UNITED STATES DISTRICT COURT
EASTERN DISTRICT OF LOUISIANA

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| SOPHIA RDZANEK, M.D. | CIVIL ACTION |
| VERSUS | NO: 03-2585 |
| HOSPITAL SERVICE DISTRICT #3, PARISH OF LAFOURCHE D/B/A THIBODAUX REGIONAL MEDICAL CENTER, ET AL. | SECTION: "R" |

**ORDER AND REASONS**

This is an action in which Dr. Sophia Rdzanek challenges the peer review process at Thibodaux Regional Medical Center that resulted in the reduction of her staff privileges. Plaintiff applied for a preliminary injunction and the defendants filed a motion for partial dismissal. The Court held a hearing on the application for preliminary injunction on October 30, 2003, at which it heard oral argument and received evidence in the form of affidavits and exhibits. For the following reasons, the Court denies plaintiff's preliminary injunction application. As to defendants' motion to dismiss, the Court denies defendants' motion to dismiss plaintiff's Section 1983 claim and will rule on defendants' Federal Rule of Civil Procedure 17(b) motion in a separate order.

## I. Background

Dr. Rdzanek, a cardiologist, holds medical staff privileges at the Hospital Service District #3, Parish of Lafourche d/b/a Thibodaux Regional Medical Center (the "hospital"). On September 9, 2003, the Board of Commissioners of the hospital reduced Dr. Rdzanek's medical staff privileges to consulting privileges after the hospital conducted a review of several issues related to the patient care administered by Dr. Rdzanek.[1] The Board of Commissioners also required that Dr. Rdzanek complete a minimum of 50 hours of continuing education course work in the areas of cardiology, internal medicine, and interventional angiography procedures.[2] The Board decision allows Dr. Rdzanek to reapply for medical staff privileges after a year, provided that she submits proof of completion of the required course work.[3]

In response, Dr. Rdzanek filed this action against the hospital, its Board of Commissioners, its Medical Executive Committee ("MEC"), and Greg Stock, the hospital's Chief Executive Officer. She alleges several claims, including a claim under

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[1] Defs.' Ex. 41, Board Decision dated Sep. 9, 2003, at p. 6. Throughout this opinion, citations to defendants' exhibits refer to exhibits attached to their memorandum in opposition to plaintiff's preliminary injunction application. Similarly, cites to plaintiff's exhibits refer to exhibits attached to plaintiff's memorandum in support of her preliminary injunction application.

[2] *Id.* at pp. 6-7.

[3] *Id.* at pp. 7-8.

Title 42, United States Code Section 1983 based on her contention that the defendants violated her due process rights when they reduced her medical staff privileges. The Court denied plaintiff's motion for a temporary restraining order and ordered a hearing on her application for a preliminary injunction. The Court restricted the preliminary injunction hearing to the issue of whether plaintiff's Section 1983 claim warrants injunctive relief. In addition, defendants moved for dismissal of plaintiff's Section 1983 claim for failure to state a claim and for dismissal of the Board of Commissioners and the MEC as improper defendants. The parties made excellent presentations of the complex factual and legal issues at the preliminary injunction hearing. Based on the Court's review of the record, it finds the following facts.

**A. Credentialing and Peer Review**

The hospital's bylaws require practitioners like Dr. Rdzanek who already enjoy staff privileges to reapply for and be reviewed for clinical privileges every two years.[4] The bylaws also require practitioners to agree in writing to abide by the bylaws, rules, regulations, and policies of the hospital and to agree to peer review and quality review. In evaluating applications for renewal of staff privileges, the hospital considers a range of information, including peer recommendations and the outcomes of

[4] *See* Def.'s Ex. 10, Hospital Bylaws.

treatment and quality reviews of the care administered by the physician. The hospital's Credentials Committee reviews the renewal application and makes a report and recommendation to the MEC. The MEC makes a recommendation on the application to the hospital's Board of Commissioners. If the recommendation of the MEC is adverse to the practitioner, the hospital Administrator must notify the physician by certified mail, and the notice must include the reasons for the recommendation.[5] The practitioner is then entitled to a hearing before an ad hoc committee, composed of members of the medical staff who are not in direct economic competition with the practitioner. At the hearing, the practitioner may call and examine witnesses, introduce written evidence, cross-examine witnesses and rebut evidence presented by the MEC. If the ad hoc hearing committee issues an adverse recommendation, the physician is entitled to appellate review by the governing Board. The bylaws establish a timetable and procedures for notice, the conduct of the hearing, the rendering of a written decision and the conduct of appellate review.

The hospital reviews the quality of care rendered by its physicians on a day-to-day basis through its peer review process. Information from this process is considered when a physician applies for renewal of his or her privileges, and it may also become the basis for a recommendation for corrective action.

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[5] *Id.*, at p. 25.

Under Article IX of the bylaws, members of the medical staff have a duty to report matters of physician competence or quality of care to the hospital Administrator, who may refer the matter to the MEC to investigate and determine if corrective action is necessary.[6] The MEC may appoint an ad hoc investigating committee to look into the issue and interview the physician before making a recommendation to the Board. If the MEC's recommendation is adverse, the practitioner is entitled to a hearing and an appeal.

During Dr. Rdzanek's tenure, the hospital conducted peer reviews through a number of committees composed of medical staff members, including the Quality Medical Care Review Committee ("QMC"), the Surgical Care Review Committee, the Cath Lab Committee, and the Transfusion Committee. Under the hospital's procedures, these committees receive information about particular cases from the case management department, which uses a number of screening criteria approved by the medical staff to identify cases for peer review. If a case meets one of these criteria, then it "falls out" as an "occurrence," and a physician peer review committee will then review it. For example, an identified morbidity event, such as the death of a patient, will trigger peer review. Quality Resource Manager Dana Rodrigue, a registered nurse, oversees the eight case managers in the case

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[6] *Id.* at p. 21.

management department. In addition, the Quality Resource Manager will bring a case to a peer review committee if she believes it represents quality of care concerns, even if it does not meet one of the peer-review triggering criteria. Peer review committees also review cases when another medical staff member or nurse files a "Variance Report" indicating a concern about how the physician handled a case. Indeed, the bylaws provide that every member of the medical staff should report questions regarding a practitioner's clinical competence, management, or treatment of a patient.

When a peer review committee receives a case for review, the committee assigns it an occurrence level from 0 to 6 based on the committee's evaluation of the severity of the patient care issues presented. The medical staff established the following scale for use by peer review committees:[7]

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| Level 0 | Not a true fall out/unassigned |
| Level 1 | Problem often seen with illness or procedure. Result not unusual with severity. |
| Level 2 | Complication infrequent but seen with illness or procedure; recognized timely and treated appropriately. |
| Level 3 | Possible deviation from standard of care in treatment, diagnosis, or recognition/treatment of complication. |
| Level 4 | Significant deviation from standard of care. |

[7] Pla.'s Ex. 19, Chart Review Procedures for Medical Staff Peer Review Committees.

Level 5 Discrepant case/questionable transfusion.

Level 6 Deviation from practice guidelines, rules and regulations.

The hospital's written procedures provide that severity levels of Level 3 and 4 indicate a problem with patient care and require the physician to be notified and invited to respond before the committee makes its final occurrence-level determination.[8] The physician is notified if the final level assigned by the review committee is still severe. The peer review committee forwards the minutes of the meeting that reflect its decision to the Medical Executive Committee. The MEC reviews the findings of the physician review committee and either determines the final level assignment, or it may recommend that the case be reviewed by an outside reviewer before it makes its final determination.[9] Information from peer review committee activities becomes part of the physician's quality profile, and the Credentials Committee reviews the information when it makes its recommendation regarding the physician's staff privileges. Peer review findings can also become the basis for a recommendation for corrective action by the MEC.

**B. Dr. Rdzanek's 2001 Application for Reappointment**

Dr. Rdzanek began to perform interventional cardiology

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[8] *Id.*

[9] Defs.' Ex. 2, Hearing Transcript, Vol. III, at p. 165.

procedures at the hospital in 1994 under an arrangement between the hospital and the Cardiovascular Institute of the South ("CIS"). Dr. Rdzanek left CIS in 1996 because of a contract dispute.[10] She then established her own practice and obtained staff privileges at the hospital.[11]

Dr. Rdzanek applied for reappointment to the medical staff for a two-year term in mid-2001. The hospital's CEO, Greg Stock, sent Dr. Rdzanek a letter regarding her reappointment application to inform her that, as a part of the review of her reappointment application, the Credentials Committee noted that her physician profile was not complete because certain patient charts were

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[10] Defs.' Ex. 2, Hearing Transcript Vol. VII, at p. 37.

Plaintiff moves to strike defendants' Exhibits 1 and 2. Plaintiff moves to strike Exhibit 2, the peer review hearing transcript, because the defendants labeled the transcript as "redacted." Plaintiff expresses concern that the accuracy of the documents may have been inadvertently compromised. Defendants filed an affidavit that attests to the accuracy of the hearing transcripts. The affidavit states that Exhibit 2 represents the complete transcripts of the peer review hearing except that patient names were changed to patient initials. Because plaintiff's concerns regarding the accuracy of the transcript appear unfounded, the Court denies plaintiff's motion to strike defendants' Exhibit 2.

Plaintiff also moves to strike defendants' Exhibit 1, which is the defendants' summary of Dr. Rdzanek's deviations from the standard of care. Plaintiff argues that the Court should not consider the exhibit as evidence because it fails to meet the requirements of the Federal Rules of Evidence. The Court admits this document for demonstrative purposes only and does not consider it as evidentiary support for the defendants' arguments.

[11] *Id.*, at p. 39.

still under review by the hospital peer review committees.[12] The hospital indicated that, as a result, Dr. Rdzanek's medical staff privileges would be extended for three months, until November 2001.[13] The hospital followed its established procedure and published its board minutes in the local newspaper.[14] The newspaper announcement stated that the Credentials Committee had recommended a three-month extension of Dr. Rdzanek's privileges, which the Board "granted for clarification of a credentialing issue."[15]

Shortly after Dr. Rdzanek received the July 10, 2001 letter, she received another letter from the hospital's CEO.[16] The second letter, dated July 25, 2001, indicated that the hospital's Board of Commissioners had approved Dr. Rdzanek's reappointment to the active staff in cardiology for a two-year term.[17] This second letter was sent in error because Dr. Rdzanek's reappointment application was still under review by the

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[12] Defs.' Ex. 29, Letter from Stock to Dr. Rdzanek dated July 10, 2001.

[13] *Id.*

[14] Pla.'s Ex. 6, Newspaper Excerpt.

[15] *Id.*

[16] Pla.'s Ex. 1, Letter from Stock to Dr. Rdzanek dated July 25, 2001.

[17] *Id.*

Credentials Committee.[18]

At the time that the Credentials Committee extended Dr. Rdzanek's staff privileges for three months, a number of occurrences in her cases were in various stages of the peer review process. In early 2000, two of Dr. Rdzanek's cases (patients S.J. and D.B.) were peer reviewed because the amount of time that she used to perform certain procedures exceeded the "procedure time" criterium that the relevant peer review committee, the Cath Lab Committee, had adopted.[19] The Cath Lab Committee reviewed these two patients and assigned both occurrences a Level 3.[20] The committee later abandoned the time standard in March 2001 because it concluded that "procedure time was an administrative issue."[21]

In December 2000, two nurses filed Variance Reports related to Dr. Rdzanek's treatment of patient A.C., who died after Dr. Rdzanek performed a pericardiocentesis and a right and left diagnostic catherization on her.[22] The patient suffered from

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[18] Defs.' Ex. 15, Stock Depo., at pp. 67-68.

[19] Pla.'s Ex. 3, Credential's Committee Meeting Minutes from Oct. 12, 2001.

[20] Defs.' Ex. 3, Ad Hoc Committee Report.

[21] Pla.'s Ex. 24, Cath Lab Committee Meeting Minutes from Mar. 6, 2001.

[22] Defs.' Ex. 2, Hearing Transcript, Vol. VII, at p. 107; *see also id.*, Vol V, at pp. 110-12.

severe pulmonary hypertension. The nurses questioned Dr. Rdzanek's administration of levels of the drug Nipride in amounts that increased from 0.5mcg/kg/min. to 50mcg/kg/min. over a three-hour period.[23] The nurses also expressed concerns about Dr. Rdzanek's management of the patient after she administered Nipride and the patient went into extremis.[24] On April 18, 2001, the Quality Medical Care Review Committee reviewed the case and assigned it a Level 1.[25] The MEC thereafter determined that this level was inappropriate and sent the case to the Greeley Company for external peer review. The Greeley Company had not issued its report when the Board issued the three-month extension of plaintiff's staff privileges in July 2001.[26]

When the Credentials Committee met again on October 12, 2002, several new cases involving Dr. Rdzanek's care were under review, but the process was not complete. One of these cases involved patient F.P., on whom Dr. Rdzanek performed peripheral angiography and then performed both right and left peripheral angioplasty within 24 hours in April of 2001.[27] The patient had

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[23] Defs.' Ex. 3, Ad Hoc Committee Report.

[24] *Id.*; *see also* Defs.' Ex. 2, Hearing Transcript, Vol. V, at pp. 110-12.

[25] Pla.'s Ex. 31, QMC Meeting Minutes from April 18, 2001.

[26] Pla.'s Ex. 32, Greeley Co. Report dated August 15, 2001.

[27] Defs.' Ex. 3, Ad Hoc Committee Report.

a history of impaired kidney function, and the consulting nephrologist recommended that Dr. Rdzanek wait at least 48 hours before performing additional angioplasty after the first procedure, because the patient was at high risk for toxicity from the dye used in the procedure.[28] Dr. Rdzanek performed additional angioplasty within 24 hours after the first procedure, and the patient went into renal failure and needed dialysis.[29]

In August 2001, another occurrence transpired in the F.P. case. After the angioplasty in April, the patient remained in the hospital from May to August, and Dr. Rdzanek was his attending physician during his stay. After the patient was discharged from the hospital, he returned to the emergency room a few days later with gastrointestinal symptoms. Although the ER contacted Dr. Rdzanek, she would not admit the patient.[30] Dr. Rdzanek told the ER to consult other physicians who could better address the patient's current symptoms.[31] After another physician eventually admitted the patient, the patient died the following day.[32] On September 19, 2001, the QMC assigned both this occurrence and the April 2001 morbidity event involving this

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[28] Defs.' Ex. 2, Hearing Transcript, Vol. VI, at p. 153.

[29] Defs.' Ex. 3, Ad Hoc Committee Report.

[30] Defs.' Ex. 2, Hearing Transcript, Vol. VIII, at p. 51.

[31] *Id.*

[32] Pla.'s Ex. 44, QMC Meeting Minutes from Sept. 19, 2001.

patient a Level 4.[33] The QMC notified Dr. Rdzanek of its determination and invited her to present the case.[34] After she did so, the QMC continued to assign a Level 4 to her refusal to admit the patient to the emergency room but lowered its level assignment regarding the morbidity event to a Level 3.[35]

Another pending case involved patient D.T., who experienced a hypertensive episode during an angiogram performed by Dr. Rdzanek in early June 2001.[36] The hospital log from the procedure indicated that Dr. Rdzanek administered a significant number of different drugs in a short period of time, *e.g.*, the procedure log lists several drugs 15 to 20 seconds apart.[37] In addition, some of the drugs that Dr. Rdzanek administered counteracted drugs previously administered.[38] Further, the

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[33] *Id.*

[34] Pla.'s Ex. 53, Memos from the QMC to Dr. Rdzanek re: Level 3/4 Recommendations.

[35] Pla.'s Ex. 53, Memos from the QMC to Dr. Rdzanek re: Level 3/4 Recommendations. In addition, the Greeley Company reviewed the first occurrence in the F.P. case in December 2001 and assigned it a Level 4. Defs.' Ex. 6, Greeley Co. Report dated Dec. 28, 2001. After receiving the Greeley Company report, the MEC approved a final severity assignment of Level 4. Defs.' Ex. 23, MEC Meeting Minutes from Jan. 10, 2002.

[36] Defs.' Ex. 2, Hearing Transcript, Vol. VII, at p. 133-36; Defs.'s Ex. 3, Ad Hoc Committee Report.

[37] Defs.' Ex. 2, Hearing Transcript, Vol. VII, at pp. 149-50.

[38] *Id.*, at pp. 143-45. For example, Dr. Rdzanek administered Versed, then administered Romazicon, which reverses the effect of the Versed, and later administered Versed again.

patient's medical records contained contradictory information about whether Dr. Rdzanek administered 10mg or 20mg of the drug Hydralazine during the procedure. The order sheet listed 10mg of Hydralazine, but the procedure log indicated 20mg.[39] The log contained a handwritten change to 10mg, but it is unclear who altered the log.[40]

The hospital sent the D.T. case to the Greeley Company for outside review, and Greeley issued its report on August 15, 2001.[41] Using the hospital's classification system, it assigned the case a Level 3.[42] Greeley concluded that the Hydralazine dosage was at "the upper end of recommendation for hypertensive emergency, and this patient did not meet the criteria for hypertensive emergency."[43]

Another case involved questions as to whether Dr. Rdzanek had performed an unwarranted angioplasty and stenting on patient A.L. in mid-June 2001. Dr. Rdzanek diagnosed a blockage of 75-80%, but the physicians who reviewed this case through the hospital-requested external reviews determined that the amount of

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[39] Defs.' Ex. 2, Hearing Transcript, Vol. VII, at pp. 142, 147.

[40] Defs.' Ex. 3, Ad Hoc Committee Report.

[41] Defs.' Ex. 4, Greeley Co. Report dated Aug. 15, 2001.

[42] *Id.* at p. 15.

[43] *Id.*

blockage was less than Dr. Rdzanek indicated.[44] The peer review committee that reviewed the case assigned it a Level 3.[45]

Also pending was the case of patient V.U., in which Dr. Rdzanek performed a cardiac catherization and angioplasty on the patient on June 27, 2001. The patient experienced complications, which Dr. Rdzanek determined were due to a retroperitoneal bleed, *i.e.*, internal bleeding within the patient's abdominal area. The peer review committee assigned the case a Level 4 because of concerns that Dr. Rdzanek failed to timely diagnose and treat the retroperitoneal bleed.[46] The Greeley Company reviewed the case and determined that Dr. Rdzanek's recognition of the bleed was "quite delayed."[47] In its October 3, 2001 report, it assigned the case a Level 4.[48]

By the October 2001 Credentials Committee meeting, the Greeley Company had also completed its independent review of patient A.C.'s case, which involved issues regarding Dr.

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[44] Defs.' Ex. 7, Greeley Co. Report dated Feb. 7, 2002; Defs.' Ex. 8, NPRC Report.

[45] Defs.' Ex. 3, Ad Hoc Committee Report.

[46] Defs.' Ex. 3, Ad Hoc Committee Report; Defs.' Ex. 33, Letter re: Hearing dated Dec. 13, 2002.

[47] Defs.' Ex. 5, Greeley Co. Report dated Oct. 3, 2001.

[48] *Id.* at p. 11.

Rdzanek's administration of drugs to a patient who died.[49] Greeley assigned the A.C. case a Level 1 and noted that "[d]eath is a frequent complication of pulmonary hypertension this severe."[50]

At its October 12, 2001 meeting, the Credentials Committee recommended that Dr. Rdzanek be reappointed to the active medical staff for one year with quarterly updates on the levels assigned to her cases that were still under review.[51] The MEC approved this recommendation and forwarded it to the hospital's Board of Commissioners, and the Board approved the reappointment on October 16, 2001. Dr. Rdzanek now contends that her reappointment for only one year, after she was notified in July 2001 that she had received a two-year appointment, is an adverse action and that she was entitled to an appeal of that decision.

**C. The Ad Hoc Committee**

The Credentials Committee met on December 10, 2001 and reviewed the severity levels assigned to Dr. Rdzanek's cases.[52] Dr. Sandeep Patel, another cardiologist on staff at the hospital

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[49] Defs.' Ex. 4, Greeley Co. Report dated Aug. 15, 2001. *See* discussion at pages 10-11, *supra*.

[50] *Id.* at p. 15.

[51] Pla.'s Ex. 3, Credentials Committee Meeting Minutes from Oct. 12, 2001.

[52] Defs.' Ex. 22, Credentials Committee Meeting Minutes dated Dec. 12, 2001.

and a competitor of Dr. Rdzanek's, recused himself from the discussion regarding Dr. Rdzanek because of a potential conflict of interest.[53] The committee noted that Dr. Rdzanek had received two Level 3 assignments in 2000, and three Level 3 and two Level 4 assignments in 2001.[54] The Credentials Committee held a special meeting on December 12, 2001 to address Dr. Rdzanek's quality profile.[55] Dr. Patel recused himself from the special meeting also.[56] The Credentials Committee invoked Article IX of the bylaws and recommended that the MEC appoint an Ad Hoc Committee to fully investigate the quality of care Dr. Rdzanek provided to her patients.[57]

On January 10, 2002, the MEC appointed an Ad Hoc Committee composed of five physicians from the medical staff.[58] The MEC asked the Ad Hoc Committee to interview Dr. Rdzanek regarding the cases in question, review the patient records and related documents, and interview individuals with relevant knowledge of

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[53] *Id.*

[54] *Id.*

[55] *Id.*

[56] *Id.*

[57] *Id.*

[58] Def.'s Ex. 23, MEC Meeting Minutes from Jan. 10, 2002.

the care provided by Dr. Rdzanek.[59] The Ad Hoc Committee reviewed the medical records and variance reports for the eight Level 3 and 4 occurrences assigned to Dr. Rdzanek and conducted interviews with Katie Richard, RN,[60] Dr. Herminio Suazo, the consulting nephrologist in the F.P. case, and Dr. Rdzanek.[61] The committee found that three of the occurrences did not represent quality of care concerns.[62] Another occurrence involved questions regarding Dr. Rdzanek's interpretation of angiogram films, and the committee concluded that this one case was not sufficient for it to reach a conclusion regarding her technical ability.[63] The committee found, on the other hand, significant

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[59] *Id.* The MEC asked the Ad Hoc Committee to review seven patient cases. One of the cases, the F.P. case, involved two separate occurrences to which hospital committees assigned Level 4's. Thus, the Ad Hoc Committee reviewed a total of eight occurrences.

[60] Nurse Richard filed one of the Variance Reports regarding Dr. Rdzanek's care in the A.C. case. Defs.' Ex. 3, Ad Hoc Committee Report; *see also* Defs.' Ex. 2, Hearing Transcript, Vol. V, at pp. 110-12.

[61] Defs.' Ex. 3, Ad Hoc Committee Report.

[62] Defs.' Ex. 3, Ad Hoc Committee Report. The Ad Hoc Committee concluded that the cases involving procedure time deviations (patients S.J. and D.B.) and Dr. Rdzanek's refusal to admit patient F.P. to the emergency room did not represent quality of care concerns. Dr. Paul Gaudet, a member of the Ad Hoc Committee, later testified that, in reviewing each of the cases, the committee tried "to give Dr. Rdzanek the benefit of the doubt in trying to understand the case." Defs.' Ex. 2, Hearing Transcript, Vol. II, at p. 23.

[63] *Id.* Because no one on the Ad Hoc Committee was proficient in reading angiogram films, the committee sent patient A.L.'s films

concerns associated with the other four occurrences. It found that Dr. Rdzanek exhibited a lack of medical judgment and a lack of knowledge regarding medical dosages, indications, and side effects; that her ability to interpret tests that measure the level of gases in the blood was poor; and that her knowledge of and ability to recognize and appropriately treat angiography complications were poor.[64] In addition, the Ad Hoc Committee noted that Dr. Rdzanek's refused to admit any error or room for improvement in her treatment of the patients in question.[65] The committee forwarded its report to the MEC.

**D. Additional Outside Review**

When the MEC considered the Ad Hoc Committee's report, Dr. Robert Hansen, a cardiovascular surgeon, who Dr. Rdzanek contends is her competitor, participated in the discussions regarding Dr. Rdzanek but did not vote.[66] The MEC interviewed Dr. Rdzanek and decided to send her cases out to a second outside reviewer, the

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to an outside reviewer (the Greeley Company) to determine the level of blockage and whether it warranted angiography. In its report dated February 7, 2002, Greeley concluded that the blockage (30-40% blockage) did not warrant the angioplasty and stenting performed by Dr. Rdzanek but assigned the case a Level 2 based on the lack of a poor patient outcome. The Ad Hoc Committee noted the significant difference between the outside reviewer's blockage estimate (30-40%) and Dr. Rdzanek's estimate (75-80%) but determined that it did not have enough information to reach a conclusion on this issue.

[64] *Id.*

[65] *Id.*

[66] Defs.' Ex. 24, MEC Meeting Minutes from February 26, 2002.

National Peer Review Corporation ("NPRC").[67]

Dr. Andrew Weintraub, a board certified cardiologist and associate director of the diagnostic cardiac catherization laboratory and the interventional cardiology program at Tufts-New England Medical Center, reviewed the cases on behalf of NPRC and prepared a report of his findings, which NPRC included in its report dated June 20, 2002.[68] The introduction to the NRPC report describes the two types of reviews that NRPC performs.[69] The first level of peer review is a Provider Performance Review, which is a comprehensive review of the practitioner that involves an in-depth review of cases selected from a definite time period.[70] The cases selected may focus on a particular area of the physician's practice or may encompass a systematic sampling of the patient's entire practice. The case-by-case findings are then aggregated and patterned. The second type of review is a case review, which is a review by NPRC of a limited number of cases designed to provide a hospital with an independent third-party opinion regarding the quality of care provided by the

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[67] *Id.*; *see also* Defs.' Ex. 25, MEC Meeting Minutes from Mar. 4, 2002; Defs.' Ex. 8, NPRC Report. Dr. Hansen was not present at this meeting.

[68] Defs.' Ex. 8, NPRC Report; Defs.' Ex. 2, Hearing Transcript, Vol. I, at pp. 150-52.

[69] Defs.' Ex. 8, NPRC Report.

[70] *Id.* at pp. 1-2.

practitioner in the reviewed cases.[71] The hospital requested a case review of each of Dr. Rdzanek's cases at issue.[72]

After reviewing Dr. Rdzanek's cases, Dr. Weintraub concluded that Dr. Rdzanek exhibited a lack of medical judgment and deviated from the standard of care in numerous instances.[73] He noted several cases in which Dr. Rdzanek intervened when the clinical presentation of the patient did not warrant intervention. He found that she failed to recognize co-existing health conditions in a number of the patients that required consideration of other treatment options. He also identified several situations in which Dr. Rdzanek exhibited a lack of medical knowledge.

Dr. Weintraub identified specific issues in each of the cases:[74]

Patient S.J.: Although the hospital review committees reviewed this case because it was a deviation from the time standard, Dr. Weintraub considered the entire case and did not limit his focus to the time standard deviation. He identified concerns with the patient's treatment. He noted that Dr. Rdzanek failed to consider surgical revascularization as an alternative

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[71] *Id.* at p. 2.

[72] *Id.* at pp. 1-2.

[73] *Id.* at pp. 4-6.

[74] *Id.* at pp. 8-23.

to her chosen course of treatment. He concluded that she exhibited a lack of medical knowledge because (1) she failed to obtain a run-off in the left lower extremity and therefore did not obtain a complete assessment of the adequacy of the vascular perfusion into the patient's left foot, (2) she failed to consider additional balloon angioplasty or stenting when the balloon angioplasty performed on the patient revealed a residual 60% stenosis, and (3) she failed to perform a cardiac ultrasound, a Holter monitor or additional central nervous system imaging studies to determine the source of a cerebral embolus.

Patient D.B.: As in the S.J. case, Dr. Weintraub reviewed the entire case and again did not limit his focus to the time standard deviation. He opined that Dr. Rdzanek intervened when the clinical presentation of the patient did not warrant intervention. In this case, he determined that the coronary angiogram was not supported by conventional criteria.

Patient A.C.: Dr. Weintraub again found that Dr. Rdzanek unnecessarily intervened in this situation. He concluded that she should not have performed a vasodilator drug therapy trial on the patient, who had longstanding pulmonary hypertension, before she hemodynamically stabilized the patient after the patient's pericardiocentesis. Further, he noted that she should have considered removal of the pericardial fluid as an initial step in treating and analyzing the separate contributions of the

patient's pulmonary hypertension and the onset of a large pericardial effusion. Dr. Weintraub noted that she should have determined the effect and implications of that procedure first, instead of immediately proceeding with coronary angiography. He therefore concluded that the clinical indications did not warrant a coronary angiography on this patient.

Patient F.P.: Dr. Weintraub noted that Dr. Rdzanek disregarded the recommendation of a consulting renal physician to delay the second angiogram at least 48 hours following the diagnostic angiogram due to concerns about contrast dye toxicity.

Patient D.T.: Dr. Weintraub found that while managing the patient's hypertensive episode, Dr. Rdzanek administered medications that were not clinically indicated and administered multiple drugs simultaneously, contrary to accepted criteria.

Patient A.L.: Based on his own estimation, Dr. Weintraub concluded that Dr. Rdzanek overestimated the severity of the patient's coronary stenosis and therefore unnecessarily intervened in this case.

Patient V.U.: Dr. Weintraub found that Dr. Rdzanek unnecessarily administered intravenous insulin when the patient was in a state of hemodynamic collapse from blood loss. He again noted that she exhibited a lack of medical knowledge, in this case because (1) she failed to recognize and diagnose the patient's retroperitoneal bleed despite clear indications of a

bleed, (2) she failed to treat the patient, who was on a potent platelet inhibitor with a major bleeding diathesis, with platelets, and (3) she failed to obtain an activated clotting time value before administering a potent platelet inhibitor, thereby exposing the patient to an increased risk of bleeding.

**E. The MEC's First Recommendation**

When the MEC reviewed the NPRC report in June 2002, it concluded that the NPRC confirmed the findings about Dr. Rdzanek's patient care reached by the previous external reviewer (the Greeley Company), the hospital peer review committees and the ad hoc investigative committee.[75] Based on all of these findings, the MEC recommended that Dr. Rdzanek take remedial courses and that her medical staff privileges be reduced, as follows:

(1) Dr. Rdzanek must complete a Cardiology, Internal Medicine, and Interventional Angiography Procedures board review course within a one-year period of time.
(2) Dr. Rdzanek's staff category will be changed to Consulting Staff.
(3) Dr. Rdzanek will be allowed to have an Active Staff physician admit her patients if that physician has been granted a "Level 3 or above" delineated category of clinical privilege. Dr. Rdzanek must be consulted and the admitting physician must remain the attending on the case.
(4) Dr. Rdzanek's angiography privileges will be restricted to diagnostic only.[76]

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[75] Defs.' Ex. 27, MEC Meeting Minutes from Jun. 24, 2002.

[76] *Id.*

**F. Dr. Rdzanek's Hearing Request**

The MEC notified Dr. Rdzanek of its adverse recommendation by letter dated July 16, 2002.[77] The letter described the MEC's recommendation, including the provision that she could reapply for active staff privileges in a year if she completed the required course work.[78] The letter also informed Dr. Rdzanek that the Medical Staff Bylaws entitled her to a hearing regarding the adverse recommendation if she requested one in writing and that the bylaws accorded her a number of procedural rights in the hearing process.[79]

Dr. Rdzanek requested a hearing and retained an attorney to represent her at the hearing. She was entitled to notice of the hearing time, place, and date, and the basis for the adverse recommendation. The hospital sent Dr. Rdzanek notice regarding her hearing dated August 19, 2002.[80] The notice included the date and location of the hearing, the composition of the hearing panel, and the basis for the MEC's adverse recommendation. As the basis for the MEC's recommendation, the letter listed the findings the hospital peer review committees, the Greeley Company

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[77] Defs.' Ex. 30, Letter from Stock to Dr. Rdzanek dated Jul. 16, 2002.

[78] *Id.*

[79] *Id.*; Defs.' Ex. 10, Medical Staff Bylaws.

[80] Defs.' Ex. 31, Letter from Stock to Dr. Rdzanek dated Aug. 19, 2002.

reports, the ad hoc investigating committee report, and the NPRC report. The letter listed the patient cases at issue by account number. The hospital supplemented the notice of hearing on September 13, 2002 with a list of potential witnesses.[81]

The hearing was initially scheduled to begin in October 2002.[82] The hospital selected a hearing officer and five hearing committee members.[83] Dr. Rdzanek objected to the hearing officer and the hospital appointed a new hearing officer, Frank Beahm, Esq., to whom Dr. Rdzanek did not object.[84] In addition, Dr. Rdzanek exercised her right to object to two of the hearing panel members.[85] The hospital replaced one of the hearing committee members to whom Dr. Rdzanek objected, but the hearing officer denied her objection with respect to the second committee member.[86] Dr. Rdzanek also informed the hospital that she believed that it had not provided her with a clear indication of

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[81] Defs.' Ex. 32, Letter from Locke Liddell & Sapp, counsel for the hospital, to Kathleen DeBruhl & Assoc., counsel for Dr. Rdzanek, dated Sept. 13, 2002.

[82] Defs.' Ex. 31, Letter from Stock to Dr. Rdzanek dated Aug. 19, 2002.

[83] *Id.*; Defs.' Ex. 32, Letter from the hospital to Dr. Rdzanek, dated Sept. 13, 2002.

[84] Rec. Doc. 54, Defs.' Suppl. Memo. in Opp., Ex. C, Letter from the hospital to Dr. Rdzanek dated Sep. 20, 2002.

[85] Rec. Doc. 1, Verified Complaint, ¶51.

[86] *Id.*

the allegations against her.[87] In response, the hospital provided an additional summary of the cases on which the MEC based its decision. The summary identified each case by patient name, account number, admit date, and the case numbers assigned by each reviewer, *i.e.*, the hospital peer review committees, the ad hoc committee, and the outside reviewers.[88] On October 14, 2002, the hearing officer issued an order that placed the burden on the hospital's MEC "to show its adverse recommendation to Dr. Rdzanek's staff privileges is supported by the evidence."[89] The hearing was rescheduled until January of 2003.[90]

**G. The MEC's Second Recommendation**

In the meantime, the MEC received another Level 4 recommendation from a peer review committee involving a patient under Dr. Rdzanek's care.[91] The case involved the patient C.S., whom Dr. Rdzanek admitted for elective valve replacement on May 13, 2002. For the next 16 days after surgery, the patient went in and out of atrial fibrillation, with Dr. Rdzanek administering

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[87] Defs.' Ex. 33, Letter from hospital counsel to Dr. Rdzanek dated Dec. 13, 2002.

[88] *Id.*

[89] Defs.' Ex. 37, Order with Reasons dated Oct. 14, 2002.

[90] Defs.' Ex. 2, Hearing Transcript, Vol. I.

[91] Pla.'s Ex. 34, Quality Medical Care Review Committee Meeting Minutes from Oct. 16, 2002; Pla.'s Ex. 40, MEC Meeting Minutes from Jan. 9, 2003.

drugs to the patient intravenously and then administering electric shock therapy, five times on May 21 alone, only to discharge the patient on May 29, 2002 in atrial fibrillation.[92]

At the first level of peer review, the QMC in August 2002 assigned the case a Level 4 for deviations from practice guidelines and invited Dr. Rdzanek to respond at an October 16, 2002 meeting.[93] The QMC then assigned the deviation from practice guidelines a Level 3 and recommended external review of the case, which was done by NPRC.[94] Dr. Weintraub reviewed the case for NPRC and determined that the severity level for the case was between a Level 3 and a Level 4, because, in his view, certain aspects of the case indicated a possible deviation from the standard of care and others indicated a significant deviation from the standard of care.[95] He faulted both the choice and dosage of drugs Dr. Rdzanek administered to the patient in the hospital and upon discharge and found that Dr. Rdzanek should not have performed the electric cardioversion on May 21, 2002.[96]

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[92] The description of patient C.S.'s treatment is gleaned from the hospital course timeline in the NPRC Report. Defs.' Ex. 9, NPRC Report.

[93] Pla.'s Ex. 34, QMC Meeting Minutes from Aug. 21, 2002.

[94] Pla.'s Ex. 34, QMC Meeting Minutes from Oct. 16, 2002; Defs.' Ex. 9, NPRC Report.

[95] Defs.' Ex. 9, NPRC Report.

[96] *Id.*; Defs.' Ex. 2, Hearing Transcript Vol. III, at pp. 61-84.

After the QMC reviewed the NPRC Report, it assigned the case a Level 4.[97] When the case reached the MEC on December 17, 2002, the MEC voted to notify the Credentials Committee of the recent Level 4 assignment.[98] Dr. Rdzanek's one-year renewal of privileges expired in October 2002 and the Credentials Committee had recently voted to extend her privileges for three more months while the peer review issues were in the hearing stage.[99] After the most recent incident, the MEC asked the Credentials Committee to review its recommendation to extend Dr. Rdzanek's privileges.[100] Dr. Hansen, now MEC Chairman, recused himself from this vote.[101]

The Credentials Committee met on December 19, 2002 to discuss Dr. Rdzanek's reappointment application.[102] The committee reviewed the C.S. case in detail and concluded that Dr. Rdzanek did not meet the standard of care for postoperative atrial fibrillation.[103] It also noted that there were other factors,

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[97] Pla.'s Ex. 40, MEC Meeting Minutes from Jan. 9, 2003.

[98] Pla.'s Ex. 35, MEC Meeting Minutes from Dec. 17, 2002.

[99] *Id.*

[100] *Id.*

[101] *Id.*

[102] Pla.'s Ex. 42, Credentials Committee Meeting Minutes from Dec. 19, 2002.

[103] *Id.*

such as Dr. Rdzanek's drug choice, dosage, and number of cardioversion attempts, that affected the severity level assigned.[104] The Credentials Committee unanimously voted to recommend termination of Dr. Rdzanek's medical staff privileges.[105] Dr. Patel, a cardiologist, recused himself from the vote on this issue.[106]

Dr. Rdzanek asked the MEC for the opportunity to respond to the most recent Level 4 assignment before it made its final decision.[107] Rdzanek presented the case to the MEC at its January 9, 2003 meeting.[108] After her presentation, the MEC voted to recommend termination of her medical staff privileges.[109] Dr. Hansen recused himself from Dr. Rdzanek's presentation and the vote regarding her privileges.[110]

The hospital administration notified Dr. Rdzanek of the MEC's recommendation to terminate her privileges on January 13,

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[104] *Id.*

[105] *Id.*

[106] *Id.*

[107] Pla.'s Ex. 40, MEC Meeting Minutes from Jan. 9, 2003.

[108] *Id.*

[109] *Id.*

[110] *Id.*

2003.[111] The hearing on Dr. Rdzanek's appeal of the MEC's first adverse recommendation was scheduled to begin the next day. Dr. Rdzanek moved to continue the hearing on the first MEC recommendation until it could be consolidated with the hearing on the second MEC recommendation.[112] The hearing officer opted to proceed with the hearing on the first recommendation.[113] He noted that all of the hearing committee members were present and ready to begin the hearing, and Dr. Weintraub, the cardiologist who reviewed Dr. Rdzanek's cases for NPRC, was also present to testify. Further, Dr. Rdzanek had not yet requested a hearing on the second recommendation.[114] The hearing officer determined that the parties could proceed with the hearing on the first recommendation based on the first seven cases, and if necessary the hearing committee members could be informed later and asked to render a decision on the second adverse recommendation based on all eight cases.[115]

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[111] Pla.'s Ex. 13, Letter from Stock to Dr. Rdzanek dated Jan. 13, 2003.

[112] Defs.' Ex. 2, Hearing Transcript, Vol. I, at p. 4.

[113] *Id.*, at p. 28.

[114] *Id.*

[115] *Id.*

**H. The Hearing**

The hearing panel convened on January 14 and 15, 2003.[116] On January 14, 2003, after the parties made opening statements, the MEC presented the testimony of Dr. Weintraub, and Dr. Rdzanek began her cross-examination of him.[117] Dr. Weintraub testified about his findings described in the first NPRC report. On January 15, 2003, the MEC presented the testimony of members of the hospital committees that reviewed Dr. Rdzanek's cases and reappointment application, as well as the testimony of Nurse Rodrigue, the hospital's Quality Resource Manager.[118]

Dr. Rdzanek then requested a hearing on the second MEC recommendation.[119] At that point, the hearing officer consolidated the hearings on both of the MEC recommendations and reconvened the hearing panel on March 24, 2003.[120] Dr. Rdzanek objected to the consolidation on the grounds that the panelists might consider all eight cases to support the MEC's first recommendation, when the MEC based its first recommendation on

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[116] Defs.' Ex. 2, Hearing Transcript, Vols. I and II.

[117] Defs.' Ex. 2, Hearing Transcript, Vol. I, pp. 68-237.

[118] Defs.' Ex. 2, Hearing Transcript, Vols. I and II.

[119] Defs.' Ex. 39, Consolidation Order with Reasons dated Feb. 15, 2003.

[120] *Id.*; Defs.' Ex. 2, Hearing Transcript, Vol. III.

only the first seven cases.[121] The hearing officer overruled Dr. Rdzanek's objection and allowed each party five minutes to present opening remarks regarding the change in circumstances in the hearing.[122] The remainder of the hearing consisted of six sessions held over the next three months, at which the MEC completed its presentation of two witnesses and called two additional witnesses, and Dr. Rdzanek presented six witnesses. The March 24 segment of the hearing was devoted to the C.S. case and to testimony from a MEC member about the bases for its two recommendations. Dr. Weintraub, who was available by conference call, testified on direct and cross-examination about the second NPRC report and his review of the C.S. case.[123] Carla Ott, the nurse who filed the variance report regarding Dr. Rdzanek's treatment of patient C.S., then explained that she filed the report because she felt that it was inhumane to shock the patient as many times as Dr. Rdzanek had done without trying other solutions.[124] She stated that, after the second round of shocks on May 21, 2002, she refused to shock the patient any more.[125]

The MEC called Dr. J. Vance Broussard to describe the MEC's

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[121] Defs.' Ex. 2, Hearing Transcript, Vol. III, at p. 6.

[122] *Id.*, at p. 47.

[123] *Id.* at pp. 57-145.

[124] *Id.* at pp. 149.

[125] *Id.* at p. 150.

peer review process, including its decision to send Dr. Rdzanek's cases out to the two outside reviewers and to appoint the Ad Hoc Committee.[126] He testified that after it interviewed Dr. Rdzanek regarding the first seven cases, the MEC was concerned about her refusal to recognize any concerns regarding her patient care.[127] The MEC decided to reduce Dr. Rdzanek's privileges but conservatively decided to send the cases out for review first.[128] He stated that the MEC interviewed Dr. Rdzanek again after the last occurrence and again had concerns about her inability to admit that her care was improper.[129] He stated that when the MEC made its first recommendation, it was concerned about patient care, ensuring that the hospital was not complicit in the provision of substandard patient care, and rehabilitating Dr. Rdzanek.[130] Because the MEC later determined that Dr. Rdzanek did not acknowledge a need for rehabilitation, it issued its second recommendation after the last occurrence and recommended termination of her privileges.[131]

At the next two sessions on March 26 and April 30, 2003, the

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[126] *Id.* at p. 163-86.

[127] *Id.* at pp. 173-74.

[128] *Id.* at pp. 174-75.

[129] *Id.* at p. 180.

[130] *Id.* at pp. 181-82.

[131] *Id.*

MEC completed its case, and Dr. Rdzanek began her side of the case.[132] Dr. Rdzanek continued her presentation on May 1, 2003 with testimony of three physicians.[133] Dr. Coleridge Franklin, a member of the MEC from 1998 through December 2002 and its chair from December 2001 to December 2002, testified about the MEC's review of Dr. Rdzanek's cases.[134] Dr. Philip Robichaux, a cardiothoracic surgeon, testified that he experienced problems with the peer review process within the Cath Lab Committee.[135] He indicated that he witnessed unprofessional conduct and in-fighting among the cardiologists on the committee.[136] Dr. Suazo testified that, as the consulting nephrologist in the F.P. case, he warned Dr. Rdzanek and the patient about the risks associated with repeat contrast dye exposure, but the decision whether to perform the procedure is within the cardiologist's purview.[137]

At the last two sessions on May 12 and June 24, 2003, Dr. Rdzanek described her background and then discussed her care in

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[132] Defs.' Ex. 2, Hearing Transcript, Vols. IV and V.

[133] Defs.' Ex. 2, Hearing Transcript, Vol. VI.

[134] *Id.* at pp. 6-73.

[135] *Id.* at pp. 94-99.

[136] *Id.*

[137] *Id.* at pp. 148.

the eight cases.[138] Dr. Rdzanek defended her care in each of the challenged cases. For example, Dr. Rdzanek contended that the Level 3 assignments for deviations from the procedure time standard in the S.J. and D.B. cases were inappropriate because there was no national standard governing how long a particular procedure should last, and a recorded time could exceed the usual time, if, for example, equipment fails mid-procedure.[139] In other cases, such as the A.C., D.T. and C.S. cases, she defended her drug choice and dosage based on the patient's specific circumstances.[140] She also testified that, in cases that involved concerns about her medical judgment, her decisions were appropriate. For example, she said that in the F.P. case, she weighed the risks of contrast dye toxicity against the benefits

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[138] Defs.' Ex. 2, Hearing Transcript, Vols. VII and VIII. Rdzanek had begun her testimony twice during the previous hearing session while the panel waited for the next witness to arrive, but each time she answered only a general question or two before the witness arrived. Defs.' Ex. 2, Hearing Transcript, Vol. VI, at pp. 74-75, 123-24. Almost all of her testimony was presented consecutively.

Further, at the beginning of the May 12 session, the hearing officer, with the parties' agreement, excused one of the panel members and proceeded with the four remaining panel members. The excused panel member was unable to attend that evening's session when Dr. Rdzanek would testify, and the hearing officer wanted all of the panel members who would render a decision regarding Dr. Rdzanek's privileges to hear her testimony. *See* Defs.' Ex. 2, Hearing Transcript, Vol. VII at pp. 5-6.

[139] Defs.' Ex. 2, Hearing Transcript, Vol. VII at pp. 52, 55.

[140] *Id.* at pp. 113-14, 116-17, 136-53; Defs.' Ex. 2, Hearing Transcript, Vol. VIII, at p. 36-42.

of proceeding with the second procedure shortly after the first and decided to proceed.[141] Similarly, Dr. Rdzanek testified that, in the C.S. case, she administered electrocardio shocks multiple times because it was important to reestablish normal sinus rhythm to aid the patient's recovery.[142] In cases like the D.T. case, in which the timing of Dr. Rdzanek's drug administration was questioned, Dr. Rdzanek contested the accuracy of the times recorded in the procedure log.[143]

Dr. Rdzanek's medical expert, Dr. Jonathan Marmur, a board certified interventional cardiologist and director of the interventional cardiology fellowship program at the State University of New York, Health Science Center at Brooklyn, then testified regarding his review of the medical records for the eight cases at issue.[144] He based his opinions on his review of the medical records in each case and several conversations he had with Dr. Rdzanek about her treatment of the patients.[145] He opined in each case that Dr. Rdzanek's care was within the standard of care. He admitted, however, that her approach in

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[141] Defs.' Ex. 2, Hearing Transcript, Vol. VIII at pp. 19-24.

[142] *Id.* at pp. 36-42.

[143] Defs.' Ex. 2, Hearing Transcript, Vol. VII at pp. 63-64, 150.

[144] Defs.' Ex. 2, Hearing Transcript, Vol. VIII at pp. 93-228.

[145] *Id.* at p. 99.

some of the cases was "aggressive,"[146] and he found her drug choice, dosage, and timing in some instances to be puzzling or confusing.[147] He conceded that there were inconsistencies in her treatment choices and her justifications for making those choices.[148] He ultimately concluded that the cases at issue suggested that "some degree of oversight would be reasonable," but revocation of her privileges was unnecessary.[149]

Before the last session, the hearing officer informed Dr. Rdzanek and the MEC that he intended to place time limits on the remaining testimony of Dr. Rdzanek and Dr. Marmur and requested from counsel for each party good faith estimates of the time needed to complete the testimony.[150] He notified the parties of the assigned time limits and indicated that if the parties believed that the time restrictions did not allow sufficient time for the witness's testimony, they could take the witness's deposition and present it in lieu of live testimony.[151] The

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[146] *Id.* at pp. 180-82, 202.

[147] *Id.* at p. 211.

[148] *Id.* at pp. 188-89, 195.

[149] *Id.* at pp. 224-25.

[150] Rec. Doc. 54, Defs.' Suppl. Memo. in Opp., Ex. D, Facsimile from the hearing officer to Dr. Rdzanek and the hospital dated May 28, 2003.

[151] Rec. Doc. 54, Defs.' Suppl. Memo. in Opp., Ex. E, Letter from the hearing officer to Dr. Rdzanek and the hospital dated Jun. 5, 2003.

hearing officer did not place time restraints on questions from the hearing panel.[152]

After Dr. Marmur's testimony, the hearing officer gave the MEC and Dr. Rdzanek until June 30, 2003 to provide written arguments for submission to the panel.[153]

**I. The Hearing Panel's Decision**

On July 14, 2003, the panel unanimously rejected the MEC's second recommendation to terminate Dr. Rdzanek's privileges and instead accepted the MEC's first recommendation to reduce her privileges to consulting privileges, albeit with a modification.[154] The hearing panel recommended an additional provision that would have allowed Dr. Rdzanek to perform interventional angiography in the presence of a physician proctor with active clinical staff privileges in interventional angiography at the hospital after she completed 50 hours of continuing medical education in interventional angiography.[155] Based on its review of "the totality of documents and testimony admitted into evidence during the hearing by both parties," the hearing panel found that Dr. Rdzanek had violated the Medical

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[152] *Id.*

[153] *Id.* at pp. 229-30.

[154] Pla.'s Ex. 14, Hearing Panel's Recommendation and Reason, dated July 14, 2003.

[155] *Id.*

Staff Bylaws "when she failed to provide proper patient care and thereby placed patients' safety at risk."[156] The hearing panel expressed concern regarding Dr. Rdzanek's medical judgment.[157] Further, the panel "adopt[ed] the above recommendation to afford Dr. Rdzanek the opportunity of remedial training in order to protect patients from risk of harm."[158]

**J. Dr. Rdzanek's Appeal to the Board of Commissioners**

Dr. Rdzanek filed a timely appeal of the hearing panel's decision to the hospital's Board of Commissioners in accordance with the Medical Staff Bylaws.[159] Dr. Rdzanek and the MEC both submitted written statements with attached exhibits.[160] The Board held a hearing August 20, 2003, at which each party was allotted 20 minutes to present oral argument.[161] In a written decision dated September 9, 2003, the Board found that "the adverse recommendations of the Hearing Committee were justified and were not arbitrary or capricious."[162] The Board adopted the first recommendation of the MEC without the modification imposed by the

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[156] *Id.*

[157] *Id.*

[158] *Id.*

[159] Defs.' Ex. 41, Board Decision dated Sep. 9, 2003.

[160] *Id.*

[161] Pla.'s Memo. in Support, at p. 33.

[162] Defs.' Ex. 41, Board Decision dated Sep. 9, 2003.

hearing panel that allowed Dr. Rdzanek to perform interventional angiography under a volunteer proctor, and the Board's decision therefore resulted in the reduction of Dr. Rdzanek's privileges to consulting privileges.[163]

**K. Dr. Rdzanek's Allegations**

Dr. Rdzanek now seeks injunctive relief under Section 1983 from the final decision of the Board of Commissioners pending the outcome of this litigation. Dr. Rdzanek alleges that the defendants violated her substantive due process rights because she was unfairly singled out for review, and the peer review process to which she was subject was inherently unfair. Dr. Rdzanek contends that the screening criteria utilized to identify cases for review are subjective and susceptible to abuse. Also, Dr. Rdzanek argues that the individuals that evaluated her were biased. Dr. Rdzanek further argues that the MEC improperly relied on the NPRC case review to make its decision regarding her staff privileges, which the NPRC warns against doing.

Dr. Rdzanek also argues that the defendants violated her procedural due process rights when they failed to provide her with reasonable notice of the charges against her and a fair opportunity to be heard on those charges before a panel of fair-minded doctors. Dr. Rdzanek further contends that she did not

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[163] *Id.*; *see also* Defs.' Ex. 30, Letter from Stock to Dr. Rdzanek dated Jul. 16, 2002.

receive any requisite due process when her medical staff privileges were arbitrarily reduced from two years to one year in 2001.

Defendants, on the other hand, dispute Dr. Rdzanek's arguments that they violated her due process rights. Defendants also assert that the adverse action against Dr. Rdzanek did not deprive her of a legally protected interest. They contend that she can still perform the diagnostic procedures that comprise the majority of her practice.

## II. Preliminary Injunction Application

### A. Legal Standard

Under Fifth Circuit law, the plaintiff must make a clear showing that her case satisfies the following four criteria before she can receive a preliminary injunction: (1) a substantial likelihood exists that plaintiff will succeed on the merits of her claim; (2) a substantial threat of irreparable harm exists if the injunction is not granted; (3) the threatened injury outweighs any harm to the defendants if the injunction is granted; and (4) the injunction will not undermine the public interest. *See Valley v. Rapides Parish School Board*, 118 F.3d 1047, 1051 (5th Cir. 1997); *see also Ingebresten v. Jackson Public School District*, 88 F.3d 274, 278 (5th Cir. 1996); *Doe v. Duncanville Independent School Dist.*, 994 F.2d 160, 163 (5th Cir. 1993); *Holland American Ins. Co. v. Succession of Roy*, 777 F.2d

992, 997 (5th Cir. 1985). The movant must satisfy all four factors; a failure to satisfy even one of the four factors requires a denial of the preliminary injunction. *See Mississippi Power & Light v. United Gas Pipe Line Co.*, 760 F.2d 618, 621 (5th Cir.1985).

The Fifth Circuit has frequently cautioned that a preliminary injunction is an "extraordinary remedy," which should be granted only if the movant has clearly carried the burden of persuasion on all four of the above prerequisites. *See, e.g., Cherokee Pump & Equipment Inc. v. Aurora Pump*, 38 F.3d 246, 249 (5th Cir.1994) (quoting *Mississippi Power & Light*, 760 F.2d 618). As a result, "[t]he decision to grant a preliminary injunction is to be treated as the exception rather than the rule." *Id.; see also House the Homeless, Inc. v. Widnall*, 94 F.3d 176, 180 (5th Cir. 1996).

To determine whether the plaintiff has clearly shown a substantial likelihood of success on the merits, the Court turns to the law underlying the plaintiff's claim for injunctive relief. Section 1983 provides:

> Every person who, under color of [state law], subjects or causes to be subjected, any citizen ... to the deprivation of any rights, privileges, or immunities secured by the Constitution and laws, shall be liable to the party injured in an action at law, suit in equity, or other proper proceeding for redress.

42 U.S.C. § 1983; *see also The Police Assoc. of New Orleans v. Cannatella*, 100 F.3d 1159, 1170 (5th Cir. 1996). To be entitled

to relief, the movant must show that "(1) that the defendant deprived him of a right secured to him by the Constitution or federal law and (2) that the deprivation occurred under color of state law." *Brown v. Miller*, 631 F.2d 408, 410 (5th Cir. 1980).

*i. Substantial Likelihood of Success*

Defendants do not dispute that they are state actors who acted under the color of state law under 42 U.S.C. § 1983. Defendants dispute, however, whether Dr. Rdzanek has a legally protected interest at stake for the purpose of advancing a due process claim.

The Fifth Circuit has held that medical staff privileges constitute an interest protected by the fourteenth amendment when

> there was an explicit or implicit agreement providing for no termination of the privileges without cause and a hearing, or because denial of staff privileges 'might effectively foreclose ... practicing in the area because of harm to [a] professional reputation and because of the lack of other [comparable] facilities.'

*Darlak v. Bobear*, 814 F.2d 1055, 1061 (5th Cir. 1987) (quoting *Daly v. Sprague*, 675 F.2d 716, 727 (5th Cir. 1982)); *see also Martin v. Memorial Hosp. at Gulfport*, 130 F.3d 1143, 1148-49 (5th Cir. 1997). Further, when the hospital's regulations provide for a hearing before staff privileges can be suspended or terminated, the Fifth Circuit has held that these provisions imply that privileges will be terminated only for cause and that staff privileges therefore constitute a property interest protected by the fourteenth amendment. *See Darlak*, 814 F.2d at 1061-62. In

this case, the hospital's bylaws grant the right to a hearing when there is an adverse recommendation concerning the granting or renewal of clinical privileges.[164] Further, the hospital acknowledged in writing that the proposed action by the MEC on Dr. Rdzanek's privileges entitled her to a hearing.[165] It is true that the MEC's recommendation left Dr. Rdzanek with some residual privileges at the hospital. On the other hand, Dr. Rdzanek is an interventional cardiologist who had privileges to admit patients and to perform non-diagnostic interventional cardiological procedures on those patients in the hospital. The MEC's recommendation deprived her of those privileges. The Court finds that Dr. Rdzanek has a property interest in her privileges for the purposes of triggering due process review.

Further, Dr. Rdzanek argues that the hospital's action effectively foreclosed her from practicing in the area and therefore deprived her of a liberty interest. In support of her contention, Dr. Rdzanek attests that the hospital is the only facility in Lafourche Parish accessible to her with the equipment and staff she needs to deliver interventional cardiology services, which provide the majority of her practice revenues.[166] Dr. Rdzanek is unable to obtain staff privileges at the next

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[164] *See* Defs.' Ex. 10, Medical Staff Bylaws, Arts. VI-VIII, X.

[165] Defs.' Ex. 30, Letter from Stock to Dr. Rdzanek dated Jul. 16, 2002.

[166] Pla.'s Ex. 49, Affidavit of Dr. Rdzanek, at ¶¶ XI, XXII.

closest catherization facility, Terrebonne General Medical Center, because Terrebonne has an exclusive arrangement with the Cardiovascular Institute of the South to provide cardiac catherization services.[167] She also attests that the facilities at St. Anne's Hospital, the other hospital in the area at which she has medical staff privileges, are not technically sufficient and too inconveniently located to support her practice.[168] Dr. Rdzanek attests that, in addition to these problems, the limitations the hospital imposed on her practice will stigmatize her reputation and dry up her access to patients, which will foreclose her from earning a living. Without admitting privileges at the hospital, Dr. Rdzanek must rely on other physicians to admit her patients, and the admitting physician can refer the patient to another cardiologist after the initial consultation.[169] Further, Dr. Rdzanek asserts that she is stigmatized by having to inform her patients that she cannot admit them to the hospital and that she cannot perform needed procedures.[170] Also, the hospital's action removes Dr. Rdzanek from the list of on-call cardiologists in the emergency room and eliminates her access to this source of new patients. Defendants

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[167] *Id.* at ¶ XI.

[168] *Id.*

[169] *Id.* at ¶ XX.

[170] *See id.*

dispute the extent to which Dr. Rdzanek's practice is dependent upon interventional cardiology procedures and whether the limitation on those privileges and her inability to admit patients to the hospital would adversely impact her practice. Defendants do not dispute, however, that Dr. Rdzanek has experienced a significant decrease in her practice, nor do they dispute that Dr. Rdzanek no longer has access to a facility that is technologically sufficient for her to continue her interventional cardiology practice.

In *Martin*, the Fifth Circuit held that the appellant might be foreclosed from practicing in the area if the hospital's actions "stigmatized him and so damaged his reputation that he could not earn a living as a nephrologist." 130 F.3d at 1149. There exists little guidance beyond the *Martin* case to assist this Court in determining whether Dr. Rdzanek is effectively foreclosed from practicing as an interventional cardiologist. The peer review process and reduction in plaintiff's medical staff privileges has clearly had a severe impact on her practice. The hospital implicitly conceded that the reduction of Dr. Rdzanek's privileges would have an adverse impact on her practice when they gave her a full hearing and appeal under the bylaws. On balance, the Court finds that Dr. Rdzanek presented enough evidence of a liberty interest for the Court to reach the constitutional question of whether she received due process.

Dr. Rdzanek also argues that she was entitled to due process

when her medical staff privileges were "reduced" from two years to one year in 2001.[171] The Court rejects this argument. The hospital demonstrated that Dr. Rdzanek was never awarded a two-year renewal of staff privileges in 2001 because the letter she received was a clerical error. Even if Dr. Rdzanek had actually been granted a two-year renewal, requiring reapplication for staff privileges after a year instead of two is not an adverse action against her. Dr. Rdzanek was still able to practice with full, active medical staff privileges. Nothing in the bylaws requires that physicians must be granted two-year reappointments; two years is the maximum reappointment period, not the minimum period. Further, Dr. Rdzanek continued to practice without any reduction in privileges until the Board decision in 2003, which was more than two years after her initial reappointment application. Also, Dr. Rdzanek never asked for a review of this decision or made any complaints about it. The Court concludes that Dr. Rdzanek did not have a legally protected interest in a two-year, as opposed to one-year, reappointment. The Court therefore addresses the question of whether she received due process only in the context of the hospital's decision to reduce her staff privileges to consulting privileges.

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[171] As noted above, Stock sent Dr. Rdzanek a letter dated July 25, 2001 that indicated that the Board of Commissioners approved her privileges for a two year term, and then in October 2001, the Credentials Committee recommended renewing her privileges for only one year, and the MEC and Board approved the Credentials Committee's recommendation.

a. Substantive Due Process

Substantive due process, in cases like this one in which no fundamental right is implicated, requires that the challenged action be supportable by some legitimate goal and that the means used to achieve that goal be rational. *See Martin*, 130 F.3d at 1149. The right protects against arbitrary and capricious governmental action. *See id.*, at 1150. In the staff privileges context, the Fifth Circuit requires that the decision be "supported by substantial evidence and ... made using proper criteria, after a satisfactory hearing, on a rational basis, and without irrelevant, discriminatory and arbitrary influences." *Woodbury v. McKinnon*, 447 F.2d 839, 846 (5th Cir. 1971). The issue is "whether the standards set by the hospital authority are reasonable and whether they have been applied without arbitrariness, capriciousness or unreasonableness." *Id.* at 845. In *Woodbury*, the Fifth Circuit indicated that a court must accord great deference to the decision of a hospital's governing body concerning the granting of hospital privileges because of the court's obvious lack of medical expertise. *Id.* at 846; *see also Laje v. R.E. Thomason General Hospital*, 564 F.2d 1159, 1162 (5th Cir. 1977); *Sosa v. Board of Managers of the Val Verde Memorial Hospital*, 437 F.2d 173, 177 (5th Cir. 1971).

There is ample evidence here that the challenged action of the hospital involved the application of reasonable standards

without arbitrariness or capriciousness. The hospital has a powerful interest in the provision of quality patient care, through which it protects patient safety. *See Caine v. Hardy*, 943 F2d 1406, 1413 (5th Cir. 1991). To this end, the hospital requires its physicians to participate in its peer review process, which is designed to identify deviations from the standard of care. The standards applied in the peer review process are reasonably designed to promote the hospital's goal. Further, the plaintiff has provided no evidence that the hospital applied these standards in an arbitrary or capricious manner. The hearing panel's recommendation was based on the findings by the hospital's peer review committees, the ad hoc investigating committee, and two independent reviewers. The panel relied on competent evidence and witness testimony to reach its conclusion that Dr. Rdzanek posed a threat to patient safety. Indeed, even Dr. Rdzanek's expert physician concluded that her care necessitated oversight by the hospital. The Board of Commissioners had the same evidence before it, as well as the written and oral arguments of the parties, and it also concluded that the risk of harm to patients warranted reduction of Dr. Rdzanek's privileges. The Court finds that there was a reasonable basis for the hearing panel's recommendation and the Board of Commissioners' final decision and that the hospital's actions were not arbitrary or capricious. Indeed, the restrictions the hospital imposed on Dr. Rdzanek's privileges

reflect a decided effort to tailor the restrictions narrowly to address only the areas in which Dr. Rdzanek was shown to be professionally deficient.

Dr. Rdzanek nevertheless alleges that the defendants violated her substantive due process rights when they unfairly singled her out for review and subjected her to an inequitable and partial peer review process. First, the Court notes that Dr. Rdzanek presented no evidence that she was unfairly singled out for review. She has not shown that, under the hospital's established standards, her cases were improperly singled out for peer review. Dr. Rdzanek contends, however, that several deficiencies in the hospital's peer review process led to an unfair reduction of her privileges. The Court finds no support for her arguments in the record.

Dr. Rdzanek argues that the peer review process was unfair because she was evaluated by her competitors. She points out that the Cath Lab Committee was composed entirely of her competitors. Also, another cardiologist on staff at the hospital, Dr. Wayne Pharo, was Chairman of the MEC when her review first began. Dr. Patel, also a cardiologist, was on the Credentials Committee during the time that the committee made recommendations to the MEC regarding her reappointment application, and Dr. Hansen, who Dr. Rdzanek contends is a competitor, was on the MEC when it made adverse recommendations against her.

At the outset, the Court finds that Dr. Rdzanek has made no showing that the results of any of the committee proceedings were tainted by bias or anticompetitive animus. As noted above, she proferred no evidence that her cases were not the proper subject of peer review under the standards approved by the medical staff. Further, although it is true that the Cath Lab Committee, which often made the initial determinations of the severity levels of plaintiff's cases, consisted of Dr. Rdzanek's competitors, the multiple layers of review of the cases after the Cath Lab Committee's initial review ensured the fairness of the process. The Ad Hoc Committee reviewed these cases. Then the MEC reviewed these cases. In addition, NPRC, an outside, independent reviewer, reviewed all of the cases for which Dr. Rdzanek received Level 3's and 4's during the years 2000-2002. Moreover, Dr. Rdzanek was notified in writing and given an opportunity to respond even at the first peer review level, if the committee proposed to issue a classification of Level 3 or higher. Finally, she was given a full-blown evidentiary hearing with the assistance of counsel before a panel of physicians, none of whom was her competitor.

Additionally, when a competitor or potential competitor was on a committee that made a decision that affected Dr. Rdzanek's privileges, such as Drs. Patel or Hansen, the committee member recused himself from the interview with Dr. Rdzanek and from the

vote that affected Dr. Rdzanek.[172] Further, Dr. Pharo was not on the MEC when it appointed the Ad Hoc Committee to investigate Dr. Rdzanek's cases or made an adverse recommendation on her staff privileges.[173] Moreover, participation by competitors in the decision to revoke a physician's privileges does not amount to a *per se* due process violation. The Fifth Circuit has said as much in the context of a physician's challenge to the procedural due process he received. *See Caine*, 943 F.2d at 1413. The *Caine* Court dismissed the plaintiff's claim of bias:

> [The plaintiff's] assertion that he was the victim of partisan decisionmaking is of no moment. He is stating no more than that the risk of erroneous decision presented by the participation of his competitors in the decision to suspend his privileges was unacceptable. The *Mathews v. Eldridge* balance has, however, answered that assertion - concluding that this is a tolerable risk when compared with the state's powerful interest in protecting patient safety.

*Id.* at 1412-13 (citing *Mathews v. Eldridge*, 424 U.S. 319 (1976)).

Dr. Rdzanek also argues that the committees that reviewed her cases included physicians who were "potentially biased or improperly influenced by other physicians."[174] Dr. Rdzanek fails to present *any* evidence, however, that supports a conclusion that

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[172] *See* Defs.' Ex. 22, Credentials Committee Meeting Minutes dated Dec. 12, 2001; Pla.'s Ex. 42, Credentials Committee Meeting Minutes from Dec. 19, 2002; Defs.' Ex. 24, MEC Meeting Minutes from February 26, 2002; Pla.'s Ex. 35, MEC Meeting Minutes from Dec. 17, 2002; Pla.'s Ex. 40, MEC Meeting Minutes from Jan. 9, 2003.

[173] Def.'s Ex. 23, MEC Meeting Minutes from Jan. 10, 2002.

[174] Pla.'s Prelim. Inj. Memo., at p. 19.

any physician who reviewed her cases was biased or improperly influenced in any manner. Allegations of bias, without any evidence to support the allegations, are insufficient. *See Caine*, 943 F.2d at 1414 ("Our court has consistently held that mere conclusory allegations of bias do not render infirm otherwise constitutionally adequate procedures."); *see also Woodbury*, 447 F.2d at 844-845.

Furthermore, none of the hearing panel members had been involved in Dr. Rdzanek's peer review process before they became hearing panel members, and therefore they had not been pre-conditioned. Dr. Rdzanek removed one of the panel members because of a potential conflict.[175] The hearing officer who presided over the hearing was chosen with the consent of both parties. The hearing panel had all of the medical records before it, as well as the testimony of both Dr. Weintraub and the plaintiff's expert, Dr. Marmur. The panel also considered the testimony of the reviewing committee members, doctors and nurses directly involved in the cases, and the testimony of Dr. Rdzanek. The Court finds no indication that the hearing committee's decision was in any way biased, arbitrary, capricious or based on improper considerations.

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[175] Dr. Anne Marie Ardoin was removed from the panel. Dr. Ardoin is the daughter of Dr. Carolyn Hebert, a cardiologist who was on the active staff of the hospital at the time Dr. Ardoin was appointed to the hearing panel. *See* Defs.' Ex. 32, Letter from hospital counsel to Dr. Rdzanek's counsel dated Sep. 13, 2002.

Dr. Rdzanek also contends that the MEC improperly relied on the NPRC "case review" to make its peer review decision. She argues that the NRPC case review does not provide conclusions or recommendations regarding the practitioner and even though the NPRC warns against relying solely on its case review reports to take definitive action against a practitioner, the MEC did so when it made the adverse recommendation against her privileges.[176] The Court finds, however, that the case review was simply one of the factors, and not the sole factor, in the MEC's decision. As the minutes of the meeting at which the MEC made its first adverse recommendation state, "the NPRC *confirmed* the findings of the previous external reviewer, [the hospital] peer review committees and the ad hoc investigative committee about Dr. Rdzanek's patient care." (emphasis added)[177] Further, the letter the hospital sent to Dr. Rdzanek regarding the MEC's initial adverse recommendation clearly explains that the MEC considered all of these findings when it made its decision.[178] The Court finds Dr. Rdzanek's allegations that the MEC improperly relied on the NRPC report to be without merit.

Dr. Rdzanek also argues that Dr. Weintraub, the NPRC reviewing cardiologist, admitted that the main issue he noted

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[176] Rec. Doc. 1, Verified Complaint, ¶49.

[177] Defs.' Ex. 27, MEC Meeting Minutes from Jul. 24, 2002.

[178] Defs.' Ex. 30, Letter from Stock to Dr. Rdzanek dated Jul. 16, 2002.

"was not inappropriate care but improper documentation."[179] The record does not support this characterization of Dr. Weintraub's testimony. As described above and as he testified in the peer review hearing, Dr. Weintraub identified a number of instances in which Dr. Rdzanek exhibited a lack of medical knowledge and deviated from the standard of care. He also identified instances in which Dr. Rdzanek intervened when the patient's condition did not warrant intervention and in which she failed to consider relevant treatment alternatives. Further, he questioned her drug choice and dosage in several situations.

Dr. Rdzanek avers that, on the other hand, her expert, Dr. Marmur, concluded that her treatment of her patients is "totally acceptable."[180] On the contrary, Dr. Marmur noted several instances in which he questioned Dr. Rdzanek's approach or her drug choice or dosage. He characterized her treatment in some of the cases as aggressive and noted inconsistencies in Dr. Rdzanek's reasoning for her treatment decisions. He ultimately concluded that the problems identified in the cases warranted oversight of Dr. Rdzanek's treatment.

Based on the foregoing analysis, the Court concludes that the plaintiff has failed to demonstrate a strong likelihood of proving a substantive due process violation.

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[179] Pla.'s Memo. in Support, at p. 21.

[180] Pla.'s Memo. in Support, at p. 23.

b. Procedural Due Process

The Supreme Court held in *Mathews v. Eldridge*, 424 U.S. 319 (1976), that "'due process,' unlike some legal rules, is not a technical conception with a fixed content unrelated to time, place and circumstance. ... [D]ue process is flexible and calls for such procedural protections as the particular situation demands." *Id.* at 334-35; *see also Darlak*, 814 F.2d at 1062. The *Mathews* Court further identified three distinct factors to consider:

> 1) the private interest that will be affected by the official action; 2) the risk of an erroneous deprivation of such interest through the procedures used, and the probable value, if any, of additional or substitute procedural safeguards; and 3) the government's interest, including the function involved and the fiscal and administrative burdens that the additional or substitute procedural requirement would entail.

*Mathews*, 424 U.S. at 334-35.

The Fifth Circuit has applied the *Mathews* factors to claims of procedural due process violations in a number of cases involving the termination of medical staff privileges. *See, e.g., Caine*, 943 F.2d 1046; *Leach v. Jefferson Parish Hosp. Dist. No. 2*, 870 F.2d 300 (5th Cir. 1989); *Darlak*, 814 F.2d 1055.

In this case, Dr. Rdzanek has failed to show that she has a substantial likelihood of success in proving that her procedural due process rights were violated. First, Dr. Rdzanek challenges the pre-hearing notice she received that identified the basis of the MEC's adverse recommendation. The Supreme Court held in

*Mullane v. Central Hanover Bank & Trust Co.*, 339 U.S. 306, 314 (1950), that to satisfy the procedural due process requirements, notice must be "reasonably calculated, under all the circumstances, to apprise interested parties of the pendency of the action and afford them an opportunity to present their claims." The hospital provided Dr. Rdzanek with ample notice before the hearing, and she had a fair opportunity to present her case. The MEC made its adverse recommendation in July of 2002, and the hearing on the recommendation did not begin until January 2003. During that time, the hospital sent Dr. Rdzanek numerous letters that listed the cases that formed the basis for the MEC's recommendation. In response to Dr. Rdzanek's contention that the notice she received was unclear, the hospital provided an additional listing of the cases at issue that identified each case by patient name, account number, admit date, and the various case numbers assigned by each reviewer, *i.e.*, the hospital peer review committees, the ad hoc committee, and the outside reviewers. Further, the Ad Hoc Committee interviewed Dr. Rdzanek on all of these cases except the C.S. case, and she had already presented most of the cases to a peer review committee before the Ad Hoc Committee investigation. Moreover, Dr. Rdzanek had access to the medical records of the patients, and the six months between the adverse recommendation and the hearing provided her ample opportunity to review them.

Dr. Rdzanek also contends that the consolidation of the

hearings on the first and second recommendations prejudiced her. To begin with, the Court notes that at the January 14, 2003 hearing session, Dr. Rdzanek requested consolidation of the hearings and now argues that the consolidation prejudiced her. More importantly, Dr. Rdzanek has provided no evidence of prejudice. The MEC made its second adverse recommendation in January 2003, and after she requested a hearing on the recommendation, the hearing resumed on a consolidated basis in March 2003. Dr. Rdzanek therefore had two months to prepare for the consolidation and presentation of the last case. Dr. Rdzanek attended the January 9, 2003 MEC meeting to present information on the last case, and thus she clearly had notice of the MEC's concerns and the basis for its decision to recommend termination of her privileges.

Dr. Rdzanek contends that she did not have a meaningful opportunity to present her case because the hearing officer unfairly limited her presentation. The Court finds that the Dr. Rdzanek's arguments lack merit. The hearing officer imposed the burden of justifying its recommendations on the MEC. The hearing panel met on eight different occasions to hear testimony, and the parties submitted evidence and written statements to the panel. The MEC presented seven witnesses over four and one-half of the hearing sessions, and Dr. Rdzanek presented six witnesses over the remaining three and one-half sessions. The hearing officer allowed Dr. Rdzanek to present relevant evidence and testimony

and cut her off only when he determined that the proffered evidence was irrelevant to the issues before the panel. Dr. Rdzanek contends that the hearing officer unfairly limited her cross-examination of the Quality Resource Manager, Nurse Rodrigue. The hearing panel was charged with consideration of the MEC's two recommendations that were based on the findings the hospital peer review committees, the ad hoc committee, and the outside reviewers. Nurse Rodrigue was not a decision maker on any of those committees. She prepared the charts for review by the peer review committees, and each physician committee made the ultimate decision and recommendation on the case based on its detailed review. There is no indication that the peer review committees relied on Rodrigue's analysis of any issue. Limitation of Dr. Rdzanek's cross-examination of Nurse Rodrigue did not materially impact her ability to present her case to the hearing panel. Dr. Rdzanek also contends that the hearing officer unfairly postponed the hearing session at which her expert, Dr. Marmur, was scheduled testify, which precluded Dr. Marmur from testifying in person. Dr. Marmur instead testified via video conference. The Court fails to see how presentation of her expert witness via video conference materially prejudiced the presentation of her side of the case. Moreover, the Court notes that the physician expert presented by the MEC, Dr. Weintraub, testified remotely at two of the three sessions at which he testified. Dr. Rdzanek also asserts that the hearing officer

unfairly excluded information from the NPRC website that demonstrated that the NPRC was biased in favor of hospitals and against practitioners. Plaintiff fails to show, however, how the information to which she refers was not duplicative of the information contained in the introduction to the NPRC report.

Dr. Rdzanek contends that she had presented only two witnesses to the panel when the hearing officer limited her to one more night of testimony, placed time limits on the testimony, and set the order of witness presentation. First, by the end of the seventh session, Dr. Rdzanek had presented four witnesses plus a full session of her own testimony. In addition, the time limitations imposed by the hearing officer were based on counsels' best estimate of the amount of time required to present the testimony of the remaining witnesses. Also, the hearing officer placed no limits on the time for questions of the witness from the panel members. At the preliminary injunction hearing in this matter, Dr. Rdzanek could not identify any testimony that she would have presented in the absence of the imposed time limits. Finally, the Court finds that the hearing officer's requirement that Dr. Rdzanek complete the testimony that she had begun at the previous session before she presented Dr. Marmur's testimony did not materially impair her ability to present her case to the panel.

Dr. Rdzanek also asserts that her appeal to the Board of Commissioners was insufficient. The Court again finds her

allegations to be without merit. The parties submitted written statements to the Board, and the Board permitted each side 20 minutes each to argue its respective position orally. The Board also had access to the full hearing record. Dr. Rdzanek contends that written argument is insufficient when credibility and veracity are at issue. Presentation of witnesses to the Board, however, would effectively convert the appeal into another full hearing, which due process does not require in light of the opportunity Dr. Rdzanek had to present her case to the hearing panel.

The Court's finding is consistent with Fifth Circuit precedents in which the Court rejected procedural due process claims arising from reductions in medical staff privileges. *See, e.g., Caine*, 943 F.2d 1046; *Leach*, 870 F.2d 300; *Darlak*, 814 F.2d 1055. Further, these cases involved plaintiffs who had greater interests at stake but who received less due process than Dr. Rdzanek received. For example, in *Darlak*, a public hospital temporarily suspended the plaintiff's privileges before it conducted a full investigation and held a hearing before the hospital's Credentials Committee. *See Darlak*, 814 F.2d at 1057. The committee then took evidence and allowed the plaintiff to make a statement at a hearing, after which the committee recommended that the hospital suspend the physician's privileges for two months. *See id.* The Court analyzed the three *Mathews* factors and found that the physician received all the process

that was due to him in connection with both his initial and subsequent suspensions. *See id.* at 1065.

On the issue of the plaintiff's interim suspension, the *Darlak* Court found that the private interest at stake was relatively minor compared to the state's interest in maintaining the quality of medical care at the hospital. *Id.* at 1063. The Court found that the interim suspension did not affect the plaintiff's ability to continue to practice medicine, albeit not at that hospital, and the plaintiff therefore was not deprived of his livelihood. *Id.* The hospital's procedures for the interim suspension were adequate because after the hospital received a complaint against the plaintiff, but before it temporarily suspended him, the hospital interviewed the physicians that made the allegations, the patient's primary care physicians and the plaintiff. The Fifth Circuit held that these procedures "served to minimize, as much as possible, the risk of erroneous deprivation." *Id.* The Court concluded that, even though he did not received advance notice of the interview, the physician's due process rights were not violated by the interim suspension. *Id.* The Court found that plaintiff's interest increased when the hospital suspended him for two months because the potential deprivation was for a longer period and could result in a permanent blemish on his record. *Id.* The state's interest in providing quality medical care to its patients, on the other hand, remained the same. *Id.* The Court held that the additional

procedures employed by the hospital appropriately accommodated the plaintiff's increased private interest. *Id.* The hospital conducted a full investigation and the physician was given an opportunity to respond before the committee. *Id.* The hospital provided an appeal process, but the plaintiff chose not to utilize it and filed suit instead. The Court concluded that the brief hearing at which the hospital Credentials Committee took evidence and permitted the plaintiff to make a statement afforded the physician sufficient due process before his staff privileges were completely suspended for two months.

The Fifth Circuit reached a similar result in the *Caine* case, in which a hospital suspended a physician's privileges after an investigation of the death of one his patients, but before a formal hearing was held. *Caine*, 943 F.2d at 1407. To investigate the claim, the hospital formed an Ad Hoc Committee that reviewed the treatment of the patient in question and met with the plaintiff on two occasions for a total of three hours. After review of the Ad Hoc Committee's recommendation, the hospital's Executive Committee suspended the plaintiff's privileges but offered him an opportunity to reapply for privileges after completion of certain requirements. The hospital's medical staff bylaws gave the plaintiff the right to a formal post-suspension hearing before an ad hoc hearing committee and an appeal to the hospital's Board of Trustees, but he declined to participate in the hospital's post-suspension

procedures. The physician asserted that he had insufficient notice of the two meetings with the Ad Hoc Committee and that he did not have sufficient access to the patient's chart at issue. He also alleged that all the decisionmakers in his case were biased due to their self-interest or by the gossip campaign mounted against him. *Id.* at 1409. Nevertheless, the Court upheld the district court's conclusion that the physician received sufficient pre-suspension due process when an investigation was conducted. *Id.* at 1406. The Court rejected the argument that the presence of competitors biased the process and noted that the hospital had "no constitutional duty to provide a procedural regimen that guarantees faultless decisionmaking; the state's interests in safety and efficiency find expression in the tolerable level of risk." *Id.* at 1413. *See also Leach*, 870 F.2d at 302 (finding hospital procedures that provided for a hearing and an appeal after summary suspension of physician's privileges to be constitutionally adequate).

In this case, Dr. Rdzanek's staff privileges were reduced to consulting privileges for a year but were not completely suspended, as they were for the plaintiffs in *Darlak, Caine* and *Leach*. Furthermore, Dr. Rdzanek was afforded a full hearing and appeal *before* the reduction of her privileges to consulting privileges took effect. Thus, Dr. Rdzanek received significantly more due process than the plaintiffs in the cited cases. Moreover, unlike the physicians in these cases, Dr. Rdzanek was

allowed to object to the composition of the hearing panel and the hearing officer. Further, Dr. Rdzanek was represented by counsel at her hearing. The hearing panel convened on eight separate occasions to hear testimony and argument and receive evidence. At the hearing, Dr. Rdzanek presented argument in the form of an opening statement, presented witnesses and evidence, cross-examined witnesses offered by the MEC and submitted a written statement to the panel at the conclusion of the hearing. In her appeal to the hospital's Board, Dr. Rdzanek submitted a written statement and presented oral argument to the Board, and the Board had before it the extensive record from the hearing. Further, the many layers of review of Dr. Rdzanek's case before the hearing and appeal process, through which she was given ample opportunity to respond to the reviewers regarding the patients in question, all served to further minimize the risk of erroneous deprivation of Dr. Rdzanek's privileges. Based on the foregoing, the Court concludes that the plaintiff has failed to show a strong likelihood of proving a procedural due process violation.

*ii. Some Likelihood of Success*

Plaintiff cites *Canal Auth. of the State of Fla. v. Callaway*, for the proposition that she need show only "some" likelihood of success on the merits if she makes a strong showing of the other three requirements for a preliminary injunction. *See* 489 F.2d 567, 575-76 (5th Cir. 1974). The Court's findings above, however, lead it to the conclusion that the plaintiff has

also failed to show some likelihood of success on the merits.

The plaintiff has the burden of proving all four requirements for preliminary injunctive relief, and because the plaintiff failed to prove the first element, the Court need not reach the remaining three elements. Out of an abundance of caution, however, the Court considers them below.

*iii. Remaining Preliminary Injunction Requirements*

Plaintiff contends that there is a substantial threat that she will suffer irreparable injury if the Court denies her preliminary injunction application. As described above, plaintiff contends that the reduction in her staff privileges effectively forecloses her ability to continue her practice. Even assuming *arguendo* that plaintiff will suffer irreparable harm, plaintiff has failed to show that this threatened harm to her outweighs any damage to the defendants and that the injunction is in the public interest. The hospital has a powerful interest in protecting the public by providing quality medical care to its patients. The hospital reduced Dr. Rdzanek's privileges because it identified several concerns regarding the care that Dr. Rdzanek provided. The hospital found her medical judgment to be lacking and that as a result, she placed patient's safety at risk. The Court affords appropriate deference to the hospital's medical judgment in this regard, and based on the evidence before it, the Court is not in a position to dispute the hospital's determination that Dr. Rdzanek presents a threat to

patient safety. *Cf. Samuel v. Herrick Memorial Hosp.*, 201 F.3d 830, 836-37 (6th Cir. 2000); *Everett v. Franciscan Sisters Healthcare, Inc.*, 882 F.2d 1383, 1386-87 (8th Cir. 1989). Accordingly, the balance of harms weighs in favor of denial of the preliminary injunction.

For the foregoing reasons, the Court denies plaintiff's preliminary injunction application.

**III. Partial Motion to Dismiss**

Defendants move this Court to dismiss the Section 1983 claim against them for failure to state a claim and to dismiss the Board of Commissioners and the MEC pursuant to Federal Rule of Civil Procedure 17(b).

**A. Section 1983 Claim**

*i. Legal Standard*

In a motion to dismiss for failure to state a claim under Rule 12(b)(6), the Court must accept all well-pleaded facts as true and view the facts in the light most favorable to the plaintiff. *See Baker v. Putnal*, 75 F.3d 190, 196 (5th Cir. 1996); *American Waste & Pollution Control Co. v. Browning-Ferris, Inc.*, 949 F.2d 1384, 1386 (5th Cir. 1991). The Court must resolve doubts as to the sufficiency of the claim in plaintiff's favor. *See Vulcan Materials Company v. City of Tehuacana*, 238 F.3d 382, 387 (5th Cir. 2001). Dismissal is warranted if it appears certain that the plaintiff cannot prove any set of facts

in support of her claim that would entitle her to relief. *Id.*; *Piotrowski v. City of Houston*, 51 F.3d 512, 514 (5th Cir. 1995) (quoting *Leffall v. Dallas Indep. Sch. Dist.*, 28 F.3d 521, 524 (5th Cir. 1994)).

*ii. Analysis*

Defendant argues that the plaintiff is unable as a matter of fact to establish that the temporary restrictions on her medical staff privilege imposed by the defendants adversely affects her ability to earn a living. Defendant also alleges that plaintiff's allegations are, as a matter of law, insufficient to state a cognizable claim under 42 U.S.C. § 1983.

Plaintiff contends that the reduction in her staff privileges from active to consulting privileges effectively forecloses her ability to practice in the Thibodaux area and that the defendants therefore deprived her of a liberty interest. *See Martin*, 130 F.3d at 1149. She asserts that the defendants failed to provide her with adequate substantive or procedural due process in connection with this deprivation. Dr. Rdzanek alleges that the defendants violated her substantive due process rights because they unfairly singled her out for peer review, and she identifies several aspects of her peer review process which she contends were inherently biased and inequitable. Dr. Rdzanek also asserts that the defendants failed to provide her with reasonable notice of the charges against her and a fair opportunity to be heard regarding those charges before an

unbiased panel and thus violated her procedural due process rights.

Notwithstanding the Court's conclusion that the plaintiff has not shown a substantial likelihood of success on the merits of her Section 1983 claim, the Court finds that the plaintiff has stated a claim. Viewing the facts in the light most favorable to the plaintiff, the Court cannot conclude that there exists no set of facts that the plaintiff can prove to support her claim. The Court therefore denies defendants' motion to dismiss plaintiff's Section 1983 claim.

**B. The Board of Commissioners and the MEC**

The Court will rule on the defendant's motion to dismiss the Board of Commissioners and the MEC under Rule 17(b) in a separate order.

**IV. Conclusion**

For the foregoing reasons, the Court denies plaintiff's preliminary injunction application and denies the defendants' motion to dismiss the plaintiff's Section 1983 claim. The Court will rule on the defendant's motion to dismiss under Rule 17(b) in a separate order.

New Orleans, Louisiana, this 15th day of January, 2004.

Sarah Vance

SARAH S. VANCE
UNITED STATES DISTRICT JUDGE