ATTORNEYS FOR APPELLANT

Craig R. Patterson
Megan M. Torres
Beckman Lawson, LLP
Fort Wayne, Indiana

ATTORNEYS FOR APPELLEE

Lyle R. Hardman
Hunt Suedhoff Kearney LLP
South Bend, Indiana

Michelle K. Floyd
Kathryn R. Yarnelle
Hunt Suedhoff Kearney LLP
Fort Wayne, Indiana

IN THE COURT OF APPEALS OF INDIANA

Bhaktavatsala R. Apuri, M.D.,
Appellant-Plaintiff,

v.

Parkview Health System, Inc., Parkview Hospital, Inc., and Roy Robertson, M.D.,
Appellees-Defendants.

February 21, 2022

Court of Appeals Case No. 21A-PL-591

Appeal from the Allen Superior Court

The Honorable David J. Avery, Judge

Trial Court Cause No. 02D01-1903-PL-112

Molter, Judge.

[1] Appellant-Plaintiff Dr. Bhaktavatsala R. Apuri, M.D. sued Appellees-Defendants Parkview Health System, Inc., Parkview Hospital, Inc., and Dr. Roy Robertson, M.D. for claims based on the non-renewal of his hospital

privileges, alleging breach of contract, intentional interference with a business relationship, and intentional interference with a contract. The trial court determined Appellees were immune from suit under the Health Care and Quality Improvement Act ("Act"), 42 U.S.C. §§ 11101–11152, and therefore granted their motion for summary judgment. We affirm.

Facts and Procedural History

[2] Dr. Apuri is a cardiologist who practices medicine in Fort Wayne, Indiana. He maintained privileges at all Fort Wayne area hospitals, including privileges at Parkview Hospital from 2001 to October 15, 2014. But on that date, Parkview Hospital decided not to renew his privileges.

[3] That decision stemmed from events dating back to at least 2012, when Parkview Hospital's quality department documented various complaints against Dr. Apuri concerning his failure to respond to pages and phone calls, his failure to round on patients, and his poor communication with nursing staff. Due to these complaints, Parkview Hospital staff began informal collegial intervention. After those complaints continued, formal collegial intervention began, and Dr. Apuri responded to these processes by offering to reduce his caseload.

[4] Next, in 2013, Parkview Hospital's quality department documented more complaints involving Dr. Apuri. These occurred throughout the year and included: failing to round on patients in a timely manner (sometimes for more than twenty-four hours and including critical patients); failing to complete admission orders, transfers, or discharge summaries on time; failing to respond

to pages, phone calls, or nursing inquiries; failing to notify patients or hospital staff of imminent medical procedures; and failing to apply certain medical devices during procedures.

[5] Also, on February 22, 2013, and March 29, 2013, letters were sent to Dr. Apuri noting concerns from the nursing staff regarding his failure to round on two patients (including one that was in critical condition) and to enter proper patient documentation. Appellant's App. Vol. 6 at 21–22. As a result of these concerns, Dr. Apuri appeared before the relevant Parkview Hospital personnel, and was placed on 100% chart review. *See id.* at 23.

[6] At a staff meeting in May 2013, relevant hospital personnel addressed their concerns about Dr. Apuri's practice. Appellant's App. Vol. 13 at 121. Dr. Robertson, Medical Director of Parkview Hospital's Cardiac Catheterization Lab, was invited to speak at the meeting to discuss concerns involving Dr. Apuri's performance. *Id.*; Appellant's App. Vol. 7 at 91–94. After his presentation, Dr. Robertson was excused from the meeting, and the remaining staff decided whether to investigate Dr. Apuri's practice. *See* Appellant's App. Vol. 7 at 92. Dr. Apuri was soon informed of this decision, and an Inquiry Body met in July 2013. *See* Appellant's App. Vol. 5 at 60.

[7] The Inquiry Body recommended: (1) Dr. Apuri must submit to mental and physical evaluation to help him improve practice management and his personal accountability; and (2) 100% chart review must be continued, and noncompliance must be taken seriously. Appellant's App. Vol. 6 at 31. Dr.

Apuri was twice warned that noncompliance (including failure to adhere to staff bylaws) could lead to the revocation of his hospital privileges. *Id.* at 25–27.

