licenses without receiving basic due process. By allowing summary suspensions without justification, the Fourth Circuit destroys this congressionally ordained balance. See *Bryan*, 33 F.3d at 1322.

2. As the AAPS brief explained, the cost of this misguided decision will include not only needlessly ruined careers and wasted expertise, but the loss of innovative and compassionate medical care. Sham peer review is already a nationwide problem, which the decision below promises to make worse. See AAPS Br. 16 (citing multiple medical journals documenting epidemic of sham peer review).

Unlike the record in this case, moreover, which is notably bereft of a single patient suffering under Dr. Wahi's care, every other leading circuit court decision involved serious wrongdoing. For example:

- "the committee concluded that 27" of Dr. Mathews' "cases evidenced a substandard level of care" and "[t]wenty-three of those cases * * * involved spine surgery," *Mathews* v. *Lancaster Gen. Hosp.*, 87 F.3d 624, 629 (3d Cir. 1996);

- "review of 24 of Dr. Sugarbaker's surgical cases raised concerns with respect to Dr. Sugarbaker's practice," *Sugarbaker*, 190 F.3d at 917;
- "of the 5 people who had done [a certain type of procedure] one surgeon accounted for 50 percent of the mortality," and "[t]hat one surgeon was Brader," *Brader*, 167 F.3d at 836.

Thus, while the Fourth Circuit characterized Dr. Wahi as "not a first-time offender" Pet. 29a, it ignored the fact that *none of CAMC's reports about Dr. Wahi was ever vindicated.* Indeed, CAMC's own investigation vindicated Dr. Wahi; and the medical board of West Virginia has investigated Dr. Wahi *three times* at CAMC's request—and has cleared him every single time. JA 248-265.

In short, if Dr. Wahi can be summarily suspended, any physician can be. "Peer review" that allows such a travesty is not worthy of the name, and it is expressly forbidden by the HCQIA. Unless this Court grants review, such misadventures will only be further multiplied—to the detriment of excellent physicians such as Dr. Wahi, and of patients nationwide. AAPS Br. 12-18.

3. Finally, the decision below can only encourage the departure of physicians from the five states within the Fourth Circuit—Maryland, Virginia, West Virginia, North Carolina, and South Carolina—and hamper efforts to recruit excellent physicians to practice in those states. Given the option, what physician would choose to practice where the local hospital—the lifeblood of her medical practice—can suspend her privileges on a whim and without any possibility of recourse to a jury?

Protecting hospitals and peer reviewers from frivolous suits is one thing, but protecting them from *any* legal challenge is quite another. "Absolute power corrupts absolutely." J. Acton, *Essays on Freedom and Power* 364 (H. Finer ed. 1948). And good doctors will be deterred from practicing in any area where the law confers such power on local hospitals.

CONCLUSION

This case gives the Court an opportunity to resolve both a new and a pre-existing circuit split on two issues of critical importance to doctors, hospitals, and our entire health-care system. It also provides an opportunity to rein in the overly deferential approach to peer-review immunity embodied in the decision below, and to prevent that approach from spreading to other circuits.

Petitioner thus respectfully urges the Court to grant plenary review of both questions presented. At a minimum, the Court should grant review of the first question and, if it believes plenary review is not warranted, summarily reverse the decision below.

Respectfully submitted,

KENNETH W. STARR
24569 Via De Casa
Malibu, CA 90265
(310) 506-4621

GENE C. SCHAERR
Counsel of Record
ANDREW C. NICHOLS
Winston & Strawn LLP
1700 K Street, N.W.
Washington, DC 20006
(202) 282-5000

LETITIA NEESE CHAFIN
H. TRUMAN CHAFIN
The H. Truman Chafin Law Firm
P.O. Box 1799
Williamson, WV 25661
(304) 235-2221

Counsel for Petitioners

September 2009