[8] Moving forward to 2014, Parkview Hospital's quality department documented at least fourteen more incidents where Dr. Apuri failed to round on his patients or communicate promptly. Consequently, on October 15, 2014, Parkview Hospital's Medical Staff Executive Committee decided not to renew Dr. Apuri's hospital privileges. The Ad Hoc Committee held a hearing in early 2015, and one committee member was replaced at Dr. Apuri's request. Additionally, at the hearing, Dr. Apuri was represented by counsel, presented his own witnesses (including an expert witness), and cross-examined witnesses.

[9] The Ad Hoc Committee, on March 25, 2015, upheld Parkview Hospital's non-renewal of Dr. Apuri's privileges. It made several findings (including late rounding and communication problems) and concluded that "Dr. Apuri's professional and clinical judgment . . . put patients at risk and [w]as . . . below Parkview Hospital's standards." Appellant's App. Vol. 4 at 105–08. Further, it noted:

> In its deliberations, the [Ad Hoc] Committee grappled with the question of whether Dr. Apuri's pattern of unprofessional conduct did actually support the drastic recommendation to deny his privileges. Some members expressed reservations about such a severe consequence for Dr. Apuri. However, the [Ad Hoc] Committee ultimately concluded that Dr. Apuri had been given two years' worth of chances to correct his professional conduct issues, which were laid out very clearly for him by Hospital and Medical Staff leadership, but he refused to fully address those

> issues and will likely continue to do so in future years, which continues to put patients at risk.

Id. at 108. Dr. Apuri appealed the Ad Hoc Committee's determination. But, after considering Dr. Apuri's written and oral arguments and the evidence presented, the Appellate Review Committee of the Parkview Hospital Board of Directors upheld the non-renewal of Dr. Apuri's hospital privileges.

[10] Next, on October 14, 2016, Dr. Apuri sued Appellees in the United States District Court for the Northern District of Indiana, raising a federal claim and various state claims. His federal claim was for the violation of his civil rights, alleging race discrimination in violation of 42 U.S.C. § 1981. The District Court granted summary judgment for Appellees and dismissed Dr. Apuri's state claims without prejudice.

[11] Dr. Apuri then filed a state court complaint initiating the lawsuit here in March 2019. He asserted claims for the non-renewal of his hospital privileges, breach of contract, intentional interference with a business relationship, and intentional interference with a contract. Appellees later moved for summary judgment, and the trial court granted their request. Relevant here, the trial court determined Appellees were immune from suit based on the Health Care and

Quality Improvement Act,[1] and therefore entitled to judgment as a matter of law. Dr. Apuri now appeals.

Decision and Discussion

I. Standard of Review

[12] When reviewing a summary judgment motion, we apply the same standard as the trial court. *David v. Kleckner*, 9 N.E.3d 147, 149 (Ind. 2014). Summary judgment is proper only when the designated evidence shows there is no genuine issue of material fact and the moving party is entitled to judgment as a matter of law. *Id.* All facts and reasonable inferences from the designated evidence are construed in favor of the nonmovant. *Id.* "Whether a defendant is entitled to immunity under the [Act] is a question of law for the court to decide." *W.S.K. v. M.H.S.B.*, 922 N.E.2d 671, 690 (Ind. Ct. App. 2010).[2]

II. Immunity Under the Act

[13] When enacting the Health Care and Quality Improvement Act, Congress' statutory findings included that "[t]he increasing occurrence of medical malpractice and the need to improve the quality of medical care have become nationwide problems that warrant greater efforts than those that can be

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[1] Indiana has a version of the Act — the Indiana Peer Review Act, Ind. Code §§ 34-30-15-1 through -23. However, Dr. Apuri's Appellant's Brief does not argue any separate error under our state statute, so our review is confined to the federal statute.

[2] While our review is *de novo*, it is significantly aided by the thoughtful analysis in the exceptionally thorough opinion issued by the trial court here.

undertaken by any individual State"; that this "nationwide problem can be remedied through effective professional peer review"; and that "[t]here is an overriding national need to provide incentive and protection for physicians engaging in effective professional peer review." 42 U.S.C. § 11101(1), (3) & (5). With that in mind, the Act provides "a professional review body" "shall not be liable in damages under any law of the United States or of any State" for a "professional review action" (except that there may be liability for civil rights claims). 42 U.S.C. § 11111(a)(1); *W.S.K.*, 922 N.E.2d at 689. The immunity covers not only the professional review body, but also "(1) any person acting as a member or staff to the body, (2) any person under a contract or other formal agreement with the body, and (3) any person who participates with or assists the body with respect to the action." *Graves v. Indiana Univ. Health*, 32 N.E.3d 1196, 1210 (Ind. Ct. App. 2015); 42 U.S.C. § 11111(a)(1).

[14] A "professional review action" is:

> [A]n action or recommendation of a professional review body which is taken or made in the conduct of professional review activity, which is based on the competence of professional conduct of an individual physician (which conduct affects or could affect adversely the health or welfare of a patient or patients), and which affects (or may affect) adversely the clinical privileges, or membership in a professional society, of the physician. Such term includes a formal decision of a professional review body not to take an action or make a recommendation described in the previous sentence and also includes professional review activities relating to a professional review action.

42 U.S.C. § 11151(9). It is undisputed that all of these elements of the statutes are satisfied here—Dr. Apuri is suing defendants involved in a professional review body for professional review actions.

[15] However, for immunity to attach, the review action must have been taken:

> (1) in the reasonable belief that the action was in the furtherance of quality health care,
>
> (2) after a reasonable effort to obtain the facts of the matter,
>
> (3) after adequate notice and hearing procedures are afforded to the physician involved or after such other procedures as are fair to the physician under the circumstances, and
>
> (4) in the reasonable belief that the action was warranted by the facts known after such reasonable effort to obtain facts and after meeting the requirement of paragraph (3).

42 U.S.C. § 11112(a). "A professional review action shall be presumed to have met the preceding standards necessary for the protection set out in section 11111(a) of this title unless the presumption is rebutted by a preponderance of the evidence." *Id.*

[16] The only requirement in section 11112(a) Dr. Apuri challenges is the third one—adequate notice and hearing procedures. Because he did not designate evidence of a material factual dispute over whether he can overcome the presumption of adequate notice and hearing procedures, the trial court was correct to grant summary judgment against him.

III. Adequate Notice and Hearing Procedures

[17] "A health care entity is deemed to have met" the adequate notice and hearing procedures requirement "if the following conditions are met (or are waived voluntarily by the physician)":

> **(1) Notice of proposed action**
>
> The physician has been given notice stating--
>
> (A)(i) that a professional review action has been proposed to be taken against the physician,
>
> (ii) reasons for the proposed action,
>
> (B)(i) that the physician has the right to request a hearing on the proposed action,
>
> (ii) any time limit (of not less than 30 days) within which to request such a hearing, and
>
> (C) a summary of the rights in the hearing under paragraph (3).
>
> **(2) Notice of hearing**
>
> If a hearing is requested on a timely basis under paragraph (1)(B), the physician involved must be given notice stating--
>
> (A) the place, time, and date, of the hearing, which date shall not be less than 30 days after the date of the notice, and
>
> (B) a list of the witnesses (if any) expected to testify at the hearing on behalf of the professional review body.
>
> **(3) Conduct of hearing and notice**
>
> If a hearing is requested on a timely basis under paragraph (1)(B)--

(A) subject to subparagraph (B), the hearing shall be held (as determined by the health care entity)--

(i) before an arbitrator mutually acceptable to the physician and the health care entity,

(ii) before a hearing officer who is appointed by the entity and who is not in direct economic competition with the physician involved, or

(iii) before a panel of individuals who are appointed by the entity and are not in direct economic competition with the physician involved;

(B) the right to the hearing may be forfeited if the physician fails, without good cause, to appear;

(C) in the hearing the physician involved has the right--

(i) to representation by an attorney or other person of the physician's choice,

(ii) to have a record made of the proceedings, copies of which may be obtained by the physician upon payment of any reasonable charges associated with the preparation thereof,

(iii) to call, examine, and cross-examine witnesses,

(iv) to present evidence determined to be relevant by the hearing officer, regardless of its admissibility in a court of law, and

(v) to submit a written statement at the close of the hearing; and

(D) upon completion of the hearing, the physician involved has the right--

(i) to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations, and

(ii) to receive a written decision of the health care entity, including a statement of the basis for the decision.

42 U.S.C. § 11112(b). The "failure to meet the conditions described in this subsection shall not, in itself, constitute failure to meet" the adequate notice and hearing procedures requirement. *Id.*

[18] Dr. Apuri believes there are three reasons the trial court was wrong to conclude that the adequate notice and hearing procedures requirement was deemed satisfied. We disagree as to each.

A. Requested Information

[19] Dr. Apuri's first basis for arguing the requirement for adequate notice and hearing procedures should not be deemed satisfied is that he did not receive all the information he requested before the hearing. Specifically, he designated his own testimony that he requested, but did not receive, nursing staff communications records, other cardiologists' patient charts, and panel members' employment contracts. Appellant's Br. at 14, 24–25. This argument fails.

[20] To begin with, Dr. Apuri does not identify which aspect of section 11112 was allegedly violated by the failure to produce these documents. Presumably, this argument relates to his right "to present evidence *determined to be relevant by the hearing officer*." 42 U.S.C. § 11112(b)(3)(C)(iv) (emphasis added). But as Appellees explain in their brief—and Dr. Apuri ignores this in his reply brief—he does not point to anything in the record suggesting the evidence was determined to be relevant by the hearing officer. Appellee's Br. at 26.

[21] That is especially important because it is not even clear which documents Dr. Apuri contends he needed. His designation is to the transcript discussion of his pre-hearing requests, but that discussion also includes an explanation that some of these records were provided to him, some were unavailable, and some were considered confidential. Appellant's App. Vol. 13 at 105. He also complains that he did not receive information related to the compensation for members of the Ad Hoc Committee which he thought might show a potential conflict of interest, but he acknowledges he received that information through discovery in this litigation, Appellant's Br. at 13, and as discussed below, that information does not reveal that the members are direct economic competitors, as Dr. Apuri contends.

[22] Lastly, Dr. Apuri does not respond to the reasons Appellees contend whatever unidentified documents Dr. Apuri failed to receive were irrelevant, or at least immaterial. They point out this information was never reviewed by the Medical Staff Executive Committee who initially made the recommendation to not renew Dr. Apuri's privileges; the charts of other physicians' patients were not comparative with respect to the issues before the committee; Dr. Apuri admitted his late rounding, delayed charting, and communication issues which gave rise to his peer review process and non-renewal; and even if there were medical errors in other cardiologists' patient charts it would be immaterial to this peer review process because it focused on recidivism for quality issues related to late rounding, delayed charting, and communication. Besides failing to address this argument, Dr. Apuri does not explain how he was prejudiced by

these unavailable documents considering his other opportunities to present his own evidence and cross-examine witnesses.

B. Direct Economic Competition

[23] Dr. Apuri next argues the requirement for fair notice and hearing procedures should not be deemed satisfied because the hearing was not "before a panel of individuals who are appointed by the entity and are not in *direct economic competition* with the physician involved." 42 U.S.C. § 11112(b)(3)(A)(iii) (emphasis added). He is a cardiologist, and he concedes that none of the members of the Ad Hoc Committee were cardiologists. Appellant's Br. at 26 n.10. But he argues they were competitors nonetheless because three of the five members of the Ad Hoc Committee were employees of Parkview Physicians Group, and a portion of the incentive compensation for those members is based on the overall growth of the Parkview Physicians Group, which includes cardiologists.

[24] Specifically, "[t]he System incentive is 1.25% of the 5% incentive compensation for salary-based physicians and 2.5% of the 10% compensation for productivity-based 'Group A' physicians." Appellant's Br. at 28 n.11 (emphasis removed). Moreover, these members may benefit from the Group's referral resources. So, as Dr. Apuri sees it, it is possible that when he lost his privileges, some portion of his patients at Parkview Hospital could go to one or more cardiologists in the Parkview Physicians Group; that might increase the Group's growth; and that growth could increase incentive compensation for even the non-cardiologists in the Parkview Physicians Group.

[25] This argument fails because the type of potential competition Dr. Apuri identifies is *indirect*, and what the statute prohibits is participation by someone who is "in *direct* economic competition with the physician involved." 42 U.S.C. § 11112(b)(3)(A)(iii) (emphasis added). Dr. Apuri is not arguing that the non-renewal of his medical privileges presented an opportunity for members on the Ad Hoc Committee to take his patients, which is what would make them direct competitors. *See, e.g.*, *Direct*, Black's Law Dictionary (11th ed. 2019) (defining "direct" as "immediate"). Instead, he argues that the non-renewal of his privileges means there may be an opportunity for other cardiologists—who are not members of the committee—to gain access to his patients; those other cardiologists might be affiliated with the Parkview Physicians Group; their new relationship with these patients might grow their practice; and that practice growth might result in some increase to the incentive compensation of three of the members on the Ad Hoc Committee.

[26] Illustrating how attenuated this connection is, Dr. Apuri notes that he is admitted in every hospital in Fort Wayne, Appellant's Br. at 6, and there were 250 physicians employed by the Parkview Physicians Group at the relevant time, *id.* at 12. So, the effect of Dr. Apuri's Parkview Hospital patients on the overall growth of the Group—or more precisely, on the roughly 1-2% incentive compensation—would have to be infinitesimal, and Dr. Apuri does not designate any evidence suggesting otherwise.

[27] In short, if the growth incentive makes committee members economic competitors of Dr. Apuri, they are only indirect competitors at most.

C. Medical Staff Bylaws

[28] Dr. Apuri further contends that the peer review process was procedurally unfair under the Act because the Ad Hoc Committee's report and recommendation was untimely under the Medical Staff Bylaws. This argument fails for three reasons.

[29] First, the Act provides that a health care entity is deemed to have met the adequate notice and hearing procedures requirement if "upon completion of the hearing, the physician involved has the right" "to receive the written recommendation of the arbitrator, officer, or panel, including a statement of the basis for the recommendations" and "to receive a written decision of the health care entity, including a statement of the basis for the decision." 42 U.S.C. § 11112(b)(3)(D). Dr. Apuri does not point us to a provision in the Act providing that the adequate notice and hearing requirement is not deemed satisfied if a panel's report and recommendation is late under the Medical Staff Bylaws.

[30] Second, Dr. Apuri's designated evidence does not support his argument. In his Appellant's Brief he points to his designation of the Medical Staff Bylaws, which required that within ten days after final adjournment of the hearing the Ad Hoc Committee was required to submit a written report and recommendation to the Medical Staff Executive Committee. Appellant's Br. at 32; Appellant's Conf. App. Vol. 12 at 218. The Committee's final adjournment occurred on March 16, 2015, and its decision was submitted on March 25, 2015—nine days after final adjournment. Appellant's App. Vol. 3 at 233–35; Appellant's App. Vol. 4 at 105–08. Thus, Dr. Apuri's argument fails because

the Ad Hoc Committee's report and recommendation was timely under the Medical Staff Bylaws.

[31] Third, even if February 27, 2015—the date Dr. Apuri points to—was the final adjournment date, and even if the report and recommendation was a few days late, Dr. Apuri does not explain how a slightly overdue report and recommendation would have deprived him of adequate notice and fair hearing procedures.

IV. Claims Against Dr. Robertson

[32] Lastly, Dr. Apuri makes a brief argument that summary judgment on his claims against Dr. Robertson for intentional interference with a business relationship and intentional interference with a contract was inappropriate because those claims originated outside the context of the peer review process and were therefore not subject to immunity. We disagree.

[33] Dr. Apuri argues "Dr. Robertson's participation in the peer review process *must have* begun with *casual discussion* outside of official channels." Appellant's Br. at 37 (emphasis added). He reasons that meeting minutes from a staff meeting "indicated [that] Dr. Robertson was a cardiologist [who] '[wanted] to meet with the officers to provide . . . information regarding Dr. Apuri's performance.'" *Id.* But the meeting minutes which Dr. Apuri designated state that "the *cardiologists* [wanted] to meet with [the] Officers to provide additional information regarding Dr. Apuri's performance." Appellant's App. Vol. 13 at 121 (emphasis added). The minutes also state that Dr. Robertson, who was the Medical Director of

Parkview Hospital's Cardiac Catheterization Lab, was *invited* to speak at the Medical Staff Officers' meeting in question. Appellant's App. Vol. 7 at 91–94; Appellant's App. Vol. 13 at 121. And Dr. Apuri was placed on 100% chart review a month before Dr. Robertson was invited to speak at the Medical Staff Officers meeting. Appellant's App. Vol. 5 at 57; Appellant's App. Vol. 6 at 23.

[34] Further, Dr. Apuri contends that his claims against Dr. Robertson originated outside the peer review process because the two physicians had an argument in 2010, which was at least two years before the peer review process began. He explains that this disagreement and the meeting minutes "infer[ ] that Dr. Robertson had made his opinion of Dr. Apuri known to others [before and] outside of the peer review process." Appellant's Br. at 37. But Dr. Apuri's allegations merely reflect conjecture, and "guesses, supposition and conjecture are not sufficient to create a genuine issue of material fact to defeat summary judgment.'" *Beatty v. LaFountaine*, 896 N.E.2d 16, 20 (Ind. Ct. App. 2008) (internal quotation marks omitted).

[35] In sum, Appellees were immune from suit for Dr. Apuri's claims, and the trial court therefore correctly concluded that Appellees were entitled to judgment as a matter of law.

[36] Affirmed.

Vaidik, J., and May, J., concur